Quincy Family Medicine Resident Handbook

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Manual Acknowledgement

Please scan the QR code or use the link to complete the receipt of the manual attestation.
It will state the following:

I acknowledge that I have received a copy of the Family Medicine Resident handbook.
I have read and fully understand this handbook in its entirety and that I am responsible for any of my own actions that go against guidelines outlined in this handbook and subsequently may be subject to consequences to be determined at the time of violation.

https://docs.google.com/forms/d/e/1FAIpQLSdkZJMX_8IP9eTgLy1fpLIUTMvnnNUMSg_B_BDpWSZmIn6f5w/viewform?usp=sf_link

Preface

This manual is intended to provide information to residents regarding SIU Family Medicine Residency Program, Quincy, Illinois.
This manual can be expected to change and conform to the changes of the program.
In general, any questions or problems residents have concerning residency policy and procedure should be addressed first with the chief residents.

Important Phone numbers

Program Director – William Dixon – 217-242-3421
Associate Program Director – Paula Mackrides – 217-696-4189

Chief Residents
Alex Gauer – 605-520-5398
Rachael Solomon – 847-420-8494

Scheduler – to call in sick or scheduling questions
Stacy Miller - Halo, email or call 217-277-5772

SIU Clinic 217-224-9484
Behavior Health/Psych & Family Community Medicine – Angie Henderson 217-277-5720
IT – Information technology - Amanda Wetzel
IT/EHR – Adam Bruns 277-5781

Blessing Hospital phone center – 217-223-1200

Mission Statement

1. To train excellent family physicians, eligible for board certification
2. To provide excellent medical care to the people of Quincy and surrounding areas.

Vision

In harmony with the Missions of the SIU School of Medicine and the SIU School of Medicine Department of Family and Community Medicine, Quincy Family Medicine Residency Program will provide quality healthcare to the people of Quincy and surrounding areas and will enhance public health through education, service, and scholarship. Our vision is to:

- Educate resident physicians in the principles and practice of Family Medicine.
- Train residents to provide comprehensive, high-quality medical care for acute and chronic medical problems to patients of all ages, races, and socioeconomic status.
- Provide compassionate and continuous patient-centered care at all levels- outpatient, inpatient, extended care, and care in the home.
- Recognize the impact of the environment, cultural background, the community and family upon the health and well-being of individual patients.
- Develop the knowledge and skills necessary for our graduates to establish practices that meet the criteria for a patient-centered medical home
- Provide educational opportunities for healthcare professionals other than resident physicians including medical students, pre-medical students, nurse practitioners, physician assistants, and others.
- Provide medical leadership in the community and mechanisms to enhance public health.
- Promote scholarly activity and academic inquiry into primary care medicine for the advancement of the discipline of family medicine.
- Enhance healthcare delivery to medically vulnerable and rural populations.

Guiding Principles of the Vision

- The Program will maintain a curriculum in accordance with the recommendations of the Residency Review Committee, assuring that the resident's training will be complete and that each resident will be eligible for board certification.
- The curriculum promotes the skills and competencies essential to the development of a family physician.
- All rotations will emphasize the development of clinical decision-making skills and residents will be deemed competent in these skills when the resident can perform a thorough history and comprehensive physical examination, employ appropriate diagnostic services, formulate an appropriate differential diagnosis, and take an appropriate action. This skill is not achieved unless proper communication is maintained with the patient and unless the resident is able to present this information correctly and concisely to other professionals.
- Both personal and professional growth of resident physicians is encouraged through non-clinical curricular elements that include self-assessment, cultural diversity, health literacy, community-oriented primary care, health systems management, and others.
- Preparing physicians to practice in rural and underserved areas requires the development of a "tempered independence" or a higher level of expertise in the areas of procedures, behavioral health, public health and obstetrics. The Program will provide opportunities for resident physicians to develop these higher-level skills.
- The Program will train excellent family physicians who have a complete understanding of the philosophy of family medicine and who can deliver comprehensive, continuous medical care to people and families in all walks of life.
- Research and scholarly activity will enhance the quality of patient care and advance the discipline of Family Medicine and will be encouraged among faculty and residents.
- The Program will actively collaborate with the community to improve health and access to healthcare.

About SIU School of Medicine

SIU School of Medicine was established in 1970 with a mission to educate physicians to remain in central and southern Illinois. We are a medical school with four areas of excellence: medical education, patient care, research and community service.

Our 270 physicians treat patients throughout the region through our multidisciplinary clinics called SIU Medicine. We also engage in world-renowned research, notably in cancer, Alzheimer's and audiology. Community service is a part of everything we do.

As a community-based medical school, we don't own our hospitals, but partner with numerous hospitals in Illinois to ensure the needs of the communities are met with a patient-centered focus.

Our mission is to assist the people of central and southern Illinois in meeting their health-care needs through education, patient care, research and service to the community. We do this through the Triple Aim + 1: health care that is more effective, efficient, equitable and enjoyable.

The SIU School of Medicine exists for two reasons: 1) to improve the delivery of healthcare and improve the health of the people of western, central and southern Illinois. 2) to advance the discipline of medicine. By educating physicians, physician assistants and scientists, by researching the causes and cures of disease and by caring for people and communities through systems of care, the team at SIU School of Medicine strives to meet the Triple aim + 1: Health care and education that's effective, efficient, equitable and enjoyable.

Clinic First

The goal of Clinic First is to streamline clinic operations, improve continuity of care and be responsive to the needs of patients and residents. The concept of clinic first encourages a turnaround of the traditional residency concept of hospital first to one in which residents can have improved focus both on their rotations and while in their clinic. This can allow prioritizing of ambulatory and continuity care with few distractions.

It is setup in a half month schedule (2 weeks + 2 weeks) in which each 4-week block is split into two 2-week rotations. In the 2-week ambulatory block, residents spend 6 -7 sessions per week in their family medicine continuity clinic, one academic session, one longitudinal curriculum learning session, and one scholarly activity session. In their 2-week rotation residents spend focused time on both inpatient and outpatient required rotations (i.e., obstetrics, adult inpatient service, geriatrics), as well as electives. A half day of admin time during continuity clinic is given per week to complete unfinished notes, tasks, CBLs, and meeting with team nurses. Residents are expected to be on campus to complete their admin work and should check in with faculty. If a resident fails to appear for admin time, a half day will be taken out of their PTO.

OB Continuity Patients

Purpose: Standards of care for OB continuity patients

- During your residency, you will be assigned AT LEAST THREE continuity patients. You may be subject to more pending OB flow at the clinic or if you have a desire for additional experience.
- The resident will see the pregnant patient assigned to them in clinic for the remainder of the prenatal visits when F
- The assigned resident is required to attend the delivery whether it is vaginal birth or a c-section. If your patient has a c-section, you are expected to scrub in.
- When an OB continuity patient comes on to the L&D floor, the SIU resident holding the ROC phone will find the appropriate resident that needs to see the patient (likely the assigned resident unless signed out). The assigned resident should come into L&D to complete the H&P and give report to the listed OB attending physician on call. If patient comes in laboring overnight, the assigned resident is required to come in and complete the H&P. This may be negotiated with the night float resident or other resident willing to cover over night. If the patient is less than 6 cm, the assigned resident may sign out to the night float to manage the patient while in latent labor. If the patient is greater than 6cm, the resident must stay on the L&D floor while the patient is in active labor until delivery. If the assigned resident is up for multiple hours during the night with a laboring patient, the scheduler should be made aware so arrangements can be made and the schedule can be adjusted for duties the assigned resident may have the next day.
- If a resident is on vacation, out of town, or has the weekend off, the OB continuity patient must be signed out to another resident with an official sign out. A full sign out must be given to the covering resident. Ensure that the scheduler is updated and aware of the dates and time the resident signing out and who is the covering resident for their continuity OB's.
- While the patient is in active labor (6cm or greater), a progress note in the Blessing record must be completed every two hours and every 1 hour while pushing (if able). A new note should also be generated if there is a change in the patient's status.
- Once the OB continuity patient has delivered, it must be logged in new innovations within 24 hours after delivery under "continuity delivery".
- After delivery, complete the delivery note, place in postpartum and newborn orders, and update the prenatal with the birth outcome.
- OB Continuity patients must be followed through until they are discharged from postpartum. BEFORE they are discharged, the assigned resident must ensure the patient has a postpartum visit and newborn visit scheduled.

OB Triage Patients Purpose: Expectations of residents on SIU OB continuity triage patients

1. When an OB continuity patient presents to the L&D floor, the patient must be seen, evaluated, and admitted if needed within 30 minutes of patient presenting to the floor. If they are not seen, this is considered an EMTALA violation.

2. Triage of the OB continuity patient is the responsibility of the FM resident who is scheduled on the L&D floor that block IF there is one. If there is no FM resident scheduled to be on the L&D floor, the FM resident who is assigned the OB continuity patient (primary) will triage the patient. If the FM resident who is assigned the OB continuity patient (primary) is not available to be there within 15 minutes, they must let the FM senior resident on service aware who will then see the patient. If the hospital service is busy and a lot of activity on the hospital floor, back-up must be called in. The assigned resident can ask for help from other fellow residents if another resident has time and is willing to see the patient.

3. Sign out patient to the OB Faculty on call (Drs. Miller, Aguirre, or the OB Hospitalist group). A list of the OB attending who is on for OB can be found in Amion. A formal sign-out must be given. This includes patient's age, G's and P's, gestational age, what they are presenting for and their OB and medical history, pertinent objective, and your plan for the patient.

Prenatal Care Purpose: Provide a guide of prenatal care and testing required at visits.

1. Before a new OB is seen in clinic, OB intake will be performed by the Clinical Prenatal nurse or her back-up if primary is unavailable.

2. The OB RN will be asking and recording (in the prenatal) the following information: Name of patient, DOB, contact information, Best mode of contact, Emergency contact, Positive home test vs confirmed testing at a facility (such as ER or urgent care), Gestation, Para, Medical History, current medications, allergies, and substance use. An SDOH (social determinants of health) questionnaire will also be completed by Clinic Prenatal nurse and provided resources**. It is the responsibility of the resident to confirm this information at their IOB (initial OB) visit as well as complete the remainder of the documentation required for IOB visits.**

3. If the patient has a positive home test, but does not have a confirmatory test, the patient will be scheduled for an amenorrhea visit first. At this visit a POC urine pregnancy test should be ordered. If positive, IOB labs should be ordered, the OB RN should be made aware, and an IOB visit will be scheduled before they leave the office.

4. Initial OB visits should include discussion of the importance of coming to their prenatal appointments, well-balanced diet, No ETOH, smoking, illicit drugs, no medications unless prescribed by a physician who knows the patient is pregnant, always wear a seatbelt, avoiding undercooked meat, unpasteurized dairy products, unheated cold cuts, hot dogs, and deli meats. Patient should also know to call the office if any concerns especially but not limited to abdominal pain, bleeding, vaginal discharge, or decreased fetal movement (later in pregnancy).

5. Follow-up OB visits should occur every 4 weeks until 28 weeks, every 2 weeks until 34 weeks, then weekly from 34 weeks until delivery. If needed, patients may schedule closer follow-up.

6. See the Prenatal Testing Guide about what labs are ordered when and when additional testing may be warranted outside the standard order sets.

7. After every OB visit, a full sign-out if an initial OB or brief update if a routine OB visit should be provided to the OB attending who is scheduled at the end of the clinic day. **IF there are pressing issues such as an elevated blood pressure or other more urgent concerns, contact Dr. Miller, Dr. Aguirre, or the OBH group immediately**. If unsure if something is an emergency or not, we would much rather you err on the side of caution and call us.

Curriculum

We believe that excellent family physicians are curious, thoughtful, and critical problem solvers who are committed to lifelong learning. They believe in and practice both the art and science of medicine. They recognize that an individual's health and well-being cannot be abstracted from the environment in which they live. Thus, issues of relationship, family, culture, psychosocial health, spirituality, economic status, and life stressors are always relevant and often critical to the well-being or illness of a given patient.

Implicit in our educational curriculum are these assumptions:

- Residents are adult learners, each with individual learning styles. Though not all residents come to us having developed an understanding of their particular educational needs, part of the residency's goals is to facilitate this knowledge in order to maximize individual growth.
- Residents must feel both supported and challenged in their clinical learning.
- Independent clinical decision-making, properly supported, is the best and fastest road to competence.

Most of the rotations have a curriculum associated with them which can be found in New Innovations (NI). Clinic First system allows for residents to have 2 weeks of continuity clinic with minimal distractions. Here they will maintain continuity with their own panel of patients, including pediatric and prenatal patients, and they follow patients who are in nursing homes or are home-bound. In addition to the block curriculum, several tracts are offered in a longitudinal curriculum- sports medicine, rural health, and obstetrics. We offer a wide variety of electives which the residents can utilize to tailor their educational experience.

The curriculum is designed so that each resident will satisfy all requirements for ACGME, ABFM and/or ACOFP.

For each rotation there are required readings/videos that are located on New Innovations. These must be completed during each rotation.

Below illustrates a brief overview of residency for each year:

PGY-1

First year residents will have the same 2 week + 2 week block schedule. Instruction by family medicine faculty helps residents develop skills in the evaluation and management of a variety of health problems. Instruction in patient care emphasizes disease prevention, health maintenance, utilization of community resources and management of the emotional aspects of patient care, with special attention to the appropriate use of consultants. First years take call from home in the evenings and/or weekends. They will work alongside a senior resident and sign out patients to attendings. Scholarly activity and longitudinal education will be incorporated during the clinic first blocks. First year residents will have continuity OB patients that they will care for through pregnancy, delivery, the postpartum, and newborn care. They can start seeing OB patients in the clinic after their first OB rotation is successfully completed. First year residents will also work at Pathway Health Clinic. Residents will also be expected to take the yearly in house training exam.

PGY-2

Second year residents provide continuing care to a larger number of patients than first year residents and have a greater degree of responsibility. Second year residents are on call and take Answer Quincy calls during in-patient services, night float rotations, and 24-hour call (about 6-8 weekends a year). Second year residents also admit their own patients on weekdays 6:00am - 5:00pm and will care for their patients on weekends and holidays when not scheduled to be off. Second year residents will have continuity OB patients that they will care for through pregnancy, delivery, postpartum, and newborn care. Scholarly activity and longitudinal education will be incorporated during the clinic first blocks. Second year residents will be seeing nursing home residents and have the opportunity to do home visits. Second years will also work at Pathway Health Clinic. Residents will also be expected to take the yearly in house training exam.

PGY-3

Third year residents provide continuing care to a larger number of patients. Each resident provides healthcare for his or her panel of patients. Third year residents generally have matured sufficiently in clinical judgment to know when they need assistance; however, faculty supervision is always available. Second year residents are on call and take Answer Quincy calls during in-patient services, night float rotations, and 24-hour call (about 6-8 weekends a year). Third years may also occasionally have continuity OB patients, although the required 3 are typically fulfilled in the first two years. The service admits patients to labor and delivery, critical care unit, medicine, surgery, and pediatric units as needed. Scholarly activity and longitudinal education will be incorporated during the clinic first blocks. Third years will also work at Pathway Health Clinic. Residents will also be expected to take the yearly in house training exam.

Resident Responsibilities

1. Halo – Answer all messages promptly, regardless of rotation or "post-call" state.
2. Maintain task list and boxes daily (including for individuals you are covering).
3. Check SIU email daily.
4. Touch base with one of your team nurses at least once a day.
5. Arrive promptly for clinic and rotations. Clinic team huddles begin 15 minutes before clinic starts.
6. Must stay in clinic until 5pm (walk-ins can be added at any time).
7. Complete all clinic notes within 72 hours.
8. Attend resident education didactic conferences and complete the conference surveys in New Innovations.
9. Log duty hours in New Innovations. 1st of the month through 14th required by 21st of same month and 15th through 31st required by the 7th of the following month. If hours are not logged could result in clinical suspension and increase in residency time.
10. Complete self-assessment semiannually.
11. Complete required resident rotation evaluations and be responsible to return a completed preceptor rotation evaluation at the end of each rotation.
12. Meet with faculty advisor quarterly.
13. Complete Individualized Learning Plan (ILP) and Milestones.
14. Complete resident surveys and evaluations of the program and faculty.
15. Complete required CBLs.
16. Incomplete notes, duty hours, CBLs, tasks may require Saturday school.

Clinical and Education Hours

ACGME has requirements on resident duty hours.
These include:

- No more than 80 hours per week, averaged over a four-week period. Time spent on clinical work at home, and moonlighting must be included.
- 8 hours off between clinical and education periods
- Work periods must not exceed 24 hours of continuous scheduled time
- Must have 14 hours free of clinical and education time after a 24-hour in-house call
- Must be scheduled for 1 day in 7 off, averaged over 4 weeks.
- Moonlighting must not interfere with residents scheduled time or goals
- PGY1 residents are not permitted to moonlight
- In-house call can be no more frequent than every 3rd night.

Every effort should be made by senior residents and faculty that first year residents do not exceed the 80-hour limits. When professional responsibilities necessitate extended hours, residents are expected to document the reason for the duty hour violation. Example of a duty hour exception would be a critically ill patient.

See Appendices:
Appendix B – Institutional Policy for Clinical and Work Hours (including Fatigue Mitigation)
Appendix C – SIU Quincy Family Medicine Duty Hour Policy
Appendix D – Fatigue: How to Recognize It
Appendix E – Moonlighting Policy

Supervision

Supervision by an attending physician must be available at all times for all residents. Schedules published identify the attending physician responsible for supervision of residents. Levels of supervision vary depending upon the experience and level of training and competence of each resident.

See Appendix A – Supervision Policy

Dress Code

Be professional through appropriate dress, good grooming and hygiene.
General Appearance:

- Clean clothes.
- Length must be reasonable and size sufficient to allow for movement, comfort and professional appearance.
- Personal hygiene must be maintained. A clean well-groomed appearance is the expectation of the program.

- Scrubs are allowed to be worn in clinic if they are neat and tidy.
- Closed toe shoes only.
- Proper identification enhances confidence by our patients.

Some attire that are not appropriate at any time. This list is not inclusive of all attire deemed inappropriate.

- Sundresses or sleeveless tops
- Sweatshirts, sweat pants or jogging pants, shorts, spandex pants, denim
- Bare mid-drift, exposed cleavage
- Visible under garments
- Open toed shoes of any kind

Lab coats – 1 lab coat will be provided to each resident as an intern

Resident Benefits

Personal Time OFF (PTO)
All residents are allowed a total of 25 business days (Monday through Friday) per academic year (July 1st-June 30th) that may be used for vacation, sickness, or bereavement leave each year. Three (3) unused days can be carried over to next year. No more than 3 days can be carried over per year. If a resident is absent from the program for more than the 25 allotted days, the same amount of time for residency completion will be required at the end of third year. Ex: If a resident uses 27 PTO in their intern year and they use 25 days or less in second and third years, they will be required to stay 2 additional days at the end of third year.
Medical records, time logs and evaluations must be current before the resident begins leave.
See Appendix C for ABFM/ACGME requirements.

Vacation Request Guidelines:

- Due to Clinic First, PTO is only allowed while on continuity clinic rotation.
- Vacation request forms must be submitted to the chief residents at least 90 days prior to the time of PTO for requests four (4) or more days. Requests should be made using the Absence Request Form. Please check with the scheduler after vacation submission if you need to know about approval, otherwise there is no formal process of notification of approval.
- Reversal of requested PTO can be changed with minimum 30-day notice.
- PTO can be requested in ¼ day increments.
- In general, no more than 4 senior residents and 2 interns will be scheduled away from the program at any one time. This includes residents who may be on away rotations, education leave, or PTO, etc. Thus, if other people are off during the time requested, it is possible to have your request denied.
- No PTO will be allowed the last 2 weeks of June or first 2 weeks of July. Requests for PTO (not including the winter holiday schedule) will be honored according to the date of submission for approval, on a first come, first served basis.
- You need to find coverage and inform the person covering for you that you will be gone before you leave (PGY-1's cover each other, PGY 2-3 cover each other). Each resident (excluding the residents on FPS) will be limited to covering a maximum of 2 other residents in addition to their own patients. Sign out to covering resident, including anticipated outpatients and OB care/deliveries. Senior residents will help with weekend and holiday inpatient coverage regardless of the rotation and will be assigned responsibilities accordingly. Notify your nurses when you are going to be gone and who is covering you.

Unexpected Sick/Bereavement Guidelines

1. Call a Chief resident as soon as it is known that a leave is needed. (Are you on call? Are you scheduled for clinic? Expected return? Hospital duties?)

2. Notify scheduler via Halo, email or phone. Make sure you speak to them or get a response from them.

3. Notify your rotation preceptor physician you are working with.

4. You are responsible to find someone to cover you. If you are physically/emotionally able, try to find another resident to cover you, especially if you are on call the day unavailable. If unable to do this, ask the chief resident for assistance.

5. Complete an absence request form as soon as possible or when able to return to work.

Education Leave
All residents are allowed a total of 5 working days for education leave per year. Education leave CANNOT be carried over to the following year. These days are separate from 25 PTO days. Use of education leave is subject to approval by the Program

Director. A flyer/brochure/agenda must be submitted at the time of request and proof of in-person attendance also needs to be provided afterwards (brochure, name tag, lecture schedule, welcome packet). Residents may use up to 3 days of their 5 education days as self-study in preparation for board exams. A clearly written study plan must be submitted and approved in advance by the program director. Otherwise, the same rules apply for turning the request in 90 days early, resident coverage, limiting the number of residents off, etc.

Parental Leave
There is flexibility regarding parental leave. Up to six weeks of leave through FMLA may be taken without prejudice and without compensation. Residents may use PTO time as part of their paid leave. Once available vacation and sick leave is exhausted, any additional maternity leave will be family leave without pay. Contact the Program Director ASAP to discuss scheduling when maternity/paternity leave is anticipated.

Board Exams
Board and licensing exam time does not count against PTO time. Residents may elect to take their exam at a more distant location of their choice, but must use their PTO days to cover travel time.

Career/Fellowship Placement
Successful career placement of the resident physician is the goal of this residency program. The SIU School of Medicine and affiliated hospitals foster and allow for sufficient time in job search endeavors. The Program Director may grant up to 6 calendar days throughout the three years of residency for travel and interviews. Job search time requires written submission of the proposed interview agenda to the scheduler and Program Director for time off to be considered. Time off request must be submitted at the earliest possible date.

Education Fund

Residents receive an educational allowance for educational expenses. Approved educational expenses include testing fees, conference attendance fees, travel and meals to, from and during an educational conference, medically related computer hardware and/or software, medical equipment and other medically related educational expenses.
NOTE: Required training such as PALS, ALSO, ALS, BCLS, cost does come out of your educational fund automatically but time off does not count towards educational leave.

PGY1 $1,750 PGY2 $2,250 PGY3 $5,000

**Important to note: You are responsible for keeping receipts and turning them in to the Program Coordinator if you desire repayment. If you have questions about certain items/courses being covered by your educational fund, confirm with Program Coordinator PRIOR to purchasing such items. **

Additional Benefits

- Onboarding bonus $5,000 amounted with the first paycheck
- Malpractice Insurance
- Health, dental and vision Insurance: Plans can be selected by chosen tier and is provided for resident and dependents
- Term Life Insurance: Provided in an amount equal to the resident's gross annual salary
- Disability Insurance
- Professional Dues:
    - Membership dues for the AAFP and IAFP (all resident physicians)

    - Membership dues for AOA and ACOFP (D.O. resident physicians)
- Information Technology Package: laptop computer
- Access to software resources: UpToDate, Essential Evidence Plus and others.
- Lab Coats: one lab coat provided for each resident
- Lunch provided during afternoon educational sessions
- Blessing Cafeteria food stipend of $800 per year with access to Blessing physicians lounge
- Chief Resident: additional $4,000 salary (divided between 2 residents)
- Professional, confidential counseling
    - Appendix J Resident Wellness Guide for Mental Health Resources

Call

This section outlines the call schedule in effect. There is a potential for call schedules to change at any time. The philosophy of the program regarding call is that on-call duties will maximize each of the following:

- Contact with patients with a variety of medical illnesses.
- Supervised progressive increases in patient responsibility and learning
- Increasing responsibility and care for patients with emergent and urgent needs

The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.

