FAMILY MEDICINE INPATIENT SERVICE

Policies and Guidelines

This handbook describes the policies and guidelines that govern the smooth operation of the Family Medicine Inpatient service . It contains information concerning admission criteria , scheduling of residents and faculty, education and supervision of residents.

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FAMILY MEDICINE INPATIENT SERVICE
Algorithm for determining Family Medicine Admission

1. Look at the PCP field
   a. If this field contains the name of one of our providers then patient is admitted by Family Medicine (please look at the list of providers)
   b. If this field contains the name of a Department of Medicine or Extended Care provider then Medicine admits the patient.
   c. Family Medicine admits for a limited number of providers at Northpoint Health and Wellness (please look at the list)
   d. We do NOT admit for any providers at the Brooklyn Center Clinic

2. If the PCP field has NO PCP or the name of someone not associated with the Department of Family and Community Medicine, look at the Encounters field
   a. If the most recent completed visit within the HHS system is with one of the listed providers then Family Medicine takes the admission.
   b. Sports Medicine is not considered a part of the Primary Care Clinic – so if this is the only point on contact within the system Family Medicine does NOT take the admission

3. **3 years** without any contact within our clinic system makes the patient an unassigned patient, therefore Family Medicine does not admit.

4. Patients currently being cared for by Extended Care should be assigned to Medicine even if they have been seen by one of our listed providers in the past. This is at the request of the Extended Care Attendings.

This is a linear algorithm, if #1 assigns the admission go no farther.

The **Family Medicine Inpatient Service** provides care for hospitalized patients who receive primary care from members of the Department of Family and Community Medicine:

Whittier Clinic (WHC): all providers* except Marjorie Hogan MD, Sonia Colliani MD, Susy Rosenthal MD
HCMC East Lake Clinic (HCMC EAST LAKE): all providers*
HCMC Richfield Clinic (HCMC RICHFIELD CLINIC): all providers* except John Anderson MD, Eileen Crespo MD
HCMC Brooklyn Park Clinic (BPC Primary): all providers* except Hakanson MD, King-Schultz MD
Northpoint Health and Wellness (NPH PRIMARY CARE) – only the following providers

- Paul Erickson MD
- Lourdes Pira MD
- Robin Councilman MD
- Henry Kerandi MD
- Tsewang Ngodup MD

- Michelle Schabert MD
- Kevin Gilliam MD
- Jana Carlson MD
- R. Wahlburg MD
- N. Xiong MD

St. Anthony Village Clinic (ST ANTHONY VLG CL): all providers*
Golden Valley Clinic (GOLDEN VALLEY CL): all providers*

*To find the providers at a clinic go to info-oncall, then hit the HCMC.org tab, Find a clinic and click on the clinic

FAMILY MEDICINE TEAM AND COVERAGE
The family medicine team consists of 4 senior residents, 4 interns, 1 APP and 1 and ½ faculty members. One senior resident, 1 intern and a rotating faculty member cover 6 consecutive night shifts and then switch to days. The rest of the team divides their time between inpatient duties and clinic duties. There is APP coverage every day of the week
Day shifts are from 7am to 7:30pm and night shifts are from 7:30pm to 7am. Day and night teams overlap for transition of care and morning teaching.

Weekend coverage:

24 hour in house faculty
Senior resident and intern each on 12 hour shift
APP covering 7 am – 6 pm
Saturday morning 7 am – 12 team intern covers
Sunday morning senior on nights stays until noon

Sign-Outs:
Sign-outs occur at 7 am 7:30 pm every day of the week. The inpatient service uses verbal and written sign-outs. The resident primarily caring for the patient updates the written sign-out and delivers verbal sign-outs

Limit of Resident Workload:
Background

It is the responsibility of the Program Director to ensure that the residency program does not place excessive reliance on the residents to provide for the service needs of the residency. The residency program is charged to ensure that a proper balance between service and education exists. One component of this is the program policy limiting the number of patients for whom residents provide ongoing care.

The Family Medicine Inpatient Service has a dynamic census and provides care for our clinic patients. Faculty physicians are ultimately responsible for all inpatient care and delegate responsibility to residents based on resident skills and patient needs. It is the goal of the Family Medicine Inpatient Service to maintain a sufficient number of patients to ensure adequate learning and growth for each resident.

On rare occasions the Family Medicine Inpatient Service census becomes high and raises concerns about Patient Safety. In response to this the following limits are placed on the workload of the residents.

