INTRODUCTION

Welcome to the Nellis Family Medicine Residency (FMR). You are a member of the newest AF Family Medicine training program. Our residency achieved initial accreditation and opened in 2009. Renewal of accreditation was awarded in 2012 for 5 years and continued accreditation since that time. We provide full-spectrum Family Medicine within our clinic, and many providers have their own niches where they can thrive. I trust that the unique talents which you bring with you to this assignment will contribute to the further excellence of this program.

In this electronic handbook you will find a review of the credentials and requirements for faculty members, detailed guidelines as to the faculty responsibilities, individual patient responsibilities, administrative responsibilities, and a discussion of the faculty development.

Matthew Snyder, Lt Col, USAF, MC, FAAFP
Director, Nellis Family Medicine Residency Program

Founding Faculty and Residents of the Nellis Family Medicine Residency with Lt Gen Bruce Green.
Vision: Premier Medical Education, Trusted Patient Care Always

Mission: Provide world-class graduate medical education to produce board-certified, deployment-ready family physicians capable of serving all patient populations, whether deployed or in garrison.

Goals:

To produce COMPETENT and QUALIFIED physicians:
The primary goal of the program is to produce highly qualified, board-eligible family physicians capable of providing continuing and trusted care to the individual and family as an integrated unit, in any military or civilian medical system. Graduates are capable of independent practice in the field of Family Medicine and recognize that our responsibility is not limited by sex, age, organ system, or disease process but is comprehensive delivery of medical care.

To propagate our specialty through MENTORING:
The program should cultivate mentors who particularly focus on medical students learning our specialty while helping them foster skills unique to Family Medicine that they can use in their future specialty by modeling full-spectrum Family Medicine as a cadre of diverse faculty. All instruction is performed in an environment that places the highest priority on patient safety and empathic care.

To perform as LEADERS:
Graduates will lead patient care and be able to assume responsibility for directing a team approach to health management. Emphasis will be placed on the integration of a body, mind, and spirit approach as well as promoting healthy family dynamics within the broad context of community health care. The goal is learning how to engage patients and help them utilize their resources to cope with an illness and injury.

2. Objectives:

Founded in the ACGME core competencies, the FM Milestones and Family Medicine for America’s Health

a. Precepting family physicians to create a broad-spectrum, patient-centered medical home which results in generative growth for each individual patient and family.

b. Promoting patient ownership of all military families enrolled to the panels of the Family Medicine Residency through continuous on-going relationships in the outpatient, inpatient and nursing home settings.

c. Model full-spectrum Family Medicine

d. Supervising through mentoring relationships with team chiefs, fellow residents, and medical students to support the individual and the specialty of Family Medicine

e. Preparing residents to gain sufficient medical knowledge to pass examination by the American Board of Family Medicine

f. Requiring scholarly activity and encouraging active participation in organizations which further life-long learning such as AAFP (American Academy of Family Physicians) and USAFP (Uniformed Services Academy of Family Physicians)

g. Creating a conducive atmosphere for academic, emotional and spiritual growth of the entire staff by balancing time spent between medicine and family life; supporting weekly Balint meetings for morale and stress relief as well as providing clear policies regarding resident fatigue.
h. Teaching family physicians to become educators of patients, their fellow health care workers, as well as curious, self-directed learners for their own identified needs; clinical curiosity is paramount.

i. Supporting community and international medical experiences including civilian and military humanitarian missions

j. Enriching resident and staff experiences by partnering with civilian medical resources at Sunrise hospital, University Medical Center, the VA, Marquis Plaza Regency Nursing Home, and local physician offices.

k. Developing ethical physicians who consistently display professionalism and integrity, as they humanize the health care experience in the family context of problems.

l. Incorporating evidence-based medicine (EBM) concepts into their practice and self-directed learning to develop a natural command of medical complexity

m. Promoting cost-effective health care maintenance and disease prevention at all stages of the individual and family life cycle.

n. Learning key military medicine concepts of the USAF medical service such as readiness, Patient Centered Medical Home (PCMH), use of physician extenders and expeditionary medicine.

o. Leading nurses, technicians, and other ancillary staff in interdisciplinary team work, as they handle stressful situations, deal with ambiguity, and interact with the system around them.

p. Leveraging electronic records (AHLTA) and population health information technology resources to document clear concise notes, code accurately to allow appropriate billing, and target health care delivery to high-risk disease management diagnoses.

q. Organize, interpret and advocate for the patient’s needs when coordinating consultant care for empanelled patients

3. Assessment of Goals & Objectives:

A 3-year program of advancing responsibility, privileges and independence has been developed. This program emphasizes inpatient medicine, block rotations, and weekly Family Medicine clinic in the PGY 1 year and supervisory experience with subspecialty/elective focus, longitudinal format and continuity OB/emergency medicine in the PGY2 and PGY3 years. Increasing emphasis is placed on ambulatory rotations as the resident progresses. Evaluation by peers, Family Medicine faculty and faculty from outside departments is used not only as an educational formative feedback tool, but also as a summative means of documenting the resident’s progress towards staff level competence. Evaluation also serves to identify those residents who are in need of special assistance or remediation. National in-service training examinations and Family Medicine board examinations provide further documentation of performance relative to Family Medicine peers in other residency programs.

The residency environment includes a continuously evolving curriculum experience, which is under constant evaluation; evaluation informs curriculum to complete the residency assessment process. Residents are guided by monthly team chief sessions to monitor acquisition of appropriate knowledge, skills, attitudes, performance, and practical experience. Within the Clinical Competence Committee (CCC), the faculty will discuss each resident’s performance quarterly and provide feedback to the team chief to take back to the resident.

Residency Partner is our web based system to collect formative and summative evaluations, including 360 evals from peers, patients and ancillary staff. Every quarter, the faculty reviews every resident’s progress as reported by their team chief/advisor and records it into the ‘resident dashboard’. Every 6 months, the resident is scored, formally, on the ABFM
milestones which satisfy both AF regulations and ACGME requirements. Additionally, every 12 months an AF Form 475 narrative training report is composed which summarizes performance and is used later for consideration of promotion to a higher officer rank. The faculty also account for In-Training Exam performance when making decisions for adding progressive responsibility. Specifically by year group, the **MILESTONE ACADEMIC PROMOTION criteria** are as follows:

PGY1 to PGY2 (includes supervisory role)
1. Pass all rotations
2. Maintain ACLS/BLS/PALS/NRP
3. Pass Step 3/COMLEX 3
4. 150 outpatient visits
5. Demonstrate safe and competent outpatient medical care including appropriate lab/imaging follow-up, evidence-based/guideline care and appropriate consultations
6. Consistent evaluation-based evidence that resident has sufficiently grown as a clinician to assume supervision responsibilities including:
   a. Demonstration of patient ownership by actively managing assigned patients
   b. Performing appropriate H&Ps
   c. Independently developing own assessments (including differential diagnoses), and appropriate treatment plans based on current guidelines/evidence-based medicine
   d. Independently following-up on ordered labs/imaging
   e. Documentation accurately reflecting the patient’s current subjective and objective findings
7. Complete HSM requirements for PGY1

PGY2 to PGY3
1. Pass all rotations
2. Maintain ACLS/BLS/PALS/NRP
3. 750 outpatient visits
4. Obtain state medical license
5. Have scholarly activity project approved
6. Demonstrate real progress towards completion of scholarly project
7. Complete HSM requirements for PGY2

PGY3 to Graduation
1. Pass all rotations
2. Maintain ACLS/BLS/PALS/NRP
3. Take Board Certification exam in April
4. Complete scholarly activity/HSM requirements
5. Home visits (2) completed
6. Complete OB continuity and delivery requirements
7. Complete 1650+ outpatient FM center visits (165 visits with patients <10 yrs. old, 165 visits with patients >60 yrs. old)

**SCOPE OF SERVICES**
**FAMILY MEDICINE SERVICES**

**TYPES AND AGES OF PATIENTS SERVED:**
1. Types of patients served in the Family Medicine Clinic include but are not limited to:

   a. Infants and children (newborn to age 12) requiring general pediatric care to include well-baby exams, preventive medicine, physical exams, chronic and acute medical problems.
   b. Adolescents (from age 13), adult, and geriatric patients requiring ambulatory care such as self-limiting acute and chronic illnesses, physical examinations, health/wellness education, a limited number of minor surgical procedures, preventive medicine, general medicine, obstetrics and women's health, and coordination and referral of clients requiring specialty services.
   c. Application of technologies such as infusion therapy, patient/family education, pain management, minor surgical procedures, skin biopsies, vasectomies, nebulizer therapy, exercise stress tests, ear irrigations, colonoscopy, colposcopy, LEEP, obstetrics and gynecological procedures, OMT, acupuncture, and orthopedic measures such as slings, splints and casting.