Call Team and hours:

Call team consists of On-call intern and On-call/Night Float Senior

- On-call intern:
  - Intern on call is at home until called in.
  - 5:30 p.m. – 10:00 p.m. weekdays, 6:00 a.m. – 10:00 p.m. weekends and designated holidays (days the clinic is closed).
  - Sign out patients to On-Call/Night Float Senior and Attending.
- On-call senior:
  - In-house
  - 24-hour call Saturday starting at 6am ending Sunday at 6am
    - Will be taking sign out from the service team Saturday evening and covering their patients Saturday night along with any new admissions during that period.
  - Sunday 6am- 6pm while on FPS

Responsibilities while on call

On Call Intern

- On call senior will notify intern when new admission is received.
- Call family medicine service attending after senior resident discusses case with you.
- Attend codes, rapid responses, and procedures if indicated.

Nursing Home/ other clinics

1. We admit patients from East Adams Clinic in Golden, Illinois.
2. Pediatric patients with no PCP's or whose PCP is a Blessing Family Medicine physician
3. We also cover multiple nursing homes listed below:
   a. Timberpoint Healthcare
   b. Rushville Nursing and Rehab
   c. Golden Good Shepherd
   d. Good Samaritan
   e. Sunset
   f. Mt Sterling Nursing and Rehab

No docs

Our inpatient service has a policy of accepting 3 "no docs" per 24-hour period from 6am to 6am.

No docs include:

1. Patients without PCPs or patients whose PCP's do not work for Blessing or QMG
2. Transfer patients from outside facilities (Sunday and Thursday)

- Exceptions to the rule: if we are already at 3 no docs for the day resident on call will still accept no docs if it is a pediatric patient or when the attending accepts a transfer.

OB call/rotation

- 24/7 home call
- In house hours during the week: 7 a.m. – 7 p.m.
- Please see OB GYN rotation for additional guidelines.

Weekends, holidays, and other **Night float senior covers as normal (without holidays)**

Holiday (July 4th, Christmas, New Year's Day, Memorial Day, Labor Day, etc. -- when the clinic is not open) duties are the same as weekends. This means, seniors do not admit their own patients --treat as a weekend.

Computer-based Learning (CBLs)

- These are a requirement of being an employee at Blessing Hospital and a graduation requirement. These can be found through the Blessing intranet.
- Most of these are repeated on a 6-month to annual basis, although there could be new ones posted at any time.
- Failure to complete these will affect the "Professionalism" evaluation of the resident by the program.

Library and Educational Resources

Blessing Hospital

- Provides access to UptoDate, MicroMedex and additional resources

Southern Illinois University

- Electronic resources are available through my.siumed.edu

Scholarly Activity/Conferences

In addition to the experiential learning of rotations, residents' knowledge and skills are augmented with educational conferences that occur every Wednesday afternoon during lunch hour. These are led by a rotating combination of residents, faculty, community members associated with community resources and community attendings (often specialists). Topics will address key competency areas of the curriculum, such as disease prevention and wellness, and patient safety and quality improvement. Residents will have a yearly case conference to present a patient with good educational points.

Expected Scholarly Activity:

- PGY-1: 1 case conference + GEM (Good Evidence Matters) project.
- PGY-2: 1 case conference + Help Desk Answer.
- PGY-3: 1 case conference + Quality Improvement Project
- One abstract of a case conference will be submitted (usually third year) which will also need to be transitioned to poster format. The suggested conference to submit the abstract to is the Annual Teaching and Learning Symposium. At a minimum, the poster will be presented at the annual graduation CME.

NOTE: Residents following the Osteopathic Recognition Program Requirements may end up following a different timeline for their journal club, which will be osteopathically focused.

Noon Conference Guidelines/Expectations

- It is expected that Wednesday afternoon block conference attendance rate will be 90%. Failure to maintain these standards will lead to further discussion with the Faculty and Program Director and could affect your ability to graduate from the program without significant remediation.
- Night float residents are excused from Wednesday conference, this counts as part of the 10% missed conferences.
- Residents on their service rotation are expected to attend noon conference, unstable patients are, of course, an exception.
- A noon conference survey will be sent via New Innovations to be completed by each resident.

Quality/Performance Improvement (QI) Project

The purpose of ABFM's Performance Improvement (PI) Activities is to help you identify an improvement opportunity, implement a change in care delivery and measure the impact of that change. Demonstration of high-quality patient care includes your ability to identify performance gaps, design an improvement intervention to address the gap(s), and reassess to see if your intervention was effective.

For clinically active physicians, meaningful participation in and completion of one PI activity every three-year stage allows residents to successfully meet the requirements of the Family Medicine Certification process through the ABFM.

The QI project will typically be started in the second half of residents' second year with the entirety of the second-year class participating. Project design, implementation, data collection, analysis and interpretation should be completed at latest by December 1st of the residents' third year. Even though this is not a requirement for residents planning to take only AOBFP boards, it is still a requirement of the residency for successful graduation.

Case Conferences

Each resident will be expected to present one case conference per year. The cases that are the basis of these conferences may be the resident's own continuity patient or patients encountered on other services. The residents are encouraged to present continuity patients as much as possible and to emphasize all aspects of patient care including psychosocial information. The residents are encouraged to present the case conferences as an exercise in clinical decision-making, presenting pieces of information and then allowing fellow residents to discuss the problem list, differential diagnosis, work-up, honing of the differential diagnosis throughout the case and proper therapeutic intervention. The resident should also

prepare a general discussion on the medical condition after the case is discussed as learning points. Five board-style questions covering the disease or related disease should be prepared after the discussion/integrated into the discussion. Please see guidelines/grading rubrics below for help in structuring your presentation.

***Osteopathic residents should have an emphasis on osteopathic principles towards the end of the discussion portion of the presentation.

Guidelines for Formal Patient Case Conference

Purpose: To provide an educational discussion to family medicine residents, medical students and faculty on a specific disease state or relevant clinic issue.

Goal: To effectively present a thorough case with emphasis on proper management of a specific disease state.

Expectations: An oral presentation (PowerPoint preferred), and a written submission incorporating all pertinent patient and disease state data. The oral case presentation should be at least 35, but not longer than 45 minutes in length followed by 5-10 minutes for questions and answers. The written case should be no more than 3 pages in length.

See Appendix F for case conference template.

Osteopathic Recognition Program Requirements

Curriculum

- Attend all OMM workshops conducted by faculty unless specifically excused (i.e. vacation, night float, business leave, etc.)
- In the third year of training, residents are expected to assist as table trainers for junior residents and/or medical students.
- Participate in designated osteopathic journal club on a rotational basis.
- Attend regularly scheduled OPP webinars or educational sessions quarterly (unless otherwise excused.)

Evaluations

- Complete biannual milestones self-assessment annually
- Complete annual osteopathic specific program evaluation
- Complete annual osteopathic faculty evaluation
- Complete annual ACGME Osteopathic Recognition Survey
- Meet semi-annually with Director of Osteopathic Education to review competencies, milestones and performance

Procedures

- Maintain logs of OMT procedures in New Innovation (expectation of 40 outpatient encounters over the course of 3 years)
- Document osteopathic structural exam in the hospital setting – 8 in the first year, 4 in the second year, and 4 in the third year of training. – Copy of each structural exam to be stored in a secure location in the program.

Examinations

- Take the yearly ACOFP in-training exam (or Program-designated equivalent)
- Take either AOBFP (recommended) or ABFM boards.

Scholarly Activities

- One scholarly project with osteopathic focus in the 3 years of training, which includes the submission of a poster presentation abstract to a regional or national conference.
- Residents will present a yearly case presentation with OPP or OMM component at a local interdisciplinary educational conference
    - Incorporating OPP/OMM (This can be used to meet the current program case presentation/grand rounds requirements with abstract submission.)
- Additional Osteopathic Learning Enhancement (Optional, talk with Director of Osteopathic Program)
- Attend one regional or national osteopathic conference in 3 years (to be approved by Director of Osteopathic Education).

Goals and Objectives for Designated Osteopathic Curriculum

Goals

To maintain and further develop osteopathic skills so that, upon graduation from residency, the physician will confidently continue these skills in the everyday practice of medicine.

To gain deeper understanding of the osteopathic principles and promote and utilize these principles throughout their medical career.

Objectives

Junior Residents

1. Be able to perform complete and focused osteopathic structural exams. (MK, PC, ICS, P)
Assessment tools: Direct Observation

2. Applies the physician resident's osteopathic diagnostic skills to create accurate assessment and treatment plans. (MK, PC)
Assessment tools: Direct Observation, Chart Review, In-training Exam

3. Identify and describe the indications and contraindications to the various methods of osteopathic manipulative treatment. (MK)
Assessment tools: Direct Observation

Senior Residents

In addition to the Objectives set for the Junior Residents, the following objectives are to be met for the Senior Residents:

1. Applies appropriate documentation skills of an osteopathic structural exam in the inpatient and outpatient setting. (MK)
Assessment tools: Direct Observation, Chart Review)

2. Demonstrates the appropriate use of osteopathic manipulative techniques in all clinical settings. (MK, PC)
Assessment tools: Direct Observation, Chart Review, Procedure Logger

3. Performs appropriate osteopathic coding and billing. (SBP)
Assessment tools: Direct Observation, Chart Review

4. Recognizes the types of somatic dysfunctions that occur with certain disease states (MK, PC)
Assessment tools: Direct Observation, Chart Review, In-training Exam

5. Defines and integrates the osteopathic philosophy: that impairment of the body involves multiple systems including skeletal, arthrodial, myofascial, vascular, lymphatic and neural. (MK, PC)
Assessment tools: Direct Observation, In-training Exam

6. Defines and integrates the osteopathic principles, including treating the whole patient rather than the symptoms, in all aspects of patient care to provide complete comprehensive care. (MK, PC, ICS, P)
Assessment tools: Direct Observation

The Osteopathic Oath

I do hereby affirm my loyalty to the profession I am about to enter. I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature's laws and the body's inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly purposes to any person, though it be asked of me.

I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college I will be loyal and strive always for its best interests and for the interests of the students who will come after me. I will be ever alert to further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy which were first enunciated by Andrew Taylor Still.

Chief Resident Responsibilities

The chief resident position is typically shared between two 3rd year residents who are selected by the resident body via voting and approved by the Program Director. Responsibilities include:

- Communication between program directory/committees and resident body
- Addressing/resolving small concerns as well as answering questions for other residents
- Creating the intern/senior call schedule
- Attend GME committee meeting, all faculty meetings (semi-monthly) and all chief resident/program director meetings (semi-monthly as needed)
- Lead resident conference (monthly)
- Upholding rules and regulations of the residency program
- Setting good examples
- Setup and organize the yearly resident retreat

Required Rotations

FIRST YEAR	SECOND YEAR	THIRD YEAR
Family Practice Service	Family Practice Service	Family Practice Service
Family Practice Service	Family Practice Service	Family Practice Service
Family Practice Service	Family Practice Service	Family Practice Service
Family Practice Service	Family Practice Service	Family Practice Service
Family Practice Service	Family Practice Service	Dermatology
OB	ICU	Outpatient Pediatrics
OB	Geriatrics	Night Float
ED	NICU (Springfield rotation)	Night Float
ED	MSM	Elective 1wk
Inpatient Peds/Sick Nursery	Cardiology	Elective
Gynecology	Selective (OB, ER, Pulm)	Elective
Family Community Medicine	Night Float	Elective
Psychology	Night Float	Elective
Outpatient Pediatrics		Elective

The above represents required rotations per year but not the order in which they will be done. There is some minor flexibility with trading a few rotations between second and third year. First year has a set schedule of rotations to be completed.

Elective Rotation Options

This list is not all encompassing, but represents popular resident choices in the past. Elective rotations can be created as long as it is approved by the Program Director, Blessing GME Committee, and has an appropriate set of goals and objectives which needs to be outlined by the resident. Goals and objectives for a new/away rotation should be turned in ASAP to help ensure that it has time to clear administratively and that the rotation is secured. Consideration as to future career paths should be utilized with selecting electives. Certain rotations could be repeated with other community attendings for additional experience in those fields (Ex. cardiology, pulmonology, etc.).

- Hematology/Oncology
- Allergy/Immunology
- ENT
- Ophthalmology
- Nephrology
- Endocrinology
- Rheumatology
- Gastroenterology
- Podiatry
- Sports Medicine

- Wound Care
- Urgent Care
- Walk-In Clinic
- Anesthesiology
- Physical Medicine and Rehab
- Practice Management
- Lab
- Radiology/Interventional Radiology
- Hospitalist
- VAS Team
- Ambulatory Medicine
- Wound Care
- Urgent Care
- Away rotation

Required Rotations

Family Practice Service (FPS)

Schedule

Service am sign out: 6:00am. Service team is **REQUIRED** to be physically present at morning sign out.
Residents are **REQUIRED** to physically be in the hospital for sign-out in the evening.
The "Senior On" must be in the hospital from 6a-6p.
If you are on HITS (admissions), you will carry the Roc phone with you. This is the phone that is called by the ED and the Hub for admissions and transfers. You must also be in the hospital from 6a-6p.
Resident on weekday call (HITS): 6am until *6:00pm, all admission calls received after 5:30pm will go to the intern on call. (FPS "senior on" will supervise intern until 5:30 pm, after which time the overnight senior will supervise)
Residents on service but not on HITS, may go home after completion of rounds and all notes including progress notes and discharge summaries.

Resident Responsibilities

- FPS admits all patients from the ER and direct admits from clinic whose PCP is documented as an attending, sports medicine fellow, or a 3rd year resident (non-traditional tract) in AllScripts. (We also admit BPS Family practice Peds, East Adams Clinic and area nursing home patients, as well as all EMTALA pediatric patients)
- Admit maximum of 3 "no doc (EMTALA)" patients in a 24-hour period unless instructed otherwise by FPS attending. Transfers from outside facilities will NOT be deferred because of the previous number of "no doc/EMTALA" patients admitted that day.
- Pre-round on all assigned patients before rounds, attempt to complete progress notes before rounds
- You are required to attend all conferences while you are on service. Faculty has been advised to release you from rounds early enough to allow you to finish notes/discharges and present to noon conference on time – this should be 11:30am most days. Notify Chief Residents if this is not consistently happening.
- ALL FPS residents must attend all Wednesday afternoon conferences unless a patient is in critical condition. HITS admissions shared among service team.
- Expected for all notes to be completed daily
- H&Ps need to be completed within 12 hours of admission and discharge summaries within 24 hours of discharge. This should occur without fail.
- Discharge paperwork needs to be completed by noon daily. If controlled substance scripts are required at discharge, they should be pre-loaded in BAR prior to rounds, so the attending can send this electronically during rounds.
- If PCP of the patient is a PGY-2, and are informed before 5pm about patient admission, they will admit and manage their own patients. If after 5pm then the on-call team admits, until the senior can resume care the following morning at 6AM. Remember to update BAR accordingly. PGY-2's seeing their own patients must sign patients out to attending on in-patient service before 9am. They will stop admitting their own patients into the hospital 5 days prior to the end of their second year of residency.
- If direct admit is seen by a resident in clinic, that resident will do the H&P and admission orders until the care can be transitioned to the senior or service team. Resident must sign out patient to in patient service team. If a direct admit is sent over by attending/PA/NP/fellow, the resident on HITS for that day performs the H&P (or the on-call resident if they arrive or are notified after 5:30pm).
- Education topics are to be discussed daily. Assignments/plans will be made by the seniors on service.
- Seniors on service are responsible for oversight of the care provided by the interns. It is recommended that prior to attending rounds the senior and interns meet to discuss patients.
- The senior resident on FPS will cover Answer Quincy responsibilities from 6am– 5:30pm on Sunday or on clinic holidays.
- One of the seniors will prepare a HITS schedule for the two weeks of service.
- Any time you see a patient for assessment (Rapid response, change in condition status, etc.) you must enter a note. This can be abbreviated and only address the request at hand. Can use the Physician Miscellaneous Note. There is also a Rapid Response note template. Be familiar with the times that you must contact an attending.

During service:

- In-person sign out starts at 6am and 6pm. Arrive to sign outs early so that they can start on time.
- Must add name to patients within BAR.
- Check our EHR before going to see the patient to see who the PCP is, even if ED reports them as a no doc.
- Everyone must be physically present for sign outs.
- Table rounds are an educational opportunity. It is expected that you do not work on notes during this time.
- When signing out your patients to the on-call/night float resident, you must check on your patients prior to signing out to the senior to make sure they are stable

VOALTES/ PHONE CALLS:

- Respond to all Voalte/phone calls promptly, even if you think it was an error. You cannot turn your Voalte off unless you are on vacation or education leave.
- Inform the senior right away as soon as you have an admission.

CLINIC

- Residents on FPS clinic will have one half day of clinic that will end at 3:30pm

CONTACTING THE ATTENDING

- Faculty attendings are available anytime. Interns should first speak with senior prior to contacting attending.
- Interns can sign out a patient after reviewing the admission with senior resident
- Any significant change in status (transfer to ICU, death, etc.)

INTERNS

- Intern patient numbers per service:
  Service 1-2: 1-4. Senior must see all intern patients
  Service 3-4: 5-8. Senior should see at least critical patients.
  Service 5-6: 8-10. Senior should only see patients at intern request or as identified by the senior/attending.

- Max patient load is 10 patients (no exceptions). This does not include admissions you get while on call or HITS.
- In general increase patient load for intern by 1 patient per week
- Seniors should use their best judgement when adding on more patients to interns above their limit.

ICU PATIENTS

- The ICU at Blessing Hospital offers exceptional patient care and learning opportunities for resident physicians. The ICU is staffed by Intensivists, who oversee the care for almost all of the patients within the ICU, regardless of whichever primary care physician and/or hospital service shares responsibility for the care of the patient outside of the ICU. FPS Resident Physicians are expected to follow SIU patients into the ICU.
- The assigned resident physician (a senior resident) should see patient(s) at least daily and then discuss/check out the patient with the Intensivist.
- When a SIU patient is transferred to the ICU for ICU-level care (NOT CVU/PCU overflow, etc.), the resident following the patient should “switch” the Attending physician in BAR to that of the Intensivist caring for the patient, unless instructed otherwise.
- Resident physicians should be prepared to present and discuss the ICU patient with the Family Medicine attending and service team as appropriate per the FPS attending.

PEDIATRIC CODES AND RAPID RESPONSES

- Residents are expected and required to respond to every pediatric code or rapid response called in the hospital at any time.
- You will need to join the team “Rapid Response Junior” on Voalte to be notified specifically when it is a pediatric patient rather than an adult patient.

- If no resident responds to the Voalte messaging, the operator will call the on call resident to notify them.
- If it is a Code Blue, the ED physician will respond for patients 15 or younger, and the hospitalist will respond for patients 16 and older.
- If a patient on CAS has a rapid response and needs medical stabilization/admission, SIU will admit the patient unless they have a pediatrician/family physician with admitting privileges.

Night Float

The Night Float rotation is a nightly rotation designed to cover the Family Practice Service. The same goals and objectives apply to this rotation as for the FPS rotation. This rotation assures compliance with the 80-hour work week objective of the ACGME.

Schedule

- 2-week rotation twice per academic year, senior residents only
- Sunday through Friday, 6:00 pm to 6 am. Saturdays 6am - Sunday at 6pm time off and covered by assigned 24-hour senior on call.
- Vacation may NOT be scheduled during this rotation.
- No Continuity Clinic is scheduled during this rotation.
- Wednesday afternoon education conferences are excused during the Night Float.

Resident Responsibility

- Resident must be in-house at all times during night float rotation.
- Take all new admissions from 6:00 pm to 6:00 am.
- Manage all FPS care-based inpatient needs from 6:00 pm to 6:00 am.
- Follow-up on all sign out activities.
- Maintain and update sign-outs.
- Teach and supervise interns on-call.
- Attend all hospital deliveries with pediatric/neonatal resuscitation coverage when a Sick Nursery resident is not on call.
- Attend all hospital deliveries of SIU Family Medicine-Quincy patients if the on-call OB resident is not available/scheduled.
- Serve as the on-call person for any Answer Quincy phone calls after clinic hours, 4:45 p.m. - 8:30 a.m. weekdays, 6:00 a.m. - 6:00 a.m. weekends.
- Report to all CODES called within the hospital (not ER).
- Report to and lead all Pediatric Rapid Response calls within the hospital.
- The senior resident is required to examine all potential admissions and to give advice to the intern resident.
- Enter a progress note in the H&P format for each patient that is admitted by the Intern.
- Must be physically present at 6:00 a.m. sign-out to FPS team at end of shift.
- Check and address your clinic tasks and notes nightly.

SENIOR RESIDENT ON 24 HR SATURDAY CALL

A Senior Resident will be on call with these same responsibilities Saturday 6:00 a.m. - Sunday 6:00 a.m. and the senior resident on FPS will cover these responsibilities from 6 a.m. Sunday – 5:30 p. m. Sunday (except for responding to all CODES – this will be required only for SIU-Quincy Family Medicine patients only). The Saturday on-call resident will take sign out from FPS service team and assume care of FPS patients at 5:00pm.

NOTE: Night Float may be taken as an elective rotation for senior residents who want additional experience with acute patient management in the overnight setting. If there are no electives scheduled, then call will be scheduled during Block 7 in a traditional manner for Senior Residents

Inpatient Pediatrics and Sick Newborns

Schedule

- One rotation during intern year
- Hours 7:00am-7:00pm. You are not expected to take admissions overnight, but you will be expected to perform the admission H&P the following morning.

Resident RESPONSIBILITIES

- Round on ALL inpatient pediatric patients (QMG/BPS/FPS) before the attendings arrive and contact attending after patients have been seen.
- You will write H&Ps on each new patient unless told otherwise. Be sure to touch base with the admitting attending (via Voalte/text, page, office phone).
- You will write progress notes on each of the patients seen each day.
- The nurses and/or attending physicians will notify you if there's a high-risk delivery. You must attend these deliveries whenever possible. ****To help ensure that you are notified, please provide the **NURSERY** and **OB** unit secretaries with your name and contact information, and inform them to please notify you of high-risk deliveries****
- Other procedures to keep track of include any circumcisions, lines, LP's, suprapubic bladder aspirations you participated in or performed.
- Residents must have at least 100 hours (or one month) of experience with the care of acutely ill children in the hospital and/or emergency setting. This experience should include a minimum of 50 inpatient encounters with children.

CONTACTING THE ATTENDING

- All the attendings' contact information including pager numbers, office, and cell numbers can be found by clicking the "telephone icon" in BAR. Some of the physicians are using Voalte.
- You should contact the attending physician any time you are unsure or uncomfortable with the patient's situation.
- Contact them with critical labs, or if a patient is "crashing", or any dramatic change in status.

LEVEL 2 NURSERY

- Please provide the nursery a card/piece of paper with your name, pager number and request that they call you with any level II nursery baby admissions. (It helps to call/report to nursery daily and inquire about any new admissions overnight!)
- You also are expected to round on, and write daily progress notes on the newborns in the sick nursery (level II). You are not expected to round or write progress notes on regular newborns. You should follow the level II babies until they are discharged from hospital (even if they are released from level II status).
- Newborn exams may be performed if attending is agreeable.

TIME OFF

- Days off should be communicated with the nursing staff, secretary (a written note works best), and attending physicians.
- Level II nursery babies should still be rounded on if inpatient peds/sick nursery resident is on vacation. This will be covered by the FPS team. Please communicate with the FPS team so that they are aware and can round on all level II nursery babies.

ICU

Schedule

- The beginning months of PGY2 are dedicated to PGY2s rotating through the ICU in one two-week rotation. Hours are 7a-7p every day unless on 24-hour call.
- Morning rounds in the ICU are at 10am. Always update attendings if a patient experiences sudden change in status or if you have any questions.
- The ICU is a great location for procedures. Be sure to log all procedures in new innovations.

Obstetrics and Gynecology

Schedule

- You are required to be physically present on the labor and delivery floor from 7am until 7pm on days you are working. You are on call 24/7 (from home when not at hospital) unless you sign that responsibility out to another resident.
- Please indicate to the unit secretary on L&D and postpartum your name and number so they get to recognize you and know who you are!