Policy:

- Each intern may care for up to 7 patients per day. The senior resident supervising the intern will care for an additional 4 patients independently of the intern's patients.
- Senior residents working without an intern will care for up to 8-10 patients per day depending on their experience and skill
- The APP present on the service will care for up to 10 patients daily.
- In the event that the med/peds census exceeds the above parameters then additional patients will be rolled over to the FM OB intern and senior to help mitigate the work load. They may take up to 7 patients. These patients are redistributed to the other residents when appropriate.
- Patients admitted during the night are cared for by the residents present during the day. Distribution of workload is a joint responsibility of the faculty and senior resident on the service and should take into account volume, complexity and acuity.
- In the RARE event that there are still patients in excess of the above parameters then the Family Medicine Inpatient Service faculty will independently take care of the remaining patients

DIDACTICS AND ROUNDS:

Family Medicine:

- **Morning report**: 7:15-7:45 am daily. To start in May on 2015. Senior resident three days per week. Faculty one time per week
- **Teaching rounds**: Time of these reports are usually determined on a daily basis but should occur no later than 9:30 am
- **Interdisciplinary team /discharge rounds**: 9:20 am
- **Wednesday Core conference**: 7:30 am: 1:00 pm at Whittier clinic. All residents are expected to attend. Service is covered by FM faculty and an APP.

Other didactics:

- **IM morning report**: 7:45 to 8:15 daily : Breakfast served
- **Pediatrics noon report** : Tuesday 12 noon
- **Stab Room Conference**

DUTY HOURS:

The ACGME duty hours apply to the FM Inpatient service as in all other areas where residents are trained . Residents must report duty hours in RMS

Key issues surrounding duty hours

- Maximum Hours of Work per Week

- Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.
- Mandatory Time Free of Duty
  - Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks).
- Maximum Duty Period Length
  - Duty periods of PGY-1 residents must not exceed 16 hours in 1035 duration. (Core)
  - Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. (Core)
- Minimum Time Off between Scheduled Duty Periods 1082
  - PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. (Core)
  - Intermediate-level residents (PGY2 residents) should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. (Core)
  - Residents in the final years of education (PGY3) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or 1 extended periods. (Outcome
    - Senior residents who work longer than their 24 hour shift for managing patient in Labor and Delivery or who have remained to care for a seriously ill patient or patient at the end of life must file an exception report in New Innovations

Sick Call/Emergency Policy for FM inpatient Service

Sick Call/Emergency Policy

Purpose:
A resident unable to attend to his/her call duties due to illness or an emergency (unscheduled absence) must:

- Contact the Family Medicine Residency Coordinator by telephone (612-873-8082). If she is unavailable a message with directions on who to contact will be left for the resident to follow.
- During evening and weekends, the resident must call the back up call resident by beeper or call at home.
- Contact the faculty and other resident on call to notify them of the change.

A resident unable to take a scheduled call on the FMS due to illness will need to provide a physician note to the residency in order to return to work. The G2/G3 resident will also have to repay the call missed. This applies to emergency leave. The residency coordinator will keep track of the call day(s) missed.

Residents who do not arrange for call coverage: The residency program does not intentionally assign residents for call during vacations and other approved time away from the program. It is the resident's responsibility, however, to check the call schedule for such conflicts. If such conflicts are found, it is the resident's responsibility to rectify the situation.

BACK UP CALL ON FMS

Backup call covers the absence of residents on the inpatient service in the case of illness, emergencies or (on a case-by-case basis) other extenuating circumstances such as resident fatigue, concerns for patient safety or when clinical care needs exceed the residents' ability.

For weekend coverage, backup CAN be used to help out with service IF the senior resident and faculty feel that patient safety is an issue.

It is the responsibility of Senior Residents to look at the FM Inpatient schedule at the start of the block. This ensures that they are aware of being short staffed due to vacations or academic leave. The AMION schedule for leave is finalized >1month prior to the current block and placed on AMION.

Residents are scheduled for back up call when on a non call rotation, at the beginning of the academic year. If a resident is unable to take back up call due to a vacation or other commitment, the resident scheduled is responsible for finding a replacement and notifying the residency coordinator.

Only G2 and G3 residents are able to be on back up call. He/she is to have his/her beeper on 24 hours a day during the period he/she is serving as the back-up call resident. When listed as back-up call resident, you are expected to be able to take call. Please plan accordingly. Residents are to arrive at the hospital within one hour of notification if call has already begun.

If a resident agrees to switching back-up call with another resident, the resident agreeing to the switch must be sure that they have no commitments that will prevent them from coming in to take call should the need arise.

