

RESIDENT RESPONSIBILITY

This Policy Manual is updated on an annual basis and is available in both electronic and paper copy for resident review. It is required that the resident be aware of the information contained in this manual and follow the policies contained herein.

GOALS OF FAMILY MEDICINE RESIDENCY

Family Medicine is comprehensive medical care, with particular emphasis on the family unit, in which the physician's continuing responsibility for health care is neither limited by the patient's age or sex nor by a particular organ system or disease entity.

As a specialty, it builds upon a core knowledge derived from internal medicine, pediatrics, obstetrics and gynecology, surgery and psychiatry. By combining these traditional clinical sciences with the behavioral sciences, the family physician is prepared for a unique role in patient management and education, problem solving, counseling and coordination of total health care delivery.

Residents in Family Medicine should be specifically trained to develop the unique attitudes and skills which qualify them to provide this type of care whether the problem is identified as biological, behavioral, or social. They should also learn about the appropriate use of consultants.

The functions of the Family Medicine resident are multiple - learning, providing patient care and teaching. Residents are urged to become involved in policy-making decisions; implementation must rest with the chairman, program director, and faculty.

Residency Requirements

The Review Committee for Family Medicine, The American Board of Family Medicine and this program have established minimum requirements that all residents must meet in order to complete the program and sit for boards. Residents should familiarize themselves with the requirements and be pro-active in attaining them. Progress towards completion of the requirements will be shared with each resident as part of the 4 month triennial evaluation.

The following are the minimum expectations of the program:

- Successful completion of 36 months of training
- Attainment of the 6 core competencies as outlined by the ACGME
- Completion of a Senior Project (scholarly activity)
- 1650 continuity clinic visits over 36 months
- 10 continuity OB deliveries and 40 total deliveries
- 2 documented home visits from your continuity panel
- 1 training room visit and 1 sideline event for sports medicine

Failure to reach these requirements will result in your extending your residency until they are met.

FAMILY MEDICINE OUTPATIENT SERVICES

The University of Nebraska Medical Center has a number of clinics in the Omaha metropolitan area, many of which are staffed in part or solely by family physicians. Residency training in family medicine is currently conducted at the Durham Outpatient Care Center on the main campus, Summit Plaza in Bellevue, UNMC Physician West in west Omaha, the One World Community Health Center (OWCHC) in South Omaha, and the Family Medicine Clinic at Ehrling Bergquist Clinic (EBC), Offutt Air Force Base. In addition, family physicians provide services in the South Omaha Neighborhood Association building in south Omaha, the Eagle Run facility in northwest Omaha, and the Baker Place Health Center in north Omaha. Other clinics in the University system include: Turner Park in eastern Omaha, the Plattsmouth facility in Plattsmouth, Nebraska, and the Brentwood Village clinic at 84th and Giles Road, LaVista.

In each residency training clinic there is a Physician Manager who has the responsibility for overseeing the clinical activities of the clinic. These include: Dr. Douglas Wheatley at DOC, Dr. Carol LaCroix at UNMC Physician's West, Dr. Dan Halm at Summit Plaza, and Dr. Kris McVea at OWCHC.

University of Nebraska Medical Center Physician's (UNMC Physician's) is the group practice at the University of Nebraska Medical Center (UNMC) with over 275 specialists in all major medical fields. Major sites of care are at Nebraska Medical Center University and Clarkson towers, DOC, and select services are available across the community. UNMC Physician's participates in multiple health care plans. These range from traditional indemnity and discounted fee-for-service plans such as Blue Shield of Nebraska or Blue Shield of Iowa, managed care plans such as United Healthcare, ExcluciCare, Principal, and a variety of other products. In addition, the Medicaid system has gone to two basic plans, one a more traditional modified fee-for-service plan administered via HMO Nebraska which is called Primary Care Plus. UNMC Physician's participates in a managed care plan for Medicaid, called Share Advantage.

Because of the changing nature of health care systems, there have been ongoing changes in alliances, partnerships, and with health care insured. The above description outdates on almost a daily basis. Don't worry if you haven't got it all straight, it will change by the time you revisit the topic.

Residents assigned to UNMC Physician's Clinics – DOC, UNMC Physician's West, SP

Radiologic services are available at each clinic. The University Clinic utilizes x-rays through the Radiology Department of NMC Hospital and the UNMC Physician's West Clinic utilizes the radiology group at Clarkson West. On site radiology equipment is

available at Summit Plaza. X-rays obtained at Summit Plaza are usually read by the resident and staff physician at that clinic; over reads and second opinions are obtained through the Radiology Department at NMC Hospital and at Clarkson West. EKG equipment is available at all clinics and EKGs are read at each separate clinic. However, over reads are available through the Cardiology Division. Each laboratory is equipped with typical outpatient services which include hematocrit, urinalysis, microstix, dipstix testing, Uricults, wet mounts, and hemocults to name a few. Also available are some commercially available tests including gravindex, monospot, Strep screen, and Dextrostix. Full laboratory evaluations can be obtained at each clinic through the Department of Pathology. Blood is drawn on site at each clinic and regular daily pick up makes any test readily available. Each clinic also offers some minor surgical procedures including flexible sigmoidoscopy with biopsy, vasectomy, colposcopy, endometrial biopsy, and mole removal. In addition, ETT is available at Summit Plaza and UNMC Physician's West.

Student Health Services are provided by the clinic at DOC and have a select staff that provides coverage.

Residents assigned to the One World Community Health Center (OWCHC)

Ninety percent of the adult patients and 40% of the pediatric patients seen at the OWCHC do not have insurance coverage. The center is able to provide free laboratory services through Creighton Labs, and provides on-site phlebotomy and specimen collection. Radiology studies are arranged at 10% of usual charges through the donated services of a private radiology group, Radiology Consultants, for those patients without insurance. Radiology services for insured patients are arranged at Saint Joseph Hospital or Nebraska Health Systems. The clinic is equipped to evaluate KOH and wet preps. On-site diagnostic labs include hematocrit, urinalysis, pregnancy tests, Hgb A1C and cholesterol. The clinic offers a variety of minor office procedures including EKG, pulse oximetry, tympanometry, endometrial biopsy, colposcopy, rapid strep testing, limited OB ultrasound, Nitrizine testing, Fern testing, vasectomy, cryotherapy, and minor dermatological and surgical procedures. Consultations are available with a wide variety of disciplines through the Project Hope program for patients without insurance. The clinic offers on-site OB/GYN, ophthalmology, infectious disease, pediatrics, orthopedics, ENT, diabetic teaching, lactation consultation, neurology, mental health counseling and dental referrals.

Residents assigned to EBC

The Family Medicine Residency (FMR) Clinic at Ehrling Bergquist Clinic is attached to an ambulatory hospital and utilizes the laboratory, radiological and cardiopulmonary services on an acute and routine basis. X-rays obtained on an acute basis during clinic hours are wet read by the radiologist. Laboratory services are located on the ground floor where routine and stat specimens are obtained and diagnostic studies performed. The clinic is equipped to evaluate KOH and wet preps, OB ultrasound, Nitrizine testing and Fern

testing. Consultations are available with a wide variety of disciplines including general surgery, urology, orthopedics, ENT, ophthalmology, dermatology, internal medicine, audiology, cardiology, pediatrics, and OB/GYN. The clinic offers a wide variety of minor surgical procedures including flexible sigmoidoscopy with biopsy, vasectomy, endometrial biopsy, exercise treadmill testing, direct nasolaryngoscopy, colposcopy/cryotherapy, LEEP, sclerotherapy, EGD, colonoscopy and minor dermatological procedures.

Information regarding all clinics

Although the clinic schedule varies with each rotation, residents are scheduled for 1-2 half-days per week during the first year, 2-3 half-days per week during the second year, and 3-4 half-days per week during the third year at each particular clinic that they are assigned. Rural Fellows see patients in their continuity clinics two half-days/week.

All clinics are open daily, Monday through Friday, with clinic hours as follows:

DOC	0800-1900 Mon.-Thurs., 0800-1700 Fri., 0800-1200 Sat.
UMA West	0730-1930 Mon.-Thurs., 0730-1700 Fri., 0800-1200 Sat.
Summit Plaza	0800-2000 Mon.-Thurs., 0800-1700 Fri., 0800-1200 Sat.
OWCHC	0800-1800 Mon-Fri.
Eagle Run	0800-1700 Mon., Wed., Thurs., Fri., 0800-2000 Tues.

(The non-residency clinics have similar hours. Check a current locations guide for hours and staffing.)

EBC - 0730 - 1630.

All residents assigned to do their monthly rotation at EBC (no matter what service/rotation they are assigned), are required to attend Family Medicine Residency (FMR) Rounds. FMR Rounds are held at 1200 – 1300 on Tues./Thurs/Fri. in the FM Conference Room. UNMC Grand Rounds are viewable every 2nd and 4th Wednesday in the Commander's Conference room.

Residents in the first year are scheduled to see a minimum of four patients for the first four months and then advance in patient numbers as skill levels increase. Second- year residents will see at least 6 patients per half-day and third-year residents at least 8.

The RRC for Family Medicine requires that residents see 1650 patients in their continuity clinics during their residency. At least 150 of those visits must occur in the HOI year.

The following is the schedule for number of days a resident spends in clinic while on the various rotations throughout the three years of training

HO I	Emergency Medicine	2 half-days
	In-Patient Family Medicine (3 months)	1 half-day
	Out-Patient Pediatrics	2 half-days
	In-Patient Pediatrics	1 half-day
	Surgery	2 half-days
	OB	2 half-days
	OB/FM	1 half-day
	Orientation/Comm Med	1 half-day
HO II	Cardiology	3 half-days
	Trauma	2 half-days
	Allergy/Immunology/ENT	4 half-days
	Orthopedics	2 half-days
	GYN	2 half-days
	Nephrology/Urology	3 half-days
	Rheumatology	3 half-days
	DEM	3 half-days
	IP FM- Mole	1 half-day
	Behavioral Medicine	3 half-days
ENT/Ophthalmology	3 half-days	
HO III	Clinical Chief	2 half-days
	Geriatrics	3 half-days
	Dermatology (2 weeks)	1 half-day
	Advanced Peds	4 half-days
	Pediatric Elective	4 half-days
	Rural Rotation	0 half-days
	Rural Rotation	0 half-days
	Practice Management	4 half-days
	Elective	4 half days
	Elective	4 half days
Elective	4 half days	
Elective	4 half days	

Starting July 1, 2009, all 2nd and 3rd year residents will be assigned one fixed clinic half day per week regardless of clinic rotation. Additional half day clinics will be based on clinical rotation for that month. The goal is to increase continuity and improve clinic operations.

Individual resident initiative is invaluable, especially on the first contact with any patient and is best shown by: 1. Encouraging families to return. 2. Explaining the Family

Medicine concept to the family. 3. Identifying numbers to call day or night and on holidays. 4. Identifying the resident's partners and seeing to it that one member of the partnership is available for special circumstances (i.e. with an OB near term and a resident planning a weekend out of town). The family should be given a business card with the resident's name on it to help patients remember the name of their physician.

Patients presenting at any one of the UNMC Physician's and OWCHC Family Medicine training clinics will be assigned to a resident in an effort to eliminate the casual patient contacts, which distract from the time that residents and staff can devote to ideal family practice care. The residents will see walk-ins and call-ins as the clinic Physician Manager designates.

Residents assigned to EBC will have families empaneled into their practice in numbers commensurate with the number of clinics per week and level of training; generally, 125 patients for first years, 250 for second years, and 300 patients for third years.

Residents are responsible for maintaining quality and continuity of care with these families. The residents will see routine and acute problems during their clinic hours and may be asked to see walk-ins as the Physician Manager or preceptor designates.

All clinic encounters at UNMC Physician's clinics will be dictated on the same day of the patient contact, and charts will be up-dated in a timely fashion and information promptly put into the charting system for smooth flow of patient care. Charts at EBC will utilize the electronic medical records system ALTA2.

All clinic encounters at OWCHC will be handwritten on the same day of the patient contact. As the EHR system becomes fully implemented during the 2009-2010 year, daily completion of notes will be expected. Patient flow sheets and problem lists must be updated at every patient encounter. Project Hope referrals should be discussed with the attending physician to ensure that proper procedures are followed. Prescriptions written for patient assistance programs must utilize the appropriate formulary.

The problem oriented medical record format should be used as much as is feasible. Communication about ongoing patient care with the outpatient attending staff of each particular clinic is not only appropriate but essential. The first year house officers are expected to present each patient to the attending staff during the first six months of their clinic experience; otherwise, discussion with attending faculty is deemed appropriate when assistance is necessary. All charts are co-signed by the attending physician who is staffing that day in the clinic, and any comments and suggestions for change in therapy are discussed on an individual basis between the attending physician and resident. HMO patients are be discussed with the attending staff if it requires referral as certain procedures are followed in terms of the referrals or prescriptions being utilized. It is very important for the resident to try to maintain continuity of care with his or her patients, and good communications are essential for dissemination of information and care.

Medicare regulations require the active participation of the billing physician. Your clinic Physician Manager will explain the procedure for Medicare patients.

Residents on EBC rotations will order all services required on their patients by placing the orders in the CHCS computer system. All results of lab tests and radiological services can be found on the CHCS computer service, which is available to all residents. All residents will be oriented and briefed on the computer systems at EBC when they first arrive or on the first day of their first rotation at EBC.

RESPONSIBILITIES OF PHYSICIAN MANAGERS AND CLINIC TEAM LEADERS

A Physician Manager is responsible for the clinical activities at each family medicine continuity clinic. Physician Managers are in charge of residents' clinical activities and establishing policies with regard to them, in conjunction with the Clinic Education Coordinators, the Program Director and Department Chair. Preceptors and Physician Managers will work with residents to ensure appropriate billing. Residents should feel free to offer suggestions to the Physician Managers and Clinic Team Leaders on ways to improve their experience in the clinic. Physician Managers will help adjudicate disputes concerning clinical care and educational issues should these arise.

CLINIC EDUCATION COORDINATORS

The Residency Review for Family Medicine and American Board of Family Medicine require that, during the course of their Family Medicine residencies, residents spend a significant portion of their time in their Family Medicine Center (FMC) clinic.

When one considers that this time allotment constitutes at least 1 of the 3 years of Family Medicine training, it is clear that a substantial portion of the training curriculum is intended to take place in the FMC.

Because of the increasing clinical demands being placed on the clinic Physician Managers, they, generally, do not have time to deal with educational matters that involve residents assigned to their FMC. Therefore, there is a need for a Clinic Education Coordinator at each of our FMC's who can focus on the educational needs of their residents.

Although the Education Coordinators should be generally available to anticipate and address educational issues that come up at their respective clinics, there are some specific activities that are common to all Education Coordinators. These include:

1. Preparation of resident FMC schedules

2. Insuring that resident advisors meet, and document their meeting, with their advisees on a triennial basis.
3. Meeting with clinic support staff on a triennial basis to gather their input on resident performance (360 degree evaluations).
4. Insure that triennial resident evaluations are completed in a timely manner.
5. Attend the triennial faculty evaluation meeting and be prepared to discuss the performance of the residents assigned to his/her FMC, particularly in the absence of a faculty advisor.
6. Monitor patient load for its appropriateness and determine when a resident is ready to see an increased volume of patients.
7. Monitor residents' schedules to insure that each resident is receiving a balanced patient load with regard to OBs, well-child exams, distribution of procedures, etc..
8. To monitor clinic function and make recommendations for improvement to the Physician Managers so as to insure that residents are receiving their training in what is truly a "model clinic".
9. Insure that residents have the opportunity to see their patients in continuity and that use of resident clinic time for non-continuity acute care patients is kept to a minimum.
10. Insuring that departmental vacation and absence policies are fairly enforced.
11. Reviewing resident quarterly production figures and counseling residents on areas for improvement.
12. Making sure that resident scheduling is such that the resident is allowed adequate time to attend required conferences.
13. Monitoring resident attendance at noon conferences via the Internet (as it becomes available) and be available during the conference to answer questions.
14. Being available to assist/answer questions for rotating medical students, as needed.
15. Making sure that FMC residents have the opportunity to perform procedures that are done in some FMCs and not others, such as ETTs, nasopharyngoscopy, etc..
16. Completing the appropriate RRC documents that pertain to resident education in their FMC.
17. Attend the CEC meeting, 1200-1300, on the third Thursday of each month.

The CECs are:

- EBC - Brent Barnstuble, M.D.
- UNMC W - Lisa Backer, M.D.
- Summit Plaza - Jeff Harrison, M.D.
- OWCHC - Greg Babbe, M.D.
- DOC - John Smith, M.D.