Purpose: Expectations of residents while on OB rotation

- The resident on the OB rotation must present to L&D at 7:00 AM to listen to nurse report. Shifts will be 0700 to 1900 unless scheduled otherwise.
- Residents are expected to introduce themselves to all laboring patients after AM report.
- The resident on OB must be present in the nurses' station at all times unless completing notes in the dictation room. It is expected that the resident spends most of the time in the nurses' station. Our L&D nurses offer a lot of valuable teaching and residents should take every opportunity to learn and engage with them. If the resident needs to leave for a lunch break, let the RN's know.
- If the resident is not on L&D when they are scheduled to be there, one written warning will be issued. **If a second warning is warranted, the resident will repeat the OB rotation**.
- The resident on OB rotation may stay longer in their shift; however, they need to send Dr. Aguirre and the scheduler an email. This way if the resident on OB rotation comes in late the next day to not break duty hours, this will not count against them.
- Follow Dr. Frye in her prenatal clinic on Thursday AM starting at 0800. Concentrate on seeing prenatal appointments. Let her know if you cannot make it to her Thursday AM clinic. If she is unavailable, plan to be on L&D in the morning. After Dr. Friye's AM clinic, the resident should present to Labor and Delivery until 1900.
- Perform cervical checks with RN's backchecking until the resident is comfortable. This applies to situations when two cervical checks are appropriate. A resident performing a cervical check may not be appropriate if a patient has prolonged rupture of membranes or very uncomfortable cervical checks. Residents must have 5 cervical checks completed, documented, and back-checked by a RN on their 2nd OB month intern year starting with the new academic year 2024. Cervical check form (found in OB handbook) should be given to Dr. Aguirre once completed.
- It is expected that the resident learns how to position patients for optimal progression of labor and also learn how to push with a patient.

- Residents are expected to perform amniotomies under the supervision of the attending the first couple of times they are first performed, then solo once the resident is comfortable. Before breaking a bag, ensure the baby's head is well applied and is not ballotable, and confirm that it is okay with the appropriate attending.
- Residents are also able to place fetal scalp electrodes and IUPC's when appropriate and when competency is assured.
- If not busy in a room with another patient, the resident should attempt to see ALL triage patients with the OB hospitalist.
- If the resident delivered any patients the day prior, they are expected to follow the delivering mother to postpartum and round on them in the mornings starting the morning after delivery while the patient is admitted. DO residents may consider OMT if time allows, patient and the attending OB are amenable.
- Listen to the nurses give discharge instructions on at least 1 vaginal delivery and c/s patient that you have followed. Listen to enough that you can recite it back to the attending.
- Update Dr. Miller and/or Dr. Aguirre at the end of every week what your delivery numbers are. It can be given to the FMOB who is on for the week or coming on for the week. If in doubt, send delivery numbers to both Dr. Miller and Dr. Aguirre.
- If it is slow on the L&D unit in the morning, please go to newborn and follow one of the pediatricians. This is to develop newborn exam skills and learning how to perform circumcisions. If you do leave the unit to perform newborn exams/circumcisions, please update the nurses. Also remember, your priority on the OB rotation is L&D.

Resident Responsibility

- Triage all SIU family medicine obstetric patients and discuss directly with SIU attending on call for OB (you do not have a senior here, but can use on call or FPS senior for questions)
- If SIU patient will be staying for delivery then inform the delivering provider. If it is an OB patient of a resident, they will assume care and do the H&P. If it is a SIU attending patient admitted for delivery, you will complete the H&P and manage the delivery. Do your own note/documentation as appropriate for the clinical circumstance.
- Do H&P and/or progress, postpartum and/or procedure notes of the BPS or QMG obstetricians if they ask you to (always offer). When you are present for the delivery, follow that patient post-partum.
- Notify BPS OB-back up call when admitting any SIU family medicine patients for labor.
- Log all procedures, deliveries, complications, and OB continuities in New Innovations.

OB Triage Patients

Purpose: Expectations of residents on SIU OB continuity triage patients

- When an OB continuity patient presents to the L&D floor, the patient must be seen, evaluated, and admitted if needed **within 30 minutes** of patient presenting to the floor. If they are not seen, this is considered an EMTALA violation.
- Triage of the OB continuity patient is the responsibility of the FM resident who is scheduled on the L&D floor that block IF there is one. If there is no FM resident scheduled to be on the L&D floor, the FM resident who is assigned the OB continuity patient (primary) will triage the patient. If the FM resident who is assigned the OB continuity patient (primary) is not available to be there within 15 minutes, they must let the FM senior resident on service aware who will then see the patient. If the hospital service is busy and a lot of activity on the hospital floor, back-up must be called in. The assigned resident can ask for help from other fellow residents if another resident has time and is willing to see the patient.
- Sign out patient to the OB Faculty on call (Miller, Aguirre, or the OB Hospitalist group). A list of the OB attending who is on for OB can be found in Amion. A formal sign-out must be given. This includes patient's age, G's and P's, gestational age, what they are presenting for and their OB and medical history, pertinent objective, and your plan for the patient.

Presenting an OB Triage:

This is a __ year old _____ (ethnicity) G_P_PT _A _L _ (P=term deliveries, PT=preterm, A=abortion or miscarriages and L=living children) at __ weeks __ days Gestational Age by _____ (U/S, LMP, reliable date of conception etc.) dating with a pregnancy that is complicated by _____.Patient of Dr_____.

The patient is presenting to L&D today for _____.
(Vaginal Bleeding/Discharge, RUQ pain, changes in vision, other complaints
+/- Fetal movement, +/- Fetal heart tones)
What does the Rhythm strip look like? Are contractions present?
Fetal heart tones: variability, baseline, accelerations, decelerations
Category I strip
Category II strip
Category III strip
Sterile speculum exam: pooling of fluid, bleeding, os opened or closed
Sterile vaginal exam: dilation, effacement, station
Remainder of pertinent physical exam

Your Assessment and plan:

1. "IV fluids and rest, if contractions cease, we will then discharge home"
2. "Admit for active labor"

Appendix I - OB Manual

Emergency Medicine

[Mechanics being adjusted, watch for updates]

Schedule

Two – 2-week rotations during intern year with option for electives in the senior years
ED intern is on from 12pm to 12am.

Resident Responsibility

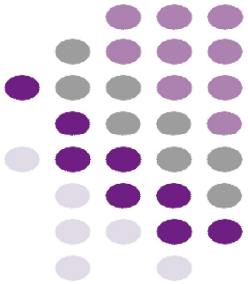
- Must be in the ER by 1:30pm
- Work with various ED attendings and perform assigned tasks from ED attendings.
- Attend all traumas, codes, and procedures possible.
- Log all procedures in New Innovations.
- Residents must have at least 100 hours (or one month) of experience with the care of acutely ill children in the hospital
  and/or emergency setting. This experience should include minimum of 50 emergency department patient encounters with children. For ED encounters to be counted, you must do an "ED assessment." ED assessment note is found under the documents tab and type that you saw/evaluated/treated the patient and the ED doctor involved. This is most important for your ED pediatric visits.

End of year Policies

- Third year residents stop seeing their hospital patients 5 business days before end of residency training.
    - Patients admitted to a current third year, will go to the FPS or their newly assigned PCP.
    - Patients admitted to the FPS, who are reassigned to a current 2nd year will have care taken over by that resident.
    - Patients admitted to the FPS, who are reassigned to a current 1st year will continue to be managed by the FPS until July 1.
    - If current third year resident is scheduled to leave early for fellowship. They will stop seeing their hospital patients 5 business days prior to their scheduled final day of residency).

- Current first years will start to see their own newly admitted patients 5 business days before July 1. (Excludes patients already being cared for by FPS—see above)
    - If patient is admitted prior to 5 business days before July 1st, FPS will continue with patient until July 1st.

Office of Graduate Medical Education
SIU School of Medicine



Work hour logging tips for Residents and Fellows

** Each program has their own set of work hour rules set by their review committee. Be sure to check with your coordinator.

Work Hour Rule	Details	Logging Tips
80 hrs max per week	• wks • hrs off • ***Includes*** -Clinical Activities -Educational Activities -Moonlighting -Clinical work done from home (time on the phone with pts, answering pages, work in EHR etc.) • ***Excludes*** -Studying -Case Prep -Reading -Research	• Work hour logs are an overview of how you spent your day. • You can log in chunks of time such as clinic or education conferences • You are not required to log meetings or other short activities that occur during those times • Lunch hours or time to eat is not excluded from duty hours; lump it in with clinical or educational time • It is important to differentiate between clinical and educational time
Days Off	• 24 hours of free time • One day off in 7 • Averaged over 4 weeks	• You should not have anything logged on these days
Maximum work period	• 24 hours • Plus 4 hours for the following if the patient is already assigned: -providing care to pt -humanistic attention to needs of a patient or family -to attend a unique educational event • Than 14 hours free of all clinical and educational duties	• The additional 4 hours should be logged separately from the 24 hour shift. • Most programs use a "post-call" assignment definition. Check with your coordinator
At Home Call	• Only time in the hospital & clinical duties from home count toward the 80-hour work week • Okay to return to hospital to care for new or know patients, but must count toward 80 hour work week • Cannot interfere with one day off in 7.	• Log only time spent making/answering calls, HALOs, working in EHR, etc. as outlined by your program • Log only time you returned to hospital and duration of time spent doing patient care
In-house Call	• Occurs no more than once every third night • Averaged over 4 weeks	• Use applicable assignment definition set by program you are working with
Night Float	• Counts toward 80 hour work week • Cannot interfere with one day off in 7 • Further specifications from Review Committee may apply	• Use applicable assignment definition set by program you are working with
Transition of Care	• Informing peer of patient care during your work day as you prepare to leave • Time spent counts toward the 80 hour work week	• This time should be logged as part of your clinical time for the day.

SIU SCHOOL of MEDICINE
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Source: https:// www.acgme.org/programs -and -institutions/programs/common -program -requirements/CPRResidency –Effective 7.1.23.pdf

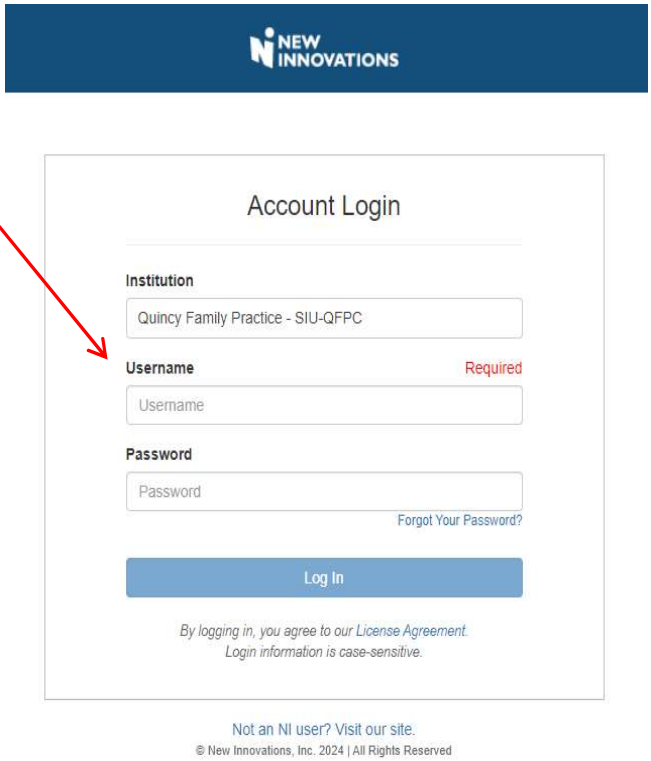
New Innovations

New Innovations is an internet-based system, accessible from any computer connected to the internet. Access the New Innovations login site at **www.new-innov.com/login. The following screen will display:**

Username and password will be provided during onboarding.

Accessing and Signing in to New Innovations

The following screen will display:



- **Enter SIU** in all capital letters in the Institution Login field and select Quincy Family Practice- SIU-QFPC.
- **Username and password are provided during onboarding**. Enter your username and password into those fields, then press enter or click LOG IN. **(Should you encounter problems with signing in contact your program coordinator.)**

The first time you login, you are prompted to change your password. To do this at any other time, **click on CHANGE PASSWORD from the menu (Your Name) at the top right of the page and follow the prompts.**

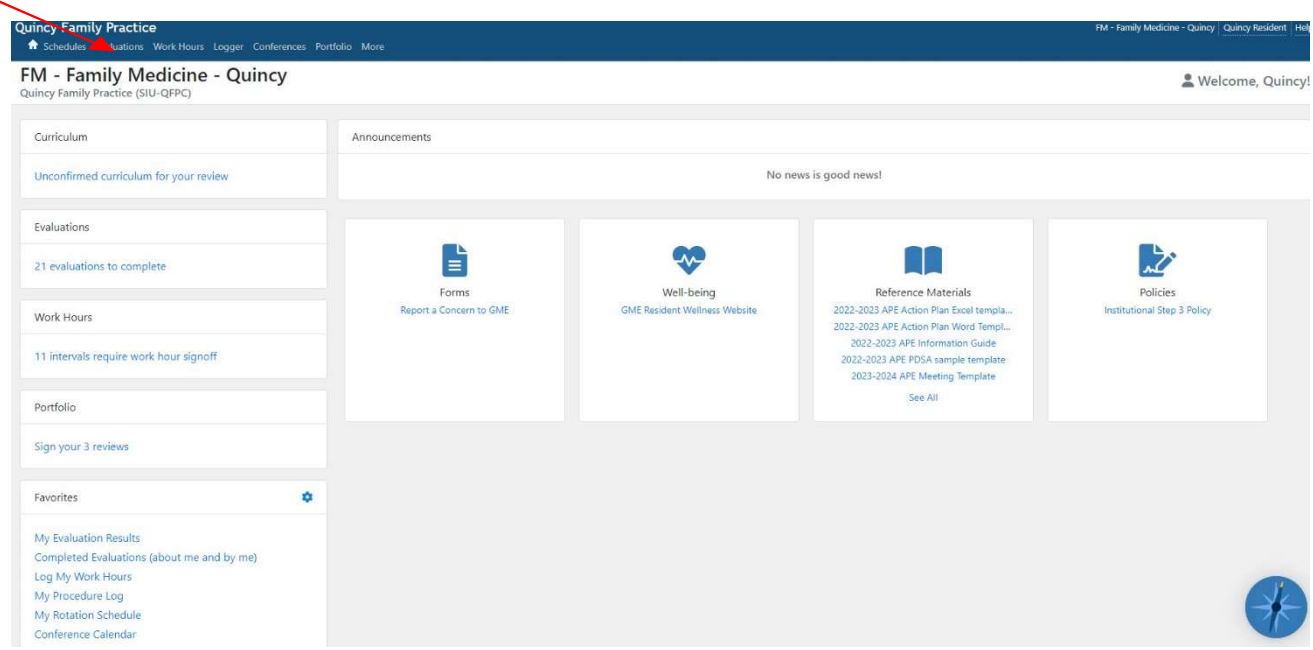
Every time you login to New Innovations you will see a Welcome Page that has links to remind you of different things. For example, if your license is about to expire you will see a reminder there, or, if you have evaluations to complete you will see a note with a link to the evaluation module.

Work hours

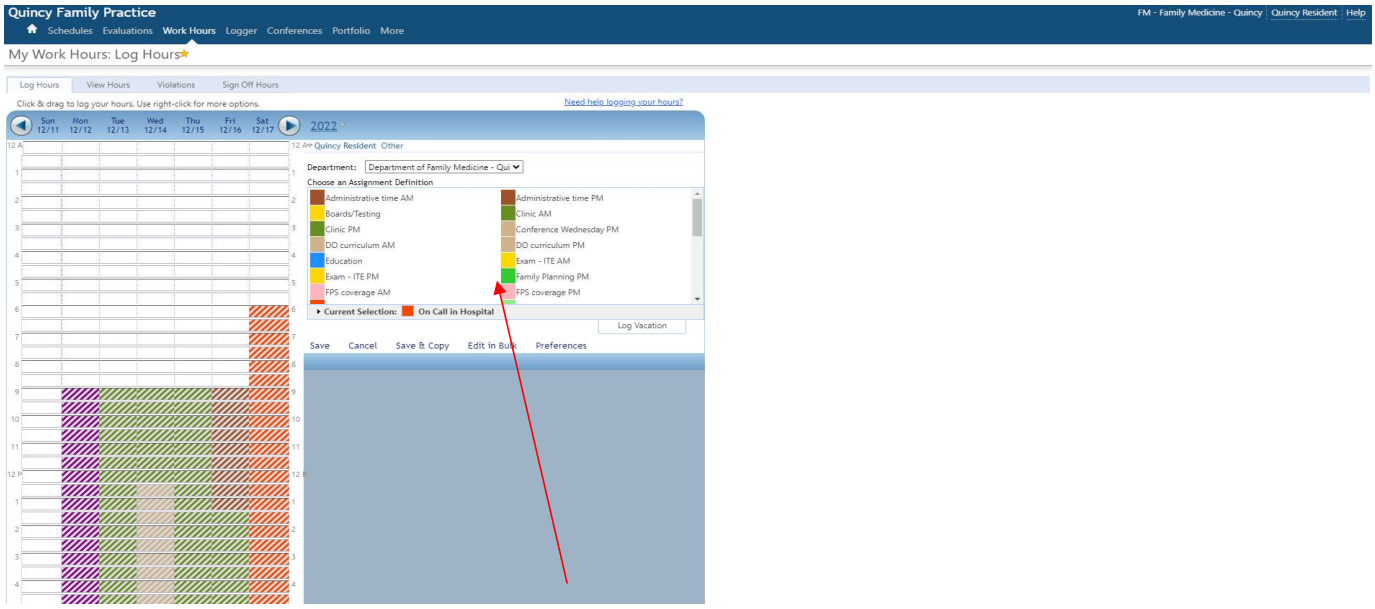
The Work Hours feature of the New Innovations enables residents to log hours worked for each duty or assignment. Think of the Work Hours log as a "time sheet" you use to record the date and duration of the various duties you perform. The logged hours are available for reporting and each entry is checked for exceptions to the ACGME Work Hour rules.

Personal reports are available that display data for only the person running the report. Administrative reports are available to persons with administrative privilege levels and provide access to all personnel within the entities they can access.

Residents and fellows are required to log and sign off on their Work Hours twice each month (the first interval is for the 1st through the 14th of the month; the second interval is for the 15th through the end of the month.) You can access the screen to enter Work Hours by clicking **Work Hours** (from the main menu bar across the top of the screen).



Each Work Hours screen that appears will display the Work Hours menu options at the top (Log Hours, View Hours, Violations, Sign Off Hours).



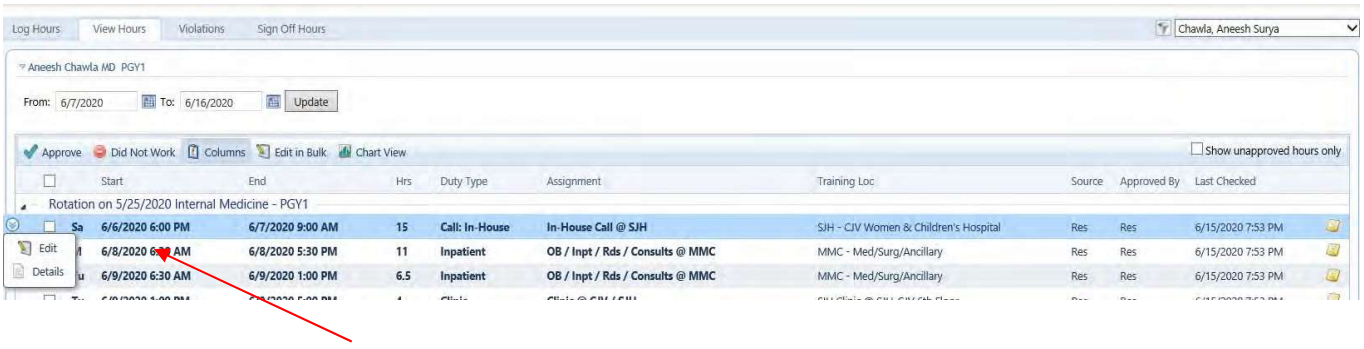
To enter your duty/work hours select what you were doing from the “Choose an Assignment Definition” box. Be sure the corresponding department is listed for the rotation you are on for the time period you are reporting work hours.

Click and hold your mouse button and color in the days and times that you worked on that assignment. Continue coloring in the blocks of time you worked for each assignment that week.
Click the link under the assignments block to save. Then click the right arrow to advance to the next week.

Once entered, to see your hours in a table view you can click the “View Hours” tab on the Work Hour screen:

The screen will expand to include a section similar to this example:

You will have the option to then **Edit** or view the **Comments or Details** for each of these entries. If a resident logs/approves hour, they can delete them. An administrator also has the ability to edit or delete a resident’s entry



By placing your mouse on the left side of an entry and clicking you will see new options appear that allow you to edit, delete or view details of an entry. You may also enter comments about a particular entry by either selecting details for the entry or by clicking on the yellow paper icon that appears to the right of each entry.

**This will be used for violation comments.
To approve your entries simply click the check box to the left of the entry or at the top for all entries, then click the word Approve.

NOTE: Work Hour entries for dates in the future can be entered but MUST be edited and approved!

- A red asterisk * next to an entry indicates that it conflicts/overlaps with one or more other entries. These entries **CANNOT** be approved until the conflict is resolved. ***The entries must be edited to fix the date or times to eliminate the conflict.***
- The **Source** column indicates where this entry originated. "Admin" identifies an administrator entering this item from within the Work Hour application. "Res" indicates that it was entered manually by the Resident. "Sched" identifies the source as the Assignment Scheduling feature (cross population) of the software. (We are not currently using Assignment Scheduling.)
- Entries **highlighted in red** indicate a violation of one or more of the Work Hour Rules. Entries highlighted in red are NOT conflicts or errors. They do not need to be "corrected" and **can be approved**. The red highlighting is simply used to draw attention to entries that violate the ACGME Work Hour rules. Verify that you have entered the information correctly and if the data is correct go ahead and approve those hours. To determine which Work Hour rule was violated you can click the **Details** link at the right side of the line. **ALL** violations must have an explanation comment entered. Work hour exceptions could include: to continue to provide care to a single severely ill or unstable patient or humanistic attention to the needs of a patient or family.

Previously entered Comments can be edited as well by clicking either on the **Edit** link or **Comments** links shown above. Only the person who entered a comment can edit it (i.e. an administrator cannot edit a resident's comment), but either the resident or the administrator can add new comments.

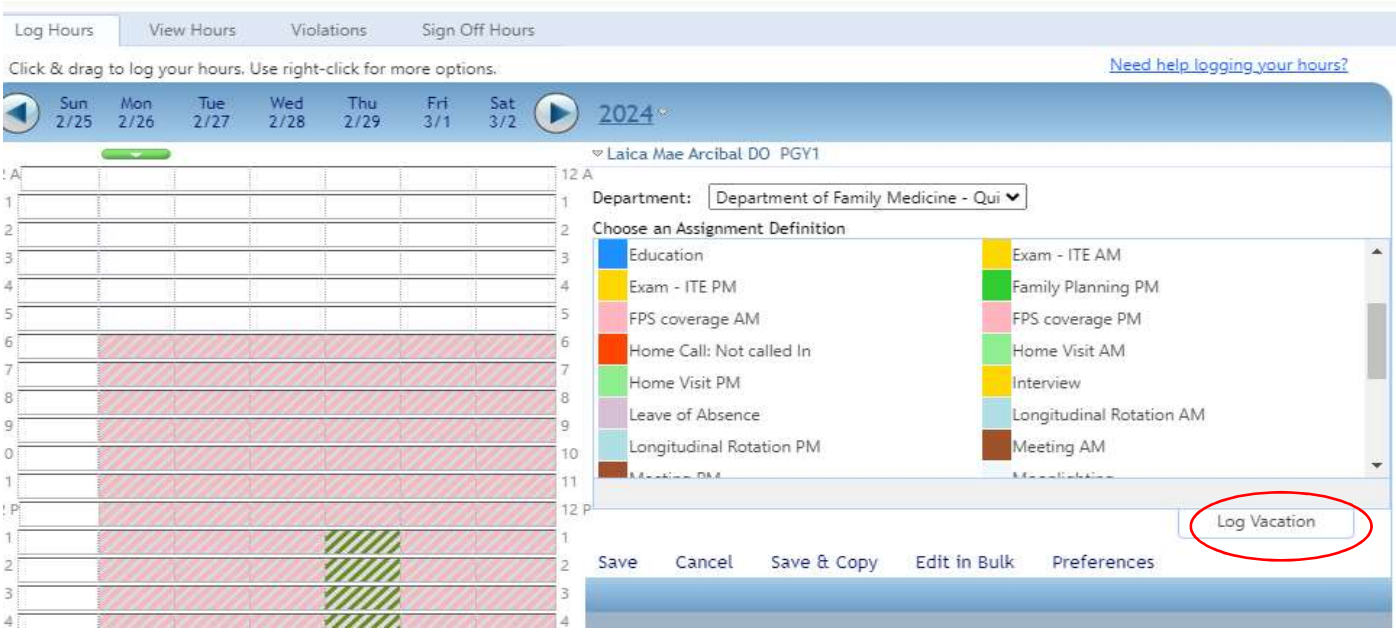
Sign Off:

In order to confirm that all Work Hours for any given interval have been entered and that those entries are correct each resident must Sign Off on their Work Hours. First you must Approve the Work Hour entries and resolve any conflicts, then you must choose the **Sign Off Hours** option at the top of the screen:

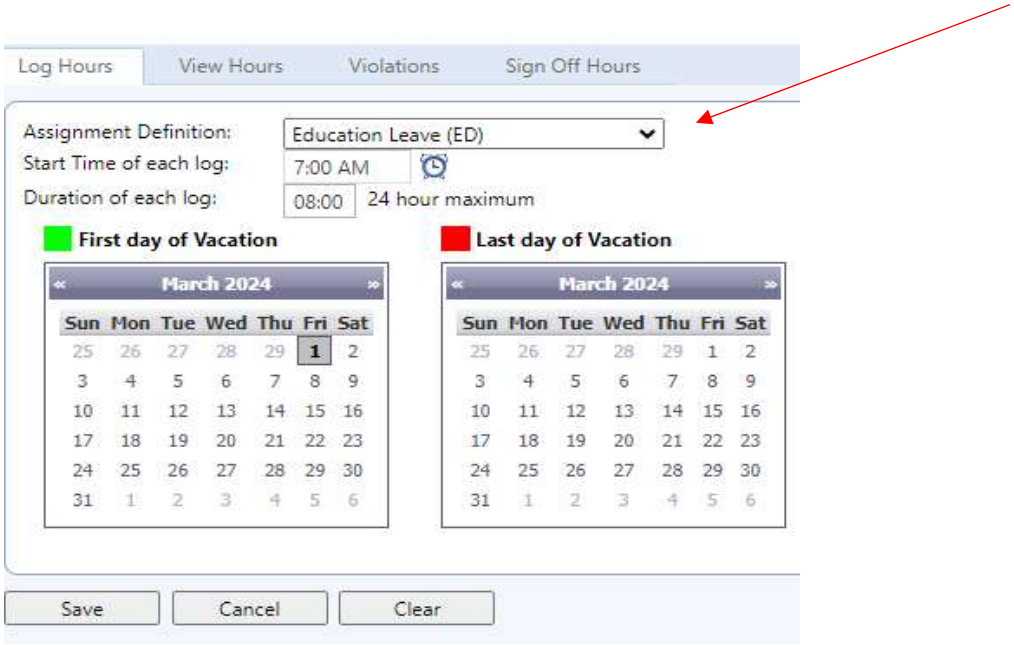
Once you click the Sign Off option the following screen will display and you can check the box then click **Sign Off. **Once you sign off on your hours, you will no longer be able to edit those hours.**

Entering PTO Time (Vacation, Sick, Bereavement, Education, etc.)

