# CONROE FAMILY MEDICINE RESIDENCY PROGRAM
# RESIDENT POLICY MANUAL

## 2020 - 2021

## "RULES OF THE ROAD"

**Prepared: 8/24/20**

## RESIDENCY RULE CHANGES

In order to avoid inconsistent application of regulations, all changes are to be subject to approval by the full core faculty. The Program 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 distributed within 10 working days for all residents and faculty.

Residents are encouraged to suggest changes to the rules if the change would benefit the mission of the residency. Suggestions may be made to the chief resident(s) who can then present the ideas to the Program Director during scheduled Program Evaluation Committee (PEC) meetings, and/or Faculty Meetings.

*TABLE OF CONTENTS*

## A. ABFM DEFINITION OF FAMILY MEDICINE

Family medicine is the medical specialty which provides continuing, comprehensive health care for the individual and family. It is a specialty in breadth that integrates the biological, clinical and behavioral sciences. The scope of family medicine encompasses all ages, both sexes, each organ system and every 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 scholarly activity by faculty, residents, and family physicians in 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, and 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 to 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. The minimum number or even recommended numbers DO NOT guarantee that the resident will be granted privileges at their institutions after graduation. It is the resident's responsibility to contact those institutions and to meet their requirements. 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, and be able to perform all medical, diagnostic, and surgical procedures considered essential to the practice of Family Medicine;

    b. Medical knowledge about established and evolving biomedical, clinical, epidemiological, 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 continuously improve patient care based on constant self-evaluation, and life-long learning;

d. Interpersonal and communication skills that result in effective information exchange and collaborating with patients, their families, and other health professionals;

e. Professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, sensitivity to a diverse patient population, ability to recognize and develop a plan for one's own personal and professional well-being, and appropriately disclosing and addressing conflict or duality of interest; 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 advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals.

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 skills 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 a variety of successful practice environments, health care finance, 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 understand the need and process for recertification/maintenance of certification.

### B.2.0. 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 Portfolio at Conroe Family Medical Education Foundation have two parts – (1) the require 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, Darshan Tolat, M.D., Kara Kern, M.D.
Designated Institutional Official: Lata Joshi, M.D.
Residency Program Director: Lata Joshi, M.D.
Co-Chief Residents
Quality Officer: Daniel Porter, 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., Associate Program Director, 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., Associate Program Director, Family Physician with Obstetrics
Ra Nae Stanton, M.D., Family Physician with Obstetrics

***2.2 Part Time Faculty***

Edward Davidson, Ph.D., Behavioral Scientist
Kenneth Davis, M.D.
Kim Norris, M.D.
Reid Singleton, M.D.
Christine Ho, D.O.

***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 (FM-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.

| D.1.0. Year 1 | D.2.0. Year 2 | D.3.0. Year 3 |
|---|---|---|
| Inpatient Adult Medicine<br>12 weeks*<br>*-One week of NF may count toward Inpatient Adult Medicine at the Director's discretion | ICU<br>6 weeks | Inpatient Adult Medicine<br>6 Weeks |
| OB/Pedi<br>12 weeks | Private Pediatrics<br>8 weeks | Sports Medicine<br>4 weeks |
| Night Float<br>5 weeks* | Gynecology<br>4 weeks | Psychiatry<br>4 weeks |
| Emergency Medicine<br>2 weeks | OB/Pedi<br>8 weeks | Radiology<br>2 weeks |
| General Surgery<br>6 weeks | Emergency Medicine<br>6 weeks | Geriatrics<br>2 weeks |
| Anesthesia<br>2 weeks | Night Float<br>4 weeks | Night Float<br>2 Weeks |
| Family Medicine Practice<br>8 weeks | | |
| Practice Management<br>100 hours (longitudinal over 3 years), including 2-week seminar in year 2 | | |
| Care of the Underserved<br>4 weeks: 2 weeks in year 1 and 2 weeks in year 2 or year 3 | | |
| Approved combinations of the following rotations may be completed during years 1, 2 or 3 but must be completed prior to graduation: | | |

| | | |
|---|---|---|
| General Surgery (4 weeks)<br>Surgical Subspecialties<br>Orthopedic Surgery (4 weeks)<br>Otolaryngology (2 weeks)<br>Ophthalmology (2 weeks)<br>Urology (2 weeks) | | Internal Medicine<br>Pulmonology (4 weeks)<br>Cardiology (4 weeks)<br>Nephrology (4 weeks)<br>Dermatology (4 weeks) |
| | Electives<br>20 weeks | |
| Family Medicine<br>2 half-days per week | Family Medicine<br>3 half-days per week | Family Medicine<br>4 half-days per week |

**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, in compliance with the Accreditation Council for Graduate Medical Education (ACGME), requires that all residents complete at least two scholarly activity projects during residency, one of which must be a quality improvement project completed under the direction of his or her faculty advisor or faculty project lead.

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. All projects MUST have prior approval from faculty advisor or faculty project lead prior to starting them.

5. An Institutional Review Board must approve of the project prior to the start of the project.

6. Residents may work together on a team project if approved by faculty. Ideally, teams should be composed of resident physicians in different states of training.

7. 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.

8. Residents are encouraged to present their projects at national, state, and local meetings.

9. Residents are required to complete and present their scholarly activities during the third year of residency.

10. Residents must e-mail their scholarly projects to the Medical Education Director. Copies will be kept on file in the Resident Portfolios maintained in that office.

11. A completion certificate will not be awarded until the resident has completed all scholarly activity requirements.

## 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 MedHub. 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; these are also completed by medical students that work alongside the residents throughout the year. Residents are also required to complete self-evaluations in MedHub as requested. In addition, twice each year each resident will be evaluated by the Clinical Competency Committee using the ACGME Family Medicine Milestones. Residents with incomplete evaluations will not receive a Residency Program Completion Certificate until outstanding evaluations have been completed.

## F. FACULTY ADVISORS

Each resident is assigned 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 evaluations with you on a 1:1 basis, 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. IN-TRAINING EXAMINATION

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 Examination is mandatory. Results of the exam may be used to direct remediation.

## H. DRESS CODE

Dress at all times is to be professional and in compliance with the current Lone Star dress code. Clothing and shoes are to be kept neat and clean, well-fitting and of matching conservative colors

and without obvious branding or other slogans. Keep in mind that the physician's appearance can affect the patient's view of their physician.

A white Lone Star lab coat must always be worn in clinic and in the hospital during patient care, unless you are performing a procedure. No other jackets are allowed. Note that hospital policy requires residents to wear a white lab coat at all times in the hospital, regardless of whether scrubs or business attire is worn. Scrubs worn in the hospital must be either CRMC or Lone Star scrubs; scrubs with other hospital branding may not be worn. Hospital policy states a physician may leave the Operating Room or Labor and Delivery Room with scrubs, but a white coat must be worn over them. Additionally, physicians must wear a hospital ID badge while at CRMC.

When on outside rotations a white coat must be worn, and especially with private attendings, scrubs should not be worn except on a surgical rotation if approved by the surgeon.

## H.1.0. LONE STAR DRESS CODE POLICY

1. Employees should wear uniforms or professional attire consistent with their position and are responsible for providing and maintaining them. The only exception will be on Didactic Fridays when scrubs of choice may be worn by clinical staff and polo shirt of choice or casual business attire for registration and billing office staff. Supervisors may also allow special holiday scrubs or polo shirts for limited periods of time.

2. Clothing must be neat, clean and appropriate for a professional environment.

3. Shoes should be clean, polished and in good condition. No open toe shoes are allowed (i.e. sandals, flop-flops); tennis shoes are allowed, but must be in clean/good condition.

4. Employees should demonstrate consistent bathing and oral hygiene.

5. Make-up should be lightly applied.

6. Employees should avoid wearing any product that produces a scent that is strong enough to be perceived by others, including but not limited to: colognes, perfumes, after-shave products, lotions, powders, deodorants, hair sprays and other hair products, and other personal products.

7. Hair should be clean, combed and neatly trimmed or arranged. Sideburns, mustaches and beards should be neatly trimmed. Hair coloration and coloration patterns should be those that would occur in nature. (No unusual colors such as pink, purple, or blue, etc. are allowed along with extremely two toned such as black on top and blonde on the bottom).

8. Jewelry should be in good taste and not be excessive. Earrings should be secure and appropriate. No dangling earrings are permitted for clinical staff. No stretched piercings, gauges or tapering large hole earrings. Wedding, engagement or conservative rings and school pins may be worn. Bracelets or loose jewelry should not be worn when performing patient care.