HCMC POST CALL FATIGUE AND CAB VOUCHER POLICY

Purpose:
We recognize that fatigued individuals often are not able to recognize their own limitations. Therefore, we provide cab vouchers for residents whose faculty or peers identify them as impaired by fatigue.

Policy:
HCMC will provide ongoing education and training for its residents/fellows in the area of fatigue mitigation via orientation and access to ongoing training materials.

All residents and fellows of HCMC who feel that they are too impaired, or identified by peers as being too impaired to dive home safely after working a shift will have the opportunity to return home and return to work using a cab voucher .

Procedure:

A. Obtaining a Ride:

1. Residents/fellows may call Yellow Cab directly at 612-888-8889 and indicate that this is a non-patient transport request for Account HCMC GME, account # 1556, and give your name

B. Reimbursement:

1. The maximum voucher will be $35.00 per call date;
2. Any additional cab fare will be borne by the resident
3. The maximum reimbursement will be to the resident/fellow's home

SIGN-OUTS

TRANSITION OF CARE POLICY

Purpose: To describe a formal process for transition of care from one team to another. This promotes health information exchange between teams about patients to improve patient safety and decrease errors

Rationale: Sign-outs are a common cause of errors in medicine, thus a standardized approach can help decrease some of these errors. Minimizing the number of hand-overs is also important to facilitate both continuity of care and patient safety.

Family Medicine Inpatient Service HCMC

To optimize patient safety, the number of hand-overs should, when practical occur no more than two times daily on the Family Medicine Inpatient Service. This frequency minimizes the number of transitions of care for patient safety and balances this with appropriate rest for residents and compliance with duty hours.

While on the inpatient service, residents are required to perform patient care transitions (sign-outs) using a standardized protocol.

Procedure:

The Family Medicine Inpatient Service at HCMC uses formalized written and verbal formats for transition of care. To ensure consistency, residents participate in formal training in this skill annually.

Sign-outs occur at 7 am and 7:30 pm. Sign-outs are supervised by faculty.

Responsibilities during Sign-outs:

The primary resident caring for the patient is responsible for reviewing and updating the information on the sign-out sheet

The senior resident is responsible for oversight of the intern's sign-out sheet

Faculty is present at sign-off sessions and expected to give feedback to residents

Characteristics of handovers:

Sign-outs should:

- not begin until all appropriate members are present
- happen in quiet and controlled environment to limit distractions

- be concise without any unnecessary information

Evaluation of the handover process:
This process is evaluated by faculty and monitored by the Program Director. Residents are evaluated at a mid-point during the block and receive formal feedback about performance

TEN INDICATORS OF EFFECTIVE SIGN-OUTS

- Sign-out should take place face-to-face to facilitate clarification and collaborative cross-checking.

- Start times should be defined. Sign-outs occur at 7:00 am and 7:30 pm and are concise.

- Sign-out should take place in a quiet/secure location. Interruptions and distractions must be minimized. One team member should be assigned to answer pages and telephone calls in and adjoining room.

- The roles and responsibilities of all participants should be clear. In general, interns should "give" sign-out with senior residents listening and/or clarifying. Medical students, when present, should attend but should primarily listen.

- The focus should be on patient safety and effective communication, with an emphasis on synthesis and summation of patient information. These are not attending rounds. It should not be necessary to replicate large amounts of information either verbally or on paper that are already in the patient's medical record.

- The sickest patients should be specifically identified and information should be discussed in a consistent order using the agreed upon structure template.

- All participants should be physically present the entire time.

- Uncompleted tasks should be completed after sign-out has been finished.

- Off-task activities, such as writing notes and putting in orders, should be minimized to promote efficiency and only the essential information should be exchanged verbally. Other information can be written on the sign-out sheet and/or found elsewhere.

- Every sign-out should include a pertinent to-do list and contingency plans for anticipated events. The focus should be on trying to anticipate issues that might arise over the next shift, and what actions might be taken.

GENERAL SUPERVISION POLICY

A. General Supervision Policy

Purpose: To ensure appropriate supervision for all HCMC Family Medicine residents that is consistent with proper patient care and the educational needs of the residents.

Policy: Residents must be supervised by faculty in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. On-call schedules for teaching staff must be structured to ensure that supervision is readily available to residents on duty. Faculty and residents are educated to recognize the signs of fatigue and will prevent and counteract the potential negative effects. The Program Director will ensure, direct, and document adequate supervision of residents at all times. Residents will be provided with rapid, reliable systems for communication with supervising faculty

1. All residents must be supervised by a qualified attending physician. The supervising physician (or his/her qualified designee with oversight from the faculty physician member) must be in the hospital providing direct supervision or indirect supervision with immediate availability to all PGY-1 residents. For PGY-2 and PGY-3 residents, supervising physicians may be in the hospital or immediately available by telephone and within 20 minutes of the hospital.