The ACGME has implemented special rules for how vacation, sick, and other leave times are handled within the Work Hour rules. If you need to log a PTO time or some other leave time you will do so using the **Log Vacation** option available on the Work Hour entry screen.



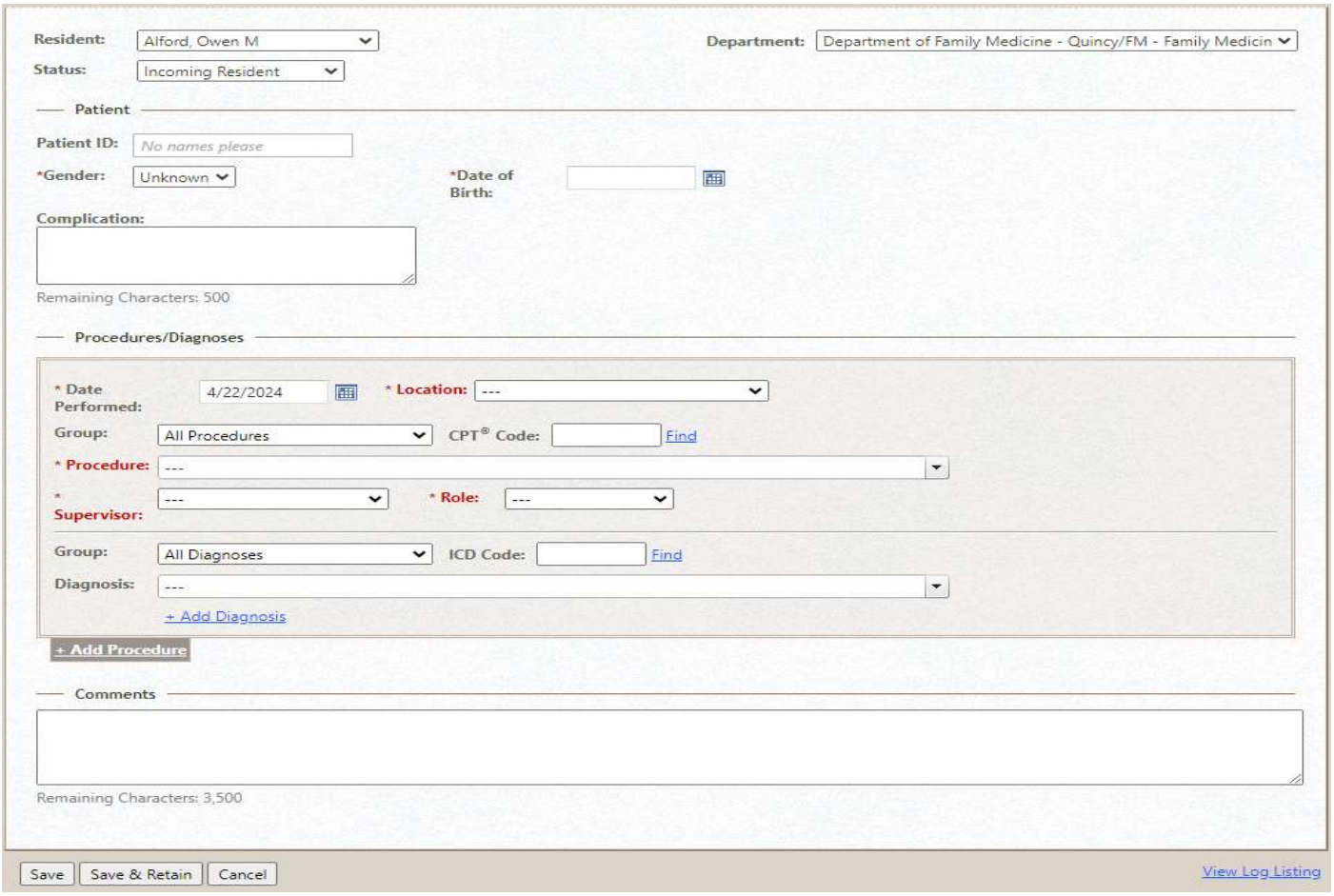
Selecting the Log Vacation option will display the following screen where you will simply indicate the type of leave and the starting and ending dates for the leave, then click **Save**



Procedure logging

After logging into New Innovations
Select the Logger tab
From the list, select Procedures

Enter the patient's MRN, Gender, DOB, and all fields marked with an *.
Use the + Add Procedure link at the bottom is you have more than 1 procedure to add.
Select Save & Retain

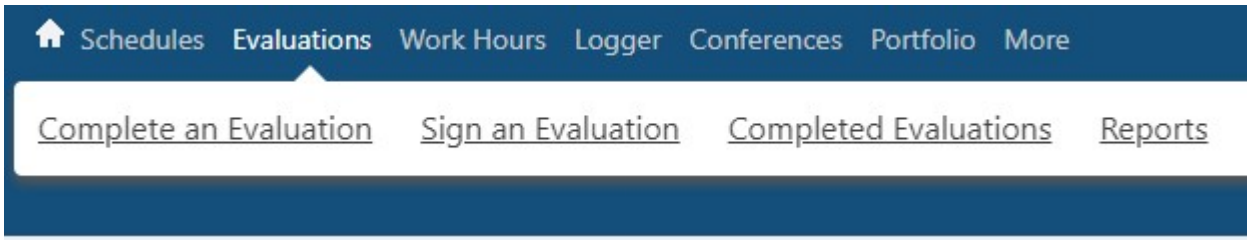


To view your list of procedures, select tab called View. You may use the Filters tab in this section to count the specific procedures in each category
Note There are tons of things you could log under “Other”. An unlogged procedure will only be missed if you have not listed it. It's better to get it counted than lost!

Evaluations

Evaluation completion

Select Evaluations
Select Complete an Evaluation
Each block should have 1 evaluation to complete about the rotation. Quarterly there will be a continuity clinic rotation evaluation to complete
THIS IS MANDATORY TO COMPLETE at the end of your block.



View evaluations
Select Evaluations
Select Completed Evaluations
Check mark ones you want to see and click on View selected evaluations

Appendix

Appendix A

SIU SCHOOL of MEDICINE	Name of Policy: **Southern Illinois University and Affiliate Hospital Policy on Patient Care Activities and Supervision Responsibilities for Graduate Medical Education Trainees and Attending Physicians**	
	Last Approval Date: **August 7, 2020**	Effective Date: **July 1, 2020**

Purpose

The purpose of GME is to provide an organized educational program with guidance and supervision of the trainee, facilitating the trainee's ethical, professional and personal development while ensuring safe and appropriate care for patients.

This policy will establish the minimum requirements for trainee supervision in clinical sites in which SIU School of Medicine residents and fellows train. An affiliated hospital or clinical site may have additional requirements for supervision as they pertain to that specific hospital. Individual training programs may also have additional requirements for their faculty/attendings and trainees.

Section I. Definitions

Trainee: A physician who participates in an approved Graduate Medical Education (GME) program. This term includes interns, residents and fellows in any GME program approved by the SIU GMEC, regardless of ACGME accreditation status.

Attending Physician: A licensed, independent practitioner who holds admitting and/or attending physician* privileges consistent with the requirements delineated in the bylaws of the affiliated hospital and/or SIU School of Medicine.

Full Time Faculty: An attending physician who is employed by SIU School of Medicine.

Community Faculty: An attending physician who is not employed by SIU School of Medicine, but has been granted privileges to teach and supervise residents by the individual residency program.

*Occasionally, supervision is provided by a licensed, independent practitioner from a discipline other than medicine (i.e. midwives, dentistry/oral surgery, etc.). Supervision standards and expectations are the same as for Attending Physicians.

Section II. Program Responsibilities

It is the responsibility of individual program directors to:

1. Approve the selection and ongoing participation of teaching faculty at all teaching sites. (whether Full Time or Community).

2. Monitor resident supervision at all teaching sites.

3. To promote appropriate resident supervision while providing for graded authority and responsibility, ensure that the program uses the following classification of supervision:
    - Direct Supervision:
        - A. The supervising physician is physically present with the resident during the key portions of the patient interaction: OR
        - B. The supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
    - Indirect Supervision:
        - The supervising physician is not providing physical or concurrent visual or audio supervision, but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.
    - Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

    PGY-1 residents must initially be supervised directly as described in Section II.3.A.

    Telecommunication technology may be utilized to provide supervision only when it is appropriate to the situation, permitted by specialty/subspecialty Program requirements and in compliance with by-laws and protocols of the clinical site providing the patient's care.

4. Establish and implement protocols describing:
    - When the physical presence of a supervising physician is required
      How PGY-1 residents are determined to have met a level of competence sufficient to progress to direct telecommunication supervision and/or indirect supervision.

5. Ensure that faculty supervision assignments are of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility.

6. Establish written policies describing trainee roles and responsibilities at each level of training for their residency programs.

7. Establish written policies on how residents are determined to have met a level of competence in specific procedures sufficient to perform that procedure in the absence of direct supervision. (See Section V.)

8. Ensure that these policies are in compliance with requirements of the ACGME, GMEC,

the Joint Commission, CMS and the by-laws of affiliated hospitals, and are reviewed at least annually.

9. Establish a written program-specific supervision policy consistent with this institutional policy and the respective ACGME Common and specialty/subspecialty-specific Program Requirements. (See Appendix A)

10. Review annually the program supervision policy to ensure that it is in compliance with accrediting agency standards for both graduate medical education and for all training sites.

11. Ensure that all attending physicians (whether full time or community faculty) are educated annually regarding appropriate supervision standard requirements, physical or telecommunication presence requirements and documentation requirements.

12. Ensure that residents/fellows can report inadequate supervision in a protected manner that is free of reprisal.

13. Establish written policies describing the program requirements for promotion to the next level of training and evaluate each residents abilities based on specific criteria, guided by Milestones. The program director, with input from the program's Clinical Competency Committee, will determine at least annually whether each resident has progressed satisfactorily to advance to the next level of training and/or demonstrated the skills necessary to supervise junior residents.

Section III. Medical Staff Responsibilities

In all clinical sites participating in GME training, the medical staff has a defined process for supervision of each trainee in carrying out patient care responsibilities. Such supervision will be provided by an attending physician with appropriate clinical privileges with the expectation that the trainee will develop into a practitioner who has the knowledge, skills, experience and abilities to provide care to patients within the scope of their training program.

The medical staff has overall responsibility for the quality of the patient care provided by individuals with clinical responsibilities. In this way, the medical staff assures that each participant in a GME program is supervised in their patient care responsibilities by a member of the medical staff who has been granted clinical privileges through the appropriate medical staff process.

Section IV. Attending Physician Responsibilities

The supervising attending is ultimately responsible for the care of the patient who is under their plan of treatment. The level or type of supervision required by trainees in various levels of training must be consistent with progressively increasing resident responsibility during a training program as well as ACGME supervision requirements and common standards of patient care, based on the needs of the patient and the skills of the trainee.

The degree of attending involvement in patient care will be commensurate with the type of care that the patient is receiving and the level of training, education and experience of trainee(s) involved in the patient's care. The intensity of supervision required varies by specialty, level of training, the experience and competency of the trainee, and the acuity of the specific clinical situation. An attending physician may provide less direct personal care of a patient seen for routine care or when supervising a senior trainee, and should provide more direct personal care of a patient receiving complex care or when supervising a junior level trainee. An attending physician may authorize the supervision of a junior trainee by a more senior trainee who is receiving supervision based on the attending physician's assessment of the senior levels trainee's experience and competence, unless limited by regulation.

All patients seen by the trainee will have an assigned attending physician. At a minimum the attending physician is expected to:

1. Exercise responsibility and control over the care rendered to each patient by a trainee.
2. Document the degree of participation in patient care in accordance with CMS, the Joint Commission and hospital/clinic policies.
3. Effectively role model safe, effective, efficient and compassionate care and provide timely documentation to program directors for their use in trainee assessment and evaluation.
4. Be knowledgeable of the individual program policies and procedures regarding resident supervision, assessment and advancement as outlined in Section II.
5. Provide timely feedback to the resident regarding their clinical interaction with the patient.

Section V: Procedures

Residents will be supervised by attending physicians who must be credentialed in that setting or hospital for the specialty care and diagnostic and therapeutic procedures for which they are providing supervision.

Each program should establish written policies determining the level of competence for specific procedures sufficient to perform that procedure in the absence of direct supervision (i.e. resident procedural autonomy). These policies should include the criteria by which the program will determine that the resident has successfully completed the procedure, the level of training in which residents are expected to achieve competency in doing each procedure, whether the procedure requires direct supervision or indirect supervision, and the method by which the resident will receive feedback about the procedure that communicates general competency strengths and areas needing improvement. In addition these policies should describe the process the CCC uses to:

- Assess and document an individual resident's achievement of competence to perform a procedure without direct supervision
- Assess and document an individual resident's maintenance of competence over time
- Ensure that residents who have been given clearance to perform a procedure without direct supervision know when they must involve their attending or senior resident (i.e. pt acuity, etc.)

At least annually, for any given resident, each program should identify or define the procedures for which the resident has been adjudged by the CCC to be capable of performing in the absence of direct supervision, and make this information available to the clinical care team(s) at all major clinical sites.

Section VI: Supervision of Trainees in the Inpatient Setting

The attending physician or provider has the primary responsibility for the medical diagnosis and treatment of the patient. Trainees may input daily orders on inpatients. These orders will be implemented without the co-signature of a staff physician. It is the responsibility of the resident to discuss their orders with their senior resident or attending staff physician as appropriate. Attending staff may input orders on all patients under their care. Trainees will follow all local hospital policies regarding verbal, telephonic and electronically entered and written orders.

The attending physician on the *primary s*ervice will personally see all hospitalized patients at least once daily.

The attending physician on *consultative services* will personally see patient for initial consultation within the specified time frame (usually 24 hours) and thereafter frequently enough to ensure safe and appropriate patient care, until the time of sign-off. When patients are acutely unwell, and/or the trainees are junior or off-service learners, this may necessitate daily attending visits.

The attending physician will, at a minimum:

1) Examine the patient within 24 hours of admission, when there is a significant change in patient condition or as required by good patient care.
2) Review the patient's history, the record of examinations and tests, and make appropriate reviews of the patient's progress.
3) Confirm or revise the diagnosis made by the trainee and determine major changes in the course of treatment to be followed.
4) Either perform personally the physician services required by the patient or supervise the treatment so as to assure the appropriate services are provided by trainees and that the care meets the proper quality level.
5) For surgical or other complex, high risk medical procedures, the attending physician must be immediately available to assist the trainee who is under the attending physician's direction.
6) Make decisions to authorize or deny any admissions, discharges or transfers.
7) Sign all DNR orders, or document appropriate involvement in the decision.
8) Assure that a properly completed, signed and witnessed consent form is obtained and placed in the patient's record prior to the performance of any operative or invasive procedure.
9) Assure that supervision of care for inpatients is documented in the patient record. It is the attending physician's responsibility to see that all documentation must be in accordance with appropriate regulations and the standards of good patient care and must provide evidence in writing of supervisor concurrence with the admission, history,

physical examination, assessment, treatment plan and orders.

10) Document appropriate attestation and/or sign all residents' notes in EHR.

Section VII: Supervision of Trainees in Outpatient Clinics

All outpatient visits provided by trainees will be conducted under the supervision of a staff provider who has full responsibility for the care provided. The extent and duration of the attending's physical presence will be variable, depending on the nature of the clinical situation and the level of training and capabilities of the trainee. The responsibility or independence given to trainees depends on their knowledge, skills and experience as judged by the responsible attending physician. The attending physician supervisor must be designated and be available in accordance with all ACGME institutional and program requirements and CMS standards and specific departmental policies.

Section VIII: Supervision of Trainees in the Emergency Department

All trainees within the Emergency Department must be under the supervision of qualified emergency medicine attendings. When residents from other services provide care to patients in the emergency department, they must be supervised by emergency medicine attendings or by faculty from their service.

Section IX: Supervision of Trainees in the Operating Room

The attending physician must be present in the operating room for the key or critical portion of all cases and must remain in immediate proximity and available to return to the procedure immediately if needed. ("Immediate proximity" is generally defined as within the OR Suite and immediately available to return to the operating room if needed). If the attending physician leaves the OR Suite after the completion of the key portion of the procedure or another case would prohibit them from returning to the original case, the attending physician must make arrangements with another physician to be immediately available for the original case.

It is the attending surgeon's responsibility to obtain written informed consent that is in compliance with all CMS, the Joint Commission and hospital regulations, including the role of the resident/fellow in the surgery or procedure.

Section X: Supervision of Trainees in Labor and Delivery

Supervision of labor and delivery must be immediately available. When risk factors are present there must be on-site supervision. If this supervision is provided by anyone other than an attending physician, there must be documentation of the skill of the non-attending physician supervisor to function competently in this capacity. Backup plans or emergency consultative arrangements must be made in case the supervising provider encounters a clinical situation or emergency outside of the scope of their practice.

Section XI. Supervision of Trainees via Telehealth

Resident supervision via Telehealth must meet all of the parameters outlined in this document and be consistent with current protocols as outlined by the SIU Medicine Office of Telehealth Services and the Office of Compliance and Ethics

Section XII: Oversight of Supervision

Any trainee, attending, or staff member will have the opportunity to report instances of inadequate supervision in a protected manner that shall be free from reprisal. Concerns about inadequate supervision may be received via a number of mechanisms, including:

- Verbally, to program director, DIO or SIU HC CMO
- Via the Patient Safety reporting mechanism at the site at which the event occurred
- Via the Office of Graduate Medical Education website
- Via the CMO/CPE at site at which event occurred, following a critical incident, RCA or verbal or written report

Inadequate supervision will not be tolerated. Any instance of inadequate supervision that involves direct patient care will be addressed promptly, utilizing the existing policies, protocols and systems in place for standards of physician conduct at the clinical sites. Information will be shared between the clinical site and SIU SOM personnel (Department Chair, Human Resources staff, Program Director, DIO, etc.) as necessary and as allowed by law and by affiliation agreements to ensure that inadequate supervisory behaviors are addressed and resolved.

Any instance of inadequate supervision that does not involve direct patient care (i.e. unclear supervisory expectations, sub-par learning environment, etc.) will be addressed by the program director.

Supervision by SIU SOM faculty

If an instance of inadequate supervision by a SIU SOM faculty member occurs at a hospital site, it will be addressed utilizing the existing policies, protocols and systems in place for standards of physician conduct by the hospital. The SIU HC Chief Medical Officer will liaise with the hospital CMO/CPE to coordinate the most appropriate manner to address the behavior and to ensure that the appropriate SIU SOM personnel are informed of the resolution. Whenever possible, feedback given to SIU GME personnel will be confidential or in aggregate.

If an instance of inadequate supervision occurs at an SIU HC clinic, it will be addressed via SIU HC standards of conduct under the direction of the SIU HC CMO.

Supervision by SIU senior residents

Any instance of inadequate supervision by a senior resident will be addressed by the Program Director, who will work in conjunction with the hospital CMO/CPE to coordinate the most appropriate manner to address the behavior and to ensure that the appropriate SIU SOM personnel are informed of any resolution.

Supervision by community faculty

If an instance of inadequate supervision by a community faculty member occurs at a hospital site, it will be addressed utilizing the existing policies, protocols and systems in place for standards of physician conduct by the hospital. The hospital CMO/CPE will work in conjunction with the Program Director or DIO to coordinate the most appropriate manner to address the behavior and to ensure that the appropriate SIU SOM personnel are informed of any resolution.

The Sponsoring Institution must ensure that each of its ACGME-accredited programs establishes a written program-specific supervision policy. Each programs' supervision policy must:

1) Be consistent with the institutional policy and the respective ACGME Common and specialty/subspecialty-specific Program Requirements. (IR IV.1.2~~s~~)
2) Outline the process and standards-based criteria by which 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. (CPR VI.A2d-d3)
3) Set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions. (CPR VI.A.2.e). These circumstances and events must include, at a minimum:
    - Patient admission to hospital (may restrict to unplanned if applicable)
    - Patient death (may restrict to unexpected if applicable)
    - Patient signs out AMA or other unplanned discharge
    - Transfer of patient to higher level of care (i.e. floor to IMC, IMC to ICU, etc.)
    - Medication/treatment error requiring intervention
    - Patient experiences an adverse outcome regardless of cause
    - End of Life decisions or DNR orders
    - Patient requires intubation or ventilatory support (may restrict to unplanned if appropriate)
    - Patient codes or Rapid Response Team is called and results in transfer to higher level of care or change in treatment plan
    - Significant change in clinical status (should expand per specialty)
    - Any clinical problem requiring an invasive procedure or surgery (may restrict to not previously discussed with attending if applicable)
    - When requesting a consultation not previously discussed
    - Family, legal or systems issues
    - Any resident or fellow uncertainty about the patient's care plans or goals
    - Residents must communicate with the RPD (or DIO) the following:
        - Feels uncomfortable or unsure of their ability to perform a procedure or patient care activity with the level of supervision provided
        - Situations in which they feel their safety is threatened

- Situations in which they personally feel impaired or witness others working while impaired
- Perceives that patient safety is at risk

4) Outline the circumstances and timeframe in which the attending must be contacted (i.e. immediately, the next morning, etc.) when residents are supervised indirectly (i.e. week-ends, ED, or consults).

Appendix B

Policy Title:	Institutional Policy for Clinical and Work Hours (Including Fatigue Mitigation)
Owner:	
Department:	GME
Origination Date:	06/21/2019
Last approved date:	12/15/2023
Approved By:	

I. Scope

This policy was developed for SIU Medicine. SIU Medicine collectively applies to the SIU School of Medicine (SIU SOM), including the Federally Qualified Health Center (FQHC), and SIU HealthCare (SIU HC). These entities are collectively referred to as SIU in this document.

This document applies to SIU staff, faculty, trainees, agents, officers, directors, interns, volunteers, contractors, and any other individual or entity engaged in providing teaching, research and health care items and services at SIU. These individuals are collectively referred to as SIU personnel in this document.