APPROPRIATENESS, CLINICAL NECESSITY, AND TIMELINESS OF SUPPORT SERVICES:

1. Appropriateness:

   a. Care is continuously evaluated by all health team members through a process improvement program consisting of review of medical records, documentation, and patient outcome evaluation as well as satisfaction survey.

2. Clinical Necessity:

   a. Metrics are designed to monitor access for the enrolled population according to pre-established TRICARE standards and are reviewed by each team every month.
   b. Monthly peer review, combined with a more encompassing q 6-month faculty peer review, assures appropriate treatment, follow-up, and referral.

3. Timeliness:

   a. Care is provided from 0740-1630, Monday through Friday
   b. Acute same day appointments are available when the clinic is open, active duty members, OB patients, infants and children under 12 will be seen by walk-in for acute concerns if appointments are not available.
   c. Telephone consult, Relay Health (MiCare) and follow-up is also used to access Primary Care Managers; All physicians should make DAILY effort to return messages and then document said effort electronically (TCONs).
   d. Community and network resources are utilized to provide timely interventions when demands exceed availability.

AVAILABILITY, KNOWLEDGE AND SKILL OF NECESSARY STAFF:

4. Knowledge required:

   a. Completion of an ACGME certified Family Medicine residency with inpatient, outpatient and procedural expertise. OB care performance is required.
   b. All medical providers meet credentials requirements of the organization.
STAFF CREDENTIALS

1. You are required to keep an updated and cumulative record of your continuing medical education activities. The Air Force requires that you obtain 150 hours of continuing medical education over a 3-year period. The AAFP has an excellent CME tracker on their web site. Remember annual maintenance of certifications is required by the AAFP (http://www.aafp.org/online/en/home/cme/boardreview.html?navid=maintain+your+certification).

2. The Air Force may provide funded (local/AFIT) TDY for CME per year, plus local approval may be granted for permissive (non-funded) TDY per year depending on availability of funds.

3. The Air Force requires you to have an unrestricted state medical license.

4. The ACGME requires faculty members to have and maintain board certification.

5. As a FM faculty member you are required to be current in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Program (NRP), Advanced Life Support in Obstetrics (ALSO), Advanced Trauma Life Support (ATLS), Advanced Fetal HR Monitoring (FHM), and STABLE. All provider courses (except ATLS) are offered here at Nellis.

6. This faculty handbook will serve as your written job description while you are a member in this department.

COMMITTEES

1. All physicians are required to participate in the hospital committees. These are assigned by the Program Director; volunteers are appreciated. Staff participates in these committees for at least one year's time. The entire list of committees is tracked on the annual FMR faculty assignment list.

2. The Clinical Competency Committee (CCC) is comprised of all faculty, chaired by the Associate Program Director, and functions to periodically assess a resident’s progression in the program via the FM Milestones. The assessments performed by the CCC identify residents performing well vs. those with areas of concern, as well as deficiencies in their educational curriculum, rotation schedules and supervision. Please see the attached Clinical Competency Committee Policy for more information.

3. The Program Evaluation Committee (PEC) is comprised of select faculty and at least two residents appointed by the Program Director. Its primary role is to plan, develop, implement and evaluate all significant activities of the program with particular attention paid to compliance to ACGME program/curriculum requirements. Please see the attached Program Evaluation Committee Policy for more information.

CLINIC RESPONSIBILITIES

1. All Core faculty are assigned a panel of approximately 200 patients. These patients are selected so that you get an adequate mix of age groups as well as disease processes. Though panel profiles vary, we make an attempt to have panels consist of a set amount of pediatrics, obstetrics, active duty, and geriatric patients. See our clinic Group Practice Manager (GPM) or log onto your Care Point to
receive a computer-generated list of your patients (https://carepoint.health.mil).

2. Faculty will typically have two to three half days of continuity clinic per week to see your empaneled patients. Routine and acute appointments will be scheduled at 20 minute intervals. Minor surgical procedures may be scheduled for 40-minute appointments.

3. The monthly clinic schedule is produced by the Scheduler and the Chief Residents with the Flight Commander providing oversight. Leave MUST be coordinated ≥3 months in advance. All leave should be scheduled in Leaveweb, which generates an electric AF form 988. Leave requests should be completed in Leaveweb 3-14 days prior to departure. Permissive TDY electronic forms must ultimately be signed by the squadron commander, but must first be sent to the Program Director and are required to be submitted 21 days prior to PTdy. Electronic leave forms are signed by your supervisor. The first signature on regular TDY forms should also be the Program Director. Those faculty separating from the Air Force or PCSing must coordinate leave including terminal leave, house hunting days, etc with the Program Director at least 6 months in advance.

4. Should you require a change in your clinic schedule, you must obtain the approval of the Clinic Chief who will notify the scheduling personnel. Since our appointments are opened 120 days out, it is important to make this notification as soon as possible. Schedule changes may only be approved by the Clinic Chief or Flight Commander. You should have no expectation of cancelling appointments without significant justification.

5. Should you require an unexpected or last minute change in your clinic schedule, please attempt to negotiate coverage with a fellow staff physician, if possible. If not, discuss the cancellation/rescheduling of your clinic with the Clinic Chief.

6. We use AHLTA as our exclusive outpatient medical record. All encounters must be complete and signed off within 24 hours of the appointment time.

7. The SOAP format will be used for documenting all patient encounters. This is the Air Force standard. Documentation of thought process and treatment goals in the A/P must be used for excellent patient care as well as modeling for the residents. Synchronicity and structure is strongly encouraged.

8. Unless down for technical reasons, physicians are expected to document all outpatient encounters in AHLTA. Paper records will not be kept. Essentris EMR is required use for inpatient notes.

9. Dragon Voice Recognition software is available by the facility, pending the current number of unused MDG licenses.

10. For obstetric patients, the OB Database will be utilized for patient tracking with a copied note placed in the AHLTA record. This allows for familiarization of faculty to the OB database and tracking of significant metrics.

Residency Meetings

1. Residency Didactics: Friday afternoons from 1230-1700. Topics and speakers are assigned by the resident lecture coordinator. Faculty are expected to provide 10-12 of these 40-minute
talks each year. Unless performing urgent patient care related duties, **you are expected to attend the didactic sessions which are part of the duty day.**

2. The 1st Thursday of each month is usually SQ CC call

3. ProStaff is the 2nd Thursday of each month at 0700.

4. Other conferences: Grand Rounds, Resident Council, and clinic meetings.

5. Resident/Staff and Journal Club as **MANDATORY** events on your calendar, superseded only by immediate patient care needs.

6. In-Training Exam: A **required** annual exam given nationwide to all Family Medicine residents in late October. Residents must be off-service from 2000 hours the night before the exam until 1300 following the exam. Staff attendings will cover the services.