9. Tattoos and body piercings (other than earrings) should not be visible.

10. Employees should wear identification name badges, with title identification, when provided, while on duty.

11. Clothing considered inappropriate to wear while working includes:

    a. Jeans of any color.

    b. Shorts.

    c. Sun dresses, dresses or tops with low cut front or back.

    d. "Mini" or extremely short skirts or spandex in lieu of slacks or a skirt.

    e. Casual T-shirt including those with inappropriate logos.

    f. Hats, hoodies, sleeves with thumbholes or sweatshirts.

12. Nails should be of a reasonable length and groomed. Ornate and extremely long nails are not acceptable.

13. No gum chewing.

14. At its discretion, Lone Star may allow employees, on occasion, to dress in a more casual fashion than is normally required. On these occasions, employees are still expected to present a neat appearance and are not permitted to wear ripped or disheveled clothing, athletic wear, or similarly inappropriate clothing.

## I. FAMILY MEDICINE CLINIC (FMC)/ FAMILY MEDICINE PRACTICE (FMP)

The **Lone Star Family Health Center** is the site of each resident's "private practice" for the three years of their training. The facilities include Residents' Rooms, Procedure Rooms, fetal dopplers, colposcope and LEEP machines, tympanometer, spirometer, flexible sigmoidoscope, ultrasound equipment, EST cardiac equipment, PFT equipment, computer equipment/Internet access, and other equipment appropriate for broad scope family medicine.

An electronic health record (Allscripts) 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. There will be documentation standards which must be adhered to at all times.

Residents are required to check Allscripts on a daily basis to answer question, review labs, and refill medications. The only exception to this is during vacations, holidays, or extended illnesses and the duty must be covered by a "buddy" fellow resident of the same class year that is designated ahead of time. That "buddy" must also not be off during the same dates, and the absent resident is responsible for making sure that the coverage is arranged. You must also notify the entire organization of the dates you are out, and the physician who is covering for you via email.

*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. The resident must voice call the preceptor directly. If a resident must be absent, they must personally and verbally notify the Program Director and the Medical Education Director immediately so that patients can be properly cared for by other providers.*

## I.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. One way to do this is to keep the acute/walk-in list open on your EHR while you are in clinic and if your patient is on that list volunteer to see them.

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. Patients are assigned generally in rotation, although First-Year Residents cannot handle as many new patient assignments as more experienced residents.

3. New obstetrical patients are assigned as equitably as possible by rotation.

4. Residents build their practice primarily from following-up previously unassigned hospital patients, but they should seek to provide medical care for the entire family.

5. Requests for PCP reassignment will be handled by the Clinical Medical Director.

6. Continuity patients are defined as the physician whom the patient identifies as "their doctor" and who has seen the patient in clinic.

## I.2.0. RESIDENT AND PATIENT SCHEDULING

### I.2.1. 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.

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. If you feel that your workload during a given clinic session is not manageable then immediately speak to your assigned preceptor.

### I.2.2. Year One

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.

### I.2.3. Year Two

Three, occasionally two, half-days per week.

### I.2.4. Year Three

Four half-days per week. Some rotations have three clinics per week.

### I.2.4. 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 the Family Medicine Practice Rotation to provide specialized teaching, training and honing of skills, as well as for procedures that require longer time to complete. 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. All residents are encouraged to seek opportunities for procedures and be proactive in finding faculty who can provide supervision for the procedure. All procedures must be performed with a faculty member present.

## I.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 the 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", Do 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.

## I.4.0. SPECIALTY CLINICS

Appointments for Procedure Clinic, PFT, EST, Vasectomy Clinic, High-Risk OB, GYN Clinic, Osteopathic Clinic, and behavior health counselors are made by the medical assistants or front desk staff. Appointments to Coumadin Clinic are arranged by the Clinical Pharmacist in charge of that clinic.

## I.5.0. PRECEPTING PATIENTS

1. All 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.

2. All patients of First and Second-Year Residents shall be precepted while they are still in the clinic. Third-Year Residents may precept up to 3 patients at a time, thus not requiring patients to remain in the clinic at time of precepting.

3. 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 the supervision requirement.

4. All office visit charts must be submitted to the preceptor for review and sign off. Chart audits by faculty are required for documentation accuracy.

5. 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.

6. All procedures done in the hospital and clinic must be precepted in person by faculty for a substantial part of the procedure for billing purposes.

## I.6.0. CHAPERONES

1. All male residents doing breast or pelvic or rectal examinations on female patients MUST HAVE A FEMALE CHAPERONE IN THE ROOM during that examination.

2. Female residents doing genital or rectal examinations on male patients, or pelvic examinations on female patients, MUST HAVE A CHAPERONE IN THE ROOM.

3. It is also recommended that all residents have a chaperone whenever they are doing these exams on persons of the same sex.

4. Sometimes the presence of a chaperone may be a good idea if the conversation becomes uncomfortable to the provider and it is felt that having a witness in the room is pertinent.

5. A family member or friend of the patient that happens to be with the patient should NEVER be considered the chaperone for the exam.

6. Chaperones must be PAID employees of the center. Medical students, nursing students, or any other students may not be utilized as chaperones.

## I.7.0. TELEPHONE CALLS, MESSAGES, MAILBOXES

All residents and faculty are to check the EHR for telephone messages and prescription refills every business day and respond to them. If a resident is not going to be in the clinic for a period of time (e.g. 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 a violation of the ACGME core competency of professionalism, and is discourteous, unethical, and may be actionable under the law (residents may be sued) to ignore telephone or other 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 or sending of personal faxes 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.

## I.8.0. CORRESPONDENCE

Periodically residents will have to write letters for patients, sign orders on patients for visiting nurses, nursing home patients, etc. The writing of these letters is the responsibility of the provider and not your MA/Nursing staff. If you have any concerns about whether it is appropriate to write such letter for a given patient or the wording of the letter, check with a precepting faculty. All letters should be done promptly, within one to two days of receipt. Patients bringing lengthy forms for the physician to fill out should 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. 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, resident must follow the policies outlined in *CMEF General Information for Residents.*

## I.9.0. PATIENT FINANCIAL MECHANISMS AND BILLING THIRD PARTIES

While LSFHC and CMEF have contractual obligations to care for a number of uninsured and/or underfunded patients admitted to Conroe Regional Medical Center who have no physician, LSFHC 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 (i.e. "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 patients 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.

### I.9.1. HOW TO CHARGE

Charge according to level or complexity of service following the Resource-Based Relative Value Scale (RBRVS) schedule. LSFHC and CMEF are reimbursed according to what the physician indicates supported by diagnosis. 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 FMP for charging LESS than the "Expanded Problem Focused" (99213 or 99203) visit. 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 on your charts in a timely manner, usually within 48 hours. *Providers are not permitted to waive charges without the permission of Lone Star's CEO, or their designated representative.* If you feel that the patient should not be billed due to some extraordinary circumstances, discuss this first with your preceptor and if they agree it can be brought to the CEO and/or Designee for a final determination.

## I.10.0. INTERPERSONAL RELATIONS

LSFHC 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 LSFHC 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.

## I.11.0. CHART AUDITS

All Residents' charts will be audited 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. DO NOT add or subtract items out of the note after the preceptor has reviewed it unless specifically asked to do so by the preceptor or by the billing coder.

For any charting concerns, please ask for help in areas that you feel you need help with. The faculty will not know your strengths and weaknesses unless you tell them. This is the best way to optimize your time in residency.

Peer:Peer chart audits are performed quarterly. Ten charts must be audited using the appropriate form. Audits are due one week from the date of assignment with a one week grace period.

## I.12.0. CONROE FAMILY MEDICINE PATIENT CARE CHECKLIST

| | | |
|---|---|---|
| 1. | Charges: | Patient charged appropriately<br>Procedures charged<br>Diagnoses and procedures coded correctly |
| 2. | Patient Care: | Pertinent History<br>Appropriate physical Exam<br>Lab data acted upon<br>Problems assessed<br>Family/Psychosocial considerations<br>Preventive maintenance<br>Proper therapy/counseling<br>Logical investigations planned<br>Follow-up plan<br>Patient education |
| 3. | Charting: | Initial Database, filled out<br>Problem list (acute and chronic), up to date<br>Medication List, up to date<br>Dictation in SOAP format<br>Well-documented, succinct notes<br>Proper diagnosis coding to the highest specificity<br>Meeting specific charting requirements for various payors |
| 4. | Pediatrics: | Immunizations<br>Growth/Weight curve<br>Development (use of R-PDQ and flowchart)<br>Health risks guidance. |
| 5. | Adult Men: | Health Maintenance/Hazards Appraisal<br>e.g., smoking, blood lipid levels, alcohol intake, exercise, genital and rectal exams, etc. |
| 6. | Adult Women: | Health Maintenance/Hazards Appraisal<br>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

## I.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.

### I.13.1. CONTROLLED SUBSTANCE PRESCRIPTION POLICY

| | |
|---|---|
| **POLICY DESCRIPTION:**<br>Controlled Substance Prescription Policy | **POLICY #:**<br>31-001 |
| **CATEGORY:**<br>Clinical | **SUBCATEGORY:**<br>Medication |
| **EFFECTIVE:**<br>10/2003 | **REVISIONS:**<br>9/2018, 01/2020 |

**PURPOSE:** To establish guidelines for the outpatient prescribing of controlled substance medications by all providers of the Lone Star Family Health Center.