II. Definitions

The term "resident" is inclusive of all trainees at SIU School of Medicine, whether training in a residency or fellowship program

III. Purpose

Individual programs, in partnership with the institution, will design effective program structures that provide trainees with meaningful educational and clinical experiences as well as reasonable opportunities for rest and well-being. The Graduate Medical Education Committee (GMEC) oversees programs' clinical and educational work hours and ensures that individual training programs are in compliance with all ACGME Common Program Requirements and Residency Review Committee clinical and educational work hour requirements.

IV. Procedure

This policy shall apply to residents in both accredited and non-accredited training programs.

a. Individual Responsibilities
    i. Residents and faculty members have a professional responsibility to:
        1. Appear for work appropriately rested and to manage their time before, during and after clinical assignments to prevent excessive fatigue.
        2. Recognize the signs or symptoms of fatigue in themselves or others, and to notify the program director or other appropriate supervisor if they or a colleague are too fatigued to provide safe care.

ii. Residents have a professional responsibility to report clinical and educational work hours accurately, honestly and in a timely manner.

b. Program Responsibilities
   i. Programs must:
      1. Structure schedules which focus on the needs of the patients, continuity of care, and the educational needs of residents, while giving attention to work intensity and work compression that impacts resident well-being.
      2. Educate all residents and faculty members to recognize the signs of fatigue and sleep deprivation.
      3. Educate all residents and faculty members in alertness management and fatigue mitigation processes.
      4. Encourage residents and faculty members to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care, learning, and well-being.

   ii. There are circumstances in which residents may be unable to work, including but not limited to fatigue, illness, family emergencies, and parental leave. Programs must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.

   iii. Each program must have policies and procedures in place to allow an appropriate length of absence for residents unable to perform their patient care responsibilities, to ensure coverage of patient care, and to implement these policies without fear of negative consequences for the resident.

c. Sponsoring Institution Responsibilities

   i. The Sponsoring Institution will oversee:
      1. Resident clinical and educational work hours, and address areas of noncompliance in a timely manner.
      2. Programs' learning and working environments, and systems of care to facilitate fatigue mitigation.
      3. Programs' educational endeavors for residents and faculty members in fatigue mitigation.
         a. Fatigue education for incoming residents and new faculty is delivered directly by the Office of Graduate Medical Education.

   ii. The Sponsoring Institution will ensure that:
      1. Adequate sleep facilities and safe transportation options are available for residents who may be too fatigued to return safely home.

2. Work that is extraneous to their educational goals and objectives is minimized, and that their educational experience is not compromised by excessive reliance on residents to fulfill non-physician service obligations.

d. Resources
   i. SIU SOM Brochure "Fatigue: How to Recognize It, How to Manage It"
   ii. The Office of Graduate Medical Education (OGME) has an online module that is available to anyone that wishes to take the course or the program identifies as needing additional training. Contact OGME staff for Brochures or to register for course.

V. References

VI. Attachments

VII. Periodic Review

VIII. Reviewed by

IX. Office of Responsibility
GME

Institutional Policy for Clinical and Work Hours

Appendix C

SIU Quincy Family Medicine Duty Hour Policy

The SIU Quincy Family Medicine Residency Program recognizes that resident education is maximized by a balance between patient care, programmatic education, and self-study. Additionally, for resident well-being, adequate time must be provided for rest and attention to personal needs. Duty hours are defined as all clinical and academic activities related to the residency program, i.e. patient care (both inpatient and outpatient), administrative duties related to patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site. The program utilizes the definitions of duty hours as stated on the acgme.org site.

- Duty hours are limited to 80 hours per week averaged over four weeks, including all moonlighting and time at the hospital during at home call. There is no In house call.
- Residents have an average of one day in seven free from all educational and clinical responsibilities. Usually two weekends off for each four-week block. During the Emergency Medicine block residents receive one day off each week.
- Residents maximum scheduled work period is 14 hours. See home call below.
- For at home call, time in the hospital (actively engaged in patient care) counts toward the eighty hour limit. At home call is not subject to every third night limitation but the resident must be off one day every week averaged over four weeks. The resident may return to the hospital to care for new or established patients. This time is included in the eighty hour limit but does not initiate a new "off duty" period.

Duty hours will be monitored in the following ways:

- Routine review at Director and Chief Resident Conferences.
- Regular evaluation in New Innovations.
- The chief resident will review/investigate any reported concerns from New Innovations and/or Duty Hour Incident Form and report programmatic issues to the faculty. Program changes will be made if needed.
- Institutional evaluation.
- As needed if signs of resident fatigue are noted.

Amended: July 2011; update 07182012, January 31, 2016, update May 22,2017

Strategies for Mitigating Fatigue

Pre-duty

- Avoid starting out with a sleep deficit
  - Get 7 – 9 hours of sleep before starting call or night float
  - Avoid stimulants to keep you up
  - Avoid alcohol to help you sleep
  - Avoid heavy meals within 3 hours of sleep

On Duty

- **If you are too fatigued to be safe – tell your supervisor or program director**
- Know your own vulnerability to fatigue
- Nap whenever you can
  - The best circadian window is between 2:00–5:00 pm and 2:00–5:00 am
  - The most effective naps are less than 30 minutes or more than 2 hours
- Avoid heavy meals
- Strategic consumption of caffeine (the T 1/2 is 3-7 hours)

Post Duty

- Alertness is lowest 6:00 am – 11:00 am.
- 20 minute nap or a cup of coffee 30 minutes before driving
- If the sun is shining, wearing sunglasses on the way home will make it easier for you to fall asleep when you get home
- If a resident is too fatigued to drive safely, take a taxi/car service and send or bring the receipt to the Office of Graduate Medical Education for reimbursement.

Resident and Patient Safety – A Shared Responsibility

It is the responsibility of programs and institutions to educate Faculty and Residents

⇒ To recognize the signs of fatigue and sleep deprivation

⇒ In alertness management and fatigue mitigation processes

⇒ Adopt fatigue mitigation processes

⇒ Have a process to ensure patient care if a resident is too tired to do so

⇒ Provide adequate sleep facilities and/ or safe transportation options for residents who are too fatigued to drive home

It is the responsibility of residents and faculty to:

⇒ Manage their time before, during and after clinical assignments to assure their fitness for duty

⇒ Recognize fatigue in themselves and their peers

⇒ Responsibly utilize fatigue mitigation strategies

FATIGUE:

How to Recognize It

How to Manage It

This brochure contains a brief review of the signs of fatigue and alertness management strategies.

It's up to all of us to ensure a culture that promotes **patient safety and personal responsibility**.

To that end, all clinicians have a responsibility to manage their time before, during and after clinical assignments to assure their fitness for duty and to recognize when they are **becoming fatigued**.

If you would like to have access to a more detailed web based course, please contact Annelisa Herter at 545-3134.

Office of Graduate Medical Education (OGME)
SIU School of Medicine
Pavilion 3A158

Sleep Requirements

- Most adults require between 6 to 10 hours of sleep per 24 hour period.
- With less than 5 hours per night of sleep, mental abilities begin to decline.
- Cognitive performance may decrease as much as 25% from baseline after 1 night of missed sleep and 40% after 2 nights.
- Sleepy people underestimate their level of sleepiness and overestimate their alertness.
- The sleepier one is, the less accurate the perception of the degree of impairment.

Effects of Sleep Loss

- Decline in performance after 15-16 hours of continued wakefulness
- Shortened sleep latencies
- Micro sleeps that cause lapses in attention
- Impaired memory and confusion
- Difficulty focusing on tasks
- Errors of omission
- Errors of commission
- Learning and recall deficits
- Moodiness, depression and irritability

Dec 2023

Warning Signs of Sleepiness

In yourself (For Individuals)

⇒ Falling asleep in conferences
⇒ Difficulty focusing
⇒ Having to check your work repeatedly
⇒ Feeling confused or forgetful
⇒ Feeling irritable
⇒ Apathy

In others (For Supervisors)

⇒ Nodding off
⇒ Closing eyes during rounds
⇒ Makes errors on presentations
⇒ Appears irritable
⇒ Appears forgetful or confused

Sleep Rooms

There are sleep rooms available at all hospitals for residents. Springfield Program Coordinators are provided with the room number(s) and code(s) for entry, if applicable. Residents should find out where their designated sleep room is and how to gain entry prior to being on night duty. If specific information on Springfield sleep rooms is needed, Betty Jones (OGME) can also be contacted from 8 a.m. – 4:30 p.m. at 545-8996. Affiliate residents should contact their Chief.

Safe Driving

Sleepiness causes variability in those attentive and cognitive functions which require executive attention processes. Driving is especially vulnerable to sleep deprivation because it requires rapid responses and sustained attention. **The period of lowest alertness after being up all night is between 6:00 am and 11:00 am, when many residents are driving home.**

Drowsy Driving

How to Recognize It

⇒ Trouble focusing on the road
⇒ Nodding off
⇒ Yawning
⇒ Difficulty keeping your eyes open
⇒ Drifting from your lane
⇒ Not remembering driving the last few miles
⇒ Closing your eyes at stop lights

How to Avoid It

⇒ ***AVOID driving if drowsy***!
⇒ **If you are really sleepy, get a ride home or take a taxi or car service, i.e. uber***
⇒ Take a 20 min nap before driving home
⇒ Stop driving if you notice the warning signs of sleepiness—pull off the road at a safe place, take a short nap
⇒ Drink a cup of coffee 15-30 minutes before driving home (trade-off: this will make it harder to sleep when you get home)

*** For residents – keep your receipt and OGME will reimburse you**

Appendix E

SIU-Quincy External Moonlighting Policy

Only PGY-2 and PGY-3 residents, and fellows, in good standing with the residency program/fellowship program are allowed to request permission to pursue moonlighting opportunities. You are encouraged to discuss this with your faculty advisor and the program director before formally requesting privileges to do so. Moonlighting is a privilege that can be withheld or rescinded at any time by the Program Director, SIU, or Blessing Hospital.

If a resident/fellow wishes to request approval to moonlight, there is a process and the request must be approved by the Program Director and Blessing Hospital. All requests to moonlight must be made in writing using the Moonlight Request Form and the form should be accompanied by the following documentation:

- Proof of current personal malpractice coverage in required indemnity limits (for example: "…at least $1,000,000 per occurrence / $3,000,000 annual aggregate on an occurrence basis…") for Blessing Hospital. The resident is responsible for requesting this information from the desired facility and providing their own malpractice insurance, if necessary.
- Copy of current full unrestricted Iowa, Illinois and/or Missouri medical license
- Copy of current Iowa/Illinois Controlled Substance License and/or MO BNDD Registration
- Copy of logged duty hours, including moonlighting hours, in New Innovations for the previous month
- Copy of current certificate reflecting personal DEA number for the state in which moonlighting will occur
- Copy of the proposed monthly schedule for the facility you plan to moonlight

If a resident/fellow requests the opportunity to moonlight, then the resident/fellow certifies that they understand and agree to the SIU School of Medicine policy and the following:

- Moonlighting should not be considered as "approved" unless approval is given in writing by the Program Director and Blessing Hospital.
- Residency/fellowship training is top priority and moonlighting activities must not conflict with residency/fellowship education.
- Moonlighting will not be considered an excuse for poor job performance, absenteeism, tardiness, early departure, refusal to travel, work different hours, or accept additional assignments.
- Residents/fellows will not moonlight during residency/fellowship work hours, while they are on medical/sick leave, or while they are on call (during the week or the weekend).

- The Program Director will be notified of any changes, corrections or additions to moonlighting place, schedule, duties, or total work hours. Additional moonlighting sites require additional approval.
- Moonlighting privileges may be revoked if difficulties with learning, performance, patient care, fatigue or other issues arise.
- Residents/fellows agree to "check in" more frequently with their advisor, Program Coordinator, or Program Director to assess their wellbeing. Moonlighting takes a toll.
- Time spent moonlighting must be counted toward the 80-hour Maximum Weekly Hour Limit, as required by the ACGME.
- Moonlighting is outside the course and scope of the residency training program and will not count towards completion of residency.
- Residents are responsible for accurately recording all moonlighting duty hours in New Innovations tracking system. Failure to do so may result in corrective action and
- Life support certifications must be current.

*The residency program follows all rules and policies pertaining to resident moonlighting for both the SIU School of Medicine's "Moonlighting Policy" and those described under Blessing Hospital's "Roles, Responsibilities & Patient Care Activities of Resident Physicians and Fellows for Blessing Hospital," along with any other rules/policies that pertain to moonlighting as described by SIU, Blessing Hospital, the ACGME, AOA, ABFM, and/or ACOFP. This policy serves to outline procedures and expectations, but does not supersede any rule or policy from these organizations.

Appendix F

Oral Case Presentation Template:

Demographic data
Age, sex, gender, race

Chief complaint, and date of admission (or clinic visit)

History of Present Illness

Briefly state in chronological order the presenting symptoms leading to the encounter. Also give any negative symptomatology.

Past Medical History

Pertinent childhood illnesses

Pertinent Adult illnesses

Pertinent hospitalizations

Past surgical history

Vaccination history

Consider chronological order

Family history

(+) for what diseases

(-) for what diseases

Social History

Smoking, alcohol, recreational drugs

Occupation

Living arrangements (housing, marital status, sexual orientation, water source, siblings, daycare, hobbies etc.)

Medication History

Prescription, over-the-counter, and herbal products at time of initial encounter

Known allergies/adverse reactions, with an explanation of the reaction

Review of Systems

List any positive or negative findings elicited during system review. To review systems, start at the top of the head and work down the body, reviewing each system as you go.

Avoid abbreviations, and define complex terminology, or specific jargon associated with your location.

Physical Examination

Vital signs with height and weight

Any pertinent positive and negative findings on examination. All findings should relate to the clinical presentation of the disease state.

Laboratory data on admission

Initial abnormal or normal pertinent results of lab tests

Prioritize problem list

List each problem that has been identified in order of clinical significance. (This is a mini-review)

Differential Diagnosis

Patient's Clinical Course

This may be presented before or after the disease state presentation

Disease state presentation of select patient care problem

*This should encompass up to half of the presentation

This may not be limited to the patient's chief complaint which resulted in the encounter. But you need to be able to relate the disease state presented to the patient case.

Definition

Incidence

Prevalence

Etiology

Pathology

Major symptoms / Clinical presentation

Diagnostic laboratory tests

Prognosis: treated and untreated

Therapy (i.e. Surgical, drug etc.)

Drug therapy

Mechanism of action Adverse drug reactions

Pharmacokinetics	Dosing
Clinical indications	Monitoring parameters
Drug interactions	Patient information

Describe the lessons learned from this case

Open for questions

Sources in Vancouver style

Questions (5 written multiple choice, they do not have to be original)

Faculty Review of Case Presentation

Evaluated 0-3 (0 for missing data, 3 is very thorough and pertinent)

_____ Patient demographic data presented

_____ Brief but complete chief complaint and HPI given

_____ Past medical history complete but pertinent

_____ Appropriate family and social history presented

_____ Current medications and allergies listed

_____ Pertinent ROS presented

_____ Physical exam complete and appropriate

_____ Laboratory data presented

_____ Problem list clear and concise

_____ Hospital course presented

_____ Disease state presentation well defined and useful

_____ Sources appropriate and in Vancouver style

____ Multiple choice questions are well thought-out and pertinent

Written Case Report Template

Title of the Case

This can be cryptic, but should grab the reader's attention

Case Presentation (presenting features, medical/social/family history)

This is the patient's story – but be very sensitive to patient confidentiality

How did they present?

What is the RELEVANT history? Why is it relevant?

Explain your findings and how they influenced your decisions.

*Do not use abbreviations

Investigations

All investigations that create a background (baseline) picture are relevant.

All investigations that are crucial to management decisions should be discussed in full.

Choose appropriate images to illustrate your point. (color preferred)

Differential Diagnosis

Do not list. This should be a short narrative of how the diagnosis was "teased" out.

Treatment (If relevant)

Include pharmacologic and non-pharmacologic care.

Outcome and Follow-up

Always include follow-up data where you can; it gives readers a clear understanding of outcome.

The follow-up period should be defined.

Please indicate if the patient died, even if not directly related to the case.

Discussion (Include a very brief review of similar published cases)

This is the opportunity to describe the mechanisms of injury, guidelines and their relevance, diagnostic pathways (use diagrams if appropriate), and the points of interest of the case.

A brief summary of relevant clinical guidelines is appropriate.

Did you have to make an exception?

Did you have to adapt the guidelines?

Learning Points/Take home messages (3 to 5 bullet points)

This is required!

What do you want your audience to remember?

References Only include relevant references in *Vancouver style*

RAPID RESPONSE JUNIOR AND CODE BLUE JUNIOR

EVENTS:

- Mock rapid junior done in Sept 2023
- Event happened in Jan 2024
- 2 cases in the last year.

RAPID RESPONSE JUNIOR

- Process for obtaining medical care during rapid response for pediatric patients.
  - a. Call 5555 announcing "rapid response JUNIOR" and room number. (telecommunications will call the on call resident phone number as well as voalte messaging
  - b. SIU resident will respond to rapid response JUNIOR.
  - c. Hospitalist will respond to rapid response to facilitate communication to SIU Resident.
  - d. SIU Resident assumes care during the rapid response.
  - e. If patient needs admitted from Child and Adolescent (CAS), the Resident will hand off to patient 's pediatrician/Family Practice attending.
  - f. If patient needs admitted from Child and Adolescent psych unit (CAS) AND doesn't have a pediatrician/Family Practice provider with admitting privileges the Resident will admit under SIU service.
  - g. On CAS, ensure someone is at the locked doors of the patient entrance (southwest doors of CAS) to allow for rapid entrance to the department

CODE BLUE JUNIOR

- At Blessing Hospital's 11th street main campus, Hospitalists may respond for patients age 16 years and above, and Emergency Department physicians for age 15 and below.
- if notified of a pediatric arrest or when pediatric equipment is needed (for children 15 years of age or younger) to respond to a Code Blue situation, a Code Blue Junior is called.
- For infant and pediatric victims, BLS is provided until the arrival of staff trained in the Neonatal Resuscitation or Pediatric Advanced Life Support. resuscitation Guidelines once trained staff arrive on the scene.

SIU-QUINCY MATERNAL HEALTH POLICY

Updated 12-12-2023

SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE- QUINCY FAMILY MEDICINE RESIDENCY
612 N 11th Street Quincy, IL 62301

Table of Contents

SIU-Quincy Family Medicine OB Policy

Subject: OB Continuity Patients
Purpose: Standards of care for OB continuity patients

1. During your residency, you will be assigned AT LEAST THREE continuity patients. You may be subject to more pending OB flow at the clinic or if you have a desire for additional experience.

2. The resident will see the pregnant patient assigned to them in clinic for the remainder of the prenatal visits when available.

3. The assigned resident is required to attend the delivery whether it is vaginal birth or a c-section. If your patient has a c-section, you are expected to scrub in.

4. When an OB continuity patient comes on to the L&D floor, the SIU resident holding the ROC phone will find the appropriate resident that needs to see the patient (likely the assigned resident unless signed out). The assigned resident should come into L&D to complete the H&P and give report to the listed OB attending physician on call. If patient comes in laboring overnight, the assigned resident is required to come in and complete the H&P. This may be negotiated with the night float resident or other resident willing to cover over night. If the patient is less than 6 cm, the assigned resident may sign out to the night float to manage the patient while in latent labor. If the patient is greater than 6cm, the resident must stay on the L&D floor while the patient is in active labor until delivery. If the assigned resident is up for multiple hours during the night with a laboring patient, the scheduler should be made aware so arrangements can be made and the schedule can be adjusted for duties the assigned resident may have the next day.

4. If a resident is on vacation, out of town, or has the weekend off, the OB continuity patient must be signed out to another resident with an official sign out. A full sign out must be given to the covering resident. Ensure that the scheduler is updated and aware of the dates and time the resident signing out and who is the covering resident for their continuity OB's.

5. While the patient is in active labor (6cm or greater), a progress note in the Blessing record must be completed every two hours and every 1 hour while pushing (if able). A new note should also be generated if there is a change in the patient's status.

5. Once the OB continuity patient has delivered, it must be logged in new innovations within 24 hours after delivery under "continuity delivery".

6. After delivery, complete the delivery note, place in postpartum and newborn orders, and update the prenatal with the birth outcome.

8. OB Continuity patients must be followed through until they are discharged from postpartum. BEFORE they are discharged, the assigned resident must ensure the patient has a postpartum visit and newborn visit scheduled.

Subject: OB Triage Patients
Purpose: Expectations of residents on SIU OB continuity triage patients

1. When an OB continuity patient presents to the L&D floor, the patient must be seen, evaluated, and admitted if needed **within 30 minutes** of patient presenting to the floor. If they are not seen, this is considered an EMTALA violation.

2. Triage of the OB continuity patient is the responsibility of the FM resident who is scheduled on the L&D floor that block IF there is one. If there is no FM resident scheduled to be on the L&D floor, the FM resident who is assigned the OB continuity patient (primary) will triage the patient. If the FM resident who is assigned the OB continuity patient (primary) is not available to be there within 15 minutes, they must let the FM senior resident on service aware who will then see the patient. If the hospital service is busy and a lot of activity on the hospital floor, back-up must be called in. The assigned resident can ask for help from other fellow residents if another resident has time and is willing to see the patient.

3. Sign out patient to the OB Faculty on call (Miller, Aguirre, or the OB Hospitalist group). A list of the OB attending who is on for OB can be found in Amion. A formal sign-out must be given. This includes patient's age, G's and P's, gestational age, what they are presenting for and their OB and medical history, pertinent objective, and your plan for the patient.

Subject: OB Rotation
Purpose: Expectations of residents while on OB rotation

1. The resident on the OB rotation must present to L&D at 7:00 AM to listen to nurse report. Shifts will be 0700 to 1900 unless scheduled otherwise.

2. Residents are expected to introduce themselves to all laboring patients after AM report.

3. The resident on OB must be present in the nurses' station at all times unless completing notes in the dictation room. It is expected that the resident spends most of the time in the nurses' station. Our L&D nurses offer a lot of valuable teaching and residents should take every opportunity to learn and engage with them. If the resident needs to leave for a lunch break, let the RN's know.

4. If the resident is not on L&D when they are scheduled to be there, one written warning will be issued. **If a second warning is warranted, the resident will repeat the OB rotation**.

5. The resident on OB rotation may stay longer in their shift; however, they need to send Dr. Aguirre and the scheduler an email. This way if the resident on OB rotation comes in late the next day to not break duty hours, this will not count against them.

6. Follow Dr. Frye in her prenatal clinic on Thursday AM starting at 0800. Concentrate on seeing prenatal appointments. Let her know if you cannot make it to her Thursday AM clinic. If she is unavailable, plan to be on L&D in the morning. After Dr. Friye's AM clinic, the resident should present to Labor and Delivery until 1900.

6. Perform cervical checks with RN's backchecking until the resident is comfortable. This applies to situations when two cervical checks are appropriate. A resident performing a cervical check may not be appropriate if a patient has prolonged rupture of membranes or very uncomfortable cervical checks. Residents must have 5 cervical checks completed, documented, and back-checked by a RN on their 2nd OB month intern year starting with the new academic year 2024. Cervical check form (found at the end of this document), should be given to Dr. Aguirre once completed.

6. It is expected that the resident learns how to position patients for optimal progression of labor and also learn how to push with a patient.

7. Residents are expected to perform amniotomies under the supervision of the attending the first couple of times they are first performed, then solo once the resident is comfortable. Before breaking a bag, ensure the baby's head is well applied and is not ballotable, and confirm that it is okay with the appropriate attending.

8. Residents are also able to place fetal scalp electrodes and IUPC's when appropriate and when competency is assured.

9. If not busy in a room with another patient, the resident should attempt to see ALL triage patients with the OB hospitalist.

10. If the resident delivered any patients the day prior, they are expected to follow the delivering mother to postpartum and round on them in the mornings starting the morning after delivery while the patient is admitted. DO residents may consider OMT if time allows, patient and the attending OB are amenable.

11. Listen to the nurses give discharge instructions on at least 1 vaginal delivery and c/s patient that you have followed. Listen to enough that you can recite it back to the attending.

12. Update Dr. Miller and/or Dr. Aguirre at the end of every week what your delivery numbers are. It can be given to the FMOB who is on for the week or coming on for the week. If in doubt, send delivery numbers to both Dr. Miller and Dr. Aguirre.

13. If it is slow on the L&D unit in the morning, please go to newborn and follow one of the pediatricians. This is to develop newborn exam skills and learning how to perform circumcisions. If you do leave the unit to perform newborn exams/circumcisions, please update the nurses. Also remember, your priority on the OB rotation is L&D.