7. USMLE or COMLEX Step III: A **required** exam, given once nationwide to all PG1s must be taken by 31 March.

8. Resident Annual Review: An annual review of the residency curriculum is held each spring. Attendance is **required by all residents and staff**. The retreat is typically held at an off-site location from 0800-1600 on Friday and 0800-1200 on Saturday. Residents are considered off-service during these hours, but must coordinate with each individual service. Following the Resident Annual Review, the Program Evaluation Committee will formalize the findings, action-items, and program improvement initiatives that will improve program quality, resident performance, faculty development and ACGME requirement compliance.

9. Graduation Banquet: An annual banquet for Family Medicine residents is held in late June. Attendance is **required by all residents and Staff**. The banquet is usually held on a Friday or Saturday evening and residents should be considered off-service from 1500 that day until 0800 the next morning. Staff attendings will cover the services.

10. Graduation Ceremony: The annual graduation ceremony that typically occurs on the morning of 30 Jun (unless this falls on a weekend, then it will occur on the closest weekday). **Attendance is required by all PG1 and PG3 residents and Staff.** Residents are considered off-service from 0800-1300 that day. PG2 residents will remain on-service during the ceremony.

11. Balint: Each residency year group will meet regularly in a group setting. These Balint groups are moderated by the FMR behavioral medicine specialist. They are designed to help residents cope with the stressors of residency while maturing into a family physician and teach behavioral medicine concepts. Attendance by the residents is **mandatory**. Residents are not to be interrupted for any reason except for true patient emergencies or continuity OB deliveries.

12. Training Days: The second Thursday of each month a readiness lecture and/or training will be given from 0700-1200. Attendance is **required by all residents and staff, except for staff covering inpatient duties**.

13. Research Symposium: The Friday before graduation. **Attendance is required.**
MEDICAL STUDENTS

1. Medical students, primarily from USUHS and Touro University-Nevada, rotate on Family Medicine clerkships on a regular basis throughout the year. In addition, fourth-year USUHS students return for electives and third- and fourth-year HPSP students come periodically for one-month electives in Family Medicine. All students will participate in several faculty clinics over the course of their rotation; they may also be assigned to one week on the inpatient service during their elective.

2. Medical student responsibilities include:
   a. Patient evaluations, in which they may see the patient individually, initially, or with their assigned physician for that clinic, at the discretion of the physician. All patients who are seen by students must be evaluated by that assigned physician.
   b. Students may write notes in the outpatient record, which must be taken over in AHLTA by the physician who also evaluated the patient.
   c. Students may write History and Physicals with staff take over in AHLTA.
   d. Students may not write official progress notes on inpatient records, but you can take over their notes in Essentris.
   e. Students may participate as a first or second assist in minor surgeries in the clinic.
   f. Students may perform minor procedures only with direct supervision of a credentialed physician.

3. All staff will evaluate each medical student after each clinic and provide these evaluations to the Predoctoral Coordinator using the standard feedback form.

4. Please refer to the more defined description of the Family Medicine clerkships and evaluation forms as maintained in the USUHS Family Medicine Clerkship Handbook.

5. Students are expected to take call as determined by the undergraduate coordinator.

6. Fourth year interviewing students will each give a 15 or 30-minute presentation as part of the lecture series on the topic of their choice.

7. Just prior to leaving, each 4th year student is briefly interviewed for future reference when evaluating potential resident applications.

DEPARTMENT LIAISON

1. Staff members will be assigned as interdepartmental liaisons for the majority of the other specialties. The liaison will function as the primary contact for communication with that department and the Family Medicine faculty, as well as maintaining the curriculum for the rotation. These communications will include:
a. Family Medicine-generated inquiries and discussions regarding any resident problems or issues related to that department.

b. Any curriculum, evaluation, or scheduling problems.

c. Any proposed policy changes or inquiries.

2. The liaison may attend monthly departmental meetings and should consider periodically attending that specialty’s morning rounds and/or check out rounds, etc., especially if particular resident issues or problems are being evaluated.

3. You should expect to be assigned as liaison to several departments.

**TRANSITION OF CARE ROUNDS**

1. Closing ("Check Out") Rounds--Held @ 1700 for the FMR Inpatient Team to sign out to the FMR night on-call staff. Checkout rounds for the IM inpatient team will be at 1900. FMR admits all patients to the hospital (covers both IM and FMR teams) from 1900-0700. These checkout rounds satisfy the both the criteria set forth by the commander for patient hand-offs and the ACGME requirements for transitional care/hand-offs.

2. Morning ("Check Out") Rounds – held at 0600 via telephone. Both the FMR night on-call staff and the Inpatient Day attending will participate

3. MOMMC Inpatient Safety Rounds occurs on the weekend days at 0800 in ECR1 – a member of the inpatient team or the attending should attend the rounds. Telephonic participation is allowed.

**CONSULTING**

1. You will be scheduled to precept the residents in clinic typically one to four times each week. You are expected to be available in the consultant room (NOT YOUR OFFICE) when assigned as the consult doc. Your responsibilities will include the following:

   a. Assist the residents with questions and evaluations of patients and CHCS/AHLTA order entry/data retrieval. Feedback should be balanced between positive comments and areas of improvement. The resident should be encouraged to think through the issues rather than just given the answers. These interactions will be dictated by the level of the resident's training and the time constraints of the clinic. The 1-minute precept model is highly encouraged. [http://www.stfm.org/fmhub/fm2003/jun03/stevens.pdf](http://www.stfm.org/fmhub/fm2003/jun03/stevens.pdf).

   b. Chart review of resident notes (see guidelines below).

   c. Staff any minor surgery procedures/third-trimester OB ultrasounds by the residents as needed. All first-trimester OB ultrasounds must be performed with the staff in the room.

   d. Primary liaison for the nursing staff for any immediate clinic problems, emergency refills, urgent walk-ins, inspection of wound repacking, etc.
e. If so designated, to precept/staff the resident’s special clinics (i.e. vasectomies, colonoscopies, GXTs, minor surgeries, or colposcopies).

f. The second consultant may occasionally be required to see walk-in acute patients. The second consultant will be responsible for care and supervision of Family Medicine patients on the Obstetrical unit when the primary attending is overtaxed or not credentialed.

g. Cross-cover residents and staff who are called away from their scheduled clinic (i.e., delivery or family emergency).

2. Guidelines for Chart Reviews are as follows:

a. All resident physicians will have charts reviewed from each clinic:
   i. PG1: Until mid-year, all patients precepted, patients seen and key parts reviewed and charts reviewed. After midyear, face-to-face precepting continues to be required and all charts are still reviewed. However, all patients do not have to be seen by the attending.
   ii. PG2: all charts per clinic
   iii. PG3: all charts per clinic.
   iv. Staff Review: handled separately in monthly peer review as well as a biannual larger peer review.
   v. **All OB charts will be reviewed for staff and residents. Residents are to staff all OB patients prior to the patient leaving the clinic. All resident OB notes will be reviewed and signed by two staff. HROB OB patient's will be reviewed by the FMOB Faculty or the OB on call if FMOB is not available.

b. Any time you are consult clinic doc, the expectation is you will log into Residency Partner and complete at least one Comment Card per resident in clinic. If the notes are all perfect, then say so. If they can be better, please record how. If immediate action is required by the resident, please check the Action box at the bottom so the notification email is sent to the resident. This is a reportable item to the Exec Staff and are essential in informing the milestone rating for that resident.

c. These charts are reviewed in depth to assess for adequate documentation, differential diagnosis, management plans, completion of SOAP-P format notes and the Problem List. The preceptor will cosign in AHLTA. Feedback forms are in Residency Partner and will be used to give positive or corrective comments to the residents.

d. The residents will send all notes that were face to face precepted to the Consult Doc they precepted with. Other notes will be sent to the predetermined faculty listed on the consult board. All late notes (notes not completed before 1230hrs for AM Clinic or before 1630hrs for PM Clinic) will be sent to the resident’s Team Chief. Therefore, Team Chief has cosigns from the day, they will input a Residency Partner Comment Card to monitor trends/progress (typically if two or more late notes from a resident are received). All visits must be closed out within 72 hrs for reimbursement requirements, therefore it is imperative for covering faculty to check the Team Chief’s cosign box and close out the notes.

