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ADMINISTRATION

The University of North Dakota Center for Family Medicine Hettinger, is a fully accredited rural residency training facility. The Center is administered by the West River Regional Health System in affiliation with the University of North Dakota School of Medicine and Health Sciences. We are a three-year program and accepts one first year resident annually through the NRMP Match.

Our program is sponsored by West River Regional Health Systems and enjoys the tremendous support from the local medical faculty.

FACULTY:

Program Director: Jeff Hostetter, M.D.

Site Director: Cathy Houle, M.D.

Assistant Program Directors: Jackie Quisno, M.D.
Gary Betting, M.D.
Guy Tangedahl,Md
Karin Willis, M.D.
Joseph Luger, Md (Dermatology)
Brynn Luger, MA, LPCC, NCC (Clinical Counselor)

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Overall Program Goals/Mission Statement

1) To provide well-trained family medicine physicians to meet the needs of the people of North Dakota.

2) To provide continuing, comprehensive quality healthcare in family medicine.

3) To provide an integrated and progressive educational program for resident physicians.

4) To provide the opportunity for each resident physician to develop and maintain a continuing physician-patient relationship.

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Paramedical/Ancillary Staff

The Center for Family Medicine is fortunate to have a dedicated and enthusiastic ancillary staff. The following is an abbreviated description of the duties for each classification of positions. The staff performs many other duties other than those described below; however, this information is to provide you with the basic function of each job classification.

Business Manager
The Business Manager is responsible for the overall supervision of the ancillary staff and insures the efficient function of most aspects of the clinic. She/he is involved with the budget process (clinic operations and financial management), risk management, personnel administration/human resources (staff procurement), marketing and public relations, and ensures compliance with regulatory agencies. In addition to this, this person is in charge of coordinating the Practice Management/Management of Health Systems module rotation and training for the Residency Program and is involved in the Residency Recruitment process. The Business Managers at the UND-CFMs now have a direct reporting relationship on our Organizational Chart the Associate Dean of Administration & Finance at UND's School of Medicine & Health Sciences. The Business Manager is also a member of the UND-CFM's Oversight Committee.

Residency Coordinator
The Residency Coordinator is responsible for the overall scheduling of the Residents. He/ She coordinates Resident schedules with Community Preceptors, Director's schedules, and clinic Preceptor schedules. He/ She is responsible for the monthly calendars (call schedules and rotation schedules) as well as preparing evaluations for dissemination for all of the required residency rotations. The Admin Assistant also is responsible for maintaining Accreditation documents for the Residency Program, and completes the Residency Billings that are invoiced to our sponsoring hospitals for GME reimbursement/reconciliation. This person is responsible for tracking the Resident's clinical and hospital encounters, rural rotations, and elective experiences.

Nursing Staff – Team
This department consists of clinic nursing staff (RNs & LPNs). In addition to this we have a Geriatric Nurse Coordinator and Diabetic Nurse Coordinator. Our nursing staff is efficient and knowledgeable. You will find that you can depend on them to serve you and your patients effectively. They prepare patients to be seen by the physicians, maintain the exam rooms for procedures, schedule appointments for your patients with other physicians and services based on your orders, keep the team pod stocked with supplies and medications, and prioritize patient messages.

Medical Records
Medical Records staff manage all patient charts prior to their visit, file test results, etc. in the patient charts and re-file the charts after the preceptor process is completed. This department is also in charge of HIPAA compliance as well as Release of Information. Presently, our Medical Transcription is outsourced, so the Medical Records Staff are responsible for obtaining signatures and filing of transcription as well.

Front Desk Receptionist/Schedulers
The receptionists are responsible for answering telephone calls that come into the clinic and maintain the core switchboard, routing calls as appropriate. They are responsible for setting up physician schedules and scheduling all patient appointments for physicians, nurses and ancillary support services. The receptionists are also responsible for collecting co-pays and writing receipts for the patients. The receptionists validate patient demographics and insurance information upon the patient's entry to the clinic system. In addition, they follow-up on no-show appointments with a letter to the patient. This department is also in charge of sorting the daily mail and payments. The payments are written on the daily payment log.

Radiology
The department is staffed with a radiologic technologist and a certified Diagnostic Operator. Service is provided during regular clinic hours. Our department performs general diagnostic x-rays and is equipped with a computerized radiology system. Images are read by Sanford's radiologists by means of a PACS system. Radiology is cross-trained to do electrocardiograms, holter monitors, event monitors, pulmonary function tests and hearing screenings.

Laboratory
This department consists of laboratory scientists. Our in- house testing is broad and includes urinalysis, chemistry, hematology, microbiology, serology, and coagulation. What we are unable to do on-site is sent to a reference laboratory. The Laboratory Director/Supervisor at the core/Bismarck site acts as the lead team member on the UND-CFM's Risk Management Committee and is responsible for tracking/trending of our Incident Reports.

Patient Accounts & Billing (Business Office)
This department consists of certified Professional Coders. The department is in charge of the clinic and hospital billing. They are responsible for maintaining proper billing procedures along with coding the charges with the correct ICD9 diagnosis and CPT Procedures. They make sure all insurance is filed and updated on any major insurance changes. They manage the accounts receivable for charges and collections and reconcile the daily deposit.

Pharmacy
The pharmacy department at the core/Bismarck site is in charge of assisting the residents/faculty with any medication/prescriptions needs. The CFM Pharmacy is open Monday-Friday from 8am-5pm. The pharmacy offers a variety of over-the-counter medications, supplies, and prescriptions to our staff, residents, and patient populations. All pharmaceutical representatives report to the pharmacy for scheduling, displays, and drug samples where the samples are stored, inventoried, and dispensed to the patient (with a valid order from MD's).