PROCEDURES CURRICULUM FOR FAMILY MEDICINE

House officers will have the opportunity to develop the knowledge base and hands-on skills in the performance of procedures currently performed by family physicians.

House officers will be expected to familiarize themselves with indications, as well as technique needed, for performance of each procedure, including patient education, consent, indications and contraindications, and pre- and post-procedure care prior to performing such procedures on a patient.

Specific workshops will be held throughout the house officer's tenure to offer the opportunity of honing the skills and hands-on techniques.

House officers will be expected to arrange time to perform procedures on their patients by proper scheduling in their clinics and arrangement with appropriate faculty. It will be the house officer's responsibility to provide patient education, gain consent and provide the necessary post-procedure education, notification of results and follow-up on their respective patients.

PALM PILOTS

The Department of Family Medicine will reimburse each resident \$200 for the purchase of a Palm Pilot or Palm Pilot programs.

PROCEDURE TRACKING

The New Innovations Internet Procedure Logger program is used to document all of the procedures that residents do while they are in residency. The program allows residents to log their procedures from any Internet ready computer. They can also download the program to their Palm. The program allows the program director, the residency coordinator and the residents to print/view customized reports on their procedure totals. It is the resident's responsibility to maintain/update their procedure totals. When they have completed the program, a copy of their procedure totals will be kept in their permanent records. **Procedure logging is a requirement of the RC for Family Medicine, therefore, tracking the procedures is not optional.**

GERIATRICS

Geriatrics is an increasingly important part of Family Medicine. Family physicians play a vital role in providing care for a growing elderly population.

Because of the importance of Geriatrics and the central role of family physicians in providing this care, the Department has developed a comprehensive curriculum in Geriatrics for residents training in Family Medicine. This curriculum is under the supervision of Tim Malloy, M.D., geriatrician/family physician, Rebecca Wester, M.D., Kalpana Padala, MD and Margaret Runyon, APRN, geriatric nurse practitioner. Any questions or concerns about any aspect of Geriatrics should be directed to one of them.

The curriculum includes: (1) a core lecture series on topics in Geriatrics, (2) a longitudinal nursing facility experience (see below), and (3) a block rotation devoted exclusively to Geriatrics.

GERIATRIC BLOCK ROTATION

The rotation in Geriatrics done by all residents during the HO II or HO III year provides a multi-dimensional exposure to Geriatrics, including ambulatory Geriatrics, assisted living facilities, skilled nursing facility care, and the opportunity to prepare and present a lecture/discussion on a selected topic in Geriatrics. You will be provided with a schedule specific to the month that you are taking the Geriatrics rotation. If you have questions about the rotation, please get in touch with Margaret Runyon, APRN, coordinator of the rotation.

POLICY FOR NURSING FACILITY CARE BY FAMILY MEDICINE RESIDENTS

Nursing Facility rounds/responsibilities

An important component of Geriatrics is the provision of care to nursing facility patients. In fact, many family physicians serve as medical directors of nursing facilities. The practice of medicine in nursing facilities presents many unique challenges which all too often are not addressed in medical training.

The Nursing Facility experience is an opportunity to gain exposure to a nursing facility setting and to develop effective management strategies for nursing facility patients.

As an incoming House Officer you will be assigned 2 or 3 patients at the Hillcrest Care Center (291-8500) for whom you will be the continuity physician throughout the 3-year training period. As the primary care physician, **you will be on call for the everyday management of these patients.** The nursing staff at the care center will be direct-paging you for your input into the management of these patients. Active physician involvement is essential.

As a primary provider you, as the assigned physician, will be involved in routine medical management and such important decisions as transferring to hospital for admission and decisions

about life-sustaining treatments. Questions regarding the management of these patients can be directed to Tim Malloy, M.D.. You **must be available** to field questions from the nursing staff or make arrangements for coverage (described elsewhere).

Availability and accountability for front line management of the nursing facility patients is the most critical element in the success of this educational program. Active physician involvement is absolutely essential to the success of the nursing facility experience and those physicians who take this approach find the experience the most rewarding. When your nursing facility patients are hospitalized, they will be cared for by the Family Medicine inpatient service. Your input to the hospital decision making process is valued and encouraged. You might be aware of important information from the patient's history that will be helpful. Following hospital discharge, you should visit your patient as soon as possible at the nursing facility to confirm orders and resume control and management.

Tim Malloy, M.D., Director of the Section of Geriatrics in Family Medicine, is the principle supervisor for both the month-long geriatrics rotation and the longitudinal nursing facility experience 24 hours a day, and Margaret Runyon, APRN manages many of the details involved.

When you receive a call from the nursing facility about your patient, you may be able to adequately manage the patient over the phone. However, **there will be instances when you need to go to the nursing facility, within a day or two of the call**, to see the patient. If your schedule does not allow you to get to the nursing facility in a timely fashion and it is a non-emergent situation, you **MUST** page the resident on the Geriatrics rotation (888-0500) and ask him/her to see your patient during weekly pre-rounds.

If you have any questions or concerns regarding your geriatric patients, you should check with Dr. Malloy. In general, before you transfer a geriatric patient from one of the nursing facilities to the emergency department or to the hospital for admission, you should first consult with Dr. Malloy. The in-patient attending physician may also occasionally provide staff coverage for the geriatric service, particularly when Dr. Malloy is unavailable.

Supervised nursing facility rounds will be made with Tim Malloy, M.D. at the Hillcrest on Thursday mornings, beginning at 7:00 a.m. Three to five residents will be scheduled each week with approximately 15 - 20 minutes/patient. Rounds will take approximately 90 minutes. When you are scheduled for nursing facility rounds, **you must notify your clinic or your service that you will not be available until 9:00 a.m.** because of your obligations at the nursing facility.

Because federal law requires that nursing facility patients be seen every 60 days, **you will be scheduled to visit your nursing facility patients once every two months**. You may also be called to do an "independent visit" on one of your patients if you do not make nursing facility rounds during the requisite 60 days. When one of your nursing facility patients becomes acutely ill or unstable, you might need to make several visits both with and without Dr. Malloy until you have your patient stabilized

Please **make pre-rounds on your nursing facility patients a few days prior to your scheduled rounds**. You should review the patients' charts, discuss the patients with the nursing staff, and see the patient during pre-rounds so that you can discuss pertinent points such as patient history, medication review, and clinical course at sit-down rounds. Morning rounds begin with brief sit-down rounds to discuss the patients with the director of nursing and Dr. Malloy.

Generally, we will try to notify you several weeks prior to your scheduled nursing facility rounds. Someone will also try to page you the day before, but please mark your calendar when you are first notified as we may not always be able to reach you the day before nursing facility rounds.

Due to vacations, scheduling conflicts, etc., some of the scheduled times undoubtedly will not work out. You **must** notify Margaret Runyon (Pager 888-5144) of any potential conflicts as soon as you receive notification of your nursing facility rounds.

You will be on telephone call for your assigned nursing facility patients Mon. - Fri. **If you are going to be unavailable for call, please make arrangements with one of your colleagues to cover your nursing facility patients**. Once your colleague has agreed to cover for you, you should call the nursing facility and ask to have a note put on your patients' charts telling the name of the resident covering for you and the dates that you will be gone. If you will be gone for any longer than a couple of days, it is a courtesy to check in with the nursing facility with a phone call upon your return.

Also, on weekends (5 p.m. Fri. - 8 a.m. Mon.), one of the residents participating in the Geriatrics rotation will be on call for all nursing facility patients. If your patients are acutely ill or unstable, it is a courtesy to "check out" with the weekend resident. In the event that there is no resident on the Geriatrics rotation, Dr. Malloy will be on call for all nursing facility patients.

Active participation in this aspect of the training program is required.

FAMILY MEDICINE IN-PATIENT SERVICE UNMC

All family medicine patients from the six UNMC Physician's clinics will be admitted to the family medicine service. The family medicine in-patient service will consist of three teams. Each team will be composed of 2 first year residents, a upper level supervisor and a faculty attending. In addition a second year resident will serve as the night float..

Residents referring their patients to the in-patient service are to remember that they are the "resident attending" physician. An admitting note must be written by the "resident attending physician". However primary patient care responsibility rests with the in-patient resident and clinical chief resident in consultation with the "resident attending physician". The Review Committee for Family Medicine expects residents to manage their continuity patients when they are in the hospital.

In order to make the admission process as efficient as possible and prevent over-utilization of ER space/personnel, and avoid extra costs to the patient, the following policies apply:

1. All admissions/transfers, whether initiated by residents or staff, must be approved by the In-Patient attending physician in order to ensure that bed space is available in the appropriate hospital/unit.
2. All transfers for "evaluation for admission" also need to go through the In-Patient attending physician, as above.
3. Direct admits should be coordinated through the faculty attending. Bed availability will determine where patients are sent.
4. In the event the faculty attending is unavailable, the Clinical Chief should be consulted.

When a patient is in the hospital the "resident attending physician" is expected to look in on his/her patient on a daily basis, write an occasional note on the chart, and generally follow the care of his/her patient so that the resident may resume continuing care of the patient after discharge from the hospital.

RESPONSIBILITIES AND DESCRIPTIONS OF THE IN-PATIENT TEAM:

A. First year house officers (Intern) Responsibilities and Expectations:

1. Will be responsible for FM in-patient medical care, under the direction of the inpatient supervisor.
2. Will be responsible for all admissions assigned to them by the clinical chief

Resident.. **Regular business hours are 7:00AM to 5:00PM. The interns should not expect to leave before 5:00PM unless it is approved by the clinical chief resident.**

3. Will do a history and physical on each of their new patients. This should be in both a written progress note and a dictation. Will work with the clinical chief resident or night supervisor in formulating a plan for each new patient. This plan should be discussed with the on call attending physician and amended as necessary.
4. **Will round on all of their patients, write progress notes, and be ready for rounds at 8:00AM. New admissions that occur between 5:30AM and 8:00AM will be done by the mole or clinical chief resident to allow the interns time to round.**
5. Will follow up on all labs and tests ordered for their patients. Will also be responsible for following up on recommendations from consultants. Essentially, the intern is “in charge” of their patients care under the guidance of the clinical chief resident, night supervisor, and the attending physicians on service.
6. **Will be responsible for doing timely and accurate discharge summaries. Typically, residents should discharge their own patients. Nevertheless, discharge summaries are the responsibility of the resident who signs the discharge paperwork. For patients with long, complicated hospital stays the resident who primarily cared for the patient is highly encouraged to do the discharge summary as a courtesy to his/her fellow residents.**
7. **Will present one case for morning report during each month on service.**
8. **Will have the opportunity to evaluate on a formal evaluation form the clinical chief resident, the night supervisor, and all attending physicians.** The clinical chief resident will distribute the evaluation forms.
9. Will not cover obstetrical patients except by prior arrangement on an individual basis, unless it is their own obstetric patient.
10. Will be allowed to leave the service at noon post-call in **all** cases after checking out with a fellow resident on the service as designated by the clinical chief.
11. Will not be assigned A.M. clinics or PM clinics post call while on the service.
12. Will be responsible for being in their assigned clinic on time while on the service.
13. **MUST always check out to a fellow resident all patients and things to be followed up on before leaving the hospital.**

B. Supervising In-House Resident

A second year night float (mole) will supervise the IP Service Monday through Thursday night for a one month block. The Friday evening through Sunday evening periods will be covered by the supervising resident for the on call team. Trading call is allowed, but it is the resident's responsibility to make sure that the final call schedule is accurate and that work hour guidelines are being followed.

Night Supervisor (MOLE) Responsibilities and Expectations:

1. Availability

- a. Monday through Thursday 6 pm to 8:00 am the following day.
- b. **The mole will NOT stay for morning rounds with the inpatient team. This will allow for the mandatory ten hour rest period between shifts.**
- c. Continuity clinics will be on Monday from 10am to 4pm.
- d. Residents will NOT attend Teaching Days.
- e. If the night float is unavailable (illness, continuity OB, etc.), then the clinical chief will assume those responsibilities.
- f. The night supervisor will be free of duties from Friday at 7 am until 10am on Monday.
- g. During those months when there are two night supervisors, each resident will serve as night supervisor for 2 consecutive weeks. The remaining time will be designated for continuity clinic or serving as a team supervisor.

Check out with the clinical chief resident will start promptly at 7:00AM. The mole can leave after check out as long as they are not working on a new admission.

2. The night supervisor will see all new admits either at the same time or after the work up has been completed by the intern.

- a. The supervisor will assess the patient, discuss the intern's plan and offer suggestions for care if needed.
- b. **The supervisor will write a brief admit note on each new patient in a SOAP note format.**
- c. The supervisor does not need to write out a complete H&P on each new patient.
- d. The supervisor or intern will discuss all new admissions with the attending physician.

During the hours of 5:30AM and 7:00AM on weekdays and 5:30AM and 8:00AM on weekends/holidays, the night supervisor will do all new admissions on their own without the help of the intern. The reason for this is to allow the

intern time to do morning rounds.

3. The night supervisor will be available to see previously admitted patients who the intern has evaluated and feels the need for upper level resident consultation.
4. The night supervisor will be available to take back up phone call.
The Call Center will triage all calls during non-clinic hours.
 - a. Calls felt to need MD input by the Call Center will be forwarded to the supervisor regardless of time.
 - b. A progress note will be generated for each phone encounter including the patient's name, birth date and clinic. These notes should be dictated on the transcription line.
 - c. The Call Center should be notified when changes to the schedule are made.
5. The night supervisor is NOT responsible for normal newborn care on infants delivered by the obstetrical service who have Family Medicine faculty identified as their pediatrician. The Family Medicine OB service will be responsible for these infants. Likewise, the night supervisor is NOT responsible for the care of any OB patients.
6. The night supervisor will be in charge of the Cardiology Clinic in the case where the external disaster plan is implemented. See page 25.
7. The night float will be responsible for their continuity OB patients during the rotation. The clinic chief resident will be available for backup.
8. Amenities:
 - a. A call room will be provided at University House; the key may be picked up daily at the front desk.
 - b. Meals are provided by the means of money being placed on your ID badges. You are also given a meal ticket for lunch (by Mary Vogel) for weekend or Holiday times when you are on call. The "lunch" tickets will be given to you at the beginning of the month. Money that is placed on your ID badges will be available during the current academic year.
9. **Will have the opportunity to evaluate the interns, clinical chief resident, and attendings on a formal evaluation form.** The clinical chief resident will distribute these forms.

Weekend Night Supervisor

In house call coverage will be provided by the supervising resident for the team on call..

1. Availability

A. The call will be divided into 3 separate shifts

1. Friday 6 pm through Saturday 8 am
2. Saturday 8 am through Sunday 8 am
3. Sunday 8 am through Monday 8 am.

2. Responsibility

- A. As listed above for night supervisor.

3. Amenities

- A. As listed above for the night supervisor.

4. In order to meet the 1 day in 7 free from all duty it is recognized the supervising resident will need to be given a week day off. This will be coordinated with the attending staff and Program Director.

C. University Hospital Sleep Room Protocol

The University Hospital furnishes sleep rooms for House Officers in accordance with the College of Medicine (COM) House Officer Agreement. Hospital sleep rooms are assigned to COM departments based on need requirements as approved by COM through the Graduate Medical Education Program. The following outlines the commitment of University Hospital to provide for the availability and maintenance of sleep rooms for House Officers.

1. A standard key core lock is provided for the door of each sleep room. When it becomes necessary to change cores, door lock devices or obtain keys, the administrative director of GME should be notified.
2. Normal repair and maintenance of the rooms, such as lights, leaks, stained or broken ceiling tiles, door mechanics, etc., should be called in to Facilities Management and Planning, ext. 94050.
3. All hospital House Officer sleep rooms are equipped with at least one phone jack. If the occupying department(s) desire to have a phone installed, the administrative director of GME should be notified.
4. All other non-building maintenance items, such as shelving, casework, furniture, carpet, etc., shall be done via requisition to the appropriate campus service.

- a. Repair and maintenance for "wear and tear" should be reported to Facilities Management and Planning, ext. 94050.
 - b. It is recognized that ordinary "wear and tear" over time makes it necessary to repair and/or replace sleep rooms and the furnishings. However, any damage determined to be from abuse will be repaired and/or replaced at the expense of the occupying department(s).
 - c. Furnishings missing from the room will be replaced at the expense of the occupying department(s).
 - d. Key inventory and/or combination lock maintenance for doors and lockers should be monitored and maintained by the occupying department(s).
5. While Campus Security will exercise diligence in keeping the area secure for the House Officers and their belongings, a joint effort will assure the greatest security.