**READINESS and MOBILITY**

1. The staff of our Family Medicine Residency Program fully supports the 99 MDG’s readiness,
mobility and disaster–preparedness missions. This may include full participation in exercises, training and the regular deployment of 1-3 of our staff members.

2. Readiness training takes place the second Thursday of each month. The lectures, exercises and other training are mandatory formations for the Family Medicine staff.

3. Hospital Disaster Preparedness: exercises are typically instituted annually. During all disaster exercises and recalls, the Family Medicine personnel will sign in (Admin area usually), then report to the Family Medicine Clinic or designated rally point.

4. During real-life natural disasters, physicians will likely be recalled to the medical facility to be available to attend any potential casualties and also to man outlying shelters. Family members will not typically accompany hospital personnel to the hospital for shelter. It is required that you have a family care plan in place at all times.

5. Staff physicians might be allowed to attend Combat Casualty Care (C-4) Course if they have not previously attended. Regular attendance at the EMEDS course is required by Readiness.

6. It is your responsibility to remain current in all readiness training. Readiness will usually work with providers to schedule classes well in advance of the clinic schedule being booked. Please ensure our clinic NCOIC has your emergency contact info for the recall roster AND that you have a copy on your phone you can access at any time.

7. You will be assigned to a specific disaster team that will be determined at a later date. This will have a separate recall roster. Please ensure that the Team chief has your information. Additionally, there is additional computer training for your respective team.

TEAM CHIEF RESPONSIBILITIES

General responsibilities include:

1. Monthly Resident Meetings. The Family Medicine Residency is organized into teams/elements for administrative purposes and to allow the team chief to act as individual liaison/mentor/counselor/supervisor to residents assigned. The team chief is responsible for meeting with each of their assigned residents on a quarterly basis throughout the academic year at a minimum – the Clinic Scheduler will schedule times on Amion. Consider occasional meetings off-site for lunch to enhance “esprit de corps”. Documentation should occur quarterly on the team chief DASHBOARD which each Staff keeps in their personal folder.

TeamChief Dashboard Sample.xls

- Review quarterly each resident's rotation/evaluations in Residency Partner. You may access the resident’s pertinent info/schedule via the Reports function. Positive feedback is especially encouraged. Review previous evaluations on the resident looking for specific areas of strengths/potential weaknesses and share the feedback with the resident. This will help residents set goals for upcoming rotations. Other topics to review:
- Discussion of goals/objectives form for upcoming rotation (found on Residency Partner) and any special circumstances surrounding it.

- Discussion of Family Medicine clinic work; progress, problems, improvements, outpatient charts, checkout rounds, feedback from Family Medicine staff.

- Discussion of Step exams, Licensure, Life support currency

- Discussion of adequacy of patient load and mix, and efficiency for seeing patients in appointment template time allotted.

- Discussion of reading time and ability to stay current with medical literature.

- Discussion of extracurricular projects and interest.

- Discussion of 360 feedback from clinic nurses, techs and patients.

- Discussion of impact of residency on home life and personal growth goals.

- Review of plans/progress of scholarly activity projects(s) required for graduation.

- Guide choice of electives.

- Check on procedure and patient diagnosis documentation for credentialing; make sure procedures, inpatients, and ICU patients are being logged in Residency Partner. After logging into your RP account, use the “Procedure Totals with Targets” report to review required activity completion. Those procedures annotated with a (+) to the left have been approved for independent performance after attending notification. Patient encounter totals targets are noted in parenthesis beside the encounter type. The point values assigned to each HSM required activity

2. CCC (Clinical Competency Committee) Review. The Team Chief will conduct a quarterly resident folder review for presentation to the faculty during CCC. The residency coordinator will notify you via email when your resident is due for presentation. Please be ready or make notification prior to CCC if you cannot attend and present.

Twice each year, a detailed review and completion of milestones for each resident is required. The Team Chief will present this review to the CCC which will then determine the official point on the milestone that the resident has reached.

3. Team Meetings. In order to foster team cohesiveness, the entire staff and resident team along with the nurse and techs should meet for huddles every Monday at 1230. Current workflow issues, team communication and ideas for improvement should be reviewed. All FMR personnel will meet in the FMR conference room at 0730 for a daily safety huddle.

4. Administrative Duties.

   a. Administrative coordinator for each assigned resident (promotion recommendations/PRFs, training remediation plans and disciplinary actions).

   b. Completion of annual officer training records. Complete one on each assigned resident by
15 May. Available on http://www.e-publishing.af.mil/: Education/Training Report (AF Form 475) and ACGME Family Medicine Milestones. The residents should assist in providing bullets for the AF 475. In particular, the PG3s should attempt to write their own bullets with the Team Chiefs providing feedback. It will typically be their first attempt at “bulletology” prior to graduating and supervising others. OF NOTE, the milestones must be completed every 6 months.

c. Personal training, clinical duties, and other responsibilities. Faculty should never be on the delinquent list since we are the examples of professionalism that the residents aspire to. Typical areas that require attention are DMRHSI, Peer Review, LeaveWeb, Readiness Training, Swank training, PHA co-signs, biannual officer feedback and MEB completion.

TEAM CHIEF AVERSE ACTIONS ADMINISTRATIVE RESPONSIBILITIES

1. Academic Notice or Probation:

   a. Academic Notice is generated when resident performance signals concern and the resident is in danger of failing the rotation or several rotations. Academic Notice is written by the Team Chief and signed by the Program Director and must include specific statements regarding problems noted, suggestions for improvement, and specific time allowances for demonstrated correction of deficiencies.

   b. Formal Probation must be approved by the GMEC upon recommendation by the Program Director. Inadequate performance and determination that the resident is in jeopardy of failing or delaying completion of that year level will be reported and monitored. The Academic Probation statement must include the deficiencies observed, specific expectations of performance, and time allowance for that improvement to be determined. Failure to meet the defined expectations generally results in resignation or termination from the residency. AFPC, the DME, GMEC and state licensing board will be notified.

   c. Letters of Admonishment/Letters of Counseling/Letters of Reprimand-these are written by the Team Chief as determined by the Program Director and faculty and must be signed by the Program Director. Letter of Reprimand must be elevated for the Commander's signature and direct counseling of the resident. All "Due Process" actions will be closely supervised by the Program Director in accordance with the MDGI and AFI-41-117, Section 2.2. and GME Policies.

WARD ATTENDING

1. Each physician faculty member will rotate as the ward "Attending" to provide teaching support to the residents on the Inpatient Service. Responsibilities for your week include:

   a. Admissions:

      (1) All ICU criteria admissions will be seen and evaluated promptly (within 1 hour or sooner) by the staff attending.

      (2) All other admissions must be discussed with the staff attending upon admission and must be evaluated in person by the attending (or senior resident on night float) in a timely manner (within 8 hours) and an admission note written.
(3) The on call Family Medicine provider will staff any FMR OB patients on the labor deck, besides covering the MSU/ICU. When the staff attending does not deliver babies, there will be another physician assigned this responsibility.

(4) The FM staff attending will act as a consultant to the specialty services when consulted.

(5) The attending will assure resident progress notes are written daily (twice daily on ICU patients). If the attending does not write their own daily SOAP note, then a statement must be written by the attending daily attesting to the fact that they have 1) seen and examined the patient, 2) discussed the management plan with the team, and 3) agree with the plan as documented by the house staff. Essentris makes this task easy. If you do not include all 3 components when you co-sign the note, then the inpatient coders cannot count the “RWP” workload by the team for that day; RWP reimbursement drives manning and budgets!!!