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Clinic and University Websites:

Policy and Procedures will be emailed to residents and all clinic departments. A hardcopy of the manual can be found in lab, medical records, nursing and administration.

The URL for the **UND Center for Family Medicine Bismarck** is:

http://www.cfmbismarck.und.edu

The URL for the **UND Center for Family Medicine Hettinger** is:

Direct patients and prospective residents to the site as necessary. Biographical sketches/photos are included on the site for all Faculty and Residents.

The URL for the **UND School of Medicine & Health Sciences** is:

http://www.med.und.edu/

You can link back to UND Center for Family Medicine Bismarck and Hettinger by locating the Department's Academic tab.

The URL for the UND School of Medicine & Health Sciences **Graduate Medical Education** information page is:

http://www.med.und.edu/residency

All UND residents and faculty are required to complete the **UND Institutional Review Board's (IRB) Human Subjects Training Module**. The URL for this module is:

www.citiprogram.org

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Resident Recruitment Criteria

Purpose: To provide the UND Center for Family Medicine Hettinger with qualified candidates for residency selection.

Policy: The UND Center for Family Medicine Hettinger will use the following guidelines for resident selection:

1. All applicants must hold a doctor of medicine or doctor of osteopathic degree from a medical school approved by the North Dakota Board of Medical Examiners with the date of graduation to be five years or less from start of residency.
2. All applicants must have completed USMLE Step I and Step II, preferably with a score of 80 or above.
3. All applicants must meet the requirements set forth by the North Dakota Board of Medical Examiners to be licensed in the state of North Dakota. In specific, applicants are permitted a maximum of three attempts to pass each step of the licensing examination. The examination requirements must be successfully completed within a seven (7) year period.
4. All applicants must submit two letters of recommendation from a US clinic/hospital or US practicing physician.
5. If an applicant does not meet the above criteria, they can be considered only if they successfully complete an observership at the UND Center for Family Medicine Hettinger or Bismarck.

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CFM Clinic Responsibilities

1. Clinic has priority over rotational responsibilities.
2. Notify the receptionist and/or your nurse at the earliest possible time if you will be late/absent from clinic.
3. Morning clinic schedules ***begin promptly at 9:00 a.m.*** Please call your team nurse directly if you anticipate running late.
4. Afternoon clinic schedules Tuesday through Friday begin promptly at 1:00 p.m.
5. Monday afternoon schedules begin after the residents business meeting (1:30 p.m.)
6. A maximum number of six physicians are scheduled per one-half day. No more than four residents per half day, unless a second preceptor is available.
7. Effective May 1st of each year, third year residents may drop to two half days per week until graduation. (During the last five clinic days in June, third year residents are scheduled to work ½ day). This is contingent upon having adequate clinic numbers. Residents are required to see 1650 total patients for the three years.
8. All PGY-1 clinic patient encounters need to be precepted by a CFM faculty member **BEFORE** the patient leaves the clinic.
9. For PGY-2 and PGY-3 residents, a minimum of every third clinic patient encounters needs to be precepted by a CFM faculty member.
10. All Medicare patient encounters need to be precepted by a CFM faculty member. A faculty member must see and examine Medicare patients that are scheduled in clinic for PGY-1 residents during the first 6 months of the PGY-1 training. All Medicare patients provided Level 4 or 5 care must be seen and examined by a precepting faculty. Also a faculty member must be physically present and actively participate for all procedures on Medicare patients. The precepting faculty must write a brief note in the patient chart for all Medicare visits.
11. Resident clinic notes will be audited/reviewed by CFM faculty preceptors.
12. It is mandatory for all OB visits seen by a Resident to be precepted with the Attending Physician **BEFORE** the patient leaves the clinic.

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Clinic Chief Resident Responsibilities

1. Meetings and Conferences:
   A. Chair the resident weekly business meeting or arrange for the Clinic Chief Resident to do so.

      1. Coordinate questions or problems that need to be discussed at the business meeting.
      2. Inform residents of policies and/or policy changes.
      3. Take and dictate minutes of the meeting.
      4. Place weekend call schedule on board in large conference room.

   B. Represent Center for Family Medicine at meetings as assigned or required.

   C. Follow guidelines of Conference Attendance Policy-please see policy for details.

2. Clinical:
   A. Act as back-up physician in clinic for: medical students, interns, physicians on extended vacations/leave and walk-in patients.

   B. Arrange medical student orientation and work/call schedule as well as be involved in overseeing their clinical education.

   C. Act as liaison between the residents and the CFM Clinical Staff.

   D. Screen telephone calls requested by receptionists and other staff.

   E. Attend all Center for Family Medicine deliveries as able.

   F. From 8:00 a.m. to 5:00 p.m., assist in taking telephone questions from Nursing Homes regarding UND's Nursing Home patients when the primary care physician cannot be reached. The Geriatric Nurse, Chris, can be very helpful when these situations arise.

3. Other duties as required or assigned:
   A. Promote educational activities.

   B. Receive and handle items referred by the program coordinator, nursing staff, and/or other clinical staff.

   C. Act as back-up to interns for the FMTS.

   D. Coordinate orientation of new interns to various departments.

   E. Escort prospective residents on date of interview.

I acknowledge that I have read and understand the above responsibilities.

_____ _____

Name Date

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FMTS Intern Responsibilities

1. Interns are expected to, under the direction of the Senior resident, utilize every opportunity to gain experience in the Emergency Room or the Inpatient ward.

2. As directed by the Senior resident, Interns will be responsible for admitting patients to the Family Medicine Teaching Service (FMTS), performing daily rounds on FMTS patients, and finding patient information among other duties as necessary for patient care.

3. The Senior resident is expected to give the Intern requested guidance and teaching regarding patient care, so ask for help.

4. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

_____ _____

Name Date

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FMTS Senior Resident Responsibilities

1. Senior residents are responsible for admitting all UND Center for Family Medicine (CFM) faculty patients, patients transferred from outlying communities and facilities as well as all "unassigned" patients that are admitted to the Family Medicine Teaching Service (FMTS).

    A. If the Senior resident admits a CFM patient that has been previously admitted and cared for by another CFM resident or another CFM resident is that patient's primary care physician, the care is transferred to the other resident the following working day at 8:00 a.m. This is contingent upon the patient's request (priority #1) and mutual understanding between the physicians involved

    B. All patients on the FMTS must have an Information Sheet (BOHICA Sheet) in order to facilitate communication at sign-out to the other residents. It is the responsibility of the admitting resident to complete the Information Sheet initially. It should be filled out at the time of admission and must be updated before each sign-out.

2. The attending physician must be notified of all acute status changes (i.e. ICU admissions, emergent surgeries, marked clinical deterioration, etc.) on patients on the FMTS.

3. Emergency Room Responsibilities.

    The Senior resident may be called for all CFM patients seen in the Emergency Rooms. The Emergency Room physician may call the CFM resident (s) on call at his/her discretion for the care of CFM patients and assistance with the Emergency Room workload. No patient may be discharge from the Emergency Room with out being seen and the chart signed by a licensed physician.

4. The Senior resident is responsible for responding to CFM patient telephone calls after regular clinic hours when they are on call from home.

5. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

_____ _____

Name Date

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Conference Attendance Policy

Purpose:
Noon conferences are a significant portion of the learning residents receive, and is essential for board preparation and future practice. Thus attending as many of these sessions as possible is of high priority. This policy delineates strategies to achieve compliance with attendance goals.

Policy:
1. Mandatory Conferences/Events will be published on the monthly calendar by the Residency Coordinator.

2. Residents are required to attend 75% of conferences.
   A. The attendance requirement can be met in two ways: 1) live attendance at the conference, or 2) viewing the recording of the conference on the internet.
   B. If the conference recording is viewed, the resident must send an email to the Residency Coordinator answering the questions at the end of this policy in order to receive credit for viewing.
   C. No more than 25% of conference attendance can be done by viewing recordings.
   D. Residents are excused from attendance if they are on vacation, CME, personal days, sick leave, or out-of-town rotations.
   E. Residents on night FMTS rotations are expected to view the conference recordings and are NOT excused from the requirement.

3. Attendance reports will be distributed monthly.

4. Deficient residents must make up their deficiency in the next semester.

5. Consequences for deficient attendance:

   A. Residents may not use ANY of their vacation time if they are below the 75% attendance mark. This includes time for family events and elective doctor's appointments. Residency Coordinator will keep track of the percentage on a daily basis and notify resident and faculty when the 75% mark is met.

   B. If the resident is out of vacation time, the resident will be required to view recorded conferences during their continuity clinic time. They will not be able to see patients until the 75% mark is met.

* Answer these questions via email to Residency Coordinator after viewing a recorded conference in order to receive credit for the conference.

Name:
Title of presentation:
Date and time watched online:
1) One thing I learned from the presentation:
2) One change I will make in my practice from watching the presentation:

Goals and Objectives Policy

1. Residents are required to review the Goals and Objectives for each rotation with their preceptor no later than the end of the first week of the rotation.

2. Residents are required to have the preceptor sign the Goals and Objectives, and then turn them into the Program Coordinator by the Monday after the end of the first week of the rotation.

3. If the resident fails to turn in the signed Goals and Objectives form, the resident can be placed on vacation until the form is turned in. They can also be taken out of their continuity clinic until the form is turned in.

4. Goals and Objectives are provided to each resident at a minimum of one week prior to any rotation. Goals and Objectives can also be downloaded from the residency website by following the link below.

   http://www.cfmbismarck.und.edu/?id=54

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Criteria for Advancement to Senior Resident Level

Purpose:
To ensure that a senior resident is qualified to supervise first year residents.

Policy:
The following criteria must be met in order for a resident to assume Second Call duties:

1. The USMLE Step 3 must be taken by June 30th of the calendar year; i.e. by the end of the PGY-1 year.
2. Faculty must confirm that the resident is qualified to provide PGY-1 supervision in a manner that is safe for patients.
3. If the USMLE Step 3 is failed, whether the resident may continue on Second Call will be determined on an individual basis. Criteria considered by faculty in this situation will include, but not be limited to:
    - A. In-Service Training Exam scores
    - B. Academic standing documented on evaluations
    - C. Number of rotations passed during the PGY-1 year

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Weekly Time Records for Residents

Purpose:
To insure compliance with all duty hour time regulations stipulated by the ACGME.

Policy:
1. All residents will daily log their duty hours using the E*Value website.
2. If the duty hours are not submitted by the end of the third day of the week, the resident will be contacted by the Program Coordinator; then, the Program Director will recall the resident from their assigned duties and place them on vacation time until they submit their duty hours. This will likely have a negative impact on the evaluation for their current rotation.

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Resident Procedure/Experience Data Base Instructions

All residents are required to turn in a listing of their procedures during their time spent at the UND Center for Family Medicine. These records will be used to obtain hospital privileges at the hospital when you have completed residency. You may use one of the following two options to record your procedures:

1. Experience Cards (Yellow Cards) Please fill in as much information as you have on the patient, the diagnoses, and procedures performed. (You may use a hospital sticker for the patient information section, but please be sure to list your preceptor).

2. Procedure spreadsheet. You may start your own spreadsheet with patient information. Please use the format of the spreadsheet template that is available from the Program Director.

This information should be turned into the Program Coordinator every year in May and November in order that it may be included on your semi-annual evaluation and ACGME Milestone assessment.