**POLICY:**

It is the policy of the Lone Star Family Health Center to limit the prescribing of controlled substances for our patients to reduce the risk of harm, diversion, abuse and misuse from these medications. We have created these guidelines with this in mind and it is the expectation that all providers will follow them at all times.

**Exceptions:**

Of note, the following guidelines do not apply to patients of the Lone Star Family Health Center while they are in the hospital or nursing home settings. Prohibited medications in the outpatient setting maybe appropriate while the patient is hospitalized or in the nursing home. Providers should not discharge patients from these settings with prescriptions for the prohibited medications or above the quantity limits for allowed medications.

The other exception to this policy is the patient that is terminally ill and the provider judges that the patient is in final stages of life, has a known etiology for pain, and requires aggressive pain management with long acting opiates such as MS Contin, Fentanyl patches, etc.

**Prescribing Guidelines:**

- Texas State statutes require very specific charting when prescribing controlled substances. Providers must meet those requirements in order to prescribe these medications. Providers are encouraged to keep up to date on those requirements. One important requirement is that for each and every controlled prescription the provider has to check the PMP Aware website PRIOR to writing the prescription to reduce the risk of misuse/abuse for a given patient. It is best practice to document in the patient's chart that you have checked the website each time. The ICD-10 code and diagnosis must be documented on each prescription.
- Providers should avoid combining medications which are sedating, this includes but is not limited to opiates, benzodiazepines, sleep aides, gabapentin/lyrica, muscle relaxers and should ask about sedating OTC medication and substance (ex. alcohol) use.
- **Prohibited Medications for ALL patients even terminally ill**

a. All forms of oxycodone products, Carisoprodol (Soma), and Alprazolam (Xanax)

- **Prohibited Medications (except for terminally ill patients as discussed above)**
    a. All forms of long acting opiates including but not limited to MS Contin, Fentanyl patches
    b. Chronic (>5 days) of immediate acting opiates such as hydrocodone products (norco, vicodin, morphine IR, etc)
- **Chronic Pain Management**
    a. First line therapies for chronic (non-cancer related) pain should not include an opiate. All attempts should be made to manage the pain without their use.
    b. Three choices of opiates and NOT to be combined:
        i. Tramadol (Ultram) and Tramadol/APAP (Ultracet) prescriptions will be limited to a quantity of 90 tablets or a 1 month supply, whichever is LESS. One refill is OK.
        ii. OR Tylenol with codeine #3 will be limited to a quantity of 90 tablets or a 1 month supply whichever is LESS. One refill is OK
        iii. OR Tylenol with codeine #4 will be limited to a quantity of 90 tablets or a 1 month supply whichever is LESS. One refill is OK.
    c. No other opiate pain medications are to be prescribed for chronic pain indications.
    d. Pain medication management requires an in-person office visit every 2 months.
    e. Patients may not be prescribed controlled medications for chronic pain at their first visit. If they have been on chronic pain medications through another provider and are establishing care with Lone Star FHC the records must be obtained and reviewed from the previous provider's office. Hand carried copies provided by the patient do not meet this requirement.
    f. If over 90 days between refills then refer to acute pain management section below.
- **Acute Pain Management**
    a. Limit of 5 or less days and a max qty of 20 tablets and NO refills.
    b. Post operative patients are limited to 7 or less days and a max qty of 28 tablets and NO refills.
    c. Preferred agents for acute pain are NSAIDS (if safe in a given patient) or Tylenol but Tramadol, Tylenol #3 or #4, Norco/Vicodin, MSIR can be used if needed if the above quantity and duration guidelines for acute pain are followed.
- **Other controlled medications**
    a. Lyrica, gabapentin, and phenobarbital products have a maximum of 1 refill, but each must be of a 30-day supply.
    b. **Benzodiazepines:**
        i. Only two benzodiazepines: clonazepam (Klonopin) and lorazepam (Ativan) are allowed and are limited to 60 tablets or a one month supply, whichever is LESS. One refill is OK. Diazepam (Valium) in the rectal preparation may be given for epileptic patients.
        ii. Management requires an in-person office visit every 2 months.
    c. **ADHD/Stimulants**
        i. Immediate release or short acting stimulants will not be prescribed for ADHD for any age patient.
        ii. No new patients (18 and older) will be prescribed stimulants (ADHD meds).
        iii. Teenagers who we have been treating with these medications PRIOR to their 18th birthday may continue after their 18th birthday until age 26, if the provider feels that this is warranted. If the patient needs to continue therapy beyond age 26, a Provider Exception Request should be submitted to the P&T committee for review.
        iv. Stimulant medications for ADHD may be written for a 60-day supply at the discretion of the provider. Insurance companies may exclude this quantity.
        v. Patients on stimulants must be seen in the clinic every 2 months.
- **Muscle Relaxants**
        i. Chronic use: Baclofen and tizanidine are strongly preferred and should be limited to a quantity of 60 or a one month supply, whichever is LESS. One refill is OK.
            1. Patients using chronic muscle relaxants must be seen in the clinic every 2 months
        ii. Acute use: In addition to baclofen and tizanidine providers can prescribe flexeril (cyclobenzaprine), skelaxin (metaxalone), and robaxin (methocarbamol). Acute indications are limited to a maximum quantity of 20 or a 10 day supply with no refills.

- **Fill and Refill Guidelines:**
    a. Lost or Stolen controlled substance medications will NOT be replaced for any reason.
    b. All patients must have a signed and current Controlled Substance Management Agreement in their chart before receiving controlled substance medications and this should be renewed at least yearly.
    c. Prescriptions for controlled substance and drugs prone to abuse cannot be refilled earlier than 3 days before due.

**Prescribing outside of this policy requires prior approval by the Lone Star P&T Committee. Requests are made by submitting a Provider Exception Request to the committee. The form can be obtained from our Lone Star Pharmacy.**

**PROCEDURE: Prescribing outside of this policy requires a Provider Exception Request through the Lone Star P&T Committee. If prescriptions outside of the policy are not approved by the P&T Committee, the Lone Star Pharmacy will not fill the prescriptions, and it is a violation of the policy for the physician to write the medication to be taken to an outside pharmacy.**

***The most up to date version of the Controlled Substance Prescription Policy is available in the Lone Star Family Health Center Manual, Policy 31-001.**

### I.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 and submitted for scanning into the patient's chart and should be periodically reviewed and updated if circumstances such as a preferred pharmacy changes.

## J. 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.

## K. URGENT PATIENT MESSAGES OR CRITICAL LAB VALUES

Urgent patient messages will be paged to the patient's doctor. You must be available by pager at all times, if you are not responsive to pages this is a violation of the ACGME core competency of professionalism. 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.

Urgent and Critical Lab values are the responsibility of the provider, not the nursing staff of the clinic. You must notify the patient of the result, by phone or in-person and discuss the next step with them. An entry must be made into the patient's chart immediately to document the call and the instructions given to the patient. If you have exhausted all attempts to contact the patient and unable to do so and the lab value is considered life threatening, then you may contact the local law enforcement office on their non-911 line and have an officer go to the patient's address and try to make contact with the patient. This effort should also be documented into the patient's chart.

After hours and on the weekends, pages will go to the resident on call.

## L. PATIENTS BEING SEEN IN CLINIC BY THE LONE STAR FACULTY OB/GYN

Patients with obstetric and/or gynecologic issues are cared for by a variety of providers in the Lone Star Family Health Center. Regardless of which provider in the clinic has cared for the patient the following should be done:

If any of our OB/GYN clinic patients present to the Emergency Department or to the Labor and Delivery Unit, the Emergency Department or L&D Nurse is to notify the Family Medicine Resident carrying the Second-Year OB/Pedi 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 the covering Family Medicine attending and assigned to the OB/Pedi team's roster. 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. In an emergency in which the covering OB/GYN Faculty or contracted OB/GYN physician is not immediately available any OB/GYN board certified physician can be asked to assist with the patient's case.