The above provides the details for handling various situations that may arise. To ensure that follow-up is handled expeditiously, it would be a good idea to always notify Vicki Hamm in Graduate Medical Education. Vicki will make sure the appropriate contacts are made with the hospital for making changes, or correcting problems. We will make every effort to respond promptly to concerns, but please help us by communicating the problem as quickly as possible.

D. Supervising Resident

- A supervisory resident will assigned to each team for the month.
- The supervisor will take weekend call duty as in house supervisor when their team is on call.
- The supervisors will ensure that interns and supervisors are able to comply with work hour rules
- Residents will not be allowed vacation time during their supervisor months.
- Supervisors will be expected to be familiar with all patients on their service and help guide the interns in developing management plans. In addition, they should chart review all patients on their service daily.
- Supervisors will be expected to complete evaluations on the interns assigned to their team.

- Supervisors will be expected to primarily see patients on their service in the event of intern vacation, illness or particularly heavy patient loads.
- Supervisors will be expected to ensure a morning teaching curriculum is carried out.
- The morning didactic sessions will occur Tuesday through Friday from 8-8:30.
- Faculty, supervisors and interns will ALL be expected to participate in the morning didactic sessions.
- A guideline of topics that should be covered will be distributed to all supervisors during 2nd Teaching Day of the preceding month.
- Faculty attendings are expected to be supportive of this curriculum. The supervisors will be expected to keep the program director apprised of any faculty reluctance in supporting this teaching session.

E. Faculty Staff Attending Physicians

1. Will be ultimately responsible for all patient care.
2. Will be aware of time constraints for morning rounds and morning teaching sessions and will attempt to adhere to that schedule whenever possible.
3. Will be available at all times for phone consultations with the supervisor, night float resident and HOIs on the service.
4. Will return to examine all patients admitted or transferred to the ICU at the discretion of the supervisor and/or HOI.
5. Will be evaluated by the HOI's and the supervisor after each period of service.
6. Will evaluate all residents after each period of service as well as provide performance feedback to the residents at regular intervals. Evaluations will address the ACGME core competencies.
7. Will be responsible for reviewing and providing feedback on discharge summaries dictated by HOIs.
8. Will assure that resident work hour regulations are followed.

Holidays

Everyone will share equally in holiday call coverage. This duty will be assigned and tracked by the Departmental Chief Resident.

Vacations

Vacation requests are honored in making the schedule. This does not imply that your vacation is approved. Simply, if you were planning on requesting vacation, you are not placed on call during that time. **It is your responsibility to find coverage for your assigned call shift if you are unavailable.**

Schedule Changes

- **If you trade calls with another resident, you must notify one of the chief residents and Marlene Hawver (559-5641).** This way, we can keep the schedule current, ensuring coverage is maintained. Also, we are required to review changes for work hour violations. This is very important for our program maintaining accreditation. Please do not create a situation in which you exceed the 30/80-hour rule. ACGME considers this a violation regardless of who created the problem.

SCRUBS

Each resident will be provided with two sets of scrubs at the beginning of residency training. Residents will be able to choose size and color of their scrubs. Residents will be responsible for the laundering of these scrubs. Residents are not permitted to wear scrubs when entering or exiting EBC.

DEPARTMENT OF FAMILY MEDICINE DISASTER PLAN

The University of Nebraska Medical Center can be subjected to disaster situations which require all personnel to be knowledgeable in ways to cope with each different disaster situation. Outlined below is the plan for personnel in the DOC building.

FIRE: If a fire is sighted within the department area or fire alarms in the area sound, the following actions will be taken:

- Call the Operator at 9-5555, identify yourself, give the exact location of the fire, and type of fire (if possible)
- Pull the nearest alarm.
- Know where the fire extinguisher is located in your area.
- Fight the fire with the proper extinguisher (if possible).
- All personnel will leave the immediate of danger.

- Personnel should evacuate by any of the following routes.
 - use stairwell in northwest corner of department (2598A) to exit outside
 - exit through doorway into Cardiology, then into the main hospital area
 - exit through the corridor opposite elevators on second floor of the UMA Bldg. into the OCC Bldg. (There is a two hour firewall installed between each building).

TORNADO: In the event of a tornado **warning**, the announcement will be made via the PA system or security officers will be in the area alerting personnel.

- All personnel will stop their work and seek shelter in the center or south of the east side of the DOC building (the hallway on the south side of the lobby past the restrooms and elevator is an ideal location).
- Close the blinds and door in your office when you leave.
Turn off all unnecessary lights.
- Do not attempt to go outside the building.
- Stay calm
- Wait for the all clear signal

BOMB THREAT: Only employees located in the building in which the bomb is believed to be located will be notified of an alert. Employees in other buildings on campus will not be notified. Employees will be requested to search their immediate area for anything unusual. Report any unusual findings to 9-5555. If a bomb or anything suspicious is found, the building will be evacuated.

EXTERNAL DISASTERS (CODE TRIAGE)

(Refer to NMC Policy #EC1000 External Disaster Plan)

The external disaster plan is activated when the medical center can expect to receive a number of victims from an on-campus emergency or an incident in the community. This includes aircraft crashes, fires, tornados, explosions, etc. The code name for external disasters is “Code Triage”. In many departments the on-call resident receives the notification for Code Triage and is expected to start the department’s calling tree. During Code Triage, the medical staff is to report as follows:

The following excerpts from the External Disaster Plan apply to Family Medicine:

V.4 Physician Assignments

- All physicians will report to the Staffing Area on third floor in the PDR to receive their assignments.
- The ED Attending is the physician in charge of the ED.
- Orthopedics Attending or Senior resident will be in charge of the patients in the Orthopedic Clinic.

- Family Medicine Attending or third year resident (supervisor) is in charge of the Cardiology area.

V.3 Cardiology Clinic

Patients who are not acutely injured (walking wounded) will be triaged to the Cardiology Clinic at UH Room 2305. The clinic can be accessed via the atrium adjacent to the gift shop. The rooms which will be used primarily for examining patients are Rooms 10 (#2315), Room 11 (#2516), Room 12 (#2317), Room 13 (#2318). Nursing pod #1 (Room 2313) will be used for computer access and phone (9-9178). If more than 4 rooms are needed, nursing pod #2 (Room #2321) can be used also and the phone number is 9-9179.

IN-PATIENT CURRICULUM

A didactic in-patient curriculum is presented to the UNMC in-patient team. These lectures are held throughout the week at 8am.. Topics include not only clinical medicine but areas of social service, chemical dependency, pharmacy, respiratory therapy and ethics. These lectures are organized by the supervising residents in consultation with the Program Director. Attendance at these is mandatory for all HOIs. .

REQUIREMENTS OF HO I ON INPATIENT FAMILY MEDICINE SERVICE WITH REGARDS TO PATIENTS IN THE UNMC EMERGENCY DEPT. (ED)

In order to improve the utilization of the on-call residents' time, as well as improving the efficiency of the ED, the following policy has been adopted. The Family Medicine supervising resident on call will be notified by the ED after evaluation of the patient has been completed by the ED staff and admission is felt to be warranted. The ED evaluation is not meant to be a comprehensive work-up of all possibilities in the differential diagnosis. It is designed to determine the need for admission and initiate treatment and stabilization of the patient.

On occasion, the resident will not agree with the need for admission. In those cases, only the Family Medicine attending faculty can override the ED staff and they must personally see the patient and assume responsibility for the outcome.

The ED volume has continued to increase without an accompanying increase in bed space. In order to facilitate this volume and the wait times that accompany it, the following policies have been implemented.

1. Residents are expected to see ED admits within 60 minutes of consultation. In those cases where the patient is stable and floor beds are available, the ED staff may write basic orders and send the patient to the floor after 60 minutes have elapsed.
2. In those instances where family medicine attendings from the outside clinics wish to directly admit patients and the in-patient faculty wish further ED evaluation, **it is the responsibility of**

the in-patient team to evaluate the patient. The ED will provide space and support personnel, but will not be responsible for the work-up.

3. In those instances where family medicine attendings from outside clinics feel further work-up is needed before the decision to admit can be made, the family medicine attending will contact the ED attending to communicate their concerns. The ED attending will see the patient and, once the evaluation is complete, contact the in-patient team if admit is warranted.
4. In all cases, communication between the ED, in-patient team and family medicine attendings is paramount.

OBSTETRICAL SERVICES AT UNMC

The Family Medicine obstetrical service will provide the resident with an obstetrical continuity experience at the Nebraska Medical Center. The resident will be responsible for the prenatal work-up, prenatal care, labor and delivery management, and post-partum care of each of their assigned patients. A Family Medicine faculty physician will be on-call for admissions and deliveries. Residents should discuss patients presenting for prenatal care with the faculty staffing their respective clinics. The faculty on-call for the Family Medicine obstetrical service must be notified when any patient presents to Labor and Delivery or when a resident is considering admission of an obstetrical patient. A staff physician must be present for deliveries and will see your patients daily while they are hospitalized. The OB/GYN service will be consulted as necessary for their advice and expertise.

MILITARY CONTINUITY OBSTETRICS AT EBC

The Family Medicine Residency Clinic will provide USAF residents with an obstetrical continuity experience at Ehrling Bergquist Clinic. The resident will be responsible for the prenatal work-up, prenatal care, intrapartum and postpartum management and care of each of their assigned patients. FM staff physicians will be available for precepting all clinic visits and for every delivery and are ultimately responsible for all OB patient care. The resident should discuss all patients presenting for prenatal care with the faculty staff in the clinic or the staff on-call at night. The Family Medicine attending on-call must be notified when any patient presents to Labor and Delivery or when a resident is considering admission of an obstetrical patient. A staff physician will be present for deliveries and will make daily rounds with you on your patients while they are hospitalized. The OB/GYN service will be consulted as necessary after checking with the FM staff physician.

All FM OB patients presenting to labor and delivery will be evaluated by the patient's personal family physician (resident covering the FM obstetrical patient), and will be presented to the Family Medicine attending on-call. If a resident or staff is on leave, it is their responsibility to arrange cross-coverage for their patients.

Family Medicine newborns are the responsibility of the Family Medicine primary/continuity resident. The Family Medicine resident is responsible for the evaluation, admitting orders, H&P, and daily notes.

The Family Medicine OB attending staff will examine all FMR newborns and supervise their daily newborn care.

Parents who wish to have their male infants circumcised must sign a circumcision permit after the procedure is explained by the resident. Residents will have supervision by a staff physician until they have demonstrated competency to perform the procedure alone.

OB/GYN AT EBC

All residents will complete a minimum of two months of obstetrical and one month of gynecological training during their Family Medicine residency. There are electives in OB/GYN at the University of Nebraska Medical Center, and at Fort Carson, Colorado Springs, Colorado for residents requesting additional training.

For those wanting to do OB in practice, an additional month of OB will be required at one of these elective sites. The elective at Colorado Springs is highly recommended. The first-year residents on the obstetric rotation will be the primary residents on home-call in Labor and Delivery, and will abide by the ACGME guidelines for resident workhours. Home-call is to be exercised only when there are no patients in labor or in need of antepartum evaluation. All patients needing evaluation on labor and delivery require the presence of the on-call resident to come in for the evaluation. The resident will be responsible for the management and delivery of patients in Labor and Delivery, management of post-partum patients, and consultations from the UCC.

Upper level residents will complete a one-month Gynecology rotation at Ehrling Bergquist Clinic during their Family Medicine residency. This will include one half-day of clinic experience per week at the DOC, as well as one evening STD clinic per week at Baker Place. They will have exposure to a broad array of outpatient gynecological problems, with exposure to colposcopy at Ehrling Bergquist Clinic. All call will abide by the ACGME guidelines for resident work hours.

Residents on the EBC GYN rotation will be allowed 2 weekdays and 2 weekend days of vacation

OB CALL POLICIES

Interns need to come in for **ALL patients** seen in triage.

Upper level residents (2nd and 3rd years having taken and passed their OB rotation) DO NOT need to come in for routine Labor checks that rule out or decrease fetal movement checks that have a reactive NST.

Once a patient is 4cm and contracting – a resident physician **must be in-house**.

You will have staff **on every patient** that leaves the hospital. If you suspect an emergency situation (nurses may have already done so) **CALL STAFF IMMEDIATELY** (before you even leave to go to the hospital so they can be on their way as well) – remember in as many things in medicine *time saves lives*.

Also residents taking home call -- for OB the standard of care is being able to get to the hospital within 20 minutes -- if you live too far you may need to make other arrangements to stay closer to the hospital.

ADVANCED OBSTETRICAL ROTATION/FT CARSON, COLORADO

This rotation has been developed to provide clinical training for Family Medicine residents in obstetrics. The specific nature of this rotation is to obtain additional experience in obstetrical deliveries for second and third year Family Medicine residents. Residents will cover the Labor and Delivery area, and, if time permits, the resident may assist the OB/GYN Clinic in seeing patients. This will greatly increase residents' clinical experience in OB/GYN. Residents will be under the supervision of Army OB/GYN physicians for training purposes. Lodging has been obtained for participating residents at 3340 Quail Lake Road, Apartment #114, Colorado Springs, Colorado 80906, telephone number (719) 579-0671.

COVERAGE OF CONTINUITY DELIVERIES

There has been discussion regarding the coverage of continuity obstetrical patients by Family Medicine residents. Continuity in obstetrical care is a practice that is often unique to our specialty. This manner of medical practice recognizes the importance to (1) patient care, (2) the patient-physician relationship and (3) requirements for resident education. Due to variable resident responsibilities and unavoidable conflicts with call and supervisor responsibilities, the following protocols for Family Medicine continuity OB are provided.

1. The intention of these provisions is to provide residents and patients the maximum reasonable opportunity for contact continuity throughout pregnancy, labor, and delivery. However this goal must be flexible in the face of conflicting availability, responsibilities and emergencies. These protocols are not meant to micromanage, nor supercede sound medical judgment, professionalism or ethical responsibilities. These guidelines are meant to specify agreed-upon responsibilities when resident continuity obstetrical care conflicts with other call schedules.
2. It is recognized that a Primary may not be immediately available for the following reasons.

3. When a Family Medicine obstetrical patient (“OB”) comes to the hospital, the resident (“primary”) to whom that patient has been assigned through their continuity Family Medicine clinic is responsible for that patient’s evaluation and care. At the Primary’s discretion the initial evaluation may be taken care of by another resident (“Secondary”), if that resident chooses to extend the courtesy. The Secondary is not required to take care of the Primary’s OB.
4. Residents on call should notify the appropriate rotation supervisors or staff of their patients’ estimated dates(s) of confinement (EDC) in advance if there is a potential of a conflict with call. If the patient is scheduled for induction or cesarean section, arrangements should be made with the rotation supervisors or staff as soon as possible.
5. An intern Primary should ideally coordinate with another resident (Secondary) for OB coverage for dates when the primary will be on call. When an intern (or any house officer taking in-house call in a non-supervisor capacity) Primary’s OB comes in for evaluation/admission while that Primary is on call or in the midst of rotation responsibilities, the Primary must still communicate with Labor and Delivery regarding the status of the patient and immediate orders (monitor, etc.)

CLINIC RESIDENT RESPONSIBILITIES

Each second-or third-year resident is encouraged to spend a month or more, full-time, in one of the four training clinics. He/she will assume considerable responsibility for teaching of students and other residents in the clinic, as well as seeing a schedule of personal patients as desired. He/she will also be called upon to see walk-ins, and encourage their follow-up by a single resident physician. Research to improve patient care is encouraged during this time.

RESIDENT STRESS AND IMPAIRMENT

The following excerpt is from the Graduate Medical Education Directory “Institutional Requirements”.

- l. **Counseling Services:** The sponsoring institution should facilitate residents’ access to appropriate and confidential counseling, medical, and psychological support services.
- m. **Physician Impairment:** The sponsoring institution must have written policies that describe how physician impairment, including that due to substance abuse, will be handled.

The next excerpts are from “Program Requirements”

III. A. 2.

- g. Resident well-being: The director must monitor resident stress, including mental or emotional conditions that inhibit performance or learning, and dysfunction related to drugs or alcohol. The director and teaching staff should be sensitive to the need for timely provision of confidential counseling and psychological support service to residents. To promote physician well-being and prevent impairment, residents should be trained to balance personal and professional responsibilities in a way that can be reflected throughout their careers. Training situations that consistently produce undesirable stress on residents must be evaluated and modified.

V. E. 2

Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular schedule.