Subject: Prenatal Care

Purpose: Provide a guide of prenatal care and testing required at visits.

1. Before a new OB is seen in clinic, OB intake will be performed by the OB RN (Hannah Rees) or her back-up (Kim) if Hannah is unavailable.

2. The OB RN will be asking and recording (in the prenatal) the following information: Name of patient, DOB, contact information, Best mode of contact, Emergency contact, Positive home test vs confirmed testing at a facility (such as ER or urgent care), Gestation, Para, Medical History, current medications,

allergies, and substance use. An SDOH (social determinants of health) questionnaire will also be completed by Hannah and provided resources. **It is the responsibility of the resident to confirm this information at their IOB (initial OB) visit as well as complete the remainder of the documentation required for IOB visits.**

3. If the patient has a positive home test, but does not have a confirmatory test, the patient will be scheduled for an amenorrhea visit first. At this visit a POC urine pregnancy test should be ordered. If positive, IOB labs should be ordered, Hannah should be made aware, and an IOB visit will be scheduled before they leave the office.

4. Initial OB visits should include discussion of the importance of coming to their prenatal appointments, well-balanced diet, No ETOH, smoking, illicit drugs, no medications unless prescribed by a physician who knows the patient is pregnant, always wear a seatbelt, avoiding undercooked meat, unpasteurized dairy products, unheated cold cuts, hot dogs, and deli meats. Patient should also know to call the office if any concerns especially but not limited to abdominal pain, bleeding, vaginal discharge, or decreased fetal movement (later in pregnancy).

5. Follow-up OB visits should occur every 4 weeks until 28 weeks, every 2 weeks until 34 weeks, then weekly from 34 weeks until delivery. If needed, patients may schedule closer follow-up.

6. See the Prenatal Testing Guide about what labs are ordered when and when additional testing may be warranted outside the standard order sets.

7. After every OB visit, a full sign-out if an initial OB or brief update if a routine OB visit should be provided to the OB attending who is scheduled at the end of the clinic day. **IF there are pressing issues such as an elevated blood pressure or other more urgent concerns, contact Dr. Miller, Dr. Aguirre, or the OBH group immediately.** If unsure if something is an emergency or not, we would much rather you err on the side of caution and call us.

Prenatal Testing Guide

Visit	Testing	Special Considerations/Notes
Initial OB Visit (All Patients)	**- Prenatal Labs**: Beta hCG, CBC, Blood type & Antibody screen, RPR, HIV, Gonorrhea & Chlamydia NAAT, Hep Bs Ag, HCV, rubella antibody, urine culture - Order dating ultrasound - Update pap if not current - Ask about interest in screening for genetic conditions- Natera Panorama can be completed as early as 10 weeks - Offer hemoglobin electrophoresis (all pts of African-American, Southeast Asian, Caribbean, or Mediterranean decent) - Offer CF panel screening if high risk (one partner is Caucasian) - Varicella IgG titer if patient does not have a prior history of chicken pox or if does not have prior history of varicella vaccination **(NEVER VACCINATE WITH LIVE VACCINE DURING PREGNANCY)** - Offer flu shot and COVID shot (can be given in any trimester of pregnancy)	- If history of thyroid disorder, add TSH - Test for BV (wet mount) and/or trichomonas if symptomatic - Early glucola screening with BMI greater than 25 or greater than 23 in Asian Americans and have one or more of the following additional risk factors: physical inactivity, first-degree relative with diabetes, high-risk race or ethnicity (African American, Latino, Native American, Asian American, Pacific Islander), previous delivery of infant weighing 4,000 grams (greater than 8lbs 13 oz), previous gestational diabetes, HTN, HDL < 35 or triglyceride level > 250, history of PCOS, A1C ≥ 5.7%, impaired glucose tolerance or impaired fasting glucose on previous testing, history of cardiovascular disease - Urine drug screen if patient with current use and/or late prenatal care. Make sure you consent the patient before obtaining a UDS - QuantiFERON Gold if history of TB exposure or high risk (ex: persons experiencing homelessness or had been incarcerated) **Risk Factors Requiring ASA 81mg QD starting at 12 weeks to 28 weeks but started optimally by 16 weeks** - **High Risk Factors** (If one or more): History of pre-eclampsia, multifetal gestation, chronic hypertension, type 1 or 2 diabetes, renal disease, Autoimmune disease, COVID in pregnancy - **Moderate Factors** (If two or more): nulliparity, obesity (BMI greater than 30), family history of preeclampsia (mom or sister), sociodemographic characteristics (ex: Low socioeconomic status), AMA (35 or older), Personal history factors (SGA, low birth weight, previous adverse pregnancy outcome, more than 10-year pregnancy interval)

Patients with history of delivery <37 weeks	- Order 1st trimester US for dating - Screen and treat BV at initial OB visit with re-screen at 24 weeks - Discuss case with MFM after visit. There are mixed reviews of offer progesterone between 16-36 weeks.	
History of HTN, prior pre-eclampsia, renal disease	- Baseline pre-eclampsia labs - Start ASA 81mg QD between 12-28 weeks (preferably before 16 weeks). Continue until delivery	- CBC, CMP, uric acid, LDH, spot protein/creatinine ratio
Family History/Personal History of Birth Defects	- Order genetics consultation in Springfield and MFM - Genetic screening (Natera Panorama)	- Patient needs to be seen by MFM before 18 weeks in the event invasive testing is required - Natera testing - CVS testing <13 weeks
Genetic Screening (As early as 10 weeks-20 weeks)	- Natera Panorama- Checks for Trisomy 18, 19, and 21, sex chromosomes, and microdeletions	- Normally covered by Medicaid - Requires form to be signed by provider. Found in our lab. Walk patient over to lab and ask for form. - Offer hemoglobin electrophoresis (all pts of African-American, Southeast Asian, Caribbean, or Mediterranean decent). Hgb Electrophoresis can be completed at any time, but usually with the initial OB labs. - Offer CF panel screening if high risk (one partner is Caucasian). Usually order with initial OB labs.
18-20 weeks (All Patients)	- Ultrasound for routine anatomy scan	- Needs to be repeated if subpar imaging of certain anatomy
24-28 weeks (All Patients)	- 1-hour glucola, CBC, and RPR - Add antibody screen if Rh negative - Rhogam at 28 weeks if needed (Patient Rh negative and Rh antibody screen is negative)	
Rh Negative Patients (28 weeks)	- CBC, Antibody screen (to be performed before Rhogam shot) - 300 mcg IM Rhogam once	
History of Previous C-section (28-32 weeks)	- TOLAC/VBAC consultation with OB hospitalist group (Dr. Colton)	- Protocol listed below
28-32 weeks (All Patients)	- Tdap Vaccine	

32-36 weeks (All Patients)	- Offer RSV vaccine in Fall and Winter Months	
36-37 weeks (All Patients)	- GBS swab (Order with sensitivities IF PCN allergy) - HIV screening	- GBS Swab- Swab outer 1/3rd vagina, down perineum and 1 inch into rectum (in that order) - Do not need to check GBS if had GBS in urine earlier in same pregnancy - If more than 5 weeks since GBS screening, and has not yet deliver, repeat GBS test
Late to Post-Term Patients (41 0/7 and up)	1st NST for late dates at 41 weeks- bi-weekly	- Should induce by 42 weeks

NST Recommendations

Adapted from ACOG

Factor	Suggested Gestational Age to Begin Antenatal Fetal Surveillance	Suggested Frequency of Antenatal Fetal Surveillance
Fetal Growth Restriction (Umbilical artery doppler normal or with elevated impedance to flow in umbilical artery with diastolic flow present, with normal AFI and no other concurrent maternal or fetal conditions)	At diagnosis	Once or twice weekly
Fetal Growth Restriction (umbilical artery doppler with absent end diastolic velocity or concurrent conditions such as oligohydramnios or maternal comorbidity such as pre-eclampsia or hypertension)	At diagnosis	Twice weekly or consider inpatient management
Decreased Fetal Movement	At diagnosis	Once
Chronic Hypertension- Controlled	32w0d	Weekly
Chronic Hypertension- Poorly Controlled or with associated medical conditions	At diagnosis	Individualized
Gestational Hypertension	At diagnosis	Twice Weekly
Gestational Diabetes- Controlled on medications	32w0d	Once or twice weekly
Gestational Diabetes- Poorly Controlled	32w0d	Twice weekly
Pre-gestational Diabetes	32w0d	Twice weekly
Renal Disease- Cr > 1.4	32w0d	Once or twice weekly
Thyroid Disorders- poorly controlled	Individualized	Individualized
Substance Use- Alcohol (5 or more drinks per week)	36w0d	Weekly
Polysubstance Use	Individualized	Individualized

Pre-pregnancy BMI 35-39.9	37w0d	Weekly
Pre-pregnancy BMI 40 or above	34w0d	Weekly
Advanced Maternal Age	Individualized	Individualized
Previous stillbirth at or after 32w0d	32w0d	Once or twice weekly
Previous stillbirth before 32w0d	Individualized	Individualized
Previous fetal growth restriction requiring preterm delivery	32w0d	Weekly
Pre-eclampsia in previous pregnancy requiring preterm delivery	32w0d	Weekly
Cholestasis	At diagnosis	Once or twice weekly
Late term	41w0d	Twice weekly
Velamentous cord insertion	36w0d	Weekly
Single umbilical artery	36w0d	Weekly
Isolated oligohydramnios (single deepest vertical pocket less than 2cm)	At diagnosis	Once or twice weekly
Polyhydramnios, moderate to severe (Deepest vertical pocket equal to or greater than 12cm or AFI equal to or greater than 30cm)	32w0d-34w0d (or at diagnosis if after)	Once or twice weekly

__Note:__ Adjustments can be made to the tentative list above depending on recommendations from MFM and OB

Previous C-Section

*** For a prenatal patient with a previous c-section wishing to have a repeat please follow the following protocol. A copy of this is also in the supervisor room, prenatal file

- Dr. Colton, the onsite director of Blessing OB Hospitalist group, would like to be the point of first contact.
- At the time of the 32-34 week visit, the resident needs to call Dr. Colton on his personal cell phone (314-803-5287) to briefly discuss the patient and set up a time for a pre-op visit with the patient after the 35-week mark.
- Dr. Colton (or another OB hospitalist, if he isn't available) will meet the patient for a no-charge pre-op visit in OB Triage on a Monday or a Thursday.
- The resident physician should also attend the time of that visit, for educational and coordination opportunities.

A patient wishing to TOLAC (Trial of labor after C-section)

- Follow the same contact plan as above, but a little earlier, 28-32 weeks
- You must have a hard copy of the actual operative report for the c/s
- Patient must have had a single low transverse c-section and be willing to TOLAC
- The resident physician will scrub in and assist with the C/S on the scheduled day – make sure to let the SIU Scheduler know if the planned time will conflict with another responsibility, so that the schedule can be adjusted as necessary to ensure the resident is available for the C/S.

Ultrasound Dating

US dating is considered accurate to within:
5 days if less than 8 6/7 weeks
7 days between 9 0/7 and 15 6/7 weeks
10 days between 16 0/7 and 21 6/7 weeks
14 days between 22 0/7 and 27 6/7 weeks
21 days if more than 28 0/7 weeks

Recommended Weight Gain

BMI	Weight Gain
<18.5	28lbs to 40lbs (13kg to 18kg)
18.6 to 24.9	25lbs to 35lbs (11kg to 16kg)
25 to 29.9	15lbs to 25lbs (7kg to 11kg)
≥30	11lbs to 20lbs (5kg to 10kg)

Follow Up OB visits

Every 4 weeks until 28 weeks gestation
Every 2 weeks until 34 weeks gestation
Every 1 week from 34 weeks until delivery

There may be patients who require more frequent visits depending on their co-morbidities, social situation, and recommendations made by OB/MFM. It is okay to schedule these patients more frequently if needed

Fetal Movement

Normal Fetal Movement	- Pregnant women feel FM between 16 and 24 weeks. FM does not decrease at term. Decreased amniotic fluid may limit FM. Decreased fetal movement is most likely due to fetal sleep and often resolves before they are triaged. Sleep-wake cycle is 20-75 minutes and can vary a lot. - Increased fetal movement is associated with FHR accelerations and may be seen with maternal hypoglycemia. Hypoxia can reduce or stop fetal movement. - Start fetal movement counting at 28-32 weeks if MEDICALLY indicated. Ten distinct fetal movements in 2 hours are considered reassuring.

Kick Counting Instructions (When Indicated)	Lie on left side with hand on stomach. Count fetal movements daily any time for at least 1 hour. Write down number of FM's. Call OB triage or L&D if: No fetal movement in 12 hours, <3 movements in 1 hr. or <10 movements in 2 hrs. if focused counting; Movements are half of what they have been **Count to Ten Method:** Start counting in AM. Record the time of day when the 10th movement was felt. Contact provider if <10 movements in a 12-hr. period or if it takes longer each day to reach 10 movements

List of OB Conditions, when to transfer and when to co-manage

Transfer patient

1. Multiple gestation
2. Preexisting diabetes mellitus- Type 1
3. Systemic Lupus Erythematosus
4. Antiphospholipid syndrome
5. History of classical cesarean delivery
6. Cervical insufficiency(incompetence) requiring cerclage
7. Partial or complete placenta previa persisting past 28-32 weeks
8. Homozygous sickle cell disease (not trait)
9. HIV/AIDS

Co-manage patient (consult OB, MFM, or appropriate specialist)

1. Cardiac disease
2. Insulin-requiring gestational/type II diabetes mellitus, poorly controlled
3. Polyhydramnios
4. Oligohydramnios
5. Chronic hypertension, poorly controlled
6. Gestational hypertension
7. Lung disease, acute/chronic: severe asthma/interstitial lung disease
8. Renal disease (not UTI)
9. Rh sensitization
10. Other isoimmunization
11. Intrauterine growth restriction (IUGR)
12. Preterm labor in present pregnancy
13. Hyperthyroidism
14. Poorly controlled hypothyroidism
15. History of unexplained stillbirth
16. DVT/PE history requiring heparin prophylaxis or newly diagnosed
17. Seizure disorder
18. Significant active psychiatric disorder, poorly controlled
19. Substance use disorder, poorly controlled
20. Prior cesarean birth (VBAC/TOLAC planned)
21. Preterm premature rupture of membranes
22. C-section needed- determined at any time throughout pregnancy
23. History of pre-term delivery

24. Any developing high-risk condition
25. History of 3 or more consecutive losses prior to 20 weeks
26. History of pregnancy loss after 20 weeks
27. Genetic abnormalities in previous pregnancies: History of child with trisomy, history of cystic fibrosis, history of sickle cell disease or trait, thalassemia, down syndrome, open neural tube defect such as meningocele, spina bifida, anencephaly, Tay-Sachs disease, birth defects, autism, hemophilia, Huntington chorea, muscular dystrophy, osteogenica imperfecta, stillbirth, miscarriage (3 or more)

Intrapartum Risk Factors Requiring Consultation

11. Induction using oxytocin or cervidil (before 39 weeks with intact membranes and before 36 weeks with ruptured membranes)
2. Placental Abruption
3. Other excessive vaginal bleeding
4. Intrapartum seizures
5. Malpresentation (face, brow, breech)
6. Cephalopelvic disproportion/dystocia
7. Cord prolapse
8. Non-reassuring fetal heart tones
9. Prolonged labor, active phase
10. Arrest of active phase
11. Vacuum extraction

Opportunities for Prenatal Education

(Adapted from AAFP)

Air Travel	- Generally safe in pregnancy up to 36 weeks; long flights are associated with an increased risk of venous thrombosis -Availability of medical resources at the destination should be considered; The CDC provides information for pregnant travelers (https://wwwnc.cdc.gov/travel/page/pregnant-travelers)
Breastfeeding	- Recommended as the best feeding method for most infants - Contraindications: maternal HIV, untreated brucellosis, active herpetic lesions on the breast, cracked nipples with hepatitis C infection, use of certain medications - Structured behavior counseling, one-on-one needs-based counseling, and education programs increase breastfeeding success

Exercise	- At least 30 minutes of moderate exercise five days per week is reasonable goal for most pregnant or postpartum patients - Pregnant patients should avoid activities that put them at risk of falls or abdominal injuries
Herbal Therapies	- Pregnant patients should avoid anything with known harmful effects to the fetus, such as ginkgo, ephedra, and ginseng. They should be cautious of substances with unknown effects
Labor and Delivery	Pregnant patients should be counseled about what to do when their membranes rupture. Discuss 5-1-1 labor rule (contractions coming every 5 minutes, lasting for a full minute for at least one hour). Discuss different strategies to manage pain and the value of support during labor
Medications (prescriptions and over-the-counter)	Risks and benefits of individual medications should be reviewed because few medications have been proven safe for use during pregnancy especially during first trimester. Ensure patient is taking daily prenatal vitamins.
Perineal Massage	- All patients should be counseled on performing perineal massage starting at 35 weeks until delivery. It has been shown to reduce the number of perineal tears (NNT=15). Patient should aim to perform 1-2 times/week for about 5 minutes. It should be avoided if the patient has an active herpes infection or other vaginal infection. Also avoid in cases of low-lying placenta.
Seat Belt Use	Pregnant patients should use a three-point seatbelt
Sex	Most pregnant people may continue to have sex throughout pregnancy; however, in certain situations (ex: placenta previa), abstaining from sex is recommended
Cat Litter	Avoid contact to reduce the risk of toxoplasmosis. Excretion of Toxoplasma gondii oocytes by cats poses risk of transmission to humans who have contact with contaminated litter; hand hygiene is recommended
Hair Treatments	- Although hair dyes and treatments have not been explicitly linked to fetal malformation, they should be avoided during early pregnancy
Heavy Metals	- Exposure should be avoided during early pregnancy because of the potential for delayed fetal neurologic development

Radiation	- Pregnant people should avoid ionizing radiation because it may affect fetal thyroid development - Adverse fetal effects are not associated with radiography that is in a normal diagnostic range (less than 50mGy) and that avoid direct abdominal views; ultrasonography; or use of microwaves, computers, or cell phones
Solvents	- Pregnant people should avoid exposure to solvents (e.g., toluene, benzene), particularly in areas without adequate ventilation - Exposure has been associated with an increase in miscarriage, stillbirth, preterm birth, and intrauterine growth restriction
Workplace Accommodations	- Working, in general, is safe during pregnancy; however, some conditions, such as prolonged standing and exposure to certain chemicals, are associated with pregnancy complications - Physician-ordered accommodations for pregnant people can ensure safe working conditions
Substance Use	- No amount of alcohol, tobacco, or illicit drug use has been proven to be safe during pregnancy
Labor (5-1-1 Rule)	- When patients reach term and are feeling regular contractions every 5 minutes, that last one minute, for one hour they should come in - This can change especially if your patient is a grand multip or has a history of fast deliveries in which case you may want them to come in sooner

Helpful Terms/Hints

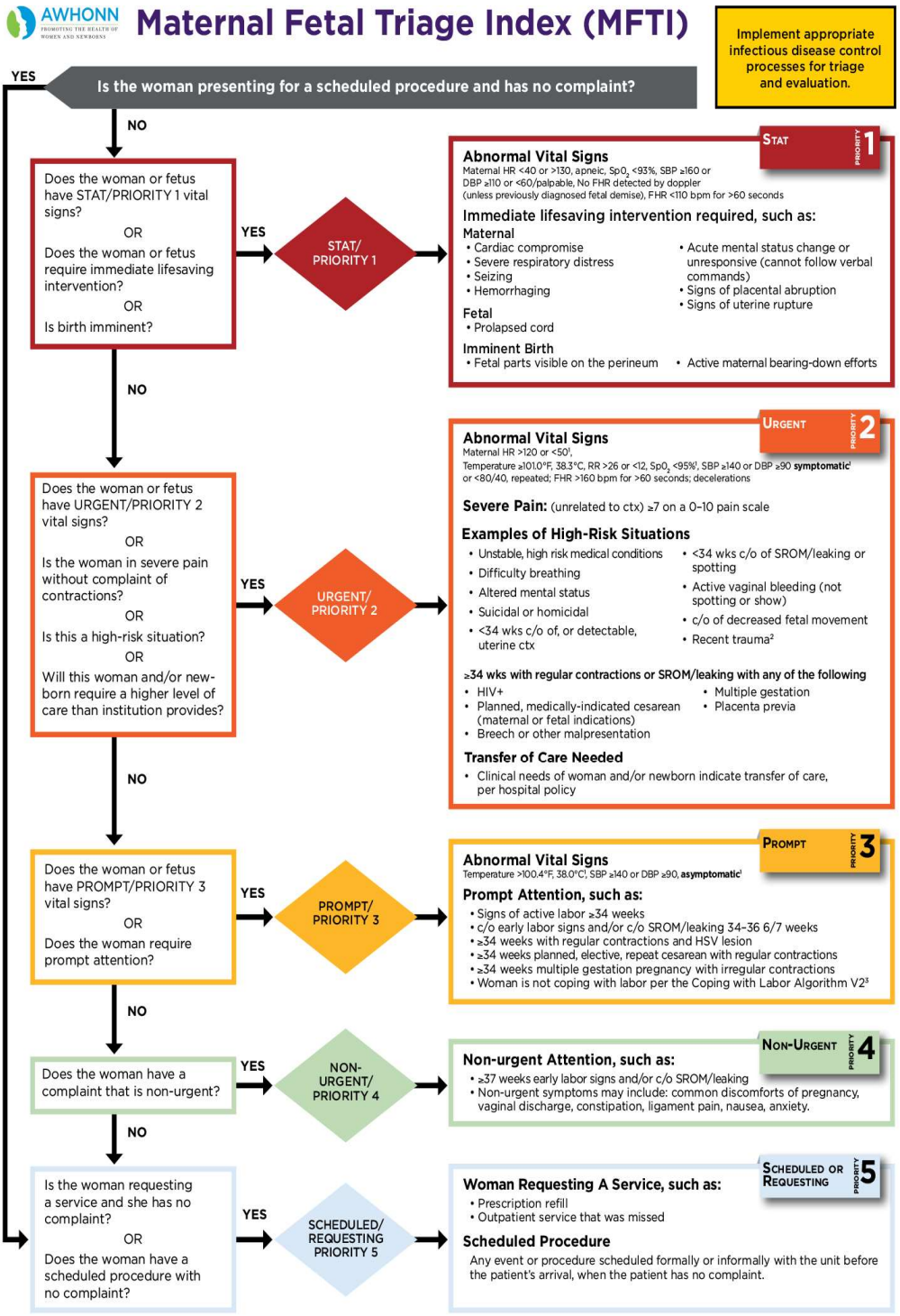
Amnisure	Insert tip of swab into the finals no more than 2-3 inches deep. Withdraw after 1 minute.
Nitrazine	False positive with BV, semen, blood (pH>6)
NST	Non-stress test
PPROM	Preterm Premature Rupture of Membranes
PROM	Premature Rupture of Membranes
PTL	Preterm Labor
ROL	Rule Out Labor
SROM	Spontaneous Rupture of Membranes
SSE	Sterile Speculum Exam
SVE	Sterile Vaginal Exam (Cervical Check)
Swab & Slide	Nitrazine, microscopy of dried specimen for fern

OB Triage

Triage Case	Triage Protocol
Decreased fetal movement <24 weeks	Doppler FHT's, US prn
Decreased fetal movement >24 weeks	NST, NO sterile vaginal exam; US to check amniotic fluid; If NST and US are WNL risk of still birth within 1 week is extremely low. Can d/c with FM counting instructions
Rule out labor (>36 weeks)	NST, sterile vaginal exam (Q2H- 2 checks total)
Rule out SROM (≥37 weeks)	If grossly ruptured, swab & slide (to look for ferning if able); The protocol at Blessing is Amnisure; If not grossly ruptured- Sterile speculum exam (look for ferning, nitrazine test if available, and ferning if microscope available), Blessing, again, we just do Amnisure; Can do US to assess amniotic fluid; BPP if no prenatal care; **Do not do a cervical exam if the patient is <34 weeks with ROM**
Rule out Preterm Labor (<37 weeks)	UA, UDS (with consent) - Sterile speculum exam (Amnisure first if 24-34 weeks) FIRST; GC/CT/Trich, wet mount for BV, swab and slide; - Collect GBS swab - GENTLE SVE Q2H (2 checks)- **If there is vaginal bleeding- US 1st to assess location of placenta** - NST to look at frequency of contractions - Prenatal labs if no prenatal care - Admit if persistent and painful contractions, rupture of membranes, vaginal bleeding, dilation >2cm or effacement >80%
Rule out Premature Preterm Rupture of Membranes (<36 weeks)	- UA, UDS (with consent) - Obtain Amnisure first - Sterile speculum Exam (VISUAL eval of cervix ONLY) - Swab and slide- Wet mount for BV, GC/CT/Trich - Consider US to assess amniotic fluid level **- Do not do a cervical exam if the patient is <34 weeks with ROM**
Vaginal Bleeding	- Locate Placenta- get prior US report or get US NOW - Sterile speculum exam (GC/CT/Trich), wet mount - Ask last intercourse and last time ANYTHING in vagina - **SVE ONLY if placenta located & safe** - If bleeding is significant- check type and screen, PT, PTT, fibrinogen and KB test. Give RhoGAM if Rh negative
Fall/MVA/Accident	- Monitor Patient x 4 hours after fall/accident - **IF** patient has 6 contractions/hr- keep for 24 hours - **IF** patient is less than 24 weeks and no vaginal bleeding or contractions, can do a doppler then send home

Pre-Eclampsia Rule Out	- BP monitoring while in triage - Ask: Headache, visual disturbances such as scotoma, chest pain, shortness of breath, RUQ/epigastric abdominal pain, swelling in legs - CBC, CMP, Spot prot/creatinine ratio, LDH, and uric acid labs - Assess for mild vs severe range BP's and need for anti-hypertensive therapy **Diagnostic Criteria for Pre-E w/o SF** - BP: SBP ≥ 140 or DBP ≥ 90 that occurs after 20 weeks gestation in women with previously normal BP. BP should be elevated on 2 occasions at least 4 hours apart. AND Spot prot/creatinine ratio ≥0.3 **Diagnostic Criteria for Pre-E WITH SF** 1. BP: SBP ≥ 160 or DBP ≥110 on two occasions at least 4 hours apart (unless anti-HTN therapy is initiated before this time) 2. Thrombocytopenia (platelet count <100) 3. Impaired liver function that is not accounted for by an alternative diagnosis and indicated by abnormal LFT's (>2x's upper normal limit or by severe persistent RUQ pain or epigastric pain unresponsive to medications 4. Renal insufficiency (serum creatinine >1.1 or doubling in the serum creatinine in the absence of other renal disease) 5. Pulmonary Edema 6. New-onset headache unresponsive to medication and not accounted or by alternative diagnoses 7. Visual disturbances **IF DIAGNOSED WITH PRE-E NEED MFM CONSULT**

Please Note, this is a general Triage Guide. Protocols may change depending on the OB or FMOB you are working with



[1]High Risk and Critical Care Obstetrics, 2013

[2]Trauma may or may not include a direct assault on the abdomen. Examples are trauma from motor vehicle accidents, falls, and intimate partner violence.