## M. RESIDENT RESPONSIBILITIES

### M.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 fails to present their assigned lecture at the scheduled time or misses didactics without a valid excuse will make up their missed lecture or unexcused absence with an assigned extra clinic session. Missed didactics without a valid excuse will also result in a deduction of an equivalent amount of vacation time to make up for the time missed. Consistent tardiness to didactics will be noted and may result in the above consequence (extra clinic and deduction of vacation time) to make up for the time missed.

   Only residents on Night Float, an away rotation, vacation, sick or administrative leave are excused from attending conferences. If a resident is going to be late or absent for any reason, they should contact the Program Director, Medical

Education Director and 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. If you are in the middle of a procedure such as a delivery and cannot return the page, please politely ask a nurse to return the page and explain the delay.

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. Residents calling in sick require immediate VERBAL notification, by the ill resident, to the preceptor, the Program Director and the Medical Education Director. If a resident must be late or miss clinic for emergencies, obstetrical deliveries or other reasons, the precepting faculty also must be notified immediately and approve the absence.

4. CONTINUITY: Having the patient's outpatient clinic continuity physician involved in a patient's hospital course is most critical at the start of the hospital stay.

   a. The continuity physician should be notified of their patient's admission as soon as possible and make every effort to see the patient before morning rounds, and meet with the attending faculty member at 8:00 AM for verbal checkout, or if the resident's rotation schedule precludes waiting to leave the hospital at 8:00 AM, give a detailed verbal checkout to the 3rd year Medicine resident. During that first morning visit, the resident can describe to the patient that the Medicine Inpatient team will be around to see them later that day and continue to provide their day-to-day care (or similar).
   b. Care of the patient will be absorbed by the Medicine Inpatient team on rounds.
   c. The continuity physician may continue to see the patient if they choose, but otherwise will be available to the Medicine 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).
   d. 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 Medicine Inpatient team must therefore make sure the continuity physician gets a discharge summary or provides a good verbal or EHR message 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").
   e. Definition of a continuity patient = a patient who has been seen by a resident at least once during their 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-RC 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 a leave request through InsperityTimeStar. Residents who are out of town on the weekend 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-TCOM Library, Challenger, and Decker Medical 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 and via the *Up To Date* app on cellular phones.

See Section P.

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 Family Medicine Practice 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 in the clinic must be precepted by a faculty member except when working in the After Hours Clinic. Procedures performed during the After Hours Clinic should be only those procedures which the resident feels 100% comfortable and confident in performing and that have already been performed during regular hours with Faculty supervision.

   For procedures performed and supervised by non-faculty physicians in the hospital or while on specialty/elective rotations, residents are provided paper procedure cards to document their experience. Residents must still log this procedure into Medhub and will submit this entry to their advisor for verification. The faculty advisor will then verify this procedure entry in Medhub after the resident submits the signed procedure card for review.

   Residents are to log procedures in the Med Hub 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 faculty to perform or teach a procedure. 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. We cannot predict the number required by different hospitals or other credentialing bodies, this is the responsibility of the resident to confirm these numbers and accomplish them prior to graduation.

8. TIME LOGS: Record hours of clinical and educational work in MedHub daily and no less frequently than weekly. Residents must include all times they are in Conroe Regional Medical Center Hospital, any other hospital, any physician office, and any other residency clinical and work location. A completion certificate will not be awarded until all required time logs are recorded in MedHub.

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: All residents are required to actively participate in recruiting faculty members and residents for the program. Each year a Recruitment Committee may be formed with the purpose of assisting in the recruitment of the next incoming Intern class during the interview season; however, all residents are required to attend the Program's annual recruitment meeting. Examples of recruitment activities include but are not limited to: interviews, tours, meals, post-interview follow up, attendance at residency fairs, procedures workshops, Family Medicine Interest Group activities, and other activities as requested. Some of these activities occur after hours.

## M.2.0. NIGHT CALL/WEEKEND CALL

1. Residents calling in sick on call should arrange for coverage by another member of their class. Immediate VERBAL notification by the ill resident is REQUIRED to the faculty on call, the Program Director and the Medical Education Director. 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. Note that it is considered unprofessional to buy or sell call shifts. Call shifts will NOT be bought or sold for financial gain. If a resident must change a pre-scheduled call shift, the resident will arrange coverage by another member of their class and this change will be notified to the Medical Education Director so that the call schedule may be updated.

3. We have a call system incorporating night float as follows.

   **a. First Year Residents:**

   **Night Float**: Monday-Friday (inclusive) 7:00 PM - 10:00 AM or completion of attending rounds and patient work, whichever is earlier.

   One abbreviated clinic session/week; last patient scheduled is 9:45 AM.

   They will round on either OB/Peds or Medicine patients on Saturday morning, depending on who the Day Call Intern is.

**Weekday Long Call:** Monday – Friday, 5:00 PM - 7:00 PM.

One first year resident from both the Medicine and OB/Peds services will be assigned long call. The Medicine first year taking Long Call will pick up and round on these patients the next day (up to their maximum # of patients). If they are already at their max, the upper level on Long Call (PGY 2 or 3) will determine who sees these patients the following day. This will be relayed to the night float team at 7:00 PM checkout as they may also have to see a few patients admitted that day. If the services are not busy, the upper level resident on Long Call should dismiss the first year resident earlier than 7:00 PM.

**Saturday and Sunday Day Call:** 6:00 AM – 7:00 PM.

Intern will be from the Medicine Team and will round on medicine floor patients Saturday and Sunday mornings. This intern can only take a maximum of one call weekend per block if on Medicine.

**Saturday and Sunday Night Call:** 7:00 PM – 12:00 Noon the next day or completion of attending rounds, whichever is earlier.

Intern taking this call should be from the OB/Peds team and will round on the OB/Peds patients and/or any medicine patients admitted during their shift Sunday and Monday morning.

Intern must leave by 12:00 PM the day following call.

*An Intern not on Medicine or OB/Peds service 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) 7:00 PM - 10:00 AM or completion of attending rounds and patient work, whichever is earlier.

One abbreviated clinic session/week; last appointment 9:45.

They will round on overnight admits on Saturday morning and some floor patients to help evenly distribute patient load.

**Weekday Long Call:** Monday – Friday, 5:00 PM – 7:00 PM.

One upper level resident from both the Medicine and OB/Peds services will be assigned long call by the Medical Education Director. Long call shifts should not be scheduled for a resident who has clinic that afternoon. If the services are not busy, the upper level resident on Long Call should dismiss the first year resident earlier than 7:00 PM.

**Weekday Home Call:** Monday – Friday, 5:00 PM – 6:00 AM the next day during the two scheduled weeks of Practice Management.

See section L5.0 for details.

**Saturday and Sunday Day Call:** 6:00 AM – 7:00 PM.

Resident will round on ICU patients, and possibly some floor patients to evenly distribute patients on both days (when the Third-Year Medicine Resident is the rounding resident), and only floor patients when the Second-Year ICU Resident is the rounding resident. Patient distribution will be made keeping in mind that the resident may be called to do admits and attend to patients in Labor & Delivery.

**Saturday Night Call:** 7:00 PM – 12:00 Noon the next day or completion of attending rounds, whichever is earlier.

Resident will round on any medicine patients admitted during their shift Sunday morning.

Resident must leave by 12:00 PM the day following call.

**c. Third Year Residents:**

**Weekday Long Call:** Monday – Friday, 5:00 PM – 7:00 PM.

One upper level resident from both the Medicine and OB/Peds services will be assigned long call by the Medical Education Director. Long call shifts should not be scheduled for a resident who has clinic that afternoon. If the services are not busy, the upper level resident on Long Call should dismiss the first year resident earlier than 7:00 PM.

**Weekday Home Call:** Monday – Thursday, 5:00 PM – 6:00 AM the next day (never done by the Third-Year Resident on Medicine).

See section L5.0 for details.

**Weekend Call:** Friday 5:00 PM – Monday 12:00 Noon.

Friday 5:00 PM – Sunday 7:00 PM will be Home Call with the same duties as above. See Section L5.0 for details.

Sunday 7:00 PM – Monday 6:00 AM will be In-House Call by the same resident. This resident attends to their morning responsibilities for the rotation/service they are on starting at 8:00 AM Monday after checking out to the Upper Level Third-Year Resident on Medicine and finish for that day at 12:00 PM.

*The Third-Year on Medicine will not be able to take any Weekend Call or overnight weekday call during that month except for Long Call or Weekend Home Call.

**d. <u>Notes/FAQ's</u>:**

1. 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.

2. Rounds begin at 8:00 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.

3. 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.