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Miscellaneous Hospital Policies

The following is a general overview of Hospital Issues. Please refer to the Medical Staff Policy Manuals of West River Regional Health Systems, Sanford Health Systems, and St. Alexius Medical Center for details.

1. All Admissions, Discharge Summaries, and Procedures need to be done under the name of an attending physician. It is important to write the name of the attending physician on **all** orders and to specifically mention the name of the attending physician on **all** dictations.

2. Family Medicine Residents are not responsible for coverage of any area of either hospital except at outlined in the section titled Residents and as assigned by rotational preceptors. This means that residents are NOT solely responsible for running CODES or coverage of the ER; however, it is expected that residents will participate in these activities.

3. It is expected that ALL documentation will be timely, written or dictated clearly, concisely and with completeness. Use **only** well recognized and approved abbreviations.

4. Services available to residents at either hospital at no charge include: Lab coats, Meals at St. Alexius, Library services, and Parking.

5. Although there is no specific dress code at the CFM or at either hospital, it is required that physicians dress in a professional and responsible manner. Scrubs are discouraged when seeing patients in continuity clinic, and are allowed to be worn only when residents are on a hospital-based rotation where changing clothes would not be possible to make it to clinic on time; e.g. FMTS, Obstetrics, and Surgery.

6. Family Medicine residents do not have Active Staff clinical privileges at either hospital. Clinical privileges for residents are determined by the clinical privileges of their attending physicians. The level of supervision of residents is determined by level of training of the resident and level of comfort of the attending physician.

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Protocol for Care for Complex Patients

These protocols provide guidance to residents in common circumstances requiring faculty involvement: care of complex patients, ICU transfer, DNR decisions, etc.

1) Inpatient FMTS service
When issues arise where there is need for 1) increased supervision of care, 2) expert consultation on the complex patient, 3) overwhelming volume of patient care, or 4) any other situation where the resident does not feel comfortable making decisions, the following protocol should be followed:

a. Contact the attending physician – explain situation and ask for guidance.
*The attending physician is responsible for determining the course of action.

b. If unable to contact the attending, contact the Site Director or Program Director.

Related policies/protocols:

A. If resident on the FMTS is ill, they should contact the attending physician who will adjust staffing and patient load as they deem necessary to ensure balance between service and educational obligations.

B. The FMTS has a hard cap of 10 patients.

2) Outpatient continuity clinic
When issues arise where there is need for acute patient care outside the scope of the clinic setting, the following protocol should be followed:

a. Contact the precepting physician – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

3) Nursing home or other long-term care facility:
When issues arise where there is need for higher level of care or any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

b. During the night, contact the FMTS attending physician – explain situation and ask for guidance.
*The FMTS attending physician is responsible for determining the course of action.

c. If unable to contact the precepting or attending physicians, contact the Site Director or the Program Director.

4) Patient phone calls
When issues arise where there is any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

b. During the night, contact the FMTS attending physician – explain situation and ask for guidance.
*The FMTS attending physician is responsible for determining the course of action.

c. If unable to contact the precepting or attending physicians, contact the Site Director or the Program Director.

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Hospital Admission Responsibilities

1. Weekdays (7:00 a.m. – 7:00 p.m.)

    A. All patients are to be admitted by FMTS residents. If there is no resident currently on the FMTS rotation, the patient will be admitted by the physician on call.
    B. When a clinic patient is admitted to the hospital by other than the primary care resident, the patient is transferred to the primary care resident or FMTS resident as soon as possible. The admitting resident is responsible for the orders and the history and physical.
    C. Unassigned patients admitted through the ER are admitted by the FMTS residents.

2. Weekday Nights (7:00 p.m. – 7:00 a.m.)

    A. All patients to be admitted and cared for by the physician on call.

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Patient Scheduling

1. First year residents are scheduled 3-6 patients per afternoon; half an hour per patient. Please contact the front desk if more time per patient is needed or if more patients can be scheduled.

2. Schedules can be checked in the EMR.

3. Except in emergencies or special arrangements, patients are seen by appointment; however, walk-ins are welcome.

4. If a physician asks an unscheduled patient to come to the clinic, the physician needs to notify the front desk so the patient's chart can be pulled before the patient is seen. If a patient comes in for an exam and is to return for lab work the nurse must be notified.

5. Residents that have morning clinic are expected to arrive at 9:00A.M. Those with afternoon clinic hours are expected to arrive at 1:00 P.M. and remain in the clinic until 5:00 P.M. to cover walk-ins and/or late scheduled patients.

6. If a physician is delayed for a scheduled appointment at the clinic, always notify the appointment desk personnel.

OB Scheduling

1. OB patients will be scheduled with a specific resident if they so request.

2. If the patient does not have a preference or does not request a physician, the patient is scheduled with a resident on a rotating basis.

Home

Inpatient Pediatrics

Purpose:
Provide adequate funding for the required inpatient pediatrics rotation.

Policy:
1. All residents will be required to do a one month rotation with the University of Colorado Pediatrics Department.
2. In addition to the regular monthly salary that the resident will continue to receive while in Denver, the UND Center for Family Medicine will refund the resident mileage to and from Denver at the current state rate.

Medical Coverage for Sporting Events

Purpose:
To delineate the procedures for insuring adequate medical coverage when residents and faculty are providing medical coverage for sporting events.

Policy:
1. Faculty, PGY-2 or PGY-3 residents are allowed to provide medical coverage at sporting events in the community.

2. If a resident is providing coverage, a faculty member must be either concurrently present at the event or be available by phone to provide immediate consultation. The resident is responsible for establishing the consulting coverage arrangements BEFORE the start of the sporting event.

3. Medical care will be provided by either the faculty or resident physician based on the policies, procedures and medical releases/permissions of the team.