[3]Coping with Labor Algorithm V2 used with permission

The MFTI is exemplary and does not include all possible patient complaints or conditions. The MFTI is designed to guide clinical decision-making but does not replace clinical judgment. Vital signs in the MFTI are suggested values. Values appropriate for the population and geographic region should be determined by each clinical team, taking into account variables such as altitude.

Figure 1. Maternal–fetal triage index. (Reprinted from Ruhl C, Scheich B, Onokpise B, Bingham D. Content validity testing of the maternal fetal triage index. J Obstet Gynecol Neonatal Nurs 2015;44:701–9.) ⇦

Scary Scenarios on L&D

Scenario	What to do
Maternal Temp >100.4 (in labor- concern for chorioamnionitis)	- Amp 2g Q6H and Gentamicin 1.5mg/kg Q24H - Use clindamycin if allergy to ampicillin - If c-section add metronidazole 500mg Q12H or clindamycin 900mg Q6-8hr
Pitocin Pump	- Order: Pitocin 20U/L: 1-2miliunits/min, increase by 1-2 Q30-45 minutes - Pitocin uterine Tachystole >5ctx/10min, twice - Hyperstim, late decels, or FHT>160bpm=> Tell OB, d/c pit, lay patient on left side, O2, c-section labs, consider terbutaline
Pre-Eclampsia (Severe)	- Make OB aware; MFM consult - 4-6g IV MgSO4 over 20-30 minutes, then 2g/hr IV gtt, titrate as needed - Check magnesium level 1 hour after starting, then Q4H (therapeutic level is 5-8); Monitor urine output and Creatinine if >0.9 - Magnesium toxicity: DTR's fail at 8-10; Respirations at 10-15, cor 15-25 - Treatment for Mag toxicity: Calcium gluconate 1g over 10 minutes, watch for s/s hypocalcemia (PTH suppression)- EKG
DELIVER ASAP	- Systolic >180, Diastolic >106, Platelets <90; RUQ pain and AST/ALT>100-200; Headache persisting after sleeping, needing >1200mg labetalol/day or more than 1 BP medicine; Cord prolapse; Etc…
Shoulder Dystocia	- HELPERR: 1. Call for HELP 2. Evaluate for EPISOTOMY 3. LEGS- McRoberts Maneuver; 4. Suprapubic PRESSURE 5. ENTER: Rotational maneuvers; 6. REMOVE the posterior arm; 7. ROLL The patient to hands and knees
Post-Partum Hemorrhage	- Normal prophylaxis: Pitocin after delivery (20-40units/L) (AKA: Pit wide open) or 10U IM - 1st steps: Massage Uterus, empty bladder - Review Causes of hemorrhage: 4T's (Tone, Trauma, Tone, Tissue, Thrombin) **1. Tone:** Uterine Atony: 70% of cases - Perform uterine massage - Perform bimanual compression - Cytotec 8000-1000mcg (4-5 tabs) PR - Methergine 0.2mg IM (if NO history of HTN) - Hemabate 0.25mg IM/IV Q15-20 minutes, max 8 doses (IF NO HISTORY OF ASTHMA) - TXA and Jada are next steps, at this point OB should be involved **2. Trauma:** Cervix or Vagina: 20% of cases - Examine and Repair **3. Tissue:** Retained Placenta: 10% of cases - Prevent with active third-stage management - Manual removal - Explore for fragments **4. Thrombin:** Coagulopathy: 1% of cases - Confirm with bedside clot test - Replace blood products
Amnio-Embolism	- Symptoms: Loss of BP, dyspnea, seizure, asystole, uterine atony, hemorrhage/DIC

Topics to review while on OB Rotation

Follow all patients where you have a meaningful labor and delivery interaction, post-partum. If two residents, cover each other on weekends, otherwise tell attending if weekend off. STAT C/S, and early on in the rotation, help move patient and not scrub unless you are the only one there.

Prenatal training video can be viewed from SIU CFM-Q only:
file:///T:/FCM_Quincy/COMMON/Training%20videos/Prenatal2016/Prenatal2016.html
Block 1 and all blocks: use Leopold maneuvers to estimate fetal weight: initially do small, normal, large and then refine as your skills improve. Write down your guess and see how you do!

Week 1: Introduction to the floor; oral and written presentation of a patient on the unit; introduction to OB ultrasound equipment; EFM nomenclature, interpretation http://www.ob-efm.com/; review delivery technique using mannequin; sterile speculum exam for ROM; dilation and effacement-vagina in a box on OB floor; bishop scoring; optional topics, per resident interest.

Week 1: Prenatal care (including completion of electronic ACOG form, review of lab and use of u/s in prenatal care, first exam etc); techniques to assess fetal well-being; amniotomy; fetal scalp electrode placement; IUPC; watch this perineal repair video:
https://www.youtube.com/watch?v=R4o4KSY4MMY optional topics, per resident interest.

Week 2: Induction techniques; bleeding in pregnancy, post-partum care and emergencies, assistance at cesarean sections, perineal repair; STABLE, optional topics, per resident interest.

Week 2: Postdate pregnancy, preterm labor, and optional topics of resident interest.
Block 2

Week 3: Review of Block 1, week 1-4 and short quiz to demonstrate competency. Review of perineal repair and hands on techniques listed above.

Week 3: Hypertensive disorders of pregnancy, Diabetes in pregnancy; optional topics per resident interest and cases

Week 4: Intrauterine growth restriction. Vacuum delivery; Optional topics

Week 4: Review of all topics, practice techniques, discussion of cases and own prenatal patients, make up for any missed sessions

Note: If Dr. Miller or the resident is absent for one of the weekly sessions, double up will occur as per negotiations with Dr Miller and the resident physician.

Optional OB Blocks-for residents interested in advanced experiences

Block 1&2 ACOG site for Practice Bulletins etc

Week 1-2 Review, practice and perfection of techniques including sterile speculum examination, assessment of cervical dilation effacement, station and fetal position; vaginal delivery, delivery of placenta; repair of perineal laceration or episiotomy; IUPC, FSE.

Week 1-2: Complicated cases in prenatal care, future work with a consultant, review and practice of techniques above including shoulder dystocia maneuvers.

Week 3-4: Review of OB ultrasound machine use. Topics of interest.

Articles: see AFP by topic
Your ALSO information
Labor, Delivery, Prenatal and Postpartum
Fetal Aneuploidy: Screening and diagnostic testing https://www.aafp.org/afp/2020/0415/p481.html
Pregnancy Myths and Practical Tips: https://www.aafp.org/afp/2020/1001/p420.html

Electronic fetal monitoring: https://www.aafp.org/afp/2020/0801/p158.html
Spontaneous vaginal delivery: https://www.aafp.org/afp/2015/0801/p202.html
Perineal Massage to Prevent birth trauma: https://www.aafp.org/afp/2021/0115/p115.html
Position during first stage of labor: https://www.aafp.org/afp/2010/0201/p285.html
Examination of the placenta: https://www.aafp.org/afp/1998/0301/p1045.html
Vacuum assist vaginal delivery: https://www.aafp.org/afp/2008/1015/p953.html
Preterm labor prevention and management: https://www.aafp.org/afp/2017/0315/p366.html
Preterm Premature Rupture of membranes: https://www.aafp.org/afp/2006/0215/p659.html
Labor induction vs. expectant management: https://www.aafp.org/afp/2019/0501/p587.html
Mechanical methods of labor induction: https://www.aafp.org/afp/2020/1101/p530.html
Labor dystocia in nulliparous women: https://www.aafp.org/afp/2021/0401/p404.html
Shoulder dystocia: https://www.aafp.org/afp/2020/0715/p84.html
Pregnant Common acute problems: https://www.aafp.org/afp/2018/1101/p595.html
Preconception care: https://www.aafp.org/afp/2016/0915/p508.html
Update on prenatal care: https://www.aafp.org/afp/2014/0201/p199.html
OTC meds in pregnancy: https://www.aafp.org/afp/2014/1015/p548.html
Nausea and vomiting in pregnancy: https://www.aafp.org/afp/2015/0915/p516.html
Thyroid disease in pregnancy: https://www.aafp.org/afp/2014/0215/p273.html
Gestational diabetes: https://www.aafp.org/afp/2015/0401/p460.html
Screening for preeclampsia: https://www.aafp.org/afp/2018/0115/od1.html
Hypertensive disorders of pregnancy: https://www.aafp.org/afp/2016/0115/p121.html
Chronic Hypertension: https://www.aafp.org/afp/2019/1215/p782.html
Gestational Hypertension and Preeclampsia: https://www.aafp.org/afp/2019/1115/p649.html
Membrane sweeping to decrease rates of postdate induction:
https://www.aafp.org/afp/2017/0101/p35.html
First trimester bleeding: https://www.aafp.org/afp/2019/0201/p166.html
Ectopic Pregnancy Dx and Management: https://www.aafp.org/afp/2020/0515/p599.html
Perinatal Group B Strep: https://www.aafp.org/afp/2012/0701/p59.html
Third Stage of Labor: https://www.aafp.org/afp/2021/0401/p404.html
Repair obstetric perineal lacerations: https://www.aafp.org/afp/2021/0615/p745.html
Postpartum hemorrhage: https://www.aafp.org/afp/2017/0401/p442.html
Pain management in labor: https://www.aafp.org/afp/2021/0315/p355.html
Postpartum Care: Approach to the fourth trimester: https://www.aafp.org/afp/2019/1015/p485.html
Breastfeeding Common Questions and Answers: https://www.aafp.org/afp/2018/0915/p368.html
Fetal Growth Restriction Before and After Birth: https://www.aafp.org/afp/2021/1100/p486.html
Updated 2022.11.02 THM

SIU-Quincy OB Chart Review

Patient Name: Patient DOB/Age:
FMOB Provider: Dr. EDD: Expected date of delivery
Pending Appt Date: Gestational Age: **GA on date of chart review**
Last visit Date:

G's, P's and Prior mode(s) of delivery	Gravida (Number of pregnancies), Para (Term, preterm, abortion, living) OB history complete, complications documented, weight of the infant(s), history of shoulder dystocia, postpartum hemorrhage, and/or pre-eclampsia documented if applicable
Dating	Dating updated- Based off of certain LMP or US? Is this accurate? (See dating guide)
Previous Medical History (PMH)	Completely filled out? Anything of concern or important to note. Any pertinent history should be documented (ex: epilepsy, asthma and severity, nephrolithiasis, chronic hypertension (controlled/uncontrolled) and meds taking, etc. Problem list should be updated with specific details
Problem List	Is there a BRIEF action plan documented for every problem? Ex- STI history, treatment plan for re-screening, HSV ppx at 36 weeks if applicable; Are all problems relevant? If a problem is resolved, recommendation should be made to discontinue it.
Medications	Medications patient currently taking, recently reconciled? Are they appropriate in pregnancy?
High Risk Pregnancy	Y/N- If high risk, what makes this pregnancy high risk? Has MFM been consulted? What are MFM recommendations? Make sure to look at the documentation from MFM that has been scanned in
Allergies	Type of reaction and severity, including latex and iodine
Social History	Is it filled out? Anything important to note? Domestic violence past or present, social support, occupation, living situation, alcohol, recreational substances, tobacco use, and seat belts
Blood Pressure	What is the trend of the blood pressures in clinic? Have all been normal? If elevated blood pressure recorded, did the patient have pre-eclampsia rule out? (Remember to look up guidelines on chronic HTN (before 20 weeks) vs gestational HTN vs pre-eclampsia
Weight category/gain	Pre-gravid weight- how much weight has been gained/lost? Is it appropriate?
Fundal Heights	Documented in flow sheet? If greater or less than 2cm, has an ultrasound been obtained/ordered?
Visit frequency	Has the patient been coming in as scheduled at appropriate intervals?
Labs	Has the patient had ALL appropriate labs performed. All abnormal labs followed up on and plan in place? Documentation correct? Reference Prenatal sheet to see what labs to order when.
Ultrasound	Dating/First trimester- Patient had a dating ultrasound? On the read any abnormal findings? Anatomy US completed? Growth appropriate? If high risk pregnancy and following with MFM or OB, has patient been getting appropriate US's recommended, if so how often?

Immunizations	Flu- anytime, T-dap 28-32 weeks, COVID- anytime RSV- 32-36 weeks; Any need for vaccinations **postpartum** (ex: Rubella or Varicella if non-immune), HPV?
Delivery/Newborn Plans	Plans to breastfeed? Pediatrician who will be following? Birthing preferences? Circ for baby if indicated?
Overall Recommendations	In summary, what are the overall updates that need to be made to the chart? What things need to be followed up on? What things need to be ordered that have not yet been? Please put order of recommendations based on the SIU chart review guide.

SIU-Quincy OB Chart Review

Patient Name: Patient DOB/Age:
FMOB Provider: Dr. EDD:
Pending Appt Date: Gestational Age:
Last visit Date:

G's, P's and Prior mode(s) of delivery	
Dating	
Previous Medical History (PMH)	
Problem List	
Medications	
High Risk Pregnancy	
Allergies	
Social History	
Blood Pressure	
Weight category/gain/loss	
Fundal Heights	
Visit frequency	

Labs	
Ultrasound	
Immunizations	
Delivery/Newborn Plans	
Overall Recommendations	

Note Templates for OB

SIU OB Triage Note

OB History and Physical

[Patient name] is a [patient age] [gravida/para] at [gestational age]

Chief Complaint:

Patient here for: [Free text]

History of Present Illness:

[Patient name] is a [patient age] [gravida/para] at [gestational age] who presents for evaluation of [Free text].

She endorses good fetal movement. Denies [vaginal bleeding, loss of fluid, or contractions]. Patient denies GU concerns of [dysuria, urgency, frequency, vaginal discharge, odor, itching, irritation, rashes or other symptoms concerning for STI or other infection].

[Denies pre-eclampsia symptoms of headache, scotoma, chest pain, shortness of breath, right upper quadrant abdominal pain, or edema]

Current pregnancy complications include: [ ]

Previous pregnancy History of: [ ]

PMH: [ ]

Past Medical History:

[Past Medical History in last 10 years]

Review of Systems:

[Review of systems- Complete]

Past Surgical History:

[Past Surgical History ALL]

Obstetric History:

[Pregnancy History]

Prenatal Provider: [ ]

Medications:

[Current Medication List]

Allergies:

[Allergies]

Social History:

Tobacco Use [ ]

Alcohol Use [ ]

Recreational Substance Use [ ]

Family History:

[Family History- ALL]

Physical Exam:

[Most recent vital signs]

Gen: No acute distress [ ]

CV: regular rate and rhythm; No murmurs, rubs, or gallops auscultated [ ]

Lungs: Bilateral breath sounds, no wheezes or crackles [ ]

Abdomen: gravid. soft. nontender to palpation [ ]

Extremities: Non-tender. Non-edematous [ ]

Sterile Speculum Exam (SSE): normal external genitalia without rashes or lesions. Vaginal mucosa appropriately pink and moist. [ ] vaginal discharge, Cervix visually [closed/open] [with/without] normal physiologic discharge. [Negative/Positive] pooling, [Negative/Positive] nitrazine, [Negative/Positive] ferning on dry mount

Wet mount: Normal squamous epithelial cells. [No/Present] yeast. [No/Present] clue cells, [No/Present] trichomonads.

Sterile Vaginal Exam (SVE): [cervical dilation]/[cervical effacement]/[station]

Fetal Heart Tones: [If NST (no contractions) reactive/non-reactive; If contractions present- Category [1/2/3]; Baseline of [ ] bpm with [minimal/moderate/marked variability]; [Accels present]; [No/late/variable/early decelerations]

Toco: 1 contraction every [ ] minutes

Prenatal Laboratory:

[Prenatal Labs]

[Labs obtained at visit]
Assessment/Plan:
[Patient name] is a [Patient age] [gravida/para] at [gestational age] who presents for [ ]. Pregnancy c/b [ ]. GBS [ ].

[**1. Labor Rule Out**
- SVE: [ ]
- Toco: [ ]
- [ ] Patient in labor, admit to L&D.
- [ ] Will keep patient on L&D and repeat cervical check in 2 hours for 2-hour labor rule out.
- [ ] Patient not currently in labor. Will send home with strict return precautions]

[**1. Rupture of Membranes Rule Out**
- [Dry Mount: Negative for pooling, nitrazine negative, negative ferning]
- Amnisure [negative/positive]]

[**1. Pre-Eclampsia Rule-Out**
- BP have been mild/severe range
    - Last BP:
- CBC, CMP, Uric Acid, LDH, Spot Protein/creatinine ratio]

[**1. Labor**
- SVE: [ ]
- Toco: [ ]
- Start Pitocin per protocol
- AROM when appropriate
- Expectant management ***]

[**1. Other Presenting Triage Problem**
- SVE: [ ]
- Toco: [ ]
- [ ]]

2. Fetal Well Being
- [Reactive NST/Category 1/2/3]
- Vertex by [Bedside ultrasound/sutures
- Last EFW- [percentile; date of US]

3. Maternal Well Being
- Afebrile, vital signs stable
    - Last BP: [ ]

4. Maternal Labs
- Rh [positive/negative], Rubella [immune/non-immune], GBS [positive/negative]
- HIV/HepB/RPR [non-reactive/reactive]
- Pre-natal Labs: Rh [pos/neg]/ Rubella [immune/non-immune]/ HBsAg, HIV, RPR [non-reactive/reactive] / GBS [negative/positive]

5. Pain
- IV meds or epidural prn

6. [Concerns/Complications- Gestational HTN, Gestational Thrombocytopenia, Gestational Diabetes ***]

Dispo: [Admit to L&D. Anticipate vaginal delivery/ Stable in L+D Triage. Patient counseled to return if she experiences contractions, vaginal bleeding, leakage of fluid or decreased fetal movement]

[Physician Name]
[Time/Date]

SIU Labor Progress Note

S:
Patient [feeling/not feeling] contractions. [Epidural in place].

O:
[Last vital signs]
Gen: [ ]
Sterile Vaginal Exam (SVE): [cervical dilation]/[cervical effacement]/[station]
FHT: Category [1/2/3]- baseline fetal heart rate at [ ] bpm with [minimal/moderate/marked] variability. [No/Yes] Accelerations present. [No/early/late/variable] decelerations present.
Toco: Q [ ] min

A/P:
[Patient name] is a [patient age] y.o. G[ ] P[ ] at [ ]w[ ]d who presented with [loss of fluid/contractions/etc.]. Pregnancy complicated by [ ]. GBS [positive/negative].

1. Labor
- SVE: [ ]
- Toco: [ ]
- Start Pitocin per protocol [ ]
- AROM when appropriate
- Expectant management [ ]

2. Fetal Well Being
- [Reactive NST/Category 1/2/3]
- Vertex by [Bedside ultrasound/sutures
- Last EFW- [percentile; date of US]

3. Maternal Well Being
- Afebrile, vital signs stable
    - Last BP: [ ]

4. Maternal Labs
- Rh [positive/negative], Rubella [immune/non-immune], GBS [positive/negative]
- HIV/HepB/RPR [non-reactive/reactive]
- Pre-natal Labs: Rh [pos/neg]/ Rubella [immune/non-immune]/ HBsAg, HIV, RPR [non-reactive/reactive] / GBS [negative/positive]

5. Pain
- IV meds or epidural prn

6. [Concerns/Complications- Gestational HTN, Gestational Thrombocytopenia, Gestational Diabetes ***]

Dispo: [Stable on L&D. Anticipate vaginal delivery.]

[Physician Name]
[Time/Date]

SIU Antepartum Progress Note

S: [Patient name] is feeling [well/unwell] this AM.

[Tolerating PO diet and fluids. Voiding spontaneously and passing flatus.]
[Positive Fetal Movement]. [Denies/Reports vaginal bleeding, loss of fluid, or contractions]
Concerns include: [ ]

O:
[Last set of vital signs]
Gen: No Acute Distress [ ]
CV: Regular rate and rhythm. no murmurs, rubs, or gallops auscultated [ ]
Lungs: normal resp effort. Clear to auscultation in bilateral lung fields [ ]
Abd: soft gravid. Non-tender. [ ]
Extremities: No pitting edema of the bilateral lower extremities
FHT: [ ]
Toco: [ ]

Labs: [Labs in last 24 hours]

A/P:

[Patient name] is a [Patient age] [gravida/para] at [gestational age] who presented on [date] with [ ]. She was admitted for [ ]. Pregnancy complicated by [ ].

1. [Patient problem]
- [ ]

2. Fetal Well-being
- Category [ ]/[Non-reactive/Reactive]
- Toco Q [ ] min
- [Betamethasone given [date]]

3. Maternal Well-being
- Afebrile, vital signs stable

4. Pain: Tylenol, Tums, Zofran PRN

5: Routine: Rh [negative/positive] / Rubella [immune/non-immune]/ GBS [positive/negative] / tdap [up-to-date/ not up-to-date] / HIV, RPR, Hep B [reactive/non-reactive]

Dispo: [Stable on antepartum].

[Physician Name]
[Date] [Time]

SIU Postpartum Magnesium Progress Note

S:
[Feeling well.]
[Denies headache, scotoma, vision changes, chest pain, shortness of breath/dyspnea, epigastric or RUQ pain, or swelling in legs].

O:
[Set of vitals in past 24 hours]
Urine Output: [urine output in past 24 hours]
Gen: No acute distress. [ ]
CV: Regular rate and rhythm. No murmurs, rubs or gallops auscultated. [ ]
Lungs: Normal respiratory effort. Clear to auscultation in bilateral lung fields. [ ]
Abdomen: soft, appropriately tender, no epigastric or RUQ tenderness [ ]
Extremities: Reflexes 2+ brachioradialis bilaterally. Non-tender, no edema. [No/Present] clonus
Labs: [Labs in past 24 hours]

A/P:
[Patient name] is a [gravida/para] now [PPD#[ ]/gestational age] who is on magnesium therapy for [ ].