2. All residents must consult with the supervising physician regarding the assessment and treatment of a patient's illness. Treatment plans must be in accordance with the attending physician's recommendations.

3. All residents, regardless of level of training, must communicate directly with the attending family physician in any clinical circumstance which constitutes a major change in an inpatient's clinical status or any situation which requires more complex medical decision making. Examples of these situations include but are not limited to:

    - Acute deterioration of an inpatient's cardiac, pulmonary, or neurologic status
    - Change in an inpatient's status requiring transfer to the intensive care unit
    - Change in an inpatient's code status
    - Complex medical decision making for hospitalized patients
    - Admission of any patient in active labor
    - Acute deterioration of an active labor patient's electronic fetal heart rate tracing

4. All supervision must be documented in the resident rotation schedules and in the attending physician on-call schedules. In addition, the electronic medical record will accurately reflect both the admitting and the current attending faculty physician.

5. Residents must be supervised in such a way that they are able to assume progressively increasing responsibility according to their level of education, ability, and experience. The level of responsibility accorded to each resident must be determined by the teaching staff.

6. The Department must have resident rotation schedules available at all times to provide

to all interested parties.

7. Residents must precept all outpatient encounters. For the first six months, all PGY-1s are required to precept all patients during the visit. The preceptor is required to meet and assess the patient to ensure that safe and competent patient care has occurred. At the end of the first six months, PGY1 residents are assessed for their ability to move from direct to indirect supervision before they are allowed to discharge patients without a face to face meeting with the faculty preceptor.

8. Residents transferring into our program as a PGY-2 must precept their patients prior to completing the patient encounter for the first two months. This does not necessitate meeting the patient face to face, unless requested by the resident or deemed worthwhile by the preceptor.

9. All office and hospital procedures must be performed with direct supervision from attending physician faculty.

10. All supervision must be documented in the resident rotation schedules and by attending physician on-call schedules. Each department will have available at all times such schedules and will provide such to all interested parties.

B. Policy on Trigger Protocols for Urgent Attending Physician Notification

Attending notification guidelines, known as "trigger protocols", identify specific criteria that should trigger a phone call by a resident to an attending physician to inform the attending of a change in patient condition. Expected communication practices when there is a critical change in the patient's condition are that the attending will be notified, ***within 1 hour*** following evaluation. These include:

Inpatient / General

1. Request for admission to hospital/outside facility requesting transfer
2. Transfer to ICU or higher level of care
3. Unanticipated intubation or ventilatory support
4. Development of new significant cardiac changes (e.g. CODE, serious arrhythmia, PE, hemodynamic instability)
5. Development of new significant neurological changes (e.g. CVA, seizure, new onset of paralysis, acute decline in level of consciousness)
6. Medication or treatment errors requiring clinical intervention (e.g. invasive procedure(s), increased monitoring, new medications)
7. Patient, family, or clinical staff request for attending notification
8. Unable to contact patient or unsure of management of "panic" lab result, or patients from community clinics or nursing home patients while on call
9. Unanticipated change in CODE status
10. Death
11. Signing out against medical advice (AMA)
12. Suicide attempt

Obstetrics

13. New triage or admission (call immediately for preeclampsia or pre-term labor)
14. Notification of need for OB consult
15. Fetal tachycardia, category II or III fetal heart rate tracing
16. Patient in active labor
17. Significant adverse changes to vitals (hyper/hypotension, T>100.4, unexpected or unexplained tachycardia)
18. Pre-eclamptic changes (e.g. hyperreflexic, visual changes, increased BP, HELLP)
19. Arrest of dilatation after onset of active labor for ≥ 2 hours

NOTE: This protocol is designed to ensure communication, but ***should not preclude*** communication for any issue short of the above criteria. Any member of the team should feel comfortable to contact the attending of record at any time for questions of clinical management.

Inability to reach the attending should NOT impede needed or emergent clinical care.*

C. Procedure for Labor and Delivery

All Family Medicine faculty physicians are qualified in obstetrics. Family Medicine faculty provide on-site supervision of family medicine obstetric patients for all deliveries. In addition, Family Medicine faculty physicians provide on-site supervision when patients are in active labor, medically complicated or in any way unstable.