Moonlighting

1. Moonlighting activities will not interfere with the resident's clinic, hospital, or rotational responsibilities.

2. Moonlighting will **NOT** take priority over the resident's clinic schedule. Clinic or rotation responsibilities will not be shortened for moonlighting purposes.

3. Residents must keep track of moonlighting in their log book.

4. Residents may not moonlight when scheduled on second call or as chief.

5. Residents must log their time spent moonlighting as duty hours in E*Value

6. Refer to the "Moonlighting Policy For Residents" at the UND SMHS GME policies website.

http://www.med.und.edu/nonou/residency/policies.html

Home

Vacation

1. Vacation time with pay is earned by residents for the purpose of freeing the resident from his/her regular duties to spend time in rest and recreation. Vacation time **cannot** be carried forward from year to year, or accumulated at the end of the residency. **Use it or lose it.**

2. Vacation requests should be presented as far in advance as possible and must be approved by the Vacation Committee. The Vacation Committee is made up of the Site Director, a faculty member, and the program coordinator. It will meet every two weeks to review leave requests.

   The committee will use the following guidelines for approving leave:
   a) First come, first served.
   b) No leave allowed if resident is on **NICU**, **Inpatient Peds**, or **FMTS** rotations.
   c) No leave allowed the last week of June and first week of July.
   d) For a two week rotation, only is two days of leave allowed. For a month rotation, only five days of leave is allowed.
   *e) For situations involving emergency, health, family problems, or other special circumstances, please attach a written explanation requesting variance from the above policies to the Leave Slip.

3. Procedure residents are to follow in requesting leave:
   a) Arrange call coverage for the days off requested.
   b) Submit request at least two weeks in advance by completing a Leave Slip and placing it in the black box on the Program Coordinator's desk.
   c) Leave slip will be returned to you in your mailbox with either approval or denial written on it. If denied, the reason for denial will be written as well. Special circumstances will be considered, but are not a guarantee that approval will be granted.
   d) Have front desk supervisor sign off that clinic is covered.
   e) Return slip to Program Coordinator.
   ***f) Leave not officially approved until you get front desk approval and return the slip!**

4. Vacation requests, during the last week of June and the first week of July may be granted with prior approval.

5. A maximum of one week is granted during any single rotation.

6. If more than two residents from a given year of training (PGY-1, PGY-2, PGY-3) request vacation for the same period, approval shall be subject to the Program Director's discretion.

7. Annual leave with pay is earned on the following basis:
   First Year Resident – 15 working days plus 5 CME days
   Second Year Residents – 15 working days plus 5 CME days
   Third Year Residents – 15 working days plus 5 CME days
   * Total leave time for conferences **includes** travel time.

8. Personal leave may be granted for illness, maternity, paternity, funerals, interviews, or family emergencies.

9. If personal leave days, plus vacation days total more than twenty working days in a calendar year (July - June), those days shall be made up at the completion of the residency per ABFM policy.

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Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about the individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is important element contributing to high quality care.

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.
2. The documentation of each patient should include:
    - Reason for the encounter and relevant history, physical examination findings and prior diagnostic results;
    - Assessment, clinical impression or diagnosis;
    - Plan for care;
    - Date and identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-10 CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Home

Dictation Time Limits

Purpose:
To keep our clinic chart dictations as up to date as possible to ensure the best possible patient care and safety.

Procedure:
1. All faculty and resident providers will have 7 days after the date of visit to have a note for the visit dictated.

2. All dictation must be verified and signed by the provider within ten days of the clinic visit.

3. If dictation is delinquent, the medical records staff will inform the Site Director.

4. The intervention for being delinquent will be to not allow any patient visits to be scheduled beyond what is already on the provider's schedule.

   a. Patient's visits will not be cancelled, but no visits will be added until the provider has completed all delinquent visits and all current visits.

5. Although providers are strongly encouraged to complete and sign all dictation before going on vacation, the above time limits can be interrupted by vacation time without penalty. For example, if a provider goes on vacation after five days of seeing a patient. They will have an additional two days to complete their dictation upon returning to work.

Notification of Diagnostic Report Results

Notification of diagnostic results to patients is to be monitored to insure that physicians are reviewing patient results and patients are receiving their diagnostic test results in a timely manner.

a. Routine reports will be communicated with the patient within 2 weeks of receiving the report.
b. Critical reports will be communicated ASAP from when the report was received.

Internal tracking of diagnostic tests will be done periodically by risk management (lab, xray, EKG, Audiograms, Pap, biopsy). Providers will be reminded monthly if outstanding reports are present in their Medicat tasks.

Notification and reading of results can be documented in Medicat in the Order/Results tab. Mark the read box to document the physician reviewing the result and that the patient has been notified of the result. Fill in the comment field how the patient was notified, by PHONE, CLINIC VISIT, LETTER or OTHER.

All paper diagnostic reports faxed or mailed to the clinic will also be stamped by the nursing staff for review by the physician. The medical records staff will return reports to the physicians if the stamp is not filled out for them to complete before filing the report in the patients chart.

Date_____Physician_____
Patient Notified
__Clinic Visit ___Phone
__Other_____ ___Letter

_____

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Consent for Treatment

Informed Consent

Purpose:

A. The informed consent process is viewed as being integral to the physician/patient relationship and to the practice of medicine. Informed consent is not simply a signature on a preprinted form; instead, it is a process of information exchange and an opportunity to educate the patient about recommended treatment. Anytime a "material risk" is associated with a procedure, informed consent should be obtained. The attending physician is responsible for obtaining the informed consent from the patient or legal guardian of a minor.

B. Basic consent entails letting the patient know what you would like to do and asking if it is alright to proceed. Basic consent is important and valid in regard to noninvasive and routine procedures such as x-rays and venipunctures.