To meet the above requirements, the University of Nebraska Medical Center has confidential counseling services readily available and residents in need should not hesitate to use these services. To access these services call Dr. David Carver at extension 97276. The counseling is free, he does keep evening hours and is willing to counsel couples.

In addition, every resident is assigned a faculty advisor and residents who have concerns are encouraged to discuss any issues with their advisor. There is lots of help available, but you need to "speak up". Every resident will participate in a quarterly Balint group during the 1st Teaching Day. These groups are organized by residency year, with HO I's, II's and III's in separate groups. The groups are facilitated by 2 faculty members - one physician and one mental health professional. The groups are a forum for residents to discuss their experiences in the residency, with particular focus on encounters with patients. Residents provide feedback and support to each other. In addition, a resident will be appointed as our departmental representative on the UNMC House Staff Council which meets on a monthly basis.

Finally, if you are having problems and "none of the above" seems to appeal to you, please do not hesitate to contact any faculty member to whom you feel you can relate. We are very sensitive to the pressures that you are under and would be honored to help you in any way we can.

SUPERVISION

The issue of resident supervision is of great concern to educators at all levels as it impacts both resident education and patient care.

The following is an excerpt from the Graduate Medical Education Directory, Common Program Requirements".

VI.

Resident Duty Hours and the Working Environment

Providing Residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

A. Supervisor of Residents

1. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervisor of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
2. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
3. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

In the "Program Requirements", the following directions are provided on .

VI

- A.1. **Supervision of residents:** Institutional and program policies and procedures must ensure that all residents are adequately supervised in carrying out their patient care responsibilities. It is the responsibility of the program director and faculty to ensure that residents are appropriately supervised. Supervising policies of the residency should be consistent with those of the institution. They must be in writing and be distributed to all members of the program staff.

Faculty schedules, including their time on-call, must be structured to ensure that supervision is readily available to residents on duty.

Finally, the policy on supervision adopted by the Graduate Medical Education Committee at the University of Nebraska Medical Center is as follows:

"Each residency program must have written policy and procedures that ensure that all residents are supervised in carrying out their patient care responsibilities. The policy should include written descriptions of lines of responsibility for the care of patients."

In developing a policy to address the above mentioned issues, the Department has considered resident training in two different general settings:

1. Where the resident's attending/supervising physician is not a full-time member of the UNMC Department of Family Medicine faculty. This would include nearly every experience except those listed in #2 below.
2. Where the resident is working within, or on call for, the Department of Family Medicine, and the attending/supervising physician is a full-time faculty member in our Department. This would apply to our In-Patient Family Medicine service, continuity clinics, nursing homes, Inpatient Supervisor, Geriatrics rotation, and deliveries on the OB floor at UNMC.

In the first situation, the resident is training with, and responsible to, a faculty member from another department or a clinical faculty member who practices outside the confines of this Department. Since there is no way that the Department can be aware of a resident's day-to-day activities outside our Department, it is incumbent upon the attending physicians of each service to provide the required supervision, and each of these faculty are aware of this responsibility and agree to accept it as part of their role as a teaching faculty/attending physician.

In the second situation, the following lines of responsibility exist:

1. In-Patient Family Medicine - UNMC - responsibility for supervision is as outlined on pages 14 and 15 of this manual.
2. Inpatient Supervisor - responsibility for supervision is as outlined on pages 16-17 of this manual.
3. Continuity clinic - residents working in their continuity clinics will have available to them, at all times, a faculty member on the premises whose primary responsibility for that time period is to be available to answer questions that may arise as residents see their continuity clinic patients and supervise the residents in the performance of their duties. For further details, see pages 1-3 of this policy manual.
4. Nursing home care and Geriatrics rotation - see pages 11-13 of this manual.
5. Obstetrical deliveries - UNMC - see page 25 of this manual. .

TAR WARS ORGANIZATION

Nebraska Tar Wars is a State Chapter of National Tar Wars, a Family Medicine Organization dedicated to counter-advertising against the number 1 cause of preventable disease and death in the United States today, namely the tobacco industry. Membership in Nebraska Tar Wars is open to any and all residents and there are no annual dues. Nebraska Tar Wars offers the following benefits to Family Medicine residents.

1. Membership in an organization dedicated to trying to counteract the number 1 cause of preventable disease and death in the United States.
2. An opportunity to speak to school groups and/or other groups about the tobacco industry's media blitz and its effect on young people.
3. A chance to develop speaking skills through workshops.
4. A chance to participate in smoke and tobacco free sporting events.
5. A chance to work and learn about health promotion and preventive medicine in the community.
6. A chance to learn about counter-advertising in several media areas including, but not limited to, radio, TV, billboards and newspapers.

Nebraska Tar Wars welcomes your participation. Dr. Paul M. Paulman is advisor. Officers are elected on an annual basis.

CONFERENCES

A. Grand Rounds

Grand Rounds are held on Teaching Days (2nd & 4th Wednesday of every month) at noon in the Center for Continuing Education, Eppley Science Hall Amphitheater. The curriculum is arranged by the Chief Residents with guidance from the Graduate Education Division.

These conferences offer the core content of Family Medicine and are fundamental to the overall educational program. Therefore, attendance at a minimum of 90 percent of the Grand Rounds is **mandatory**.

If for any reason (such as vacation, illness, emergency) you feel that you cannot attend, notify Rita Smith or Marlene Hawver.

Family Medicine Grand Rounds qualifies as one hour of continuing medical education for staff or private physicians. The CME credit is AAFM approved.

In order to make it easier to attend, residents at satellite clinics will be allowed to leave clinic at 1130 in order to arrive at Grand Rounds on time.

As an alternative, each session can be viewed via Internet streaming. Current sessions may be viewed “live” and past sessions may be viewed from the archives. Online sign-in is available.

B. Teleconferences

With support from UNMC’s Information Technology Services and from Biomedical Communications, the Family Medicine Department has developed methods for attending Grand Rounds from off-campus locations. This is done through Media Streaming (sometimes called Video Streaming) and allows you to view Grand Rounds from any off-site location where Internet access is available.

This requires a computer that has:

- A Pentium grade processor
- Speakers
- An Internet connection
- RealPlayer (which may be installed for free if not already on the computer)

Sessions can be viewed “live” at the time they are presented or they can be retrieved from the archives for viewing at any later time. Each session is currently stored in the archives for one year after the live presentation.

To access a session (“live” or “archived”):

- Go to the Family Medicine Department’s Home Page www.unmc.edu/familymed
- In the left-hand column, click on “Teleconferences”
- Follow the online instructions to select the session by Date or by Topic (Specialty Area)

Viewing these Teleconferences receives the same credit for attendance as being there in person... so please remember to register your attendance online when you view any of these sessions.

Because this process is continuously evolving to try to meet the needs of our learners, all comments and suggestions are sincerely welcomed and valued.

C. Journal Club/Quality Improvement/EBM

Included in the first Teaching Day curriculum under the direction of Dr. Kim Jarzynka..

D. Noon Conferences

Noon conferences are offered on most Mondays, 1st Thursday and Friday's from 1200-1300. Lunch will usually be provided by a pharmaceutical representative. Conferences will be in the Family Medicine Conference Room at the University. Attendance is strongly encouraged, but is not mandatory.

The schedule is as follows:

EBM/Senior Presentations	-	1 st Wednesday of the month
Geriatric Conference	-	1 st Tuesday of the month
Gyn Conference	-	Every Friday
Jeopardy	-	Last Thursday of the month
Pediatrics	-	3 rd Wednesday of the month
Now Showing	-	1 st Thursday of the month
OB Conference	-	Every Monday

Noon time conferences will be held in the Family Medicine Residency Conference Room at Ehrling Bergquist Hospital every Tuesday, Thursday and Friday. Grand Rounds are available for viewing at EBC every Wednesday in the Commander's Conference Room.

E. First and Second Teaching Days - See below

F. Required Monthly Meeting - EBC

Air Force residents have a curriculum requirement unique to them. It is a mandatory Air Force requirement that the residents attend a half-day teaching day, one time per month on the third Thursday of each month. During this time, Air Force policies, programs, specific training requirements are discussed and presented. If you are not an Air Force resident, this section does not apply to you. This meeting is for all USAF residents.

G. Others

Additional noon conferences are sometimes scheduled at the discretion of the Chief Resident. Attendance at these conferences is encouraged but not required. The Chief Resident will occasionally arrange for a pharmaceutical representative to provide lunch.

CONFERENCE COORDINATORS

Coordinators for the presentations are:

Geriatrics	-	Tim Malloy, M.D.
OB/GYN	-	David Harnisch, M.D.

TAR Wars	-	Paul Paulman, M.D.
Journal Club/EBM	-	Kim Jarzynka, M.D.
Preventive Medicine	-	Jim Medder, M.D.
Grand Rounds	-	GED Committee
Fracture Conference	-	Monty Mathews, M.D.
Now Showing	-	Layne Prest, Ph.D.

FIRST TEACHING DAY

The second Wednesday a.m. of each month is designated as the First Teaching Day. All residents are required to attend. Your services have all been notified, but it is helpful if you remind them again at the start of each rotation.

Rural Training Track residents attend via interactive video telecommunications.

During a month when 2 Family Medicine residents are assigned to the Rheumatology service, one of the two residents will attend the First Teaching Day and the other will attend the Second Teaching Day.

This activity is coordinated by Kim Jarzynka, MD.

SECOND TEACHING DAY

The fourth Wednesday a.m. of each month is designated as the Second Teaching Day. This is for HO II/III only, and all residents are required to attend. Rural Training Track (RTT) residents will attend via interactive video telecommunications. Every third month will consist of a half-day workshop.

Occasionally, an HO II may be assigned to an HO I rotation, and the rotation may be reluctant to let the HO II attend the Second Teaching Day. If this is the case, do your best to attend. If you can't make it, call Rita or Mary.

Conversely, HO Is are occasionally on HO II rotations. In this case, HO Is are welcome to attend, but it is not required.

This activity is coordinated by Dr. Ivan Abdouch.

CLINICAL PREVENTIVE MEDICINE CURRICULUM

The Clinical Preventive Medicine curriculum is taught in two formats: by faculty preceptors in a longitudinal format during the residents' ambulatory, continuity patient care clinics and during the Orientation/Community Medicine month. Residents are expected to develop: 1) attitudes and a philosophy supportive of preventive care at the individual and the community level; 2) knowledge and skills to provide clinical prevention for individual patients of all ages; 3) the ability to

appropriately use community health resources (private and public organizations) to provide optimal preventive services; and 4) communication and counseling skills that enhance patient motivation and success in life style behavior change.

Learning activities include assigned readings, discussions with faculty, visits to private and public health agencies.

DOCUMENTATION OF ATTENDANCE AT FAMILY MEDICINE CONFERENCES

We are required by the Residency Review Committee to keep track of resident attendance at conferences. This information is helpful in reviewing the lectures presented to ensure that topics at the conferences include all the medical disciplines in adequate numbers.

A report detailing attendance at Family Medicine Grand Rounds will be a part of each resident's individual record.

DOCUMENTATION REPORTS

Residents receive periodic summaries of procedures they have performed and documented, Grand Rounds they have attended, types of cases that they have seen in the clinic, and clinic billings. Clinic encounter, procedure reports and Grand Rounds attendance reports will be produced quarterly.

SUMMARY OF THE FAMILY MEDICINE ROTATION

All house officers are required to take a one month family medicine rotation, preferably during their second year. The rotation is tailored to the needs of family physicians in dealing with a broad variety of problems clearly involving a psychosocial and/or psychiatric component. The month focuses on helping residents to develop a biopsychosocial approach to management of common issues. Consequently, the rotation involves residents working with the Family Medicine behavioral staff in the Anxiety and Depression clinic, Dr. Vijay Dewan, who provides outpatient psychiatry consultation and care in the UNMC Family Health Clinic, attending sessions with patients in the NHS Pain Clinic, rounding with members of the VNA Hospice team, and observing the psychology staff in the Monroe-Myer Behavioral Pediatrics Clinic. An optional (although popular and strongly recommended) one-week experience at the Hazelden Substance Abuse Treatment Center in Minnesota is also available during this month. Residents also learn about psychosocial assessment, intervention, and consultation with patients in their own continuity clinics. Didactic presentations and seminars during the month cover four broad areas: (1) Common psychological and psychiatric problems, (2) patient management, including work with "difficult patients" (e.g. somatizing patients) and difficult problems (e.g. substance abuse, eating disorders), (3) the assessment and management of patients in the context of their families and society, and (4) reflection on the personal self of the physician as related to the practice of Family Medicine.

The primary coordinator of the rotation is Layne Prest, Ph.D., the Department's Director of Behavioral Medicine. David Robinson, Ph.D. and Jacque Krier, L.C.S.W. (UNMC), and Major Alice Turner, MSW (Ehring Bergquist Hospital) are also involved in developing and teaching this curriculum.

All residents are encouraged to utilize any of the faculty in managing patients with biopsychosocial problems. During the July orientation, you will have an opportunity to get to know these people individually and to learn how they can be of assistance to you in the management of your patients and their families, both in your clinics and in the hospital.

As part of the educational offerings within the Family Medicine Department, the behavioral science team has several other charges. They are responsible for monthly teaching on behavioral medicine topics during the Teaching Days, the videotape review program (see below), consulting on the Family Practice In-Patient Service, Balint groups, and six to eight grand rounds presentations each year.

AUDIO-VISUAL TAPE REVIEW PROGRAM

This component of residency training in the Department of Family Medicine focuses on relevant aspects of the Behavioral Sciences as they apply to the medical encounter. The videotape review program includes attention to physician-patient interaction, clinical interviewing skills, management of difficult interpersonal situations (e.g. delivery of bad news), and the behavior change process (e.g., smoking, diet, exercise, weight, chemical dependence).

The goals and objectives for the review sessions reflect a three year program for the development of skills helpful for a Family Physician. The goal for the first year is to assist the residents in continuing to develop effective clinical interviewing skills for use in the medical interview. The second and third year tape reviews provide an opportunity for house officers to focus on problematic interactions with patients and/or the management of complex biopsychosocial problems.

Residents will be responsible for preparing and attending reviews of four tapes in the first year of training, and two in the second year and third years. Both the taping and review of these tapes will take place during the resident's regularly scheduled continuity clinic. Residents will be notified of the date and time of each review far enough in advance for preparation of the tape to be reviewed. Video tapes of routine medical encounters will be reviewed by the resident along with two faculty members, one of whom is the resident's advisor. The faculty and resident will identify goals for subsequent patient encounters and tape reviews. Each tape review will build on previous reviews in order to facilitate this aspect of resident training in a logical and coherent manner.

ADMISSIONS TO THE FAMILY MEDICINE SERVICE AT UNMC

Residents on first call may admit patients to the Family Medicine In-Patient service by:

1. General Medical-Surgical Admissions: (at NMC)
 - a. Notify clinical chief resident.
 - b. Notify admitting (confirm bed space availability).
 - c. Notify Family Medicine attending on-call for the In-Patient Service.
 - d. Notify patient's primary resident.
 - e. Write admitting note and admitting orders.

OB ADMISSIONS/NMC

The primary resident or his/her backup will be notified by the labor and delivery nurses when a patient presents to Labor and Delivery. (Residents are to leave their phone and pager numbers on cards provided in L&D as well as the name, phone and pager #'s of their backup.)

1. Evaluate patient
2. Call Family Medicine staff physician on-call for OB as soon as possible.
3. If primary resident cannot be located the designated backup resident will be notified and expected to take care of the patient until the primary resident returns.
4. Once it is decided to admit your patient the resident is responsible for writing the admission orders and H&P. The nurses generally will call the admitting office.
5. Any significant change in your patient should be relayed to the attending physician.
6. OB/GYN consultation is available and should be obtained if necessary in consultation with the Family Medicine attending.
7. When your patient requires a surgical procedure (i.e., C-Section or PPTL), your attending physician needs to be notified and should assist you in determining if the OB/GYN service or a family physician credentialed in surgical OB/GYN skills should be consulted to provide the needed operative management. If the situation is deemed emergent, the provider who can provide the emergent service most efficiently should be consulted. In general, the Family Medicine residents will have the opportunity to first assist on their patients, but this will be left to the

primary surgeon's designation. The Family Medicine resident manages the post-op course with the provider who has been consulted to provide the appropriate service.

8. Several of the Family Medicine attendings have privileges to perform D&C's. If your patient needs this procedure please discuss it with the Family Medicine attending staff physician.
9. All obstetrical patients admitted with secondary medical complications or having a surgical procedure (i.e., C-Section or PPTL) will need to have a discharge summary dictated.