(8) The weekly FM ward attending will write the staff admission note, or cosign the resident admission note, on all routine, uncomplicated admissions occurring between 1900-0700 that were not directly evaluated by the on-call staff physician. The ward attending will similarly be responsible for reviewing the admission history and physical of the admitting resident and cosigning. All H&Ps written or dictated by residents require staff co-signature.

b. Call.

(1) Staff attending covers "day" call (0700-1700, Sat-Fri) for the Family Medicine Team. Another staff will cover call 1700-0700 hrs on Sat-Thurs nights. We may utilize night float for this. A separate IM staff will cover Friday night call (1700-0700), with an FMR attending as backup for all pediatric/OB concerns. Both staff members must be available by phone, if not in person, every morning at 0600 for resident-resident hand-off. The attending on Saturday must be in house at 0600 to assume the team from the night resident (because there is no senior resident on Saturday).

(2) The night call staff will come in for all obstetric, ICU or otherwise complicated patients and complete staff notes to allow for prompt medical oversight.

c. Consults.

(1) Any inpatient consults to the Family Medicine team will be addressed by the resident and discussed with the FM staff. All resident consult notes must be cosigned by the FM staff.

(2) All inpatient consults, as well as ER consults not admitted, must also be documented and coded in AHLTA (walk the patient in and copy/paste the note)

2. Continuity. Your patients expect to see you when they are hospitalized. However, the day-to-day care is managed by the inpatient team.

When a patient is admitted, the on-call inpatient resident should explain to the patient how our inpatient team care works, i.e., that a team of doctors will be seeing the patient and that the primary doctor will be informed that patient is in, and that follow-up care will be provided through the primary provider. We will provide written info with the names of the team.

RESIDENT EVALUATIONS
PROCEDURES FOR TRACKING/FILING
The FMR Program Coordinator will track and file all evaluations via Residency Partner.

a. Residency Partner will automatically send an electronic copy of the goals and objectives prior to the upcoming rotation. The staff attending(s) will receive e-mail notice to complete the evaluations 2 weeks prior to the end of the rotation. The rotation evaluations will be available to the resident electronically for review or comment, then on to the PD for review and electronic filing.

b. Senior residents on the inpatient team and night float are to evaluate their interns. Night float intern evaluations completed by the senior resident will be turned in to the day attending to help formulate the night float intern’s rotation evaluation.

c. The program coordinator will track evaluations. Team Chiefs can check for incomplete evaluations on Residency Partner. It is ultimately a resident and Team Chief responsibility to assure evaluations are completed.

d. Rotations are considered incomplete until the evaluations are returned. Incomplete rotations must be made up before TDYs, leave or progression to the next year of training. Up to half of total elective can be used for make-up rotations.

**PATIENT SAFETY**

- Patient Safety and institutional Quality Improvement are key components of the AFMS Trusted Care initiative. Residents will receive annual TeamSTEPPS training that emphasizes clear, respectful communication between all team members, situation awareness and techniques vital to patient safety.
- The Patient Safety/Quality Improvement Program is vigorously pursued in the Air Force and at the 99th Medical Group. One way for you, as a provider, to provide input into the Quality Improvement Program is by clicking on the Patient Safety Event Reporting icon on every desktop. Complete the requested information. This is an important way residents participate in Patient Safety activities within our institution. These reports should be filled out as soon as possible after the incident so that details of the incident are recorded accurately. Alternatively, please fill out a PRONTO PSR card.
- Reports of patient safety events will be provided to the resident on a quarterly basis and discussed monthly/quarterly during didactics emphasizing methods to improve patient safety within the institution.
- Residents have access to their individual as well as team quality metrics via CarePoint. Patient care teams are expected to choose at least one metric per academic year to perform a quality improvement initiative, led by the PGY3. The Disease Manager for FMR can assist with additional data management if needed.
- Patient safety and Quality Improvement initiatives will also be developed from our monthly Peds/OB M&M where specific cases will be discussed that will highlight potential interventions applicable to the entire institution in which residents will be involved.
- Residents are required to obtain a certain number of points during the longitudinal HSM rotation. All the activities that may be completed to obtain the required number of points are described in the Health System Management goals and objectives.

**DEATH CERTIFICATES**

- Death certificates are filled out at the time of the event. Any questions regarding death certificates or deaths after hours should be referred to the hospital Admission/Disposition clerk, who is available 24/7. MOFMCI 44-25 reviews organ donations. The ER is the POC for
assistance in completing a death certificate. They have one of the only computers in the hospital that can run the 'death cert' program.

**PERSONAL HEALTH**

- Health care for you and your immediate family is provided by the USAF 24/7 through their PCM office and Emergency Department, without any annual copay. Time away from clinical duties for medical/mental health appointments is certainly allowed. Faculty should coordinate with the Clinic scheduler to ensure coverage of responsibilities and patient care.
- Fatigue mitigation is an essential part of medical practice, not only for clinical performance, but also for patient safety. Faculty are trained annually on signs of excessive fatigue, sleep deprivation and mitigation strategies. Call rooms are provided for those faculty, too fatigued to drive or providing care to their OB continuity patients. Base transportation options are available for those faculty needing transportation home due to excessive fatigue.
- Mental health care is available to all faculty for their own needs 24/7 via the facility’s Mental Health provider and the Emergency Department. In addition, free self-screening tools are available at [http://www.mentalhealthamerica.net/mental-health-screening-tools](http://www.mentalhealthamerica.net/mental-health-screening-tools). Faculty are encouraged to use these tools anytime they are concerned about their mental health, substance abuse or burnout; and to seek mental health care immediately. Schedule adjustments/coverage will be made to accommodate these appointments.

**RECALLS**

- As part of Nellis’ Readiness mission, faculty are subject to recalls. Recalls may present in different forms. Telephone recalls require the relay of critical information via telephone to those colleagues below your name on the recall roster. If a recall message requires the faculty to report for duty then the faculty should make their way to the hospital **ASAP**. (This means sign in within one hour if living off base, 1/2 hour if living on base). Faculty must maintain a current recall roster and should keep it readily available at all times. Please ensure the clinic NCOIC has your current contact information. In addition, your cell phone must be kept on your person or at your side in case of recall.
Clinical Competency Committee Policy

I. Introduction
   A. In 2013 the Accreditation Council on Graduate Medical Education (ACGME), as part of the Next Accreditation System (NAS), determined that all training programs must have clinical competency committees (CCC).
   B. The theory behind the CCC is that assessment by a consensus of a diverse group of faculty reinforces when a resident is doing well and identifies areas of concern for a resident having problems.
   C. Discussions of the CCC help differentiate poor performance in isolated situations from a pattern of poor performance.
   D. The CCC helps clarify the areas of concern for a “troubled resident” i.e. specific areas of deficiency, or inability to function in different settings (for example, the ICU, operating room, or the ED).
   E. Processes of the CCC allow the program to identify weaknesses in their educational curriculum, rotation schedules and supervision.

II. Policy
   A. The Clinical Competency Committee will meet at least twice a year, but not less frequently.
   B. Outcomes of the CCC will be reported twice a year and as determined by ACGME.
   C. The residency program will maintain the policy for the CCC and provide a current copy to the GME office at the beginning of each academic year.

III. Procedures
   A. Each program will have a CCC with a structure that meets ACGME requirements:
      1. The CCC is appointed by the program director; the program director may participate on the CCC.
      2. A Chair of the CCC, who is not the program director or chair of the respective department, is encouraged.
      3. Membership of the CCC must include at least three faculty.
         a. Representatives from all divisions/services encouraged.
         b. Where there are multiple sites, representation from all sites encouraged.
         c. Representation from junior and senior faculty is encouraged.
         d. Chief residents and/or residents in final year of training are optional.
         e. The CCC may include non-physicians.
      4. Requirements for membership:
         a. All committee faculty must be actively involved in resident education.
b. All committee faculty must participate in committee deliberations regularly (75% of meetings).
c. Team Chief may contribute objective information to the discussion.
d. Feedback to must be constructive and timely following meetings.