C. The physician, may exercise "therapeutic privilege" and not inform a patient of a particular risk if the physician can document that explanation of such risk would affect the patient's ability to make a rational decision or cause harm that would exceed the risk itself.

D. The patient's consent should only be "presumed" rather than obtained, in emergency life threatening situations, when the patient is unconscious, or incompetent and no surrogate decision maker is available.

Procedure:

A. The informed consent process should be obtained for the following:

1. Minor surgery which involves entry into the body
2. Non-surgical procedures involving more than a slight risk or harm to the patient, or involving a risk of change in the patient's body structure.
3. Experimental procedures
4. Patient photographs (involving medical care)
5. Procedures in which the medical staff determines that a specific explanation to the patient is required.

B. The consent for diagnostic and/or surgical procedure form should be obtained for the following:

1. Any minor surgical procedure
2. Colposcopy
3. Colonoscopy
4. Laryngoscopy
5. Endometrial biopsy
6. HIV testing
7. Implanon Insertion

C. The physician will explain and discuss the proposed procedure with the patient and/or legal guardian.

D. The diagnostic and/or surgical procedure consent form will be executed, and the physician will obtain informed consent to include the following:

1. A description of the procedure to be performed in terms understandable to the patient.
2. A statement of the possible risks, complications and the alternative methods of treatment.
3. The identity of the physician who will perform or order the procedure.
4. A statement that indicates that the patient has read and understands the consent form.
5. A statement that indicates that the patient has had an opportunity to ask questions and has had those questions answered in terms understandable to the patient.
6. The patient or legal guardian's signature, the date and time the consent was signed.
7. The signature of a witness, (may be a physician), and the date signed.

E. Special consent forms should be obtained for the following:

1. Against medical advice

2. Sterilization – Tubal ligation and Vasectomy
3. Stress test
4. Botox
5. Pulse Light Therapy
6. HIV Testing
7. Colonoscopy
8. Medical Photography

F. For Medicaid (female) sterilization procedures:

1. The attending physician is responsible for obtaining the informed consent from the patient, but the physician or the nurse may need to read the contents of the consent form to the patient before instructing the patient to read and sign it.
2. Thirty days must elapse after the date of the patient's signature on the consent form, before the sterilization procedure may be performed.
3. One week in advance of the procedure, the nurse will send the completed form to the physician performing the sterilization procedure, one copy to the hospital, and one copy is retained in the patient's medical record.
4. The physician's statement on the consent form is to be signed by the physician at the time of the hospital admission or shortly before the sterilization procedure.
5. Refer to the Department of Health Information for Women packet.

Documentation :

In all cases the physician is responsible to document in the progress note or procedure note that the essential elements of informed consent were discussed. At a minimum this should include:

1. Treatment options
2. The risks and complications of the procedure
3. The opportunity for the patient to ask questions

Incapacitated persons:

Informed consent for health care for a minor patient or a patient who is determined by a physician to be an incapacitated person and unable to consent may be obtained from a person authorized to consent on behalf of the patient. The following is in order of priority that may provide consent to health care on behalf of the patient.

1. The individual to whom the patient has given a durable power of attorney that gives them the authority to make health care decisions for that patient.
2. The appointed guardian of custodian of the patient.
3. The patient's spouse who has maintained significant contacts with the incapacitated person.
4. Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person.
5. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person.
6. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person.
7. Grandparents of the patient who have maintained significant contacts with the incapacitated person.
8. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person or
9. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.
10. Informed consent for health care for a minor patient or a patient who is an incapacitated person must make reasonable efforts to locate and obtain authorization for the health care from a competent person.
11. Before any person authorized to provide informed consent, the person must first determine in good faith that the patient, if not incapacitated, would consent to the health care.

12. No person authorized to provide informed consent pursuant to this section may provide consent for sterilization, abortion, or psychosurgery or for admission to a state mental health facility for a period of more than forty-five days without a mental health evaluation or other court order.

Minors:
A general rule, a minor cannot consent to their own treatment and the consent of a parent or legal guardian is required to treat the minor for non-urgent matters.

1. Written consent, **Consent for Minors Medical Care and Information**, is required when someone other than parent/guardian will accompany the minor patient to the appointment if anticipated that the parent/guardian will not be present for the appointment.

2. Parents/guardian can sign the **Authorization of Release of Information form** for information to go to another person approved by the parent/guardian.

3. A provider seeking consent for a minor patient must make reasonable efforts to locate and receive authorization for the health care from a parent/guardian.

4. If written consent cannot be obtained from the parent/guardian, attempt to contact the parent/guardian to discuss the office visit findings and treatment plan, unless the minor patient is permitted by law to obtain treatment without parental consent. State of ND explains a minor to be ≥ 14 years of age for the following exceptions that can be treated without parental consent.

    a. Treatment of Minor for sexually transmitted disease
    b. Emergency Care
    c. Blood donations
    d. Prenatal Care and other pregnancy care services
    e. A minor who has been deemed emancipated by a court of law may also consent for their own treatment.

5. The HIPAA rules provide an exception to protecting a minor patient's PHI when that minor patient seeks treatment without parental consent. If the provider's professional judgment deems it in the best interest of the minor patient to inform the parent/guardian of the minor patient's visit, the provider may do so. Document the reason for disclosing information in order to support the disclosure was in the minor patient's best interest.

6. To prevent the unwanted release of information, to include billing charges, to a parent/guardian when a minor seeks treatment the dictation note and that date of service billing charges will need to be flagged to alert all staff to this RESTRICTED note and charges. Follow the **RESTRICTED MINOR VISIT checklist.**

Refusal to be Informed:
An exception to the informed consent process occurs when a patient refuses to be informed about a treatment or procedure. There could be many reasons for this and it is the responsibility of the physician to attempt to find out why the patient is refusing to be informed before a treatment or procedure is done. Another option is to see if the patient will allow the physician to provide this information to a relative or friend.