4. As outlined below, the night float/overnight 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.

5. Checkout of patients must occur whenever there is a transfer of patient care or a change in shift. See Section L.6.0.

6. One of the upper level residents on the medicine service will be assigned weekend rounds. During times of the year when the inpatient census runs high, one of the other upper level residents who is on the medicine service, not the third year resident on call, should be assigned as a backup weekend rounding resident. If the census is above 50 and the assistance of the backup upper level resident from the Medicine team is needed, the in-house upper level rounding resident should call the faculty member, and the faculty member will call in the backup resident. The backup resident should always come in when called, and if the resident feels that they were called in inappropriately, they should let the faculty member know after the fact.

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 at the time of the admission and must independently repeat the history and physical exam and then discuss all orders with the Second Year admitting resident prior to leaving the CCU/ICU. The Third Year resident must also be immediately available 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.

8. During July, all residents on call are required to be in the hospital. During the balance of the year 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 Third-Year residents are on the Night Float rotation. During those times the Second-Year resident will take Home Call and is subject to the requirements above.

## M.3.0. CALL DUTIES OF FIRST YEAR RESIDENT

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

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

2. Evaluation of newborns, including completing a newborn physical examination.

3. Doing admissions - Admission H&P's on patients in the ER, direct admits, transfers to our service, or consults.

4. All admissions must be supervised by the upper level resident until the first-year resident is approved by the faculty to admit patients independently. Supervision during this time is defined as a bedside history review and physical examination of the patient by the upper level resident with a follow note entered into the chart.

5. Night Float residents – Admissions completed on the Night Float shift which occur prior to 2:00 AM must have a separate brief morning progress note done the following morning prior to rounds to confirm patient status and get pertinent updates to present to the team on morning rounds.

6. Being the first assistant in C-Sections as experience and situation warrants.

7. Join the upper level resident during code blue situations.

8. 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 note in the chart, i.e., for a stable patient. A child whose status is changing or more tenuous will require more visits during the call.

9. Notify FMP continuity residents when their patients are admitted in labor or with complications. The FMP 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.)

10. 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 with an upper level resident.

11. It is 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 that change.

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

The role of the upper level resident is to serve as the leader of the night time 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 long call upper level resident that is being relieved AND the first-year resident for appropriate transfer of care.

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 be billed if patient seen by faculty prior to being sent home. The upper level must be physically present during the initial evaluation of all patients in L&D and at all times of major decision making.

2. Take primary responsibility for all admissions. See that admit orders, notes and H&P are written.

3. All admissions must be supervised by the upper level resident until the first-year resident is approved by the faculty to admit patients independently. Supervision during this time is defined as a bedside history review and physical examination of the patient by the upper level resident with a follow note entered into the chart.

4. Check out ICU admissions to third-year resident on call in advance of calling faculty.

5. Round on all CCU/ICU patients in the evening and make brief notes in the patient's chart.

6. Evaluate and make adjustments to care and consult faculty on patients already in the hospital if significant change in patient status occurs.

7. Discuss all pediatric patients with the first-year resident after their evening rounding on these patients and go evaluate in-person if there are any concerns of patient's status.

8. Respond to all Code Blues.

9. Be available to round with the Inpatient Medicine Team as outlined above.

10. Night Float Residents – Admissions completed on the night float shift which occur prior to 2:00 AM must have a separate brief morning progress

note done the following morning prior to rounds to confirm patient status and get pertinent updates to present to the team on morning rounds.

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

Generally third year call is taken from home. It must be recognized that taking call at home is a *privilege*. This privilege may be lost permanently by any resident not following hospital or program rules, policies, and/or guidelines.

1. At 5 PM, the resident on home call will speak with the upper level resident on long call for an update on the status of all inpatient services.

2. Third-year residents taking call from home must be able to arrive at the hospital within **20** minutes from the time they are called. 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. In-house residents will make 2 attempts, 5 minutes apart, to reach the resident on home call. Attempts should include at least 2 different methods, e.g. call, page, text. If there is no response after both attempts (10 minutes), the attending physician and both chief residents will be notified immediately.

2. The third year resident must be called and must come into the hospital in the situations below:
   a. Immediately upon being informed of *any* patient entering the ICU, the in-house resident must inform the third year. Both upper level residents must evaluate and examine the patient. The third year resident must write a note and may not leave the hospital until the admission is complete, including all orders being in, the medication reconciliation is completed, the note is written, and check-out with the attending is completed. If due to other patient care responsibilities, the second year resident is unable to be present with the third year resident for the admission, prior to leaving the hospital the third year must complete the admission as outlined above, and must check out to both the second year resident and the attending on call.
   b. 1 patient is an active labor (6 cm or more dilated) and 3 other pending admissions.
   c. 2 patients are in active labor and 2 other pending admissions.
   d. Greater than 4 pending patients at any time.
   e. "Stacking" patients resulting in a high number of pending patients will be viewed as a breach of professionalism and a demonstration of poor patient care.
   f. It is important to recognize that patient numbers are only one measure that can impact patient care. Therefore, residents on home call may also be required to come into the hospital when requested by in-house residents due the complexity of patients being cared for or other circumstances, including lower level residents becoming overwhelmed.

3. 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-section babies at the time of delivery and until infant is stable.

5. Third-year residents who have not completed their 40 required deliveries will complete this requirement while on back-up call from home. The third-year resident 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 40.

6. At home residents may not participate in any moonlighting during their call periods.

## M.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 residency.

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 them to do a good job while carrying the "medicine 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 – sign-outs can occur anywhere (call room, CCU/ICU, ER, nurse's station, etc.), except in patient rooms, while respecting patient confidentiality. Increasing transitions-in-care must lead to serious rigor and attention to detail in sign-outs.

Poor sign-outs can cost patients their lives. It is CRITICAL that they be done correctly.

## M.7.0. CHIEF RESIDENT(S)

Appointed by the Director after consulting the faculty and residents. Duties 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. If co-chief residents are

selected, the administrative time and additional salary will be divided between them. Duties include but are not limited to:

1. Resident's Call Schedule and Vacation Schedules. These schedules can be created by a class specific representative and/or Medical Education Director but the Chief Resident(s) are responsible for resolving scheduling conflicts.

2. Weekly Conference Schedule, attendance and tracking of conferences.

3. Liaison between resident and faculty.

4. Help resolve conflicts involving the residents.

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.

## N. RESIDENCY ROTATION & SERVICES

### N.1.0. INPATIENT MEDICINE SERVICE

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 Family 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.

Patient care within the hospital is one of each resident's highest priorities and responsibilities in training. If a resident feels that (s)he will require missing rounds for any reason, the resident MUST notify and obtain approval from the Program Director and Medical Education Director. The resident must also notify the Family Medicine faculty member on service as well so that patient care and rounding may not be interfered by the resident's absence.

1. STRUCTURE OF MORNING ROUNDS

a. 7:50 AM: Entire Medicine team and OB/Peds team meets in Dining Room A. A case will be presented from 7:50 AM – 8:20 AM by the residents under the direction and guidance of the Medicine team third-year resident. Note that ALL residents on the teams should be in the conference room and seated at 7:50 AM, 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.

b. Pertinent imaging and EKGs on any overnight patient should be reviewed and discussed to gain experience in their interpretation.

c. Except in 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.

2. THIRD-YEAR RESIDENT

a. Acts as the team leader and supervises the first and second-year residents.

b. 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.

c. Is encouraged to consult with the faculty at any time.

d. Is encouraged to help the resident directly responsible for the patient's care to learn and perform procedures for their patient.

e. Receives the "floor" pager from the night float resident when rounds convene at 8:00 AM and carries this pager until completion of morning rounds. This pager is then carried by the first-year resident assigned to cover the hospital that afternoon.

f. 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.

g. 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.

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

i. On afternoons covering the hospital, perform (and/or assign to lower level residents on service) ED admissions of which they are notified until 7:30 PM.

j. Facilitates morning case presentation from 7:50 – 8:20 AM.

k. The third-year resident has the discretion to determine the distribution of patients among 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. The faculty can change the distribution at his/her discretion in the interest of patient safety.

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

m. Along with the second-year resident, teach the reading of EKGs to the team under the supervision of the faculty.

n. Ensures that outpatient continuity physicians have been notified of their patient's admission as soon as possible. This should be via phone call and/or secure e-mail notification. This is extremely important with patients which we care for in the hospital that are seeing other outpatient practices. It is considered a professional courtesy and is good for patient care.

o. Responsible for billing (please see Billing Section).

p. May be required to act as team leader for the OB/Peds team in the afternoon.

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

r. Respond to all Code Blue events.