IV. Function of the CCC
A. Review all resident evaluations:
   1. End of rotation evaluations
   2. Direct observation checklists for skills i.e. CVL placement, mini-CEX, other procedural skills
   3. 360 or multisource evaluations (nurses, colleagues, students, patients, other ancillary health care personnel)
   4. Semi-annual evaluations by the program director
   5. Attendance records for conferences
   6. ITE scores
   7. Procedure logs
   8. Any other assessment information available (i.e. Command letters of excellence, patient complaints)

B. Review all resident evaluations semiannually
   1. meet to discuss the evaluations
   2. achieve consensus on resident performance
   3. complete the specialty specific milestones forms for each trainee
   4. complete reporting to the ACGME semiannually

C. Make recommendations to the program director on:
   1. Promotion
   2. Remediation
   3. Dismissal

Original policy Feb 2014; approved by GMEC March 2014
Nellis Family Medicine Residency Program

Program Evaluation Committee

I. Introduction
A. This policy is to establish that the Accreditation Council for Graduate Medical Education (ACGME) accredited Family Medicine residency program at the Mike O'Callaghan Federal Medical Center has a program-specific policy to delineate the composition and responsibilities of the residency’s Program Evaluation Committee (PEC).
B. This Program-specific policy establishes a formal, systemic process to annually evaluate the educational effectiveness of the residency program in accordance with the program evaluation and improvement requirements of the ACGME, the program specific Residency Review Committee (RRC) and this Graduate Medical Education Committee (GMEC) policy.

II. Program Evaluation Committee
A. In accordance with this policy and the AGCME requirements, the Program Director (PD) shall appoint a PEC to participate in the development of the Program’s curriculum and related learning activities. In addition, PEC will:
   1. Annually evaluate the program to assess the effectiveness of the Program’s curriculum.
   2. Identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.
B. The Program Evaluation Committee shall be composed of at least two members of the residency program’s faculty, and include at least one resident. PD’s are generally discouraged from being a member of the PEC. However, in the case of a small program, PD’s may become members upon approval by the DIO.
C. The PEC will function in accordance with the written description of its responsibilities, as specified below and participate actively in:
   1. Planning, developing, implementing, and evaluating all significant activities of the Residency/Fellowship program;
   2. Reviewing and making recommendations for revision of competency-based curriculum goals and objectives
   3. Addressing areas of non-compliance with ACGME standards; and,
   4. Reviewing the program annually, using evaluations of faculty, residents, and others as specified in Section III.

III. Annual Program Evaluation
A. The program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE).
B. The APE will be conducted on or about 15 May of each year, unless rescheduled for other programmatic reasons.

C. Approximately two months prior to the review date, the PD will:
   1. Facilitate the PEC’s process to establish and announce the date of the review meeting;
   2. Work with the GME coordinator(s) to assist with organizing the data collection, review process, and report development; and,
   3. Solicit written confidential evaluations from the entire specific program faculty and resident body for consideration in the review (if not done previously for the academic year under review).

D. At the time of the initial meeting, the Committee will consider:
   1. Achievement of action plan improvement initiatives identified during the last annual program evaluation;
   2. Achievement of correction of citations and concerns from last ACGME program survey;
   3. Residency program goals and objectives;
   4. Faculty confidential written evaluations of the program;
   5. Resident annual confidential written evaluations of the program and faculty;
   6. Resident performance and outcome assessment, as evidenced by:
      a. Aggregate data from general competency assessments
      b. In-training examination performance
      c. Procedure logs
      d. Other items that are pertinent to the program/specialty;
   7. Graduate performance, including performance on the certification examination; and,
   8. Faculty development/education needs and effectiveness of faculty development activities during the past year.

E. Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities, and to make recommendations. Written minutes must be taken of all meetings.

F. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in at least one or more of these areas:
   1. Resident performance
   2. Faculty development
   3. Graduate performance
   4. Program quality
   5. Continued progress on the previous year’s action plan

G. The plan will delineate how those performance improvement initiatives will be measured and monitored.

H. The final report and action plan will be reviewed and approved by the program’s teaching faculty, and documented in faculty meeting minutes.

I. A report will be provided to the GMEC, discussed at a full meeting of the GMEC, and documented in meeting minutes.

EFFECTIVE DATE: 13 February 2014

Approved by Graduate Medical Education Committee: March 2014

Approved by DIO: March 2014
Continuity OB Patients

1. Each resident will receive approximately two continuity OB patients per month and each staff will receive approximately 1-2 continuity OB patients per year.
   a. New OB charts will be reviewed by an OB provider and given to the OB nurse for scheduling.
   b. Only uncomplicated OB patients will be assigned to a FM resident or staff
   c. Uncomplicated OB patients already empanelled under a resident or staff will likely remain under that provider until the above requirement is met.
   d. Residents and staff will be responsible for ensuring new OB patients assigned to them are seen for their first OB visit in a timely fashion (within 1-2 wks of being notified) as well as routine antepartum visits – this may require walk-in appts. The OB nurse may assist in coordinating the appts with the patient and provider.
   e. Patients with positive screening for anxiety/depression will be contacted by the continuity physician ASAP to determine need for immediate BHOP referral/treatment prior to new OB visit if over a week till that visit.
   f. Those patients who request a particular provider may be assigned to that provider only after approval is obtained from the FM/OB Director. Residents should not guarantee a patient that they will see a particular doctor in FMR.
   g. The above number of continuity OB patients assigned to residents and staff will allow current and future RRC requirements to be met, as well as the ability for FM faculty to obtain an adequate number of deliveries to maintain currency (strive to perform ≥10 deliveries/yr).

Residents may also participate in Group OB visits in order to meet their goal number of continuity deliveries. This will provide an alternative prenatal care technique to be utilized by residents.

2. All residents will precept each OB visit with the CON doc PRIOR to the patient leaving the clinic.
   a. The visit flow sheet, lab sheet, problem list, ultrasound photos and OB Database/AHLTA note MUST be completed at the time the patient is presented to the CON doc.
   b. The resident will directly hand the chart to the CON doc during the presentation to allow close review.

3. Once the CON doc has precepted the patient, any necessary adjustments of the plan will be discussed with the patient before leaving the clinic and the chart will be placed back in the CON room, in the “Second Sign” rack, for further review. OB charts will NEVER be placed in the CON room or on a faculty desk after 1600 – this will be strictly enforced!

4. All residents performing first trimester ultrasounds MUST have staff in the room. All other ultrasounds performed by PGY1s in clinic on continuity OB patients MUST have staff (usually the CON doc) in the room. PGY2s and PGY3s do not have to have staff present in the room if they have documented proof that they have been signed off by the program director to perform.
the procedure independently. In addition if there is any question as to the findings or calculations/measurements, the staff should be present. Documentation of all ultrasounds performed in clinic **MUST ALWAYS** include photos and notations in the AHLTA note.

5. FM faculty (including FHC providers) should also ensure fully completed OB charts are placed in the “Second Sign” rack for further review by 1600 on the day of the visit.

6. Residents who are not available (i.e., on leave, TDY, or outside the immediate area only) to care for their continuity OB patients **MUST** designate a surrogate **AND** clearly document this on the chart (post-it note, etc) as well as on the Labor deck on-call board. This surrogate must be a resident that is **NOT** on an outside rotation and hence available to care for the patient during all hours. Team chiefs need to ensure a surrogate has been designated before leave/TDY is taken.