Documentation necessary in the event of Refusal to be Informed:
1. Information that was given to the patient before they refused further information, and that the patient refused to be informed.
2. Plan of care.

Refusal of Treatment :

A mentally competent patient may refuse any medical treatment. In order to satisfy the requirements of the informed consent process, it is important that patients are provided with the risks associated with not undergoing a treatment.

When informing a patient who is refusing a treatment do and document the following:

1. Evaluate the patient's capacity to make decisions.
2. Assess the patient's overall understanding of the information provided.
3. Re-educate the patient when necessary.
4. Document
    a. diagnosis and recommended treatment,
    b. risks and benefits of the recommended treatment,
    c. alternative treatments if available
    d. risks and consequences of not having the recommended treatment, and reasons for refusal.

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Patient Education

Patient education is given to a patient to provide help in solving his/her health problem. It should be incorporated in to routine office visits for all patients. Effective patient education ensures that patients have a sufficient level of knowledge and understanding, which allows them to make informed decisions regarding their care.
Patient education is selected to recognize the education level, literacy and language needs of patients. Select education materials that are written at a 5th to 8th grade level. Education materials need to support education provided and not take place of provider education.

Approved Websites to provide patient handouts for education are listed below. Multiple copies of handouts that cover common health problems in the community can be printed. Periodically check website for revisions and update handouts. If education materials are not on this list or part of current handouts the information needs to be approved by a faculty member.

Family Medicine:	http://familydoctor.org/online/famdocen/home.html
Sports Medicine:	http://www.summitmedicalgroup.com/library/sports_health/
Pediatric Medicine:	www.cpnonline.org
Dermatology:	www.aad.org
Diabetes:	http://www.diabetes.org www.internationaldiabetescenter.com
Health Maintenance	http://epss.ahrq.gov/ePSS/GetResults.do?method=search&new=true
American Academy of Pediatrics	http://brightfutures.aap.org/tool_and_resource_kit.html

Interpreters:
Pacific Interpreters Service-Nursing will be trained in how to access these services when needed.
Microsoft Office Word Document Language Translation

Documentation Guidelines:

1. Evaluation of the patient's ability to comprehend the information provided.
2. The content name and source of patient education materials that were provided to the patient. Remember to include all education used-verbal, audio, written. There is NO need to include a copy of the handout in the medical record.
3. Evaluation of the patient's understanding of the information provided. (e.g., teach back, repeat back)
4. Interpreters-Document use of and service (ex. telephone). Document name of the interpreter services, name of the interpreter, and description of the information provided, patient's stated level of understanding of the information, signature of nurse of medical provider making the entry.
5. Nursing must have approval of the provider for all education given. List source and handout given per physician.

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Patient History
Patient medical history is summarized in the patient's electronic record.
The patient's medical history needs to be reviewed routinely.

MEDICATIONS: Reconciled by nursing for each clinic visit. If dosage changes have occurred, nursing will review changes with the physician. Physicians will review and make appropriate changes.

HISTORY: Medical, Family, Surgical and Social history needs to be reviewed and updated by the physician for all established patients on an annual basis. New patients will need to be entered during their initial exam.

For health maintenance and annual medication recheck physicals need to be reviewed.

For problem focused visits, only the patient history categories related to chief complaint visit need to be reviewed.

ALLERGIES: Reconciled by nursing every visit.

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Geriatric Education

Nursing Home Rounds:

1. **Objectives**
   a) Identify aspects of the aging process.
   b) Gain an awareness and sensitivity to the medical, emotional, social, economic and physical needs of the elderly.
   c) Enhance perceptions and attitudes toward the elderly.
   d) Develop an insight into the continuity of care of the elderly in a long-term health care center.
   e) Gain knowledge regarding the role of the physician caring for the elderly patient in a long-term health care center.

2. **Protocol**
   a) There will be an assigned "nursing home week," where each physician will see their nursing home patient. To meet the Medicare guidelines, this visit will be at least every 30 days on a new admission to the nursing home facility for the first 90 days and at least every 60 days thereafter.
   b) Nursing home teaching rounds will be held one time per month, after the above completed nursing home week.
   c) At the nursing home teaching rounds, all residents will meet during a noon luncheon, along with the geriatric nurse and a preceptor.
   d) One assigned resident will present a short lecture on an assigned geriatric topic.
   e) Each resident physician will present his or her patient to the group. This will give the resident an opportunity to discuss their patient's care with a preceptor and other residents.
   f) One or two residents will be assigned to go on walking rounds with the preceptor and the geriatric nurse. This is where we will see each patient and sign the appropriate forms.

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Geriatric Home Visits:

1. Objectives
   a) Demonstrate the informational value of a home visit.
   b) Develop and maintain observational skills.
   c) Learn about cultural, social and environmental habits of the patient.
   d) Increase understanding of family dynamics.
   e) Aid the resident in developing a more holistic approach to geriatric care, utilizing the information obtained on the home visit.

2. Protocol
   a) The resident is responsible for selecting an appropriate patient for a home visit. The geriatric nurse or preceptor may also suggest patients.
   b) Geriatric team members that will attend the home visit will include the preceptor, resident physician, geriatric nurse and social worker when possible.
   c) Each resident will participate in a minimum of one geriatric team home visit per year.
   d) The geriatric nurse will schedule home visits.
   e) The geriatric team visit will be brief (30-60 minutes), and by appointment. The geriatric nurse will have the billing sheet, the patient data base, and chart when available. The nurse will also obtain the patient's vital signs, when appropriate. The geriatric nurse is available to perform venous blood draws, if needed, but this needs to be discussed in advance.
   f) Following the home visit, the resident physician will dictate findings and follow-up plans of treatment.