Verbal and Telephone Orders on 4-West and Labor and Delivery and Post-Partum

Medical Records is trying to reduce the number of hours needed to get co-signatures on verbal and telephone orders. As a result, the following recommendations are made:

1. Reduce the number of verbal orders by writing them yourself unless you are obviously busy such as doing a delivery or procedure. The nurses have been instructed to hand the chart over to you to write the orders rather than you giving them verbal orders and then the nurses writing the verbal order.
2. At the next convenient time, please co-sign verbal and telephone orders. The nurses and techs will flag with "stickers" to bring such orders to your attention.

Thanks for your cooperation. This is not meant to be punitive, but Medical Records feels it is important to meet JCAHO standards.

NMC POLICY ON FAMILY MEDICINE CONSULTATIONS FOR A PREGNANT WOMAN IN LABOR

1. After the initial examination, the family medicine house officer should notify his/her faculty member and the senior obstetrics/gynecology resident on duty.
2. Situations in which consultations with the Obstetrics Service is **mandatory**:
 - a. Multiple pregnancy
 - b. Breech presentation
 - c. Isoimmunization
 - d. Insulin dependent diabetes mellitus
 - e. Severe preeclampsia or eclampsia
 - f. Placenta previa
 - g. Suspected placental abruption
 - h. Preterm premature rupture of the membranes < 34 weeks
 - i. Preterm labor unresponsive to one intravenous agent
 - j. Two or more low transverse Cesarean deliveries considering a trial of labor

- k. One or more vertical Cesarean deliveries considering a trial of labor
 - l. Preterm cervical ripening or preterm induction of labor
 - m. Insulin dependent diabetes mellitus in pregnancy who are admitted for diabetic control
 - n. Patients in active labor (>5 cm) who have not progressed despite adequate labor
 - o. Prolonged second stage of labor
 - 1. With epidural - nulliparas > three hours, multiparas > two hours
 - 2. Without epidural - nulliparas > two hours, multiparas > one hour
3. The following are situations in which consultations, though not mandatory, are suggested:
- a. Intrauterine growth retardation or fetal growth restriction
 - b. Intra amniotic infection (chorioamnionitis)
 - c. Postpartum hemorrhage > 500 cc
 - d. Preterm premature rupture of membranes between 35 and 36 weeks
 - e. Preterm labor requiring IV tocolysis
 - f. Heavy meconium stained amniotic fluid
 - g. Persistently nonreassuring fetal heart rate pattern
 - h. Protracted active phase of labor
4. Transfer of Care to obstetrics will be left up to the discretion of the Family Medicine faculty attending covering the OB service or the clinic. Patients having a cesarean section by the OB service require a transfer of care for the surgical management. The family physician in training is generally given the option of first or second assisting at the discretion of the primary service. The postpartum care and post-op care is provided by the surgical team, however, close follow-up and interaction with the primary team is strongly encouraged while the patient is on the obstetrical service.
5. Failure to comply with these requests will be brought to the combined attention of staff representatives within the Family Medicine (Monty Mathews), Obstetrics/Gynecology (C.D. Hsu), and Pediatrics/Newborn Medicine (Dave Bolam) departments.
6. All cases will be presented at daily work rounds by the third year medical students. All cases will be entered into the weekly statistics for the obstetrics service. Any case with a complication during the antepartum or intrapartum periods will be presented at the weekly morbidity and mortality conference. Any family physician involved in a case being discussed will be invited to attend the conference.

PEDIATRIC ADMISSIONS/NMC

1. Notify clinical chief resident.
2. Notify admitting (confirm bed availability)
3. Notify Family Medicine attending.
4. Notify patient's primary resident.
5. Write admitting note and admitting orders and care for patient until inpatient service assumes responsibility.
6. Family Medicine normal newborns are the responsibility of the Family Medicine OB service. The Family Medicine resident is responsible for the evaluation, admitting orders, H&P and daily notes.
7. The Family Medicine attending staff covering the Obstetrical service will supervise and visit patients in the normal newborn nursery daily.
8. Parents who wish to have their male infants circumcised must sign a circumcision permit after the procedure is explained by the resident. The resident is responsible for notifying the Family Medicine attending and the obstetrical service to schedule a time to perform the circumcision while the attending is present.
9. If a newborn is taken to the NICU, Pediatric NICU staff will become the attending staff and Family Medicine will follow in a consultant role.
10. Faculty physicians with newborns delivered by OB may care for the newborn or have them followed by the FMOB service.

OUT-PATIENT PEDIATRIC SERVICE/EBC

Two pediatric rotations will be offered at EBC hospital. The first month emphasis will be placed on common childhood illnesses and acute dx/management skills.

The second rotation is intended as an extension of the first rotation, and will therefore only be offered after completion of the basic rotation. The advanced pediatrics rotation will consist of daily clinic. The emphasis in didactics will be on more complex diseases of childhood, developmental aberrations, and adolescent medicine topics. Residents will be responsible for weekly presentations on selected topics to staff and critique will be placed more strongly on independent diagnostic and management skills.

For both rotations, vacation time must be coordinated through the EBC pediatric rotation director with at least one month's notice in order for considerations to be granted.

RESIDENT RESPONSIBILITIES ON OTHER DEPARTMENTS' SERVICES

First year residents will spend seven months on specialty services in addition to one month in the Emergency Room and three months on the Family Medicine inpatient service. Surgery and Pediatrics have two separate services of one month each. Nurses, residents, and responsible staff must be made aware of your half-days in clinic. The primary responsibility of Family Medicine residents on specialty services is still to their Family Medicine patients. However, each resident should become aware of his/her individual responsibilities on the service prior to starting by talking to other residents who have taken the rotation and by discussion with staff on that particular service. This should insure that your clinics and calls in Family Medicine are arranged to allow for full educational value from that service.

At the end of the service each resident will be required to evaluate the service, and to be evaluated by the service. The resident should record procedures done and diseases handled on each service in order to document experiences and competence for the purpose of applying for hospital privileges upon completion of the residency.

To receive credit for a rotation, you MUST complete an evaluation of the experience.

When residents are assigned to a service and it turns out that there are half-days when there is “nothing to do” (e.g. faculty day-off or vacation), the following applies:

- If the time amounts to ½ day per week or less, then the residents can use the time for personal business.
- If the time amounts to more than ½ day per week, then the residents should call the Physician Managers at their respective continuity clinics, or the Program Director, for instructions on what to do with the “down-time”.

FAMILY MEDICINE CALL

The in-patient interns will take in-house call once every sixth night while they are on the in-patient rotation. Second and third year residents will serve as supervisor for the FM in-patient service and also provide telephone coverage. The clinical chief resident will serve as additional back-up as will the attending staff on call.

All Family Medicine residents have pagers. The first call in-house resident will be called for Family Medicine patients who are to be seen in the Emergency Department, as well as for questions concerning inpatients. Scheduled admissions are the responsibility of the

inpatient resident whenever the patient arrives. The clinical chief resident should be notified of all admissions.

When the 2nd/3rd year resident is on call, it is of vital importance that they document on a progress note any and all encounters with patients or other 3rd parties (i.e. parent, relative, friend, health professional, etc.) which may relate to the care of a patient. In recording this data pay special attention to name (check on correct spelling), age, birth date, registration number, type of insurance, which clinic they use and the name of their primary care physician.

Above is the minimum information needed on each patient for the clinics to locate the patients, their charts, and to provide appropriate follow-up care as needed. If you have the patient's university hospital number this would also be helpful as would the name of their insurance carrier.

Once your interaction with a patient is complete, you will need to record the pertinent facts. Up until this time, we have relied on a written record. We now have in place a phone dictation system for the after-hours phone calls, see page 55. This number can be accessed by the staff from the Family Medicine clinics on the next working day to gain information or guidance on those patients that may need nursing or medical intervention. The typed dictation will then be delivered to the appropriate clinic within 24-48 hours for staff perusal and signatures. See procedure below. We request that you use this service to help improve continuity of care to our customers.

The Call Center will triage all after hours calls, those felt to require physician input will be triaged to the supervisory resident. The Call Center will be able to authorize referrals to ED's and urgi-centers.

The supervisory resident will also be in charge of the "walking wounded" in the event of a disaster. As per the University disaster plan, they will report to the cardiology clinic, as outlined on page 21.

PAGERS

Nebraska Medical Center - University of Nebraska Medical Center Paging System

Option 1: Setting Personal Security Codes

This feature is used to protect the pagers and personal greetings. The security code allows only the person with the pager to change the greeting or transfer the pager into someone else's pager. All pagers under the ATS lease agreement will come with a security code.

Anytime employees want to change their greeting or utilize page forwarding they will need to use their security code to do so.

The first security code for all pagers is the last 4-digits of the employees' new pager number. If the first digit on the last four numbers is a zero, use the last three numbers. If the first and second digits of the last four numbers are zeroes, then use the last two numbers as the security code, and so on. Example: If the pager number is 888-0001, the security code is 1.

Employees should change their security code as soon as they receive a pager.

Steps to Change the Security Code:

1. Dial the pager number
2. Press “0” during the generic greeting
3. Enter the security code
4. Press “17”
5. You will hear: “You may now change the access code.”
6. Use one of the following commands to change the access code.
 - “3” To enter a new 4-digit security code
 - “4” To hear the current security code
 - “*” To hear the commands
 - “#” To end the security code edit session

Option 2: Pager Forwarding

The pager forwarding feature allows the user to forward their pager to another number to another person’s pager. **Example:** If an employee wants to forward pager 888-1234 to pager 888-4321 they would need to use pager forwarding.

Steps for Pager Forwarding:

1. Dial you own pager number
2. Press “0” during the generic greeting
3. Enter your security code
4. Enter “16”
5. You will hear “you are in page forwarding mode”
6. Press “6” followed by the number to forward your pager to, then press “#”.
Repeat this step to confirm that the forwarding has been done.
7. Press “3” to cancel pager forwarding
8. Press “*” for help

Option 3: Record Your Personal Greeting

The personal greeting feature allows anyone with a pager to record a 10-second greeting that people will hear after dialing a person’s pager number. This feature is on all ATS leased pagers.

The personal greeting feature can be used to give a short message to those dialing a pager number. Some may want to use it to state their status (in hospital, on page). The employee determines what the greeting says. All pagers will come with a generic message. This will stay on the pager until the employee changes the greeting.

Steps for Personal Greeting:

1. Dial your pager number
2. Press "9" during the generic greeting
3. Enter the security code
4. Enter "11"
5. You will hear "you may now change your greeting message"
6. Use one of the following commands to change the customized greeting:
 - "30" To record new greeting
 - "1" To stop recording at the end of the greeting
 - "40" To listen to the greeting
 - "*" To hear a command again
 - "#" To end the personal greeting edit session

Option 4: Numeric Mailbox Retrieval

The numeric mailbox feature is used to store call back numbers that employees have received on their pagers.

This option is useful if an employee forgot to turn on their pager and they want to see if they have missed any pages. This may also be used to recover a page they may have deleted by changing their battery.

Steps for Numeric Mailbox Retrieval:

1. Dial the pager number
2. Press "0" during the greeting
3. Enter the security code
4. Enter one of the following commands:
 - "2" Play time stamp (date and time of message)
 - "3" Delete current message (message just played, numeric only)
 - "4" Help
 - "5" Pause
 - "6" Play all messages
 - "7" Play later messages (oldest to newest)
 - "8" Play earlier messages (newest to oldest)
 - "9" Replay current message
 - "0" Undelete all messages (messages deleted during this session only)
 - "#" Disconnect

Common Operating Features:

1. **Inserting Dashes Between Numbers**

To insert a dash (-) between numbers in a page, employees should use the asterisk (*) key. **Example:** page 888-1234 then enter the call back number as 559*1234

2. Ending Calls and Delivering Pages More Quickly

To end a call and deliver the page (call back number) more quickly, use the pound (#) key. **Example:** Page 888-1234 then enter the call back number as 559*1234#

3. Paging Multiple Pagers

To page multiple pagers in one phone call:

- a. Dial # to finish the current page you are on.
- b. Dial *** (three asterisks).
- c. A prompt saying “please enter the pager number” followed by a dial tone will be heard.
- d. During the dial tone, callers should key in the next pager number. Example: dial pager number 888-1234, then enter the call back number, 559-1234#3***, then enter the new pager number.

LONG DISTANCE CALLS/UNMC

The use of departmental phones for personal phone calls of any type is generally discouraged. There will be times, however, when you will need to make long distance calls. If it is a business call, you may use any of the phones in the department that are wired for long distance. No authorization is required. If the call is personal, please notify our Business Manager, Roberta Gatch, so that she can watch for the call on our phone bill and bill you accordingly.

If you are on call and need to make a long distance call to talk to a patient, you may call the UNMC hospital operators and ask them to connect you, and bill the call to the Department.

LONG DISTANCE CALLS/EBC

Commercial long distance calls from Ehrling Bergquist Hospital are to be for official business related to the Air Force outpatient or inpatient care only. Long distance calls for personal matters are not allowed. A PIN number is required to make long distance calls from Ehrling Bergquist Hospital. AF residents will be assigned this official number during initial Base inprocessing.

E-MAIL - NMC

Highlights from Executive Memorandum 16 Related to E-Mail

1. Access to e-mail is a privilege, not a right.
2. Privacy of e-mail cannot be guaranteed.
3. E-Mail is intended primarily for business purposes, limited personal use is allowed.
4. Users should use common sense and appropriate e-mail etiquette when drafting e-mail.
5. E-mail messages should be retained for the period appropriate to their content.
6. Backups are for disaster recovery purposes only; backup retention is one week.
7. Users should be aware that e-mail messages are subject to Public Records Request. The University will comply with any lawful administrative or judicial order for disclosure of electronic files.
8. Users should be aware that if an act of misuse has occurred, or if there is reasonable belief that potential damage to information systems is genuine and serious, the chief information officer may access any account file or other data controlled by the alleged violator and share such information with persons authorized to investigate such incidents.
9. The University may restrict or prohibit the use of the e-mail system for any misuse of such systems or violation of copyright, state or federal laws.

IN-PATIENT CHARTS-GENERAL CRITERIA- NMC HOSPITALS

Inpatient Resident responsibilities:

1. H&P is dictated in the first 24 hours on inpatients. This should include a problem list and a copy of the H&P sent to the referring doctor (including referring resident or clinic).
2. Admitting note is written as soon as possible.
3. There is a daily progress note done in a problem-oriented method.
4. All verbal orders signed off **within 24 hours**.
5. Dictated discharge summary at the time of discharge with a copy to the referring doctor (including referring resident or clinic). Must be done within 48 hours of discharge.
6. Additional notes: Daily attending notes or notations of clearly active involvement in the patient's care by both the resident attending and staff attending should be present on all charts.
7. Dictation of H&Ps and Discharge Summaries are required on all patients discharged from the hospital (observations and inpatients). Exception: normal newborns, uncomplicated deliveries.
8. Outpatient procedures do not require a discharge summary or final progress note.
9. H&Ps completed within 30 days prior to admission or ambulatory surgery by NMC/non-NMC staff members are to be affirmed in writing by the attending and/or anesthesiologist.

OB AND NURSERY CRITERIA

Outpatient:

1. A prenatal record (yellow sheet) is completed on each OB patient at the initial visit.
2. Progress notes are placed in the prenatal record for each visit.
3. The Family Medicine resident is responsible for this patient from time of initial OB work-up to the 6 week postpartum check up.

Inpatient: (Please state "with attending physician name" on all notes)

1. Admission note
2. Orders as appropriate
3. Labor progress notes as appropriate
4. Delivery note
5. Daily progress notes
6. A discharge note, including instructions given and birth control plans
7. Complete OB statistical survey
8. Dictate discharge summary on complicated patient (i.e. concomitant medical complications and all C-Sections and PPTL's).

Nursery Care: (Please state "with attending physician name" on all notes).

1. History and physical on each patient
2. Orders as appropriate
3. Gestational age assessment to be done by resident
4. All orders need to be signed as soon as possible
5. Circumcision by the Family Medicine resident after obtaining parental consent, with the Family Medicine staff present
6. Newborns that are not otherwise considered normal need to be evaluated for newborn transition care or the neonatal intensive care unit. Please see the enclosed criteria for the newborn transition care unit, in which the Family Medicine service is allowed to care for their patients. If your patient is unstable and requires neonatal intensive care unit care, the baby will be transferred to the attending physician on call in the neonatal intensive care unit, at which time you are strongly encouraged to follow your patient with courtesy visits. If there are any questions about the stability of your child, please contact your attending physician. You may also consult the pediatric supervising resident for assistance.