7. Those continuity OB patients that develop a high-risk condition will be managed accordingly:

   a. Uncomplicated patients with potential high-risk conditions may continue to be managed by the resident with direct oversight by the FM/OB or OB. A list of high-risk conditions are detailed in an attached document.
   
   b. **Any visit of a high risk patient MUST by precepted with a FM/OB or OB provider prior the patient departing the clinic.** The patient will be comanaged with the resident/staff’s and FM/OB provider or, will be transferred to the FM/OB or WHC as the primary provider. This will be determined on a case by case basis depending on the medical condition. Residents and faculty are encouraged to present their patient at the OB HROB Conference.
   
   c. If a patient is considered High Risk, it will be the residents’ responsibility to coordinate any additional testing required for the conditions.

8. The FM/OB provider will regularly review the HROB patient list, and attend all HROB meetings on the first and third Wednesday of each month. If the FM/OB provider is not able to attend, a surrogate will be appointed.

Labor and Delivery Unit

**General:**

1. Faculty will continue to serve as the primary L&D provider on Tuesdays and Wednesdays. FHC providers may schedule L&D shifts with the OB department directly.

2. During daytime shifts the faculty is expected to remain on the L&D floor if any patient is in labor. (Brief runs to cafeteria, etc are permitted, but the faculty should always be readily available).

3. If the assigned FM faculty is not able to cover a portion or the entire shift, a replacement within FMR should be sought before approaching the OB department.

4. For the sake of patient safety, FM faculty on-call who are unable to adequately monitor and manage L&D patients due to a high volume or acuity of medicine/OB patients **MUST** notify the back-up FM provider for assistance prior to engaging the backup OB provider. This action should never be viewed as incompetence or weakness, and no retribution will result.
5. The FM faculty will review, on a quarterly basis, the workload and demands of FM providers on-call and subsequently make adjustments to minimize potential patient overload and safety concerns.

6. If the L&D nursing staff is unable to contact the FM faculty on-call, or is uncomfortable with the management of patients after discussion with the FM faculty, the L&D staff is encouraged to contact the FM/OB or OB backup provider. The FM/OB or OB backup provider schedule will be posted on AMION.

Admitted/Laboring Patients:
1. While labor management styles differ at times between FM and OB providers, accepted community and DoD standards of care must be met. To facilitate active labor management, each morning report/check-out will include an outline of expected milestones and treatments anticipated for each laboring patient, discussed between the FM faculty and OB or FM/OB backup, to ensure a clear plan is established. Periodic reviews of the plan and current progress are highly encouraged throughout the shift to ensure timely management occurs. Open and clear communication, in the TeamSTEPPS format, is paramount.
2. The criteria for FM/OB or OB notification or presence during the labor and/or delivery process are outlined in the attached file.
3. Per RRC regulations, all resident notes (antepartum, intrapartum and postpartum) must be reviewed and cosigned by the attending staff (FM, OB or Midwife).
4. A PGY2 or PGY3 resident will not independently supervise a PGY1 performing a delivery – FM or OB faculty must be present.
5. In accordance with RRC regulations, a maximum of a PGY1, one upper level resident and staff may be present at a delivery and each be able to count as a performed delivery.
6. FM and OB faculty are expected to perform confirmatory cervical checks following the PGY1s for all unruptured induction or laboring patients. Strongly consider performing the same when precepting PGY2s and PGY3s.

Triage Patients:
1. When a resident’s continuity OB patient presents to triage:
   a. If the patient is 36 0/7 wks and greater, the nurse may perform the initial evaluation and contact the resident directly. The resident will then contact the FM staff on call and discuss the case. The staff will then decide if the resident will personally evaluate their continuity OB patient or discharge home. The staff will then contact the L&D nurse to discuss the plan. This is meant to foster and reinforce the sense of patient ownership and dedication. If the primary resident is not available (i.e. on leave, TDY, or outside the immediate area only), the designated surrogate should be contacted and, if needed, evaluate the patient.
   b. If the patient is 35 6/7 wks or less, the resident is required to personally evaluate the patient, contact the FM staff on call and discuss the case. The L&D nurse should not perform the initial evaluation, unless they deem the patient an emergent situation as a bridge to physician evaluation. Whether the FM faculty needs to evaluate the patient in person is at the discretion of the FM faculty.
2. Residents must personally evaluate a triage patient within 1 hour of being called by nursing staff.
3. PGY1s must have FM faculty present to evaluate patients.
4. PGY2s and PGY3s may evaluate OB triage patients independently, and precept the patient either in person or via phone prior to the patient leaving L&D. The FM faculty **MUST** cosign the Essentris note as soon as possible.
5. Faculty are not required to always personally evaluate their continuity OB triage patients; however, deference should be given to nursing/L&D staff who deem the clinical presentation of high enough acuity to warrant personal evaluation. This means that if the patient is in threatened PTL, vaginal bleeding, etc., or the nursing staff says “I am not comfortable” the staff MUST come and evaluate the patient.
6. All triage notes will be documented in Essentris – be sure to include a description and an appropriate assessment of the fetal heart tracing (e.g. Category I – reassuring). Faculty must document triage notes in Essentris whether or not they personally evaluated the patient.
7. When evaluating a late preterm (34 0/7 to 35 6/7 wks) triage patient, faculty and residents are highly encouraged to consult the FM/OB or OB provider on call to ensure the highest standard of care/patient safety is met.
8. When evaluating an early preterm (33 6/7 wks or less) triage patient, faculty and residents **MUST** consult the FM/OB or OB provider on call to ensure the highest standard of care/patient safety is met.

MANAGEMENT OF COMPLICATED OBSTETRICAL PATIENTS BY FM/CNM PROVIDERS:

1. This document is a set of working guidelines to ensure that the highest level of communication, collaboration, consultation and referral is achieved among the certified midwives and the obstetricians at Nellis AF Base. Although this list is not all-inclusive, it offers a minimal standard by which the Nellis staff wishes to practice obstetrics.
2. The goal of these guidelines is to ensure that the FMR staff/ midwives and the obstetricians are working in conjunction to provide the safest environment for our patients while maximizing our resource.
3. The following conditions will be periodically reviewed by the FMR/OB and OB physicians to facilitate modifications.

- **Conditions Requiring Transfer of Care to FM/OB or OB:**
  - GDM A2 and above
  - Multiple Gestation
  - PPROM <36 wks
  - Hx of PTD <36 wks
  - Recurrent preterm labor
  - Persistent placenta previa ≥28 wks
  - Chronic HTN on medications
  - Mild/Severe pre-eclampsia
  - Moderate persistent asthma and above
  - PMH including autoimmune disease, severe renal/cardiac disease or hemoglobinopathy
- Trauma/MVA with major injuries
- RLTCS or C/S requiring conditions

**Conditions Requiring One-time Consultation with FM/OB, OB or Perinatology/MFM:**
- Abnormal genetic screening
- AMA
- Mild intermittent asthma
- Chronic or gestational proteinuria (>300 mg/day)
- Duration 2nd stage labor >2 hrs, 3 hrs if epidural
- Fetal anomaly detected
- GDM A1
- IUFD
- Non-vertex position @ 36 wks
- Oligo- or Polyhydramnios
- Preterm contractions/labor – 1st episode
- Transfer of any OB patient to outside facility
- Epidural
- Induction/Augmentation of labor by any method

**Conditions requiring at least informal FYI consultation, per DoD Guidance:**
- Non-reassuring FHT (repetitive late decelerations or moderate/severe variable decelerations, loss of variability, or bradycardia/tachycardia)
- Maternal temp ≥100.4
- Trauma/MVA with no major injuries
- Postpartum hemorrhage

**Conditions which may be managed by the FMR/CNM without OB physician notification:**
- Spontaneous active labor
- Meconium stained fluid
- Patient requiring amnioinfusion