3. SECOND-YEAR RESIDENT

a. Cares for the patients on our service in the CCU/ICU 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.

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

c. The second-year resident will write an extensive admitting history and physical on patients admitted to the CCU/ICU, 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.

d. When patients are transferred from the CCU/ICU 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 the CCU/ICU 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).

1. CCU/ICU patient = 2 units

2. 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.

e. 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.

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

g. On afternoons covering the hospital, perform (and/or assign to lower level residents on service) ED admissions of which they are notified until 7:30 PM.

h. Answer questions from Nursing Home regarding our patients and notify the primary providers of any problems.

i. May be required to act as team leader for the OB/Peds team in the afternoon.

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

k. Respond to all Code Blue events.

4. FIRST-YEAR RESIDENT

a. The first-year resident is the primary physician for patients on our Inpatient Medicine and OB/Pediatric services under the supervision of the teams' upper level resident.

b. 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 the team discussion on attending rounds then assume care of the patients after rounds as assigned by the third-year resident.

c. All X-rays, EKGs, CTs, MRIs, 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 consultants 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.

d. "Status rounds" are to be made on all patients prior to morning report. They can be brief but must be detailed enough that he first-year resident can discuss changes in each patient if called upon to do so.

e. 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.

f. 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.

g. Present patients to consultants when consultation is required, 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.

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

i. 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.

5. CODE BLUE TEAM AND ACLS SKILLS

During a "Code Blue," as the acting code team, a resident from Conroe Family Medicine Residency is expected to fulfill the following requirements:

a. The resident is expected to be ACLS certified upon entering residency and must maintain an active certification.

b. A resident is expected to have full mastery of ACLS skills, including drugs, rhythms, shocks, and other knowledge needed to sufficiently and effectively run a code. In this category, a resident shall:

   i. Order appropriate drugs at appropriate time intervals.

   ii. Recognize shockable rhythms and order the patient to be shocked at appropriate times.

   iii. Understand and be able to order other interventions that may prove beneficial during a "Code Blue."

c. Residents may be called upon to intubate patients when it is needed. As such, residents are expected to have mastery of intubation skills, be familiar with involved equipment, and recognize indications and potential complications of intubation.

d. A resident must be comfortable knowing at the outset of a code any appropriate immediate orders needed to stabilize the patient as best they can. These include, but not limited to, medications (including IV drips), imaging, labs, specialist consults, etc.

e. Transition of care to the primary team is expected upon resolution of any further emerging conditions requiring ACLS. Nursing staff will call the primary team at the onset of the code, and either the nursing staff or the physician will call the primary team upon its resolution.

f. The resident is expected to do all required and expected documentation both on paper and in the EMR as soon as they are able after resolution of the code.

6. FACTORS REQUIRING RESIDENT TO IMMEDIATELY NOTIFY ATTENDING

a. Admission to the hospital.

b. Transfer of the patient to the Intensive Care Unit.

c. Need for intubation or ventilatory support.

d. Cardiac arrest or significant changes in hemodynamic status.

e. Development of significant neurological changes.

f. Development of major wound complications.

g. Medication errors requiring clinical intervention.

h. Any significant clinical problem that will require an invasive procedure or operation.

i. ANY TIME THAT YOU ARE WORRIED ABOUT A PATIENT IN ANY WAY OR CONFUSED ABOUT HOW TO DEAL WITH AN ISSUE.

7. RESPONSIBILITY FOR PENDING ADMISSIONS

Any admission which the team is notified of within 30 minutes of shift change becomes the responsibility of the oncoming team if the patient is stable. If there is any concern about the stability of the patient, the current team should not delay care to wait for the oncoming team to admit the patient.

## N.2.0. INPATIENT OB/PEDS SERVICE

The Family Medicine/OB faculty member in charge of the service acts as the first consultant to the upper level in charge of the team. The faculty member is ultimately responsible for the care of the patients on the OB/Peds service.

Patient care within the hospital is one of each resident's highest priorities and responsibilities in training. If a resident feels that (s)he will require missing rounds for any reason, the resident MUST notify and obtain approval from the Program Director and Medical Education Director. The resident must also notify the Family Medicine faculty

member on service as well so that patient care and rounding may not be interfered by the resident's absence.

1. UPPER LEVEL RESIDENT

The upper level resident serves as the team leader of the OB/Peds team and is responsible for directing and supervising first-year residents on the team. With the assistance of the Interns on the OB/Peds service, the upper level resident manages patients in Labor & Delivery, newborns in Level I nursery, women in the Post-Partum Ward and pediatric patients. It follows that the upper level on the OB/Peds 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 and other patients (with permission from attending). All OB patients to be sent home are to be checked out to the faculty on call prior to the patient leaving. The upper level resident must be physically present with the first-year resident during the initial evaluation of all patients in L&D and at all times of major decision making.

The upper level resident and the OB/Peds faculty coordinate to assign relevant learning topics to each member of the team, including themselves, to present during or after rounds to promote learning.

2. FIRST-YEAR RESIDENT

First-year residents on the OB/Peds team provide care under the direct supervision of the upper level resident on the team for patients in Labor & Delivery, newborns in Level I nursery, post-partum patients on the floor and for pediatric patients. They are also responsible for brief physical exams on pre-operative dental patients having same day dental procedures in the hospital

## N.2.1. OB RULES OF THE ROAD

### 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.

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, Family Medicine and OB/GYN faculty, nurses, and anesthesiologists.

### 2. PRENATAL CARE AT LONE STAR

a. New OB appointments will be divided evenly between all residents, with preference given to the first and second-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. The expectation is that patients seen in this clinic will become

the continuity OB patients of the resident initially seeing them in OB intake clinic.

b. All OB patients must be checked out with the preceptor prior to the patient leaving the clinic.

c. Residents are responsible for prenatal care to their continuity patients. A designated buddy system will be used if the resident is out of the clinic and the patient needs to be seen during their absence to maintain good prenatal care. The continuity provider is responsible for arranging the coverage and informing the necessary faculty, residents and staff in a timely fashion.

d. 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.

e. 100% of OB visits will be precepted by a faculty member with OB privileges at CRMC, or with a faculty member who has been approved by the Program Director to precept OB visits. Precepting should occur prior to the patient leaving the clinic. The preceptor will then sign off on these charts, indicating that they have reviewed the case and agree with the resident's management.

f. All prenatal charts will be clearly labeled with the continuity provider's name by creating a pop-up reminder in the patient's chart once continuity is started.

g. OB consult visits with an OB/GYN do not take the place of routine OB visits with the residents.

h. 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/or 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. <u>RECOMMENDATIONS FOR INITIAL OB VISITS</u>**

This should not be considered a protocol, it is to serve as guidance.

a. <u>For patients presenting between 4 and 9 weeks EGA</u>

1. Confirm pregnancy with urine hCG

2. Address acute problems such as hyperemesis gravidarum, UTI, bleeding, etc.

3. Perform detailed history to stratify patient's obstetric risk status.

4. Perform physical exam.

5. 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.

6. Provide prenatal counseling, prenatal vitamins, and appropriate patient handouts.

7. Ensure that the OB profile and other indicated blood work are ordered.

8. Schedule follow-up visit at 10 – 14 weeks EGA.

b. <u>For patients presenting initially after 9 weeks EGA</u>

1. Confirm pregnancy with urine hCG.

2. Perform detailed history and appropriate physical exam, identifying high risk factors.

3. Provide prenatal counseling, vitamins, and appropriate patient handouts.

4. Auscultate FHT with Doppler and/or ultrasound.

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

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

7. 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. <u>OB CONSULTS</u> (outpatient prenatal care consults)**

a. Consults will be requested and scheduled once the resident has evaluated the OB patient. The patient should be discussed with the FM-OB faculty before a decision is made that an OB consult is indicated.

b. Routine, uncomplicated OB patients can be followed throughout their pregnancies without consultation from an obstetrician.

c. Consultation visits for OB patients do not substitute for routine prenatal visits with the continuity resident.