Newborn Transition Care:

II. POLICY

- A. Transition care is defined as “closer observation of neonates at risk for complications until they ‘declare’ themselves as either stable enough to room in with the mother for mother-baby care, or needing special care in the next level of care (i.e., Level II or III).”
- B. All infants will be assessed following delivery to determine whether they may remain with the mother, need to be placed in a transition care bed for short-term observation (no greater than 8 hours), or transferred to the next level of care (i.e., Level II or III).
- C. The assessment will consist of a:
 1. review maternal history having an impact on the infant (i.e., legal and/or illicit drug use, diabetic, seizure disorder, etc.).
 2. intrapartum history of mother (i.e., late decelerations, bleeding, narcotic administered within 4 hours of delivery, method of delivery, etc.).
 3. review of Apgar scores.
 4. complete head-to-toe assessment (to include a gestational age assessment).
- D. A physician’s order is required to place an infant in transition care.

- E. The newborn that requires transition care on the south campus will be placed in a bed in the south campus NICU with a transition care charge. The newborn who requires transition care on the north campus will remain on the north campus if there are nurses on duty with the necessary competencies; otherwise, the infant will require transfer to the south campus NICU for transition care.
- F. Care of the newborn in transition will be managed by the newborn’s primary physician unless the newborn is transferred from transition care to the next level of care in the south campus NICU (i.e., Level II care or greater) or to Level II care in the north campus Level II Nursery.
- G. **Transfer from transition care:** A decision must be made on the care needs of the neonate within no more than 8 hours after admission to transition care. A physician order (newborn pediatrician, private physician, Family Medicine physician, pediatric resident, or neonatologist) is required to transfer an infant from transition care, either back to normal newborn care or to the next level of care.

III. PROCEDURE

- A. After delivery of infant, the nurse will complete an infant assessment using the **Decision Chart to Assist in Determining Level of Care**. Any deviations from the norm will be noted, reported to the physician, and level of care will be determined, utilizing the criteria in the following decision chart.

ASSESSMENT	REQUIRES TRANSITION CARE	REQUIRES TRANSFER TO NEXT LEVEL OF CARE
GESTATIONAL AGE: X < 35 weeks and birth weight < 2 kg X < 35 weeks and birth weight ≥ 2 kg X < 35-37 weeks	X Need for transition care will be determined by physician X Need for transition care will be determined by physician	X
GLUCOSE LEVEL: X < 40 and does not respond to feedings within 1 hour X < 40 at 2 hours and may require IV management to maintain	X	X

<p>TEMPERATURE INSTABILITY:</p> <p>X < 36.5EC after first hour of life with no additional maternal risk factors (i.e., increased temperature, amnionitis, positive cultures, PROM confirmed by positive amniotic indicator).</p>	<p style="text-align: center;">X</p>	
<p>RESPIRATORY STATUS</p> <p>X Grunting or lamenting</p> <p>X Tachypnea (respiratory rate > 60/minute) with increased work of breathing.</p> <p>X Supplemental oxygen < 1 L/minute or an oxyhood of 40% or less to maintain O₂ saturation ≥ 90%.</p> <p>X Nasal flaring, retractions.</p> <p>X Frequent suctioning due to profuse mucus secretions.</p>	<p style="text-align: center;">X</p> <p style="text-align: center;">X</p> <p style="text-align: center;">X</p>	<p style="text-align: center;">X</p> <p style="text-align: center;">X</p>
<p>5 MINUTE APGAR SCORE:</p> <p>X 5 Minute Apgar of 6 which does not improve by the 10 minute Apgar.</p> <p>X 5 Minute Apgar < 6.</p>	<p style="text-align: center;">X</p>	<p style="text-align: center;">X</p>
<p>CARDIOVASCULAR STATUS:</p> <p>X Murmur with other signs and symptoms (i.e., cyanosis, respiratory distress).</p> <p>X Heart rate < 80 in term infant.</p> <p>X Heart rate < 100 in infant < 35 weeks gestation.</p> <p>X Heart rate > 180 at rest regardless of gestational age.</p> <p>X Pallor and persistent cyanosis.</p> <p>X Cardiac compressions at birth with 10 minute Apgar < 6 and/or until the infant is stable.</p>	<p style="text-align: center;">X</p> <p style="text-align: center;">X</p> <p style="text-align: center;">X</p>	<p style="text-align: center;">X</p> <p style="text-align: center;">X</p> <p style="text-align: center;">X</p> <p style="text-align: center;">X</p>
<p>POTENTIAL SEPSIS:</p> <p>X Infants with suspected signs of sepsis (lethargy, temperature instability with maternal risk factors, poor feeding or intolerance) who require CBC, blood culture, and UA.</p> <p>X Infants who require sepsis work-up which progresses to lumbar puncture and/or antibiotics therapy.</p>	<p style="text-align: center;">X</p>	<p style="text-align: center;">X</p>

<p>DELIVERY COMPLICATIONS IMPACTING INFANT:</p> <p>X Evidence of significant bruising and/or significant boggy scalp with no other symptoms due to an instrumental vaginal delivery (i.e., vacuum extraction, forceps).</p>	<p>X</p>	
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B. The procedure for infants determined to require transition care will be as follows:

1. A pulse oximeter is placed on the infant to monitor SaO2 continuously, while in transition care (Note: In the NICU at NMC, pulse oximetry cannot be separated from cardio-respiratory monitoring, so both will be initiated).
2. Vital signs on admission then every 30 minutes until stable.
3. Assessment of color and respiratory character, as indicated.
4. Lab tests and other orders per attending physician
5. Glucose testing on admission and repeated as indicated by infant's glucose level, according to policy.

C. Documentation — according to NMC policy on appropriate form.

COMPLETION OF MEDICAL RECORDS - NMC POLICY

Our greatest consideration is the information need of the Medical and Hospital staff(s) to provide safe, efficient and quality medical care to our patients. This requires that appropriate documentation be available during the active process of caring for the patient during their current stay and planning for any future care. The following documentation standards are appropriate to these needs and are consistent with accrediting organization's standards.

- History and physical and consultations completed, including signature by responsible physician within 24 hours of admission or consultation or prior to procedures.
- A post operative note written in the chart and the operative report dictated immediately after the surgery and signed within 7 days.
- As a minimum, daily progress note. More frequent notes should reflect significant changes in or responses to treatment.
- Discharge Summary dictated within 48 hours of discharge and signed within 7 days.
- Consultations dictated the day of the consultation.
- Signature of verbal orders within seven days of discharge.
- Other documentation, to include signatures within 7 days of discharge.

- Completion of a Cancer Staging form within 30 days of initial treatment of a newly diagnosed neoplasm.
- All items requiring completion should be accomplished not later than 30 days past discharge.

The process of counting suspensions over a 24 month period will be discontinued. The new process of monitoring medical records focuses on medical records being completed within 30 days of discharge. The medical staff member is suspended for failure to complete delinquent medical records within 21 days of discharge. Once suspended, the physician will not be permitted to conduct any hospital activities until records are completed. Failure to complete medical records within 30 days of discharge will result in voluntary relinquishment of privileges and medical staff membership. Once medical records are completed, the physician is required to ask the Chief of Staff to reinstate their privileges. A subsequent suspension within a rolling twelve month period will require the physician to attend the next scheduled Medical Executive Committee to discuss potential reinstatement of privileges.

Your cooperation in assuring timely completion of records is greatly appreciated.

Nebraska Medical Center DICTATION POLICIES

Discharge Summaries

Medical Staff policies require that an H&P be dictated on all one day stays.

In addition, an abbreviated discharge summary must be dictated on all one day stays. The elements that must be included, after you clearly state your name, are:

Patient's Name and Medical Record Number
 Admission Date
 Discharge Date
 Staff Physician
 Discharge Diagnoses
 Hospital Course
 Discharge Recommendations to include:
 medications, diet, activity, and follow-up.

HOW TO DICTATE INPATIENT RECORDS

MEDICAL TRANSCRIPTION SERVICES

DICTATION INSTRUCTIONS

1. Dial 2-2148 (552-2148 if off campus)
2. Enter your LASTWORD ID number followed by the “#” key.

3. Enter 1 for hospital dictation or 2 for clinic dictation
4. To dictate - press 1, to listen - press 3
5. Enter work type number followed by the “#” key.
6. Enter the Medical Record Number followed by the “#” key.
7. For clinic dictation, enter department number followed by # key (FM number is 57)
8. To begin dictating, press “2” -- to dictate several reports, press “8”, complete the first report, and repeat steps 3 through 8 for each report. To prioritize press “6”

VERY IMPORTANT
PRESS “5” TO DISCONNECT

WORK TYPE NUMBERS:

1. H&P
2. Consultation
3. Op/Procedure Report
4. Discharge Summary
5. Vascular Lab/Cardiology
6. GI Report
7. Letter
10. Transfer Summary
11. Pre-op H&P

- ** Choose “1 Hospital” for all Inpatient, Ambulatory, Observation, and Pre-operative reports
Choose “2 Clinic” for PT/OT, Speech Therapy, Burn Center, Wound Care, Clarkson Family
Medicine and UMA clinic reports
For assistance, please call 559-4151 or page 888-3574 or 888-5587

TO EDIT

- Press “3” to rewind last words. Continue to press “3” to rewind further.
- Upon hearing last correct word, press “2” to stop playback
- Press “2” again to dictate over unwanted material.
- To rewind, press “77”; after playback is complete, press “2” to resume.
- To fast forward, press “44”; then press “2” to resume.

Dictation Guidelines

- Be Concise
- Speak Clearly
- Spell unusual or new terms
- Follow appropriate content and format guidelines shown below

RECOMMENDED FORMAT FOR DICTATED REPORTS

Progress Notes

- Name of patient
- Medical Record Number
- Name of clinic
- Date of encounter
- Name of attending physician
- Name of participating resident/student/PA
- State problem
- Subjective - history of present illness, past medical history, social history, allergies, review of systems, medications
- Objective - physical findings, lab and radiology data
- Assessment
- Plan

Referring Physician Letters

Referring physician - include spelling of name and complete address.

History and Physical (Dictate within 24 hours of admission)

- Date of admission (or outpatient procedure)
- Chief complaint
- History of present illness
- Past medical history:
- Illness
- Hospitalizations/Surgery
- Allergies
- Medications
- Family History
- Social History
- Review of systems
- Physical Examination
- Comprehensive physical examination
- Impression
- Plan

Discharge Summary

(Dictate at time of discharge - overdue if not dictated within 48 hours of discharge)

- Dates of admission and discharge
- Name of attending physician
- Name of referring physician
- Name of resident physician (s)
- Final diagnoses (all conditions that affected treatment and length of stay)
- Procedures performed during admission

- Reason for admission (reason for hospitalization and pertinent physical findings)
- Hospital course (significant findings, treatment rendered, and the patient's condition on discharge)
- Discharge instructions (Instructions on physical activity, medications, diet, and follow up care)

Operative Report

(Dictate immediately after operation - overdue if not dictated day of procedure)

- Date of procedure
- Preoperative diagnosis
- Postoperative diagnosis
- State name of staff surgeon
- State name of assistant surgeon (if applicable)
- State name of resident surgeon (s)
- State name of operation performed
- Technique and findings

Consultation Report

- Date patient seen in consultation
- State name of referring staff and service
- Review of the record
- Physical Examination
- Impression/conclusions
- Recommendations

NMC RADIOLOGY **Radiology Dictation**

There are now two ways to access radiology studies/reports.

1. If you call (402) 559-3373 off campus or 9-3373 on campus and follow the voice prompts as below, you will get the verbal report of any radiology study as soon as it is dictated - usually ½ - 1 day before the report is in the computer system.

To Review:

- a. Dial the system.
- b. Enter Author ID 2222 or your Phamis number then #1.
- c. Prompt will ask you to choose - 1 to listen by Med Rec. Number or 2 - to listen by DOB.
- d. Enter the appropriate patient information:
 - 1) Is the Med Record Number followed by the # key
 - 2) Is the 8-digit DOB followed by the # key
- e. Press 9 to listen
- f. Touch 8 to skip to the next matching report. When finished, press 5 to disconnect.

Keypad Function

1. Hold/Pause
2. Dictate
3. Short Rewind
4. Fast Forward to End
5. Disconnect
6. Fast Forward
7. Rewind to Beginning
8. End Job/Next Dictation
9. Listen

2. The Magic Web system is currently on most of the computers and if not, it can be loaded on any computer within our system that has a secure ID. This system has the actual films/studies so the hard copies can be reviewed. This is usually available before the dictation is available. Eventually the plan is for reports to be available as well as the films, however, at this time the function is not currently tied together. There is a brief (15-30 minute) orientation to this system. In order to schedule this orientation, you need to call 559-3546 or page 888-1919 to arrange for this training.

PATIENT SAFETY

Content of Medical Records

Complete medical records are essential for quality care of patients and for communication among hospital personnel. The medical record should contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course and results accurately.

Essential Elements for Inpatient and Clinic Medication orders

Approved abbreviations must be used in all orders
Formulary status of medications should be verified.

Date and Time

Weight (kg or gm)

Required for those drugs that are dosed based on weight (examples, chemotherapy, ALL doses for pediatric patients)

Drug Name

Generic names are preferred
(avoid investigational or chemical names)
Specifications of appropriate salts (ex. Potassium **chloride** or potassium **phosphate**) must be written on ALL orders

Dose

Dose/kg/interval for all patients < 40kg
(ex. Mg/kg/dose or mg/kg/day)
For medications given in combination, the **dose/kg/interval** should be specified for one of the medications in the combination

Dosage Units

Metric units are encouraged
(except for standard "unit-based" dosing, ex. Insulin)
Doses should be specified in units rather than volume
If a dose must be specified in volume, specify the concentration as well (ex. mg/mL)

Diluent

Specify if requiring diluent OTHER THAN the standards (5% Dextrose or 0.9% NaCl)

Dosage Form/Route of Administration Frequency or Interval

All orders for PRN medication must include an interval and an indication

Signature (including credentials) and Pager Number

Recommendations to Enhance Medication Safety

BE CAREFUL WITH DECIMALS Ten-fold errors in drug strength and dosage have occurred with decimals due to the use of a trailing zero (1.0 mg) or the absence of a leading zero (.5 mg). When it comes to zeros, **Always Lead Never Trail.**

NEED TO GIVE A VERBAL ORDER?

Communicate verbal orders clearly and succinctly. Have the person on the receiving end **READ** back the order to you to ensure that the order is taken correctly.

NEED TO CHANGE AN ORDER? Correcting errant orders the right way is important. Cross out the entire order and **REWRITE IT.** Initial beside the erroneous order along with the word "error."

NEED TO ADD AN ORDER? If you need to ADD and additional order AFTER you have written orders and completed that section of the order sheet. **BEGIN A NEW ORDER SECTION.**

NEED TO DISCONTINUE AN ORDER? Every action on a patient's medication profile requires an order, so **BE EXPLICIT** in your order writing. If an action such as discontinuation is required, write it out. **DO NOT ASSUME** an action will be taken if it is not ordered.

NEED TO WRITE A PRN ORDER? Indications should be given for ALL medications ordered on an as needed basis. Written guidance should be provided for "Titrate," "Taper" or "range" orders specifying how those assessments are made.

DO NOT USE FLET TIP PENS OR PENCILS FOR WRITING ORDERS.

AVOID SLASHES (/) they can be misread as "ones."

**AVOID ORDERING MEDICATIONS BY
COINED NAMES FOR PREPARATIONS** Terms like "banana bag" or "magic mouthwash" should be avoided. Medication orders should state exactly what the prescriber wishes the preparation to contain.

AVOID BLANKET ORDERS The use of "renew," "repeat," "resume home meds" and "continue orders" is discouraged.

EXPECT TO BE CONTACTED FOR CLARIFICATION OF UNCLEAR ORDERS.

Nursing and pharmacy staff are expected to contact the prescriber for clarification prior to administering/dispensing any dose of medication if the intention of the order is unclear or the order is incomplete.