At all times there is an obstetrician and a senior resident in an ACGME obstetrics residency on-site for emergency consultations, and to provide c-section or emergency procedures outside the scope of Family Medicine. A resident may request an attending at any time and is never refused. Any significant change in a patient's condition must be reported immediately to the attending physician.

D. Lines of Responsibility for Residents and Attending Physicians on the Family Medicine Inpatient Service

Attending Physician

Supervision of all orders, procedures and treatment plans
Daily examinations of each patient on service
Daily note written on each patient on service
Organization of teaching responsibilities
Completion of resident evaluations
Monitoring of resident's academic action plans

PGY3

Perform the duties of the PGY2 if they are in clinic or unavailable
Direct teaching of residents and medical students
Organize the monthly M&M Conference
Promote teamwork among residents

PGY2

Review all admissions
Assignment of daily activities of the PGY1 residents medical students or extends

See all OB triage patients
Review of PGY1 daily assessment and plan
Negotiation with attending for final therapeutic plan
Daily examinations of each patient
Supervision of PGY1. Review of all laboratory and radiology results
Discussion of therapeutic plan with consulting physicians
Written and verbal sign-out to on-call team each day
Oversees communication via EPIC mail with patient's primary care physician
Carry the team pagers

PGY1
Initial assessment of new patient admissions
Daily progress note on each primary patient
Daily examination of each primary patient
Writes all orders on primary patients
Written and verbal sign outs of patients to the on-call team

E.Levels of Supervision for residents
To ensure oversight of resident supervision and graded authority and responsibility, the HCMC Family Medicine Training program uses the following classification of supervision:

Tier 1
Direct Supervision – the supervising physician is physically present with the resident and patient.

Tier 2
Indirect Supervision:
a) With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
b) With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Tier 3
Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident, is assigned by the program director and faculty members.

First year trainees entering the residency program are assigned to Tier 1 supervision in the first 6 months of training. At the end of 6 months, PGY1s are assessed by the residency faculty using the program's Developmental Milestones to ascertain promotion to Tier 2a supervision.

At the end of the PGY1 year, residents take a Supervisor's Examination. Successful passage of this examination results in promotion to determine their suitability to move to Tier 2b supervision and promotion to the second year of post graduate training.

FACULTY RESPONSIBILITY AND ACCOUNTABILITY FOR THE INPATIENT SERVICE

Being There:
Arrive no later than 7:30 am 7 days a week
½ day faculty leave at 12:30
All day faculty should be able to leave at 5:30 pm
Faculty to Faculty sign-outs should be done to satisfy the respective faculty
Attend Safety Rounds at 8:00am on L&D 7 days a week
On-call faculty should attend morning and evening sign-outs. Faculty should remain very quiet during these.

Feedback:
Attend, contribute and support Feedback Fridays
Write weekly evaluations on Google Docs

Teaching:

1. Faculty will shepherd and promote teaching by all on the Inpatient Service
2. **When on call**
    a. Residents must notify the on call faculty of new admissions at the time of their admission – be pleasant when woken up.
    b. Write notes on all admissions that you staff (if you hear the presentation then write a note)
    c. On call faculty are expected to supervise and assist the resident in providing full care for admitted patients. Therefore, thoughtful decisions about antibiotic selection, diet orders, tests and consults should be made at the time of the patient admission.
    d. Faculty are expected to examine all triage patients on L&D before their discharge from the unit and document this visit on EPIC
    e. Faculty are expected to supervise and document procedures done on laboring patients on L&D
3. **Responsibilities for faculty on the FM Inpatient service**
    a. Be a role model for a caring and competent Family physician
    b. Confer with senior resident about workload distribution
    c. Make every effort to maximize the educational experience for the residents
    d. At the start of the week, confirm which residents/interns will do formal presentations on clinical topics that week.
    e. Ensure that formal teaching occurs at least three days of the week.
    f. Evaluate patients, review and addend the resident's or intern's note
    g. Attend Feedback Friday at 12:15 pm
    h. Attend Patient Safety rounds at 8:00 am
    i. Attend Discharge Planning Rounds at 9:00 am
    j. Incorporate Coding Rounds into Team rounds on Thursday at 9 am
4. **Workload sharing**
    a. The HCMC Family Medicine residency program supports shared patient burden between faculty and residents.
    b. Do direct patient care as necessary

c. Help residents to organize the workload

5. Other expectations

Wednesday conferences

a. On Wednesday mornings, patient care is managed by the Family Medicine faculty attendings and APP.
b. Faculty are required to see patients, write notes and orders, request consults and do admission and discharge work for patients
c. Collaboration between FM Inpatient faculty is encouraged to facilitate seamless care for patients on the service.