1. Pre-eclampsia [with/without] severe features
- Blood pressures have been [mild/severe] range since delivery
- PRN BP meds:
- No [ ] symptoms
    - Pre-Eclampsia labs: [ ]
    - Urine Prot/Creatinine: [ ]
- [s/p 4g magnesium bolus, now on 2g/hr maintenance]
- Q4H clinical check, strict I&O's
- [No] Signs or symptoms of magnesium toxicity

2. Routine [Post-partum/Prenatal] Cares: Encourage ambulation as tolerated, lactation support prn

3. Pain: [Tylenol], [ibuprofen] prn

Dispo: Stable on magnesium, will discontinue magnesium at [ ].

[Physician Name]
[Date] [Time]

SIU Post-Partum Progress Note- Vaginal Delivery

Post-partum Day# [ ]

Subjective

[Patient Name] is post-partum day **[#]** and reports that she is doing well. Her foley **[in place] [was discontinued]**
The patient states pain is **[well/moderately/poorly]** controlled with current medications. The patient **[is/is not]** tolerating a normal diet**.** Patient states vaginal bleeding is **[scant/minimal/moderate/heavy].** Urinary output is **[adequate/inadequate].** The patient **[is/is not]** ambulating well**.** Flatus **[has/has not]** been passed.
The patient states feeling **[free text]** and **[has/denies]** emotional concerns.
Patient plans to **[breastfeed/bottle feed/ Both breast and bottle-feeding]**

[Problem List]
[Current Med List]
[Allergies]

Objective:
[Vital Signs in last 24 hours]
Gen: No acute distress
CV: Regular rate and rhythm, no murmurs rubs or gallops auscultated
Lungs: Normal work of breathing, clear to auscultation in bilateral lung fields
Abd: soft, appropriately tender, fundus firm 2cm below the umbilicus
Ext: nontender, no edema

[I&O's in past 24 hours]
[Last hemoglobin]
[Last hematocrit]
[Blood type & Screen]

A/P
[Patient name] is a [Patient age] [Patient G's and P's] who is Post-partum day #[ ] s/p [NSVD/VBAC/VAVD/FAVD]. Delivery was [complicated by/uncomplicated]. Her pregnancy was complicated by [list of pregnancy problems]. She is doing well post-partum.

. Maternal Well-Being:
- Afebrile, vital signs stable
    - Last BP: [ ]
- Urinary Output adequate overnight
    - Output in last 24 hours: [ ]
- Tolerating PO, okay to DC IV

2. Routine: Rh [positive/negative] / Rubella [immune/non-immune]
3. Pain: well-controlled on PO meds
4. Post-partum Birth Control: [ ]

Dispo: Continue routine PP cares, anticipate d/c to home on PPD#1-2.

[Signature of Physician]
[Date/Time]

SIU Post-Partum Progress Note - Cesarean Section

Subjective:

[Patient Name] reports that she is doing well. Her foley **[in place] [was discontinued]**
The patient states pain is **[well/moderately/poorly]** controlled with current medications. The patient **[is/is not]** tolerating a normal diet**.** Patient states vaginal bleeding is **[scant/minimal/moderate/heavy].** Urinary output is **[adequate/inadequate].** The patient **[is/is not]** ambulating well**.** Flatus **[has/has not]** been passed.
The patient states feeling **[free text]** and **[has/denies]** emotional concerns.
Patient plans to **[breastfeed/bottle feed/ Both breast and bottle feeding]**

[Problem List]
[Current Med List]
[Allergies]

Objective:

[Vital Signs in last 24 hours]
Gen: No acute distress
CV: Regular rate and rhythm, no murmurs rubs or gallops auscultated
Lungs: Normal work of breathing, clear to auscultation in bilateral lung fields
Abd: soft, appropriately tender, fundus firm 2cm below the umbilicus
-Incision: [Bandage with minimal saturation]
Ext: nontender, no edema

[I&O's in past 24 hours]
[Last hemoglobin]
[Last hematocrit]
[Blood type & Screen]

A/P

[Patient name] is a [Patient age] [Patient G's and P's] who is Post-op day #[ ] s/p [primary/repeat] LTCS for [reason for c-section]. Her pregnancy was complicated by [list of pregnancy problems]. She is doing well post-op.

. Maternal Well-Being:
- Afebrile, vital signs stable
  - Last BP: [ ]
- Urinary Output adequate overnight
  - Output in last 24 hours: [ ]
- Tolerating PO, okay to DC IV

2. Routine: Rh [positive/negative] / Rubella [immune/non-immune]
3. Pain: well-controlled on PO meds
4. Post-partum Birth Control: [ ]

Dispo: continue routine PP cares, anticipate d/c to home on POD#2-3

[Signature of Physician]
[Date/Time]

SIU Post- Partum Bleeding Progress Note

RN called with additional bleeding on fundal checks.
Pre-treated with [50mcg fentanyl/Epidural still functioning well/other]. Bimanual exam performed with removal of [ ]cc of clot. [800mcg rectal Cytotec placed.]
Uterus firm on fundal check with minimal continued oozing.

A/P:

Additional bleeding 2/2 [ ] .
EBL with delivery [ ] cc
EBL post-partum: [ ] cc
TOTAL EBL: [ ] cc
Uterotonics given: [ ]

[Physician Name]
[Date and Time]

SIU Newborn History & Physical

Subjective

Baby [Last name of newborn] is a [age of newborn] old [gender of newborn] infant born to a [age of mother] year old now G [ ] P [ ] mother at [gestational age] via [mode of delivery]. Pregnancy was complicated by [pregnancy complications]. Mother was GBS [positive/negative] Rh [positive/negative].
Mother plans to [breast/bottle/both breast and bottle] feed. Baby has been feeding for [ ] minutes on each breast every [ ] hours.
[ ] Patient has been voiding and stooling appropriately.
Mother has no concerns at this time.

Pregnancy

Gravida/Para: [ ]
Prenatal labs: [Prenatal labs]
Herpes: [Yes/No] [If yes- Mother had appropriate prophylaxis with negative sterile speculum exam?]
Pregnancy complications: [ ]
Maternal drug dependency: [none/Yes] [What substances is patient's mother dependent on?]

Maternal History: [Mother's significant medical history]
Family History: [Significant family History
Prenatal Medications: Home Medications: [ ]
Other Medications received during pregnancy:[ ]

Labor

Preterm labor?: [Yes/No]
Delivery Method: [NSVD/VBAC/VAVD/FAVD/PLTCS/RLTCS/Other]
Rupture Date: [Rupture date]
Rupture Time: [Rupture time]
Time of Birth: [Time of birth]

Analgesia: [Type of pain control mother received such as an epidural or other IV pain medications]
Labor Medications: [Pitocin, magnesium, etc.]
GBS: [Positive/Negative]- [If positive, did mother have appropriate amount of antibiotics during labor?]
Antibiotics received: [Which antibiotics received during labor and for what]

Physician Record of Newborn
Delivery
[Delivery Method]
Sex: [Gender of newborn]
Delivery Clinician: @DELRECITEM(HSB,35322,,1,,)@
Stabilization/Resuscitation:
Resuscitation: [Any resuscitation needed- Tactile, bag-mask, etc]

Additional resuscitation notes: [ ]

CORD ABGs:
[ABG's at birth if ordered]
Cord Venous Gases:
[Cord Venous Gases at birth if ordered]
Labs
[Labs ordered in last 24 hours]
APGARS
[APGARS at 1 and 5 minutes]

Newborn Measurements:
Weight: [Birth weight] Length: [Birth Length] Head circumference: [Birth Head circumference] Chest circumference: [Birth chest circumference]

Newborn
Feeding: [Breast/Formula/Both] [How often and for how long?]
First Void: [Positive/Negative]
First Stool: [Positive/Negative]

PHYSICAL EXAM

Vitals	[First set of vital signs]
General	Baby is an alert, vigorous [gender of infant] with appropriate behavior. No acute distress. [ ]
Skin/Color	Patient's skin is warm with normal turgor. The color of the skin is pink. There is no rash. There are no bruises or other signs of injury. No significant jaundice. [ ]
Head	The head is atraumatic and normocephalic. The anterior fontanel is open and flat; the posterior fontanel is open. [ ]
Eyes	Eyelid Edema. Red reflexes [obtained/deferred].
Ears	Pinnae and external ear canals normal. [ ]
Nose	There is no nasal flaring, nares patent bilaterally. [ ]
Throat	The oropharynx is normal. There is no cleft of the palate. [ ]
Neck	Clavicles without crepitus. [ ]
Thorax/Clavicles/Trunk	There are no retractions. There are no lesions on the trunk; there is no dimple over the presacral area. [ ]
Lungs	The lung fields are clear to auscultation. [ ]
Heart	The precordium is quiet. The heart rhythm is grossly regular. S1 and S2 are normal. There are no murmurs. The femoral pulses are normal. [ ]
Abdomen/Umbilicus	The umbilical cord stump is normal. There is not an umbilical hernia. The abdomen is flat and soft. [ ]
Genitalia/Anus	[Normal penis, Normal scrotum, Testes descended bilaterally. [Circumcised/Uncircumcised]] [Normal external female genitalia] [ ]
Extremities/Hips	Moving all 4 extremities. The hip exam is normal. There are no hip clicks or clunks. [ ]
Neurologic	Patient displays normal tone throughout and is not jittery. [ ] Normal tone, No Focal deficit. [ ] Moro: Present. [ ] Palmar grasp: Present. [ ] Rooting: Present. [ ] Suck: Present. [ ]

ASSESSMENT:

Impression: Newborn [term/preterm] [female/male] [infant age] infant born at [gestational age] weeks. APGARS were [ ] and [ ], at 1 and 5 minutes respectively Doing well.

1. Routine Newborn Care: Newborn admitted to Nursery. Routine Care.
- [Afebrile, vital signs stable]
- [Red reflexes obtained]
- Vitamin K shot and erythromycin drops completed [ ]
- [Will need bilirubin, CCHD screen, hearing screen, newborn screen and hepatitis B vaccine prior to discharge]
- Breastfeeding ad lib, lactation consult prn [ ]
- Monitor daily weights, follow I/O [ ]
    - Birth Weight:
- [plan for circumcision on [date] at [time]]
- Newborn talk (ABC's of sleep, breathing, crying/soothing, jaundice, fevers, I&Os, affection) prior to discharge [ ]

[**2. Any Newborn Concerns**- ex: LGA/SGA/Hyperbilirubinemia/Breech presentation]

Discharge plan: Plan to discharge on day of life [1-3]. Planned [family medicine physician/pediatrician]: [ ].

Patient will be seen by attending physician in AM.

[Physician Name]
[Date] [Time]

SIU Newborn Progress Note

Subjective: Baby [boy/girl] [Last name] is a [ ] hour old [patient sex] infant born to a [mother's age] year old now G[ ]P[ ] mother at [gestational age] via [delivery mode]. Pregnancy was complicated by [ ]. Mother was GBS [positive/negative]. Rh [positive/negative]. Mother plans to [Breast/bottle/ both breast and bottle] feed. Baby has been feeding for [ ] minutes on each breast every [ ] hours.
[ ] Patient has been voiding and stooling appropriately.
Mother has no concerns at this time.

Objective:

Vital	Last Value	24 Hour Range
Temperature	[Last temp]	[24-hour range of temp]
Pulse	[Last pulse]	[24-hour range of pulse]
Respiratory	[Last respiratory rate]	[24-hour range of respirations]

Vital	Today	Birth
Weight	[Most recent weight]	[Birth weight]
Height	N/A	[Birth Height

Weight over the past 48 Hours: [weight over last 24 hours]
Physical Exam:
Birthweight**:** [Birth weight] with [Percentage of weight lost since birth] change since birth.
General Appearance: Active, Alert, In open crib.
Skin/Color: Normal, [Pigmented birthmark(s)], Well perfused. [ ]
Head: Normocephalic, Anterior fontanel soft, Normal sutures, No Caput succedaneum, No Cephalohematoma.
Eyes: Eyelid edema, Red reflexes [deferred/present]. [ ]
ENT: Ears normally set, Nares patent, Normal facies, Palate intact, No Nasal flaring. [ ]
Neck: Supple, No Lesions. [ ]
Thorax / Clavicles: Normal. [ ]
Lungs: Non-labored respirations, Lungs CTA, No Retractions, No Stridor, No Stertor.[ ]

Heart / Pulses: Normal rate, Regular rhythm, No murmur, Capillary refill is brisk.
Femoral pulses: Left + 2 /+4, Right + 2 /+4. [ ]
Abdomen / Umbilicus: Rounded, Soft, Non-tender, Non-distended, Normoactive bowel sounds.[ ]
Genitourinary: [Normal penis, Normal scrotum, Testes descended bilaterally] [Normal external female genitalia]
Spine: No defects. [ ]
Extremities: Equal movement and strength in all extremities, Normal anatomy. [ ]
Hips: Normal Barlow's, Normal Ortolani's, Thigh creases symmetrical, No Hip click.[ ]
Neurologic: Normal tone, No Focal deficit. [ ]
Moro: Present. [ ]
Palmar grasp: Present. [ ]
Rooting: Present. [ ]
Suck: Present. [ ]

Last Stool: [Last stool]
I&O: [I&O from past 24 hours]
Labs: [Last Labs in past 24 hours]
Medications:
[Current medications]

Parent Support:
The parent(s) [have/have not] spoken with the nursing staff and [have/have not] received updates from members of the healthcare team by phone or at the bedside.

Impression: Newborn [term/preterm] [female/male] [infant age] infant born at [gestational age] weeks. [Doing well].

1. Routine Newborn Care: Newborn admitted to Nursery. Routine Care.
- [Afebrile, vital signs stable]
- [Red reflexes obtained]
- Vitamin K shot and erythromycin drops completed [ ]
- [Will need bilirubin, CCHD screen, hearing screen, newborn screen and hepatitis B vaccine prior to discharge]
- Breastfeeding ad lib, lactation consult prn [ ]
- Monitor daily weights, follow I/O [ ]
    - Birth Weight:
    - Weight change: [ ]% since birth
- [plan for circumcision on [date] at [time]]
- Newborn talk (ABC's of sleep, breathing, crying/soothing, jaundice, fevers, I&Os, affection) prior to discharge [ ]

[**2. Any Newborn Concerns**- ex: LGA/SGA/Hyperbilirubinemia/Breech presentation]

Discharge plan: Plan to discharge on day of life [1-3]. Planned [family medicine physician/pediatrician]: [ ].

Physician Name
[Date] [Time]

Postpartum Visit (Clinic)

S:
@NAME@ is a @AGE@ @GP@ *** weeks s/p *** delivery.
Outcome of delivery: ***
Mode of anesthesia at delivery: ***
Weight: ***
Apgars: ***
Pregnancy complications: ***
Bleeding: ***
Intercourse: ***
Bowel:***
Bladder:***
Mood: ***
Breast v bottle feeding: ***

Plans for future pregnancy: ***
Birth control: ***
***

O:
@VITALSLAST@
General Appearance: Alert, cooperative, NAD
Head: Normocephalic, without obvious abnormality, atraumatic
Eyes: PERRL, conjunctiva clear, EOMI
Ears: Normal TM's, canals clear bilaterally
Nose: Nares normal, septum midline, mucosa without erythema or bogginess. No congestion
Throat: normal oropharyngeal mucosa without erythema or exudate, dentition normal
Neck: Supple, no cervical lymphadenopathy, no thyromegaly
Back: symmetric, normal ROM, no paraspinal tenderness
Breast: *** no masses, discoloration or nipple drainage.
Genitourinary: ***Normal vulva, vaginal and cervix
Lungs: CTAB, respirations unlabored, no focal wheeze, rales or rhonchi
Cardiovascular: RRR, no murmur, S1, S2 normal, No murmur. No edema. Pulses WNL
Abdomen: Soft, non-tender, non-distended, no masses or organomegaly. Normoactive bowel sounds
Musculoskeletal: Normal strength in upper and lower extremities, normal gait
Skin: no rashes or lesions
Lymph nodes: cervical and supraclavicular nodes normal
Neurological: CNII-XII intact, normal strength and sensation, no focal deficit

A/P:
@NAME@ is a @AGE@ @GP@ *** weeks s/p *** delivery.
Normal postpartum course.
1. Birth control: ***
2. STI screening: ***
3. Pap: ***
4. Gardasil: ***
5. Smoking: ***
6. Routine medical issues: ***

RTC in ***

*** (Your name)***, MD/DO
Family Medicine

Dot Phrases

SIU Shoulder Dystocia Counseling [.siushoulderdystociacounseling]

[Patient name] recalls her previous delivery c/b shoulder dystocia as [ ]. When debriefing with her previous OB providers, she was told [ ]. We reviewed that the duration of her dystocia [ ] , resolution with McRoberts positioning, suprapubic pressure, and [ ] delivery of posterior arm, and no deficits (no fetal clavicular or humeral fracture, no nerve injury, or motor deficit) that she remains a good candidate for vaginal delivery, although her risk of having a recurrent shoulder dystocia would be approximately 10-15%, that risk may also be increased if this baby is larger than her previous. We discussed the possibility of primary c-section due to history of shoulder dystocia, although this is more recommended in the setting of fetal complications, which she did not have. Questions answered. She feels prepared to proceed with an attempt at vaginal delivery for this birth.

SIU TOLAC [.siuTOLACcounseling]

We discussed the risks vs benefits of TOLAC. We reviewed that a successful vaginal birth after cesarean delivery is associated with a shorter hospital stay, less blood loss, fewer transfusions, and fewer infections than cesarean delivery. The risks of an attempted vaginal birth after cesarean delivery include an approximate 0.5-1% risk of uterine rupture. When uterine rupture occurs, it may lead to fetal death, as well as severe neurologic injury to the baby. An unsuccessful attempt at vaginal birth after cesarean delivery sometimes also results in a higher risk cesarean delivery.

We reviewed the risks of cesarean delivery. These include infection, poor wound healing; injury to the baby; injury to nearby structures such as the bowel, bladder, ureter, nerves or major blood vessels; hemorrhage; the risk of needing a blood transfusion with those attendant risks; and the small, but real, risk of hysterectomy.

SIU Large for Gestational Age [.siulga]

2. Large for Gestational Age: [Birth Weight], [ ]th percentile
- blood sugars have been appropriate
- last blood glucose = [ ]
- Monitor blood sugars before feeds x 24 hours

SIU Breech Newborn [.siubreechnewborn]

2. Breech Presentation: [No hip clicks or clunks] on exam
- Hip US at 4-6 weeks of age

SIU Small for Gestational Age [.siusga]

2. Small for Gestational Age: [Birth Weight], [ ]th percentile
- Monitor blood sugars before feeds x 24 hours
- Monitor Blood sugars
    - Last blood sugar: [ ]

SIU Hyperbilirubinemia [.siuhyperbili]

2. Hyperbilirubinemia- [bilirubin level]; [Suspect [mixed picture of breastfeeding jaundice and physiologic jaundice].
Today's bili [ ] , [ ] risk; Rate of rise=[ ]
- Continue [ ] phototherapy
- Monitor I&O's
- [Rate of rise minimal and level now in low risk zone. Will stop trending bilirubin]

Cervical Exam Proctor Documentation

Date of Cervical Exam:

Proctor Name:

Proctor signature:

Comments:

Date of Cervical Exam:

Proctor Name:

Proctor signature:

Comments:

Date of Cervical Exam:

Proctor Name:

Proctor signature:

Comments:

Date of Cervical Exam:

Proctor Name:

Proctor signature:

Comments:

Date of Cervical Exam:

Proctor Name:

Proctor signature:

Comments:

June 2023

Resident Wellness
Guide for Mental Health Resources

Office of Graduate Medical Education (OGME)

Residency training is a time of tremendous personal and professional growth. It can also be very stressful. It is not at all uncommon for residents from time to time to feel stressed, overwhelmed, burned-out, or even to develop clinical depression. If you should experience any of these, we encourage you to seek or accept help. You do not need to shoulder these burdens alone. If you are feeling overwhelmed, find someone you trust to talk to, whether it be a colleague, friend or family member, your doctor, your pastor, or your program director. For any resident who needs some professional assistance, multiple resources are available.

These resources and how to access them are reviewed in this publication.

HOSPITAL EMPLOYEE ASSISTANCE PROGRAMS

Springfield

HSHS St. John's
"Compsych Guidance Health Resources"
(877) 327-7429

Springfield Memorial Hospital (217) 788-9345
Employee Assistance Program | Memorial Health Memorial Central/EAP Quicklinks

Affiliates

Alton Memorial Hospital
(888) 505-6444

Blessing Hospital—Quincy
(217) 224-4454

Decatur Memorial Hospital
(217) 788-9345 Employee Assistance Program | Memorial Health Memorial Central/EAP Quicklinks

Memorial Hospital of Carbondale—SIH
(800) 356-0845

Counseling OR Therapy: Hospital Employee Assistance Program (EAP)

An employee assistance program is provided for all residents and fellows by their employing hospital. This program provides professional, confidential assistance by a counselor to anyone in need. This is free, and no record of contact with the counselor is placed in your medical records, Health Service records or personnel file. All contact is kept confidential, except as required by law or in situations deemed potentially life-threatening.

If you are in crisis, please call or text The Suicide & Crisis Lifeline at 988 or chat online at 988lifeline.org/chat

Insurance Information

To find out the current panel of psychologists and psychiatrists available to you through your employing hospital's health insurance plan, please contact the following companies.

HSHS St. John's
Aetna HMO & PPO
Residents Benefit Plan
https://www.virtualfairhub.com/hshs/Medical-Residents

Springfield Memorial Hospital
BCBSIL PPO
844-266-8797
http://bcbsil.com/

Blessing Hospital
Self funded—SMH Benefit Services
(217) 223-1200 Ext.6850

Decatur Memorial Hospital
BCBSIL PPO
844-266-8797
http://bcbsil.com/

Southern Illinois Healthcare
Health Alliance
(800) 851-3379
OR Consociate
(800) 798-2422

Alton Memorial Hospital
Cigna Local Plus
Cigna Open Access Plus
(800) 244-6224

Office of Graduate Medical Education (OGME)

301 N. 8th Street, Suite 3A158
Springfield, IL 62701

Phone: 217-545-8853
Email: jrodgers@siumed.edu

www.siumed.edu/gme/resident-well-being.html

Visit the Wellness section of the OGME website for information on general wellness, self-assessments, stress management, and mental health.

Psychiatric Care

Any resident or fellow who is in need of brief psychiatric intervention can utilize a confidential service offered by the Office of Graduate Medical Education (OGME).

This includes one psychiatric evaluation and up to six follow-up visits, free of charge with no questions asked.

A resident or fellow wishing to utilize this service can ***contact OGME at (217) 545-8853*** and request a confidential number in order to access services.

You do not need to give your name. All treatment information is kept confidential except as required by law, or if the resident gives permission.

AVAILABLE PROVIDERS

SPRINGFIELD	Memorial Specialty Care Psychiatry (Vine Street Clinic)***** (217) 862-0115 — *Clinic Manager*
	SIU SOM Psychiatrists *** #** (217) 545-7687— *Clinic Administrator Emily Snow*
	*** accepts Memorial / Health Alliance** **# accepts Aetna HMO / PPO**
ALTON, CARBONDALE, DECATUR and QUINCY	SIU SOM Psychiatrists via Telehealth (217) 545-7687

HOW TO ACCESS CARE

1. Contact OGME to request a confidential service number; (217) 545-8853.
2. Call the number of the selected provider & identify yourself as an SIU Resident with a confidential number to access psychiatric services.
3. The *contact person* will arrange an appointment.
4. It is recommended that insurance information not be provided until the resident determines if they will continue with treatment beyond the evaluation & 6 visits.

24 Hour HelpLine: (800) 215-4357

http:// www.illinoisphp.com/

The Illinois Professionals Health Program (IPHP)

The Illinois Professionals Health Program (IPHP) is a statewide program providing support, accountability, and earned advocacy for healthcare professionals throughout Illinois. The IPHP is recognized by the Federation of State Physician Health Programs (FSPHP) as the approved physician health program for Illinois, the National Organization of Alternative Programs (NOAP), and the National Council of State Boards of Nursing (NCSBN) as the alternative to discipline program for Illinois. The IPHP provides confidential consultation, support, and monitoring/case management services to healthcare professionals facing behavioral, mental or physical health concerns that may affect the professional's health, well-being, or ability to practice his or her profession. The Illinois Professionals Health Program complies with Federal law 42 U.S.C., 290dd-2; 42 C.F.R. Part 2, which protects confidentiality. Participation in the IPHP is voluntary and confidential. Communication with the IPHP is kept strictly confidential .