**Common Dangerous Abbreviations used in Medication Orders
And Why They are Not Allowed**

Abbreviation	Intended Meaning	Potential Misinterpretation	Solution
AU	aurio uterque (each ear)	mistaken for OU (oculo uterque – each eye)	use “each ear”
cc	cubic centimeters	misread as “u” (units)	use “mL”
D/C	discharge or discontinue	premature discontinuation of medications when D/C (intended to mean “discharge”) has been misinterpreted as “discontinue” when followed by a list of medications	use “discharge” or “discontinue”
x3d	for three days	mistaken for three doses	use “for three days”
<and>	greater than & less than	mistakenly used the opposite of intended or mistaken for a number	use “greater than” or “less than”
HCl HCTZ MgSO ₄ MTX	hydrochloric acid hydrochlorothiazide magnesium sulfate methotrexate	misinterpret the H as a K (potassium chloride) hydrocortisone (seen as “HCT250mg”) morphine sulfate mitoxantrone	use the complete spelling for drug names
µg	microgram	mistaken for “mg” milligram	use “mcg”
per os	orally	the “os” can be mistaken for “left eye”	use “p.o.”, “by mouth” or “orally”
q.d. or QD	every day	mistaken for “qid” especially if the period after the “q” or the tail of the “q” is misunderstood for an “i”	use “daily”
qn	nightly or at bedtime	mistaken for “qh” (every hour)	use “nightly”
qod or QOD	every other day	misinterpreted as “q.d.” (daily) or “q.i.d.” (four times daily) if the “o” is poorly written	use “every other day”
S.Q. or SC	subcutaneous	mistaken as “SL” (sublingual) when written poorly	use “sliding scale” or “subq”
SS or ss	sliding scale	mistaken as “SL” (sublingual when written poorly)	use “sliding scale”
IU	international units	misread as “IV” (intravenously)	use “units”
U or u	units	mistaken for a zero or a four	use “units”

The Nebraska Medical Center
Approved Medication Related Abbreviations

Abbreviation	Definition
a.c.	before meals
A.M.	morning
ASA/asa	aspirin/acetylsalicylic acid
b.i.d.	twice daily
BSA	body surface area
cm.	centimeter
DTaP	diphtheria-tetanus-acellular pertussis
ET	endotracheal/esotropia
g	gram
h	hour
HS/h.s.	hour of sleep
IM	intramuscular
IPPB	intermittent positive pressure breathing
IV	intravenously
kg	kilogram
L	liter
(L)	left
mcg	microgram
MDI	metered-dose inhaler
mEq (mEq/L)	milliequivalent (per Liter)
mg	milligram
min	minute(s)
mL	milliliter
mm	millimeter
MMR	measles, mumps, rubella
MSO ₄	morphine sulfate
MVI	multiple vitamin injection
NG	nasogastric
NKA	no known allergies
NKDA	no known drug allergies
NPO	nothing by mouth
OPV	oral polio vaccine
oz	ounce
p.c.	after meals
PCA	patient controlled analgesia
p.o	per os (by mouth)
P.N./p.m.	afternoon or evening
PPD	purified protein derivative (TB test)
PR	perirectal
P.R.N.	as needed
gh	every hour
q ² h (q ³ h, etc.)	every x hours
Q.I.D./qid	four times a day
(R)	right
TKO	to keep open
TPN	total parenteral nutrition
0.45 (NaCl)	one half normal saline

The complete Medical Staff Approved List of Abbreviations can be found on-line in the medical records folder on the R drive.

RESIDENT SENIOR PROJECTS

The RRC for Family Medicine Program Requirement's dated July 1, 2006 mandate that **ALL** residents **MUST** participate in scholarly activity. To that end, the residency program requires the following Senior Project to meet this mandate.

Learning Objectives

- Medical Knowledge:
 - Perform a critical evaluation of medical literature, including assessing study validity and the applicability of studies to the
 - Gain an awareness of the basic principles of study design, performance, analysis, and reporting
 - Understand the relevance of research to patient care
- Practice-based Learning and Improvement:
 - Apply lessons learned from a critical appraisal to clinical practice
 - Preparation for ABFM's Maintenance of Certification, which will include practice improvement

Project Description

All UNMC family medicine residents will:

- Identify a topic on which to perform the critical appraisal exercise (defined below)
- Write a one-page abstract detailing your scholarly findings
- Include a practice improvement (PI) piece in the project
- Perform a 30-min grand rounds or teaching day in the last 6 months of residency

The above are the four non-negotiable pieces for your senior project. Within this framework, you can be quite creative to develop a project that is interesting for you. You may complete a case report, perform educational or clinical research, complete a clinic practice improvement project, write a chapter for a book, write a review article for a journal, or come up with another idea of your own. The program is willing to be quite flexible in making sure that you find a project that you will enjoy. Final say on project ideas for civilian residents will be from the UNMC program director and for military residents from the military program director. The quality of these projects will play a role in determining who wins the cash research award, which is awarded annually.

We do not want you to recreate the wheel. MPH/MSIA residents can use their capstone projects to fulfill this requirement. A presentation of your project at grand rounds will still be required, unless you are already presenting elsewhere in the department. ARTP residents, who do a critical review for the basic science month in December can expand this review and use the same topic for your senior project. Military residents are encouraged to use this project as the basis for a USAFP presentation.

You may work with another resident on your senior project. However, small groups are preferred. If you have more than 2, you will need to demonstrate what each resident will contribute to the project. Each individual will need to give their own unique presentation.

Timeline

Advisers will work with you on the timeline, but at the end it is your responsibility. Four Benchmarks will be followed to keep you on track:

- By Aug of second year:
 - Identify a topic for your project
- By Jan of Second Yr:
 - Identify a question that your critical appraisal exercise will address
 - Identify key words for your search
 - Identify what the Practice Improvement piece of your project will be
- By May of 2nd Year:
 - Complete your literature search
 - Submit your abstract
- By Jan of 3rd Year:
 - Presentations will be scheduled to occur at grand rounds or teaching days starting in January of each year, based on rotation schedules

Research Mentors

Because not all family medicine faculty enjoy research, your residency adviser may not be the ideal mentor for your senior project. You may wish to find a separate research mentor, especially if you are considering a submission to a conference or a journal. Talk to your adviser or to Dr. Harrison to find a mentor who would be good for your project.

The Critical Appraisal Exercise

“Precisely defining a patient problem, and what information is required to resolve the problem; conducting an efficient search of the literature; selecting the best of the relevant studies and applying rules of evidence to determine their validity; being able to present to colleagues in a succinct fashion the content of the article and its strengths and weaknesses; and extracting the clinical message and applying it to the patient problem.” Guyatt et al

REQUESTS FOR VACATIONS/CONFERENCES/LEAVE

There have been problems in the past with residents requesting absences from their services on short notice. While we have been careful to consider the effects that these absences have on the individual rotations, we have been remiss in considering the effects that these absences have on the individual continuity clinics.

There have been numerous occasions where residents have requested absence with only a few days notice, leaving a full clinic schedule/s behind. This creates a hardship for the front-office personnel and is bad for office morale. It also creates angry patients and is bad for continuity/business.

Accordingly, the Physician Managers, in consultation with the Chief Residents, have adopted the following policy with regard to requests for absence from clinic.

A request for vacation/absence from clinic will be guaranteed only if the request is made at least six weeks in advance.

Requests made for (vacation/absence) less than six weeks in advance **will be granted only if:**

- a. Prior approval is granted by the resident's Physician Manager.
- b. Adequate vacation/conference time is remaining.
- c. Vacation/conference time is requested through Mary Vogel (after approval by the Physician Manager).
- d. Vacation/conference time is granted by the rotation the resident is on, and complies with the departmental policy of the affected rotation/department.

Requests made for **vacation/conference time less than two weeks in advance will be denied unless:**

- a. The Physician Manager deems that the absence is for overwhelming personal circumstances or an invaluable resident experience, and
- b. the resident finds someone else to cover his/her clinic (resident or staff), or
- c. the resident agrees to telephone patients with scheduled appointments to reschedule those appointments on an alternative date.

VACATIONS

All time off **must** be scheduled through the Family Medicine Department.

Family Medicine residents at UNMC Physician's clinics are allowed 20 days vacation per year. In addition, they may be absent from the program for 8 weekends per year, which are not counted as vacation days. Ten days may be held over from one academic year to the next, and up to ten days vacation may be cashed-in upon completion of training.

Vacation policy for military residents is the same as for civilian residents. Unused vacation time may be accrued and utilized after completion of the residency program while on active duty.

Vacations may generally be taken at any time providing the resident arranges coverage for his/her clinics, inpatients and imminent inpatients (especially OB's), but it may not be permitted for first and second year residents during the last two weeks of June. Other services may have a specific time during the month when vacations may be taken. Specialty services must be informed in advance of vacation plans. Various departments have restrictions on the total amount of time you may take during rotations as follows:

Allergy/Imm.	1 month	1 week vacation allowed
Medicine Rotations	1 month rotation	2 days and one weekend.
Methodist Rotations	1 or two months	1 week per month of rotation. No vacations during the first week on a rotation.
OB	1 month	2 week days and one weekend per month (if only one resident, no vacation allowed)
GYN EBC	1 month	2 week days and one weekend. Needs to be Thursday through Sunday
Combined ENT/Ophth	1 month	No vacation
ER Methodist	1 month	No vacation allowed
Family Medicine In-patient Service	4 months	4 days total (this includes the weekend days) per month. The other person on the assigned team cannot be gone at the same time
In-patient Service - Clinical Chief		No vacation allowed
Geriatrics	1 month	2 days and one weekend
Night Float (Mole)	1 month	No vacation allowed
Pediatric Rotations; Peds EBC	1 month	2 days and one weekend (1 month notice required)
MRI	1 month	one week allowed
CMH	1 month	*See below
Rural Rotations	2 months	Prefer none taken (one week is allowed)

Urology/Renal (combined) 1 month No Vacation Allowed

***NOTE:** When on Inpatient Pediatrics at Children's, **no vacation is allowed**. You also cannot leave when on call. If an OB has to be admitted, you must arrange for a fellow resident to either cover the delivery or cover your pediatric call. Family Medicine residents on this service are paired with a Pediatric resident. This way, if a Family Medicine resident has to go to clinic or deliver a baby, his/her partner will remain in-house at CMH so that all service obligations are met.

Our departmental policy is that all vacation requests must be turned in by the 1st Teaching Day, two months prior to the desired time off. (Example: for a September vacation, the request must be submitted by the 1st Teaching Day in July.)

Most other rotations have no specific restrictions insofar as vacation time allowed. A good rule to follow is that one week of vacation time is allowed for each rotation.

Methodist Hospital would prefer that you not take time off at the beginning of a rotation.

Residents should avoid putting off their vacations until the last couple months of the year. In the past vacations have, on occasion, been denied or modified because everyone wanted to be gone at the same time.

If a resident is away from a service for more than one week during a one month rotation or for more than two weeks on a two month rotation, that rotation will be reviewed by the department involved and the Family Medicine Program Director in order to determine if the resident should receive full credit for that rotation.

Although the University of Nebraska Medical Center does recognize the concept of "comp time", it only applies to hourly employees.

Completion of all requirements of the training program will be necessary before the Program Director recommends the resident to sit for the ABFM Certification Examination.

MATERNITY LEAVE

Residents are encouraged to take as much time away as they need for the health of themselves and their families before, during and after delivery. Residents need to understand that the RRC and ABFM requirements are not waived in the event of pregnancy and subsequent maternity leave. Therefore, the policies of this program are:

- In order to receive credit for any block rotation, the resident will need to participate in that rotation to the same degree as any other resident in the program.

For example, if you are on a rotation that allows only one week of vacation, you must be on that rotation for 3 weeks to receive credit.

- Time cannot be double counted. In other words, either you are on maternity leave or you aren't. Time away cannot count toward your 36 month board requirement.
- Salary and benefits for maternity leave will be determined by USAF and University of Nebraska policy.
- The Program Director will retain final authority on what experiences count towards the 36 month residency requirement.

CHANGES TO ROTATION SCHEDULE

In order to facilitate the scheduling of patients for follow-up appointments, and to plan for the efficient utilization of clinic space and ancillary personnel, the clinic Physician Managers try to maintain clinic schedules for both faculty and residents at least 3 months in advance.

Concurrently, residents are constantly reassessing their rotation schedules and frequently asking Rita to make changes in their electives, etc. Sometimes these changes call for a fairly significant change in when a resident is available for continuity clinic. Therefore, when residents ask for schedule changes after the clinic schedules have been completed, it can create problems.

Accordingly, departmental policy is that schedule changes need to be made at least 2 months in advance. Requests made with less than 2 months advance notice must be cleared through the appropriate clinic Physician Manager and, the less the advance notice, the less the likelihood that the request will be approved.

RESIDENT WORKING HOURS

The following is an excerpt from the Graduate Medical Education Directory "Common Program"

F. Resident Duty Hours and the Working Environment

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to

fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents must be provided with a 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- d. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods after in-house call.

From the same document under “Program Requirements”

V.E. Resident Workload and Impairment

Each program must ensure an appropriate working environment and a duty hour schedule that are consistent with proper patient care and the educational needs of the residents. The educational goals of the program and the learning objectives of the residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations.

There must be formal written policies on the following matters that demonstrate compliance with these requirements. These documents must be available to the RRC, if requested.

1. Moonlighting

It is the responsibility of the program to see that residents provide patient care in the pursuit of their education without additional remuneration based on

productivity. Residency training is a full-time responsibility. The program director should monitor the effects of outside activities, including moonlighting inside or outside of the participating institutions, to ensure that the quality of patient care and the resident's educational experience are not compromised.

2. Workload/Duty Hours

Resident assignments must be made in such a way as to prevent excessive patient loads, excessive new admission workups, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation. The program must also ensure the following:

- a. At least 1 day out of 7, averaged monthly, away from the residency program
- b. On-call duty no more frequently than every third night, averaged monthly
- c. Adequate backup if sudden and unexpected patient care needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.

Programs must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment. There also should be a structured and facilitated group designed for resident support that meets on a regular schedule.

In order to comply with the above, it is the policy of this Department that resident work hours must be in compliance with the following guidelines:

- a. Resident work hours will not exceed 80 hours of patient care activity per week averaged over a month.
- b. Averaged over a month's rotation, residents will have at least one period of 24 consecutive hours free of patient care responsibility per week.
- c. Residents will not work more than 30 consecutive hours without having a 10 hour rest break free of patient care responsibility.
- d. In-house on-call duty will not be assigned more frequently than every third night on the average.

MOONLIGHTING

Moonlighting is permitted by the University of Nebraska Medical Center. **This type of activity must occur during your regularly scheduled time off or when you are on**

vacation. It cannot occur during your regularly scheduled working hours. Moonlighting requests must be approved by the Program Director and the Graduate Training Office <**PRIOR**> to the date of service. This is required in order to insure that the moonlighting experience is one that will not subject the resident to increased risk or unusually long hours. This approval is also required in order for your malpractice insurance to be in effect.

Residents **must** have a permanent license to do independent moonlighting, and must arrange coverage as outlined under vacations (above) for both week-ends and week-days. No private practice is permitted.

Moonlighting is a privilege and not a right and the privilege to moonlight must not be abused. If a resident's moonlighting activities start to interfere with his/her performance in the residency, or should proper procedures not be followed, moonlighting privileges will be curtailed. Residents on probation cannot moonlight.

Residents will not be allowed to moonlight more than 40 hours/week, averaged over a month's time.

Finally, when residents are working on rotations involving Methodist Hospital, they are, in effect, working for Methodist. Accordingly, all moonlighting activities while assigned to services at Methodist Hospital must also be approved by the attending physician/faculty member in charge of the rotation.

Federal law prevents IMGs with a J-1 visa from moonlighting. House officers with H1B visas are not allowed to moonlight unless they obtain a separate H1B petition for the location in which they are working.

AF residents are not permitted by AFI to moonlight.

ABSENCE FROM THE RESIDENCY

There are many reasons why a resident might be absent from the program including vacation, conference, illness, etc..

The following is from the ABFM Policies and Procedures Manual

Continuity of Care – The requirements for continuity of care are defined in the following excerpt from the “Program Requirements for Residency Education in Family Medicine”, effective July 1, 2006.

Residents should develop and maintain a continuing physician-patient relationship with an undifferentiated panel of patients and their families throughout the 3-year

period. The program must be structured to ensure that residents maintain such continuity at least throughout their entire second and third years of training.

Remote Site Experience – The “Program Requirements” provide for residents to spend time away from the Family Medicine Center, if necessary, to meet the educational needs of their training. The use of remote sites or rotations on clinical services, associated with or external to the program, must not interrupt continuity of care at the Family Medicine Center for longer than one month in the first year and two months in each of the second and third years. Upon return to the Family Medicine Center, the resident must provide continuity of care for his/her patients for at least two months before leaving for any additional away rotations.

Vacation, Illness, and Other Short-Term Absences– Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one (1) month per academic year.

Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of G-2 year and first month of the G-3 year in sequence) and a resident does not have the option of reducing the total time required for residency (36 calendar months) by relinquishing vacation time.

The Board recognizes that vacation/leave policies vary from program to program and are the prerogative of the Program Director so long as they do not exceed the Board’s time restriction.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, are not counted in the general limitation on absences but should not exceed 5 days annually. Remote site training must comply with the ACGME “Program Requirements” and will not be affected by any leave of absence taken by a resident.

Long-Term Absence– Absence from the residency, in excess of one month within the academic year (G-1, G-2 or G-3 year) must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training. Absence from the residency, *exclusive* of the one month vacation/sick time, may interrupt continuity of patient care for a maximum of three (3) months in each of the G-II and G-III years of training. Leaves may be interspersed throughout the year or taken as a three month block of time.

Following a leave of absence of less than three months the resident is expected to return to the program and maintain care of his or her panel of patients for a minimum of two

months before any subsequent leave. Leave time must be made up before the resident advances to the next training level and the time must be added to the projected date of completion of the required 36 months of training. Residents will be permitted to take vacation time immediately prior to or subsequent to a leave of absence.

In cases where a resident is granted a leave of absence by the program, or must be away because of illness or injury, the Program Director must promptly inform the Board in writing of the date of departure and expected return date. It should be understood that the resident may not return to the program at a level beyond that which was attained at the time of departure.

Leave of absence in excess of three months is considered a violation of the continuity of care requirement. Programs must be aware that the Board may require the resident to complete additional continuity of care time requirements beyond what is normally required to be eligible for certification.

Waiver of Continuity of Care Requirement– While reaffirming the importance of continuity of care in Family Medicine residency training, the Board recognizes that hardships occur in the personal and professional lives of residents. Accordingly, a waiver of the continuity of care requirement or an extension of the leave of absence policy may be granted when a residency training program closes or when there is evidence of the presence of a hardship involving a resident. *A **hardship** is defined as a debilitating illness or injury of an acute but temporary nature, or the existence of a threat to the integrity of the resident's family, which impedes or prohibits the resident from making satisfactory progress toward the completion of the requirements of the residency program.*

A request for a waiver of the continuity of care requirement or an extension of the leave of absence policy on the basis of hardship must demonstrate:

- that the absence from continuity of care does not exceed 12 months;
- the nature and extent of the hardship;
- that excused absence time (vacation/sick time) permissible by the ABFM and the program for the academic year has been reasonably exhausted by the resident;
- that a medical condition causing absence from training is within the Americans with Disabilities Act (ADA) definition of a disability.
- For absences from training of less than 12 months, the amount of the 24-month continuity of care requirement completed prior to the absence will be considered a significant factor in the consideration of the request. It is unlikely that waivers of the continuity of care requirement will be granted when the break in continuity exceeds 12 months

In communicating with the Board, the program should indicate the criteria it will use, if any, to judge the point at which the resident is expected to reenter. The resident may NOT be readmitted to the program at a level beyond that which was attained at the time of departure, but the resident may reenter the program pending a final decision by the Board on the amount of additional training, if any, to be required of the resident.

In order to comply with the above, it is departmental policy that a resident's absence, for all reasons except CME, may not exceed 30 calendar days. If it is necessary to extend a resident's training, it shall be done on a day-for-day basis, except in the case of failed rotations which shall be on a month-for-month basis. Residents may use up to 2 months of elective time to repeat failed rotations.

POLICY ON BENEFITS CONTINUATION DURING LOA

Since more house officers have become eligible for extended leaves from training programs, it is now policy that any house officer taking more than 12 weeks of family leave is responsible for the University's contributions to their insurance as well as their own. This is in accordance with the current family leave policy of the University.

EHLING BERGQUIST CLINIC POLICIES

All non-military residents who are presenting to Ehrling Bergquist Clinic for their first rotation are required to attend a brief hospital orientation prior to beginning that rotation. This orientation is from 0800 to approximately 1000 hours the first morning of the rotation and will be conducted by Mr. Wayne Cantwell, the EBC FMR Residency Coordinator. Meet him in his office in the FMR Clinic at 0800 hrs that first morning. Your participation in this orientation is mandatory and takes precedence over any other activities on your first day. You will need to bring a copy of your state license to the orientation so it can be filed in our Department of Education as required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Any questions can be addressed to the Medical Education Coordinator, 294-9270, Mr. Wayne Cantwell.

While working at EBC, on any service, the resident will follow the following dress code: Military residents will always be in the appropriate duty uniform while seeing patients. Civilian residents will wear appropriate civilian attire (scrubs are not to be worn coming or leaving the base hospital). Residents may change into scrubs once at the base hospital. Please note you **MAY NOT** wear scrubs when coming to or leaving the base hospital. You must also wear a white coat over your scrubs when not in Surgery.

While on rotations at Ehrling Bergquist Clinic, you will be off duty during federal holidays, unless on-call or otherwise specified by your staff supervisor. Military residents will not observe federal holidays while on civilian rotations, unless specified by their rotation staff supervisor.

INSTITUTIONAL POLICY REGARDING USMLE

House Officers must pass USMLE Step 2 or COMLEX exams to advance to the HOII level and must pass USMLE Step 3 or COMLEX Exams or Part II of the Medical Council of Canada Qualifying Exam to advance the HO III level. A house officer who does not meet these requirements will be placed on unpaid leave for a maximum of 6 months in order to prepare and pass the exam. Failure to pass the required examination by the end of this leave period will result in dismissal from the program.

The house officer's program director may apply to the GMCC for a one-time extension of the requirement for a period of 6 months or less. The letter must present compelling reasons for the extension and must be co-signed by the house officer. At the end of the extension, if the requirements are not met, the house officer will go on unpaid leave and must pass the test within 6 months as above. Until the requirements are met, the house officer will not advance in pay level.

RESIDENT EVALUATION AND CONTRACT RENEWAL

Residents are evaluated on a continuing basis both on their services and in their continuity clinics.

Prior to the beginning of each rotation, an evaluation packet is sent to that specific rotation. This packet will include the following:

- the resident's continuity clinic schedule for the month
- rotation contact information

The goals and objectives for the month are available for review on the departmental web site. In order to receive credit for any rotation the resident **MUST** complete the electronic evaluation form that will be sent to them via the Lotus Notes email system at the end of the month. Failure to respond within 2 weeks will result in a reminder email with a copy to the resident's faculty advisor and Program Director.

Each rotation will evaluate the resident either by electronic or paper form based on the ACGME competencies. This evaluation will be forwarded to the residents faculty advisor.

Residents will also be evaluated by the faculty in their respective outpatient clinics, with input from the ancillary staff (a 360 degree evaluation), as to their performance in the clinic setting.

Finally, at the end of each 4-month grading period, the faculty devote an entire faculty meeting to the discussion of resident performance.

All of this data is then combined by the resident's faculty advisor every 4 months into a composite evaluation which is forwarded to the Program Director for his input as to a resident's general overall performance, including such items as adherence to departmental policies, etc.

This report is forwarded to the Graduate Medical Education Office where it becomes part of a resident's permanent record.

Residents whose evaluations are less than desirable will receive recommendations for improvement from the faculty and the resident is expected to implement them.

In the Spring of each year, the faculty will meet in an Executive Session to review all residents regarding recommendations for advancement. If the performance to-date has been satisfactory, and assuming that performance will continue to be satisfactory for the remainder of the academic year, the resident will be advised of the faculty's intention to advance them to the next level for the following academic year. Actual contracts will not be available for signing until after the 1st of July.

BOOK MONEY

Every year, residents receive a \$200 book allowance that they can use at the UNMC Bookstore. \$100 is from the Associate Dean for Graduate Medical Education and the additional \$100 is from the Department of Family Medicine.

AWARDS

The following awards are presented each Spring during graduation ceremonies:

"House Officer of the Year" Award

Presented to a graduating third year resident who is considered a superior representative of our residency program. Qualifications include: scholarship (including routine evaluations and In-Training exams), leadership, clinical excellence, dedication to teaching peers and others, and extra-curricular community involvement. Selected by the faculty.

"Alumnus/a of the Year" Award

Given to a board certified graduate of the Family Medicine Residency Program at UNMC. Qualifications include: exemplary family physician, leadership and service to the community, service to family medicine at UNMC, locally and/or nationally, and additional achievements or innovations. Chosen by a Selection Committee appointed by the Chairman of the Department..

"STFM Resident Teacher" Award

Given to one third year resident who has interest, ability and commitment to family medicine education as demonstrated by peer teaching, education of medical students, physician assistants, nursing students, etc., consistent quality in presentations and/or conferences, and excellence in patient and community teaching. Selected by the faculty and residents.

The Kashinath Patil, Ph.D. Award for Excellence in Research/Scholarly Activity

The Kash Patil Award is given annually to the resident who has performed the most outstanding scholarly work during the academic year. This work may include, but is not limited to, reviews of the literature, case reports, original research, or clinical investigations. Priority for the award will be given to those residents pursuing original research projects, and to graduating residents.

Awards for Academic Excellence

In order to recognize those residents who do well on the ABFM annual In-Training Examination, the following awards are presented annually:

THE LEE RETELZDORF, MD AWARD - to the Family Medicine HOI with the highest exam score.

THE MARGARET FAITHE, M.D. AWARD - to the Family Medicine HOII with the highest exam score.

THE RALPH CASSEL, M.D. AWARD - to the Family Medicine HOIII with the highest exam score.

CHAIRMAN'S HONOR ROLE

In recognition of outstanding performance on the ABFM In-Training Examination, all residents with an overall score that places them in the top 1% of all participants in the nation will be placed on the Chairman's Honor Role and so recognized at the Spring Awards Banquet.

FACULTY OF THE YEAR

This award is presented annually by the Family Medicine residents at UNMC. The Faculty of the Year Award will be voted on yearly during the resident retreat. The requirements for nomination for this award include that the recipient be a faculty member in the Department of Family Medicine. He/she must have demonstrated commitment to education of Family Medicine residents. He/she should have also demonstrated outstanding teaching skills and ability and been a good "role model".

PHYSICIAN OF THE YEAR

This award is presented annually by the Family Medicine residents at UNMC. The Physician Teacher Award will be voted on yearly during the resident retreat. The requirements for nomination for this award include that the recipient not be a member of the Family Medicine Department, but have worked closely with Family Medicine residents. He/she must have demonstrated commitment to education of Family Medicine residents. He/she should have also demonstrated outstanding teaching skills and ability and been a good "role model."

TEACHER OF THE YEAR AWARD

This award is given annually by the Family Medicine residents to a non-physician teacher who may or may not be a member of the Family Medicine faculty. Requirements include commitment to Family Medicine education as well as outstanding service to the Family Medicine Department.

The above awards are to be voted upon by all residents. A majority is not required. The "most votes" is sufficient. If multiple nominations are made, the votes may be thinly dispersed necessitating a run off vote between the top two vote getters. During a run off, residents may not be familiar with either candidate. They may choose not to vote at their own discretion.

CHIEF RESIDENT

The Chief Resident plays a very critical role in the functioning of the Family Medicine Department. The Chief is selected by the residents, with input from the faculty, in a vote taken in the Spring prior to the HO III year. Selection to be Chief Resident is an honor and it is also recognition that the faculty and residents have sufficient confidence in an individual to offer him/her this key leadership position.

In recognition of the added responsibility of the Chief, the Department provides a \$2,400 stipend and a certificate is awarded by the Graduate Training Office in June of each year recognizing the individual who served as Chief Resident

The role of **Chief Resident** is an administrative position that is filled by an HO III who serves for the entire year. There are no in-patient care responsibilities associated with being Chief Resident. The **Chief Resident** will perform the following duties:

1. Organize Grand Rounds in such a manner so as to provide a variety of pertinent topics in the many areas that are the concern of family physicians.
2. Assist staff with Tuesday/Thursday noon conferences and assist pharmaceutical representatives in their quest for providing residents with continuing education.
3. Welcome all new residents and be available for any questions or problems that affect the incoming residents.
4. Address any problems arising with ED staff and check with ED staff to ensure ED/FM relationship is smooth. If problems arise and cannot be resolved, the Program Director will become involved.
5. Will attend faculty meetings from 0730 - 0815 on the 1st Tuesday of each month, and the Graduate Medical Education Division meeting from 0700-0800, second Thursday each month.
6. Prepare monthly call schedules and resolve any conflicts that may arise.
7. Serve as a point of contact and advocate for all residents.
8. Will serve as a liaison with regards to:
 - a. Inter-resident conflicts
 - b. Dealing with problem residents from other departments
 - c. Resolving scheduling conflicts - i.e. coverage for a resident on rural rotation or vacation
9. Coordinate the scheduling and presentation of the orientation month.

The **Chief Resident** will be responsible to the Program Director and will work closely with the Residency Coordinator.

The Co-Chief Residents for 2009-2010 are Mindy Lacy and Nate Falk.

FACULTY ADVISORS

Every resident is assigned a faculty advisor at the beginning of their training. Barring unforeseen circumstances, the resident-advisor team will remain intact throughout the entire 3 years of training.

It is hoped that the residents and their advisors will meet on both a personal and professional basis regularly throughout the training program.

From a professional viewpoint, the faculty advisor will review all evaluations on the advisee and be responsible for preparing the every 4 months evaluation that is submitted to the Program Director and the Graduate Medical Education Office. The advisor will also review the resident's In-Training Exam, conference attendance, continuity clinic production figures, etc., and make recommendations regarding correction of any deficiencies that may exist. Because the advisor works in the same continuity clinic as the resident, he/she will be readily available on a daily basis to assist and/or advise as needed on any professional issues that may arise.

From a personal viewpoint, moving to a new community and/or completing a residency program can be a very stressful experience and the faculty advisor should always be ready to counsel and guide their residents as needed, as well as interact with them on a social/personal basis.

CME COURSE OPTIONS

ACLS is required in order to be in the residency. Make sure you keep your certification up-to-date. ATLS is offered to all residents. It is recommended that you complete ATLS before going out on your CORE rotation. If you fail the course, you will be required to pay for it yourself. For the USAF residents, you can take the C4 (Combat Casualty Care Course) in lieu of ATLS. NRP and PALS are required before your inpatient pediatric rotation at CMH.

PRACTICE OPPORTUNITIES AND FELLOWSHIPS

Each month we receive dozens of letters advertising practice opportunities and fellowships. Because of the sheer numbers, it is not practical to post every one of them. Therefore, Rita's secretary maintains a file of all the materials received. If you are interested, check with her.

Because the number of Fellowships available are still at a manageable level, we will continue to post the flyers for these programs on the "Fellowships" bulletin board.

VIDEOTAPE LIBRARY

The Department of Family Medicine frequently receives complimentary videotapes from the AAFP Home Study Self Assessment series. These are usually excellent reviews on a

given topic and can provide a good review for a resident interested in getting more information. These are located in the departmental library.

Tapes are checked-out on the honor system. It is helpful, if when taking a tape, to leave a note with your name and the titles taken on it so that the tape can be located by subsequent borrowers. Please, when you're finished with a tape, return it as others may want to use it.

HOUSE OFFICER BENEFITS
DEPARTMENT OF FAMILY MEDICINE
UNIVERSITY OF NEBRASKA MEDICAL CENTER

UNMC Residents

1. Twenty working days paid vacation.
2. Professional leave with pay for approved meetings.
3. Sick leave -- Up to six months accrual after two years employment.
4. Comprehensive group health coverage at reduced rates.
5. Low rate automatic eligibility disability coverage available.
6. Malpractice insurance provided for all educational activities and some moonlighting activities.
7. Lab coats and scrubs provided at University expense at the beginning of residency.
8. Laundering of lab coats provided.
9. Prescription medication and OTC drugs provided at acquisition cost for hospital employees.
10. \$200 house officer educational appropriation to departments. (Book Allowance)
11. Travel money for residents investigating practice locations in Nebraska.
12. Reimbursement for travel to and from required training sites more than 25 miles from the Medical Center.
13. Outside employment opportunities - moonlighting (if they do not interfere with the duties, assignments, and responsibilities of the house officer's program).
14. House officers' lounge provided at the Medical Center.
15. Parking spaces near the Emergency Room for house officers on call who need to come in after working hours.
16. Preferential eligibility for Medical Center parking.
17. Evening and breakfast meal allowance while on call overnight at University Hospital.

House Officer Salaries for 2009-2010

HO I - \$48,882
HO II - \$50,692
HO III - \$52,758
HO IV - \$54,639

Salaries 2009-2010 EBC

Military pay is based on rank
and time on active duty