**Other conditions requiring FMR/OB or OB physician involvement:**
- Vacuum delivery (FMR/OB or OB physician must be notified prior to performing unless EMERGENT – then have notification occur when performing)

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<th>INDICATION</th>
<th>CNM independently manages</th>
<th>CNM co-manages with obstetrician</th>
<th>FMR independently manages</th>
<th>FMR co-manages with and notifies Credentialed C-Section Provider</th>
<th>OB or c-section provider is in-house and primary provider</th>
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<td>Spontaneous Active Labor</td>
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<td>Magnesium Sulfate</td>
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<td>PP Hemorrhage</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vacuum Extraction</td>
<td>X: doc notified prior to placement</td>
<td>X: doc notified prior to placement</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Severe Pre E with HELLP, renal dysfunction, or requiring IV anti-hypertensives</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal Demise</td>
<td>X: MD confirms demise</td>
<td>X: and second provider to confirm demise</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
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<td>-------------------------</td>
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<tr>
<td>Hx Eclampsia</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>VBAC</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer out</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>MVA c Injury</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Multiple Gestation</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Placenta Previa-complete</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Marginal Previa</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd/4th/Cervical lac</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-Section Patients</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
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</tr>
</tbody>
</table>
SCHOLARLY ACTIVITY AND THE ACADEMIC ENVIRONMENT

Put simply and succinctly, all core faculty are expected to participate in and produce scholarly activity every 1-2 years.

Examples of scholarly activity include the following (see following page for more examples):

1. Clinical research published in peer-reviewed literature or presented as a presentation or poster at regional or national meeting.
2. Educational research published in peer-reviewed literature or presented as a presentation or poster at regional or national meeting.
3. FPIN Clinical Inquiry
4. Case report research published in peer-reviewed literature or presented as a presentation or poster at regional or national meeting
5. Presentation at USAFP or similar meeting.
6. Writing a textbook chapter, AAFP monograph, or review article.
7. Presentation of IRB-approved Quality Assurance/Performance Improvement project in peer-reviewed format.

A thriving academic environment is NOT just made up of research and scholarly activity. All of us are teachers, some of us are great administrators, and some are great clinician-teachers. Please take the time to examine yourself see where your gifts lie and what skills could be developed. The Program Director is available to discuss your future and personal goals; and make every effort to assist you in reaching those goals.

INTERN ORIENTATION

1. The Family Medicine Program Coordinator coordinates the incoming intern orientation program. He/she will plan the agenda, in cooperation with other staff, the residency director, coordinator, residents and their spouses.

2. Necessary areas to schedule:

   - DEERS/ID/CAC card
   - Base In-processing List
   - Hospital routine In-processing List/Hosp ID badge
   - CBPO/Finance
   - Orderly Room (CSS)/Officer Records
   - Immunizations/Dental Evaluations
   - Official Photo
   - Ward Orientation/Shadow teams
   - Readiness/Disaster
   - CHCS/AHLTA/Essentris (Info Systems)
   - Hospital newcomers brief
   - Pharmacy
   - Training at VA, Sunrise

Initial Training

   - BLS
   - ACLS
   - ALSO
3. Additional important aspects to cover:

- Program Director/Staff Introductions
- Resident education regarding committees
- Professionalism/Courtesies
- Welcoming Picnic
- Intern/Resident Real Truth Party
- Scholarly Activity graduation requirements/ Medical Library and AF Virtual Library

**SOCIAL MEDIA POLICY**

We acknowledge the many positive attributes of internet social networking (Facebook, LinkedIn, Twitter, etc). These networks can allow us to maintain and strengthen relationships and can also be an excellent source of interpersonal support. Additionally, social networking offers a myriad of opportunities to network, share professional ideas, and learn about important medical news.

Our residency program has some specific expectations regarding the use of these sites and networks:

- Residents and faculty are strongly discouraged from connecting to ("friending," “following,” etc.) patients on personal social networking sites such as Facebook and Twitter. Use discretion when allowing patients to follow you on sites with professional networking potential such as Twitter and LinkedIn.
  - Medical information and advice must not be transmitted via these sites.
  - Online social networks provide no patient privacy protection; you may violate national Health Insurance Portability and Accountability Act (HIPAA) statutes by using them to communicate with your patient regarding health issues.
  - If a patient does attempt contact via one of these sites, providers should not give advice or solicit further information. Instead, direct him/her to the careline or MiCare.

- Accordingly, residents and faculty are strongly encouraged to set strong privacy controls on these sites (for example, allowing only "Friends of Friends" to find you in Facebook’s search engine) and monitor their followers regularly.
  - Facebook, in particular, is notorious for frequent updates of privacy settings – after which, your settings may be lost. Providers must be vigilant to maintain their privacy controls.
  - Facebook offers the option of creating a web address that links directly to your profile. This option is an easy way to share your profile with others without having to leave privacy settings at a weak level.
  - Residents and faculty should not assume that their online activity is protected from monitoring just because they choose not to “friend” or “be followed by” Nellis faculty and/or administration. The Air Force has long fingers…
  - Residents and faculty using Twitter should frequently monitor their followers. Your content should be acceptable for patients to read regardless if any are following you. Should you identify that a patient is following you, though, you may decide to block that
individual. Direct messages or tweets soliciting medical advice must be referred back to the health center.
  o Similarly, LinkedIn connections are reasonably acceptable, but direct messages soliciting medical advice must again be referred back to the health center.

- Residents and faculty should place a disclaimer on any public site they participate on that discusses medical issues (Twitter, blogs, etc.) stating that the author’s content solely reflects the author’s opinions and is not necessarily representative of the residency program, hospital, or Air Force’s opinions and views.

- Residents and faculty will not post any details or information that could identify a patient or family member they have cared for.

- Residents and faculty will not post negative or defamatory statements about the residency program, hospital, hospital employees, or the AFMS.
  o These comments – which, once posted, can be read by medical students, other hospital employees, and Air Force leadership – are not appropriate for mass distribution. They may cause difficulties with recruitment, student education, and hospital interactions.
  o Our program does welcome your grievances and complaints; these issues, however, are to be channeled within internal, previously defined outlets (if you are unfamiliar with these outlets, please discuss with a chief resident).
  o Certainly you are welcome to post comments about general happenings (e.g., “Great variety of patients today”) and/or your emotional/physical state (e.g., “I’m tired after 2 weeks of night float”).

- Residents and faculty will not post pictures of their work colleagues or their worksites without first obtaining appropriate permissions. Social activities with work colleagues away from work are permissible, but you should use good judgment regarding the content of these submissions.

Violation of these guidelines or of any Air Force or DoD guidelines will be met with swift disciplinary action. Even one violation may be grounds for dismissal from the program, prosecution under the UCMJ or other such punishment as our Commander sees fit. Comments and feedback regarding this policy are welcome; please feel free to contact your chief residents and program faculty leadership if you desire further discussion or clarification.
CURRICULUM VITAE

(All staff members should complete and update a curriculum vita to be kept on file by the program coordinator and USUHS administrative staff. In return for teaching a core USUHS MS rotation, you SHOULD apply for title of Assistant Professor of Family Medicine. The CV template is linked below: the American College of Physicians format is preferred: https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/model-curriculum-vitae. In addition, further academic promotion is possible in USUHS. Criteria for advancement can be found on the USUHS website or discuss with the Program Director.

FAMILY MEDICINE FACULTY DEVELOPMENT OPPORTUNITIES

University of North Carolina at Chapel Hill

University of California, San Francisco

Society of Teachers in Family Medicine

8880 Ward Parkway
PO Box 8729
Kansas City, MO 64114
Phone: (816) 333-9700
(800) 274-2237
Web site: http://www.stfm.org

www.teachingphysician.org

USUHS traveling Faculty Development Certificate Course

USAFP Scientific Assembly Annual FD Workshops