## 5. LABOR & DELIVERY CARE

a. Everyone must be familiar with the mandated hospital policies, particularly those that require consultation.

b. All L&D pages should be answered immediately.

c. All L&D patients will be evaluated by the on-call upper level OB resident within 20 minutes of notification by nursing and immediately reviewed with the FM-OB on call.

d. 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.**

e. The faculty on primary OB call for L&D is the admitting physician.

f. 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 request for OB/GYN and/or Maternal Fetal Medicine or other appropriate consultation(s) will be ordered and the specialist called and spoken to by phone. Verbal communication is an absolute requirement. It is not permissible to have the nurse initially discuss the case with the specialist(s). This is to be physician to physician and the notification should be documented immediately into the chart.

g. The resident covering OB will make sure the appropriate billing is completed.

h. Patients on L&D require close observation and monitoring. Progress notes are expected at least every two (2) hours, or even more frequently if unstable, for patients in active labor and those undergoing induction/augmentation with Pitocin infusion and for those with PIH/preeclampsia on magnesium infusions. Patients being induced with cervidil or cytotec, or are in latent labor should have a progress note every four (4) hours. Observation patients may need progress notes less frequently.

i. 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.

j. All inductions will be discussed with the FM-OB attending who will be on call during the time of induction. Check the most current Faculty Call Schedule to determine who is on call at that time.

k. Once the patient is admitted to L&D, the admission documentation and orders 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. Bishop scoring and estimated fetal weight should also be documented as appropriate.

l. Any change of care for L&D patients require a progress note and notification of the FM-OB attending. Before performing AROM, placing an FSE or an IUPC, or starting an induction or augmentation, 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.

m. OB patients do not require a note from the FM-OB attending in order to get an epidural.

n. 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. Reviewing placental location and all other details on ultrasound reports are also very important.

**6. <u>OB/GYN BACK-UP</u>**

a. Consultation by OB/GYN does not transfer care unless agreed upon by the OB/GYN and the admitting FM-OB.

b. Risk stratification protocols 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.

c. 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.

d. All requests for consultation will be documented in the medical record.

e. 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 the OB/GYN, he/she should continue to follow the chain of command set forth in hospital policy.

f. 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. <u>CONTINUITY OBSTETRICAL PATIENTS</u>**

a. 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 faculty must be informed about who will be covering for the continuity physician.

b. All patients on L&D require close observation and monitoring. Progress notes are expected at least every two (2) hours, or even more frequently if unstable, for patients in active labor and those undergoing induction/augmentation with Pitocin infusion and for those with PIH/preeclampsia on magnesium infusions.

c. 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.

d. 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.

e. When a resident is unavailable because of vacation or scheduled rotation, he/she must designate either the OB/Peds 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 via the leave request forms ("blue sheets"), and will provide updated schedules for Labor & Delivery. Patients should also be notified.

f. 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.

g. 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.

h. 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 (if applicable) 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.

i. The resident who manages the patient's labor will have priority for performing the delivery or assisting in an operative delivery.

## N.3.0. GYN ROTATION

1. CLINIC RESPONSIBILITIES

   a. Responsible for seeing patients in the High Risk OB, Gynecology/Colposcopy Clinics, and assisting with surgical cases with the OB/GYN faculty.

   b. Other clinic responsibilities remain the same.

   c. When not in continuity clinic, the resident should shadow the OB/GYN faculty member(s), to all surgeries and other procedures unless the patient's continuity resident is participating in the procedure.

2. OUTPATIENT GYN SURGERY (DAY SURGERY) RESPONSIBILITIES

   a. The resident assigned to the GYN Rotation is expected to attend all outpatient GYN surgeries unless they are scheduled in their own clinic. If there isn't a GYN resident, the OB team will be notified of the surgery and a resident member of the team may participate in the procedure if they are available and desires to do so.
   b. The outpatient GYN surgery patient will be admitted to the surgeon who is performing the surgery. He/she will be responsible for the admission/discharge of the patient as well as the dictation, orders, and any questions regarding the patient. The GYN surgeon may direct the resident to assist with any of the above duties as he/she sees appropriate.

3. INPATIENT RESPONSIBILITIES

   a. Inpatient surgeries will be admitted to the GYN surgeon of record and the OB/Peds team will be consulted for medical management of the patient while in the hospital.

   b. 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.

   c. The OB/Peds team will round on the patient daily and document a progress note in the chart and write orders.

   d. The Lone Star OB/GYN surgeon will round on the patient.

   e. The resident on the GYN rotation is responsible for rounding on the patient daily and placing a OB/GYN progress note on the chart.

   f. Medical issues or questions during the day and at night will be handled by the OB/Peds resident and the FM-OB attending. OB/GYN surgeon may be contacted when appropriate or if there are any questions or concerns.

g. Surgical issues or questions will be handled by the OB/Peds resident in consultation with the OB/GYN surgeon.

h. ED patients with OB/GYN conditions will be admitted to the OB/Peds service and the Lone Star OB/GYN will be consulted. The OB/GYN will manage the GYN related condition. The OB/Peds team will round on the patient and manage the medical aspect of the case.

4. OTHER RESPONSIBILITIES

a. Prepare and present a GYN based didactics lecture and present the lecture at resident didactics during the rotation. You must schedule this lecture with the chief resident(s) ahead of time.

## N.4.0. SURGERY ROTATIONS

The 4 weeks of general surgery rotations involve assignments to work with one or more of the private attending surgeons at Conroe Regional Medical Center, possibly at the local Surgery Center, and at the private physician's office. 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 their own continuity clinic during scheduled clinic times. Residents may not be excused from clinic without prior approval by the Program Director or designee.

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 by the Program Director or designee.

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

Surgical subspecialty rotations include, but not limited to, ENT, ophthalmology, urology and orthopedics.

## N.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. 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.

## N.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 that the Residency Review Committee and the American Council of Graduate Medical Education (ACGME) 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 Programs' 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.

## N.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 at least a two-week Geriatrics rotation under the supervision of the Geriatrics Director.

1. Nursing Home rounds are made every Wednesday afternoon of every week. Third-year residents on call for the hospital, whether from home or in-house, are also on call for nursing home patients during work hours and after hours. 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. The faculty on call for medicine admissions is available for nursing home issues if the resident on call wishes to consult with an attending.

2. Every patient's chart in the nursing home should carry a resident name label. When a patient is newly admitted, the admitting resident name label should be clearly displayed on the chart until this new patient becomes assigned to a different resident.

3. If a resident is unable to attend nursing home rounds, they must have their absence approved in advance by the Geriatrics Director. 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 responsibilities.

4. RESPONSIBILITIES: Primary Physician for at least two long-term patients.

    a. Initial and yearly H&P (Annual assessment)

b. Monthly visits with appropriate documentation (progress note)

c. If you will be away on the first Wednesday of the month, you must inform the Geriatrics Director one week in advance of vacation, CME, or sick leave and one week in advance of Night Float.

d. Notify the Geriatrics Director in advance if you will be unavailable for call coverage.

e. Read ABFM modules as assigned.

f. Evaluate assigned skilled (short-term) patients as needed.

5. You are expected to see your "buddy's" continuity nursing home patient during nursing home rounds if (s)he is unable to attend.

6. NEW ADMISSIONS: All patients must have an H&P within 48 hours of admission.

   a. All new Daytime Admissions during work hours go to the Geriatrics Director.

   b. All new After Hours Admissions will be called to and reviewed by the third-year on call. If the resident is concerned about a certain patient, (s)he should call the attending on call to discuss the issue.

   c. Weekend Admissions starts on Friday 8:00 AM and will continue until Monday 8:00 AM, and those admissions will be taken care of by the third-year resident on call for the weekend.

      i. Patients admitted Thursday or Friday must be seen on Saturday morning.

      ii. 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) on Monday morning.

7. PROTOCOL TO TRIAGE NEW ADMISSIONS:

   a. Get all demographics – Name, room #, DOB, insurance (medicare/Medicaid/TXHS)

   b. Get admission diagnosis + other diagnoses.

   c. Get CMP, especially creatinine level.

   d. Review all medications and adjust doses based on their estimated GFR.

   e. Call the attending on call and check out to them your plan of care.

   f. Send the Geriatrics Director an e-mail with demographic and diagnosis information, as well any other important updates, so that the patient may be assigned as soon as possible.

i. If the e-mail is not sent, the resident taking the call will continue to take care of the patient until the patient is assigned to another resident.

ii. As a consequence of not reporting an admission to the Geriatrics Director in a timely manner, the resident will be assigned to round on a Saturday or Sunday on Medicine service.

**N.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 Care of the Medically Underserved block.

3. If you are concerned about safety, please consider traveling as a pair with another resident; but the same patient CANNOT be used by each resident to fulfill the requirements.

4. Use common sense when doing the home visits and schedule during daylight hours.

5. A special home visit "doctor's bag" containing a blood pressure cuff and thermometer is available for check-out from the Orange Pod of the FMP.

6. The Home Visit Documentation Worksheet (on shared drive) is to be completed for the visit and then scanned into the electronic health record upon returning to the clinic.

    a. 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 physician.

7. If you have any concerns or questions during the home visit, contact one of the precepting or on-call faculty by phone to discuss it.

8. A brief summary of the visit should be entered into the EHR and sent to a faculty preceptor to review, and then signed off/closed by the resident as a Home Visit (not an Office Visit). This summary must be done for each home visit and signed off as a Home Visit. The EHR program can track how many home visits have been performed to meet the requirements.

**N.9.0. SCHEDULED TIME OFF**

While away from the program, but not on an approved leave, residents are to maintain access to receive pages and/or 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.

## O. LECTURE CURRICULUM GUIDE

Generally scheduled Wednesday 12:15 – 4:00 PM and the third Friday of each block 1:00 – 5:00 PM.

1. PURPOSE:

   a. To cover the breadth of problems presented to the Family Physician.

   b. To emphasize the Family Medicine perspective and philosophy.

   c. To emphasize the Family Physician's role in today's medical community and prepare for the future.

   d. To cover the most frequent problems and procedures essential to the practice of Family Medicine, as well as some of the more uncommon problems.

2. METHOD:

   a. Lectures are given in an 18 month cycle, allowing time to cover all the material and repeat it twice during a resident's three years of training.

   b. Stresses active participation by the residents.

3. ATTENDANCE:

   This is an integral part of the education process, therefore attendance is required.

   See section L.1.0. General Responsibilities.

4. PAGERS:

   During didactics, pagers will move up to the upper level residents and 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 actively delivering patient or going to the OR for a C-Section and desires to continue with that patient.

5. ELECTRONICS:

   The use of phones and other electronics during the lectures is strongly discouraged. This is rude to the speaker. The only exception should be if you are actively taking notes on the lecture and you have told the speaker ahead of time that you intend to do so. Emergent phone calls should be taken and you should quietly step out of the room for the call. Speakers may ask listeners to use their cell phones or laptops for some specific reason if desired.

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

## P. 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 can ask the senior resident on the service to talk with the resident about the mistake or can contact them directly at their

discretion. (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, also to assist residents as needed in providing their post-rotation noon conference.

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.

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.

12. Serve as faculty advisor to assigned residents.

13. Participation in faculty development.

14. Scholarly activity.

15. Oversight of quality improvement projects.

16. Participate in resident and faculty recruitment.

## Q. ACCESS TO ACADEMIC RESOURCES

### Q.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.

### Q.2.0. UP-TO-DATE

*Up-to-Date* is located on all hospital computers and is available as an app through the hospital's subscription.

### Q.3.0. CHALLENGER

All residents have access to Challenger modules. Residents are encouraged to use this valuable resource for added reading on rotations. Modules may be assigned by the faculty at any time if there is a perceived need of further education on a given topic.

**Q.4.0. HCA Library**

This comprehensive library is available through MedHub.

**Appendix A**

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

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

Advisor's Name: _____ Date: _____

| | YES | NO | COMMENTS |
|---|---|---|---|
| **PATIENT CARE** | | | |
| The Resident has received satisfactory evaluations in all clinic rotations, or has completed remediation. | | | |
| The Resident is able to perform with limited independence in clinical situations. | | | |
| The Resident shows developing clinical judgment in patient care. | | | |
| The Resident has established and maintained documentation of procedural competence/experience and has met the minimum number of suggested procedures. | | | |
| The Resident has maintained required patient logs. | | | |
| The Resident has recorded:<br>150 continuity visits in the Lone Star Family Health Center<br>5 continuity deliveries this academic year<br>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: | | | |

| INTERPERSONAL AND COMMUNICATION SKILLS | | | |
|---|---|---|---|
| The Resident has developed appropriate interpersonal and communication skills that result in teaming with patients, their families and professional associates | | | |
| ACGME Milestones: Level 2 | | | |
| 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:<br>Hospital medical records<br>Clinic medical records including review of labs & x-rays<br>Medicare time sheets (pink sheets) | | | |
| ACGME Milestones: Level 2 | | | |
| Comments: | | | |
| **SYSTEMS BASED PRACTICE** | | | |
| The Resident allocates resources, coordinates services, and advocates for quality, cost-effective care. | | | |
| ACGME Milestones: Level 2 | | | |
| Comments: | | | |

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

_____

_____

Resident's Signature: _____ Date: _____

Faculty Advisor's Signature: _____ Date: _____

Program Director's Signature: _____ Date: _____

**Appendix B**

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

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

Advisor's Name: _____ Date: _____

| | YES | NO | COMMENTS |
|---|---|---|---|
| **PATIENT CARE** | | | |
| The Resident has received satisfactory evaluations in all clinic rotations, or has completed remediation. | | | |
| The Resident is able to perform with limited independence in clinical situations. | | | |
| The Resident shows developing clinical judgment in patient care. | | | |
| The Resident has established and maintained documentation of procedural competence/experience and has met the minimum number of suggested procedures. | | | |
| The Resident has maintained required patient logs. | | | |
| The Resident has recorded:<br>Minimum of 650 continuity visits in the Lone Star Family Health Center<br>10 continuity deliveries<br>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:<br>Hospital medical records<br>Clinic medical records including review of labs & x-rays<br>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: _____

**Appendix C**

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

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

Advisor's Name: _____ Date: _____

| | YES | NO | COMMENTS |
|---|---|---|---|
| **PATIENT CARE** | | | |
| The Resident has received satisfactory evaluations in all clinic rotations, or has completed remediation. | | | |
| The Resident is able to perform with limited independence in clinical situations. | | | |
| The Resident shows developing clinical judgment in patient care. | | | |
| The Resident has established and maintained documentation of procedural competence/experience and has met the minimum number of suggested procedures. | | | |
| The Resident has maintained & completed required procedure logs. | | | |
| The Resident has recorded:<br>Minimum of 1650 continuity visits in the Lone Star clinic<br>Minimum of 40 deliveries (10 continuity + 30 other deliveries)<br>2 home visits during training<br>2 continuity nursing home patients this academic year | | | |
| ACGME Milestones: Level 4 | | | |
| 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 4 | | | |
| Comments: | | | |
| **SYSTEMS-BASED PRACTICE** | | | |
| The Resident has developed & presented a completed scholarly project. | | | |
| The Resident has maintained a current Curriculum Vitae on file. | | | |
| The Resident is competent to teach and supervise medical students and junior residents. | | | |
| The Resident is able to use technology and access data to support their own education. | | | |
| ACGME Milestones: Level 4 | | | |
| 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. | | | |
| ACGME Milestones: Level 4 | | | |
| 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:<br>Hospital medical records<br>Clinic medical records including review of labs & x-rays<br>Medicare time sheets (pink sheets) | | | |
| ACMGE Milestones: Level 4 | | | |
| Comments: | | | |
| **SYSTEMS BASED PRACTICE** | | | |
| The Resident allocates resources, coordinates services, and advocates for quality, cost-effective care. | | | |
| 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: _____

**Appendix D**

# PROCEDURE EXPECTATIONS AND REQUIREMENTS FOR TRAINING

Conroe Family Medicine Residency

- 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 Med Hub Procedure log to their May/June advisor meeting.
- A good goal is that at least 50% of all procedures 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.
- All procedures should be sent to the preceptor promptly to confirm.
- Procedures done with outside faculty should be sent to the resident's advisor with the name of the outside faculty noted on the procedure entry.
- Due to varying privileging requirements across hospitals, medical groups, etc. the program cannot guarantee privileging.

| EXPECTED PROCEDURES | MINIMUM EXPECTED FOR GRADUATION |
|---|---|
| **Circumcision** | 10 |
| **Biopsy-Punch/Shave** | 5 |
| Biopsy-Full Thickness Excisional | 5 |
| Cryotherapy/Liquid Nitrogen | 5 |
| Laceration Repair | 10 |
| Toenail Wedge Resection | 3 |
| Pap smear | 15 |
| Care of Hospitalized Adults | 750 |
| ICU Encounters | 30 |
| Family Meeting (coordinate & facilitate) | 3 |
| Abscess I&D | 5 |
| Central venous line insertion | 3 |
| Arterial line insertion | 1 |
| Endotracheal intubation | 10 |
| Endometrial Biopsy | 3 |
| Exercise Stress Test | 5 |

| | |
|---|---|
| Colposcopy | 5 |
| Joint injection | 10 |
| Casting | 5 |
| Splinting | 5 |
| OB Deliveries | Total of 40 deliveries including continuity deliveries |
| **Continuity OB Deliveries** | 15 |
| Ill Child Visits in Hospital and/or ER | 250 |
| Inpatient Child Visits | 75 |
| ER Child Visits | 75 |
| Newborn Encounters | 40 |
| IUD | 5 |
| Home Visits | 2 |
| EKG Interpretation | 15 |
| X-Ray Interpretation | 15 |