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Graduation Requirements

Criteria for receiving a certificate of completion at the end of residency:

1. Successfully complete all required rotations.
2. All completed rotations have a filled out evaluation form from the preceptor.
3. Turn in all experience cards and/or documentation.
    a. Must have 30 vaginal deliveries and an additional 10 continuity deliveries
    b. ABG Form documenting completion of 10 procedures
    c. Foley Cath Form documenting completion of 10 procedures
    d. Pap Smear Form documenting completion of 10 procedures
    e. Wet Mounts Form documenting completion of 5 procedures
4. Complete 1,650 continuity clinic patient visits.
5. Have all clinic dictation completed.
6. Turn in Procedure Log
7. Pay all late Resident Dues
8. Completed Duty Hours logs
9. Have completed the Residency to Reality Series
10. Complete QA audit
11. Have completed a Help Desk Answer (FPIN) or similar project

To be turned in on last working day of work:

1. Practice Management Book Club Book
2. Key to clinic key
3. Beeper
4. Moonlighting Log
5. Practice and Contact Address

Reminder:

Apply for your own Medicaid ID number

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Attending Physician's CFM Clinic Responsibilities

1. Attending Physician's need to be available at the clinic during the hours that they are assigned as Preceptor.
2. It is mandatory for all OB visits seen by a Resident be precepted with the Attending Physician.
3. It is strongly encouraged that the precepting Attending observe a significant portion of one patient visit for each Resident during the clinic session. This will apply to all levels of residents.

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Confidentiality and Disclosure of Concern Cards

Purpose:
To delineate the procedures for insuring confidentiality of Concern Cards submitted to Program Director or Site Director.

Policy:
1. Concern Cards submitted to the Program Director or Site Director via e*Value or written suggestion will be kept strictly confidential by the Program Director or Site Director and the Program Coordinator.

2. If the PD deems that patient safety is in jeopardy from the information on the Concern Card, the Program Director or Site Director may choose to intervene immediately in such a way that anonymity of the content of the Concern Card cannot be maintained. However, the actual Concern Card itself will not be shared with the person who is the subject of the report.

3. The Program Director or Site Director may use general information from Concern Cards to shape resident or faculty feedback. However, every attempt to maintain the anonymity of the author of the Concern Card will be made.

4. The Program Coordinator will keep all Concern Cards about a resident in a separate section of their personnel file. These will be not be able to be viewed by anyone other than the Program Director or Site Director and Program Coordinator. They will be removed from the personnel file and destroyed when the resident graduates from the program.

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Complaint Management

The Risk Management Team of West River Regional Health Systems will manage the risk associated with minor and non-critical events per their organizational policies. Complaints regarding resident performance will be managed by the Program Director or Site Director.

Purpose:
Complaints or concerns received by clinic staff reflect patient perceptions and expectations. Feedback, solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service.

Procedure:
All clinic and administrative staff will be responsible for receiving complaints. Complaints related to a specific department will be forwarded to the department supervisor. Complaints related to physicians will be forwarded either to the Business Manager or the Program Director.

1. The patient complaint is received either verbally or in writing by any staff person.
2. A complaint form will be completed by the person receiving the complaint.
3. If the complaint can be resolved at this level, the staff member receiving the complaint will:
    - Resolve complaint
    - Complete complaint form including signature and date
    - Completed form will be forwarded onto the Business Manager to be reviewed and original to be filed with the assigned CFM Risk Management Representative. A copy will be sent to the Risk Management Division of the State of ND if warranted.
4. If the complaint cannot be immediately resolved, the complaint form will be forwarded to the Business Manager, Program Director, or Site Director. An investigation will be initiated and a timely review of the events surrounding the complaint will be done. Documentation will be made on the complaint form.
5. Changes will be made in policy/process in a timely manner and communicated to all staff as appropriate.

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Electronic Communications

Purpose:
To assure the appropriate use of electronic communication within the UND Center for Family Medicine in addition to the general UND Computing and Network Usage Policy.

Procedure
1. Password Protection:
   a. All assigned to or created passwords by an employee are private and should not be shared with others. All electronic devices and applications shall be password protected. Passwords need to be changed frequently using a unique password.

   b. Only use a program under your personal login information. Do not use a program accessed by another employee. Log employee out and then log in with your information.

2. E-mail:
   a. When using the University of North Dakota's e-mail system, the individual user must understand that it is an unsecure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect against a HIPAA breach.

   b. E-mail is used within the clinic appropriately by staff using the University assigned email address for an employee. By State of North Dakota law, university email content is considered public record, and thus may be open and accessible for inspection.

   c. E-mail communication with patients shall be done with a secure system. Encryption is the only approved mechanism to electronically transmit PHI. The use of the Medicat EMR patient portal will provide a secure means to communicate with patients.

3. Personal Device:
   All personal devices are not required by staff to fulfill an employee's job requirements. By State of North Dakota law, all electronic communication records are public records, and thus may be open and accessible for inspection. The use of personal devices opens the employee to personal liability for discoverable electronic communication.

4. Texting:
   a. When using texting the individual user must understand that it is an secure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect confidential information.

   b. Texting should not replace a phone conversation in order to avoid miscommunication between you and the patient or employee. Texting should be avoided during patient care to prevent errors.

   c. Texting is not to be used for communication with patients.

5. Social Media:
   Social media is a means of communication using web-based and mobile technologies for the exchange of information. Social Media is not to be used for communication with patients about patients and/or their PHI. No health or medical related information that relates to official activities may be posted on social media.

6. Lost or Stolen Device:
   a. All lost or stolen devices need to be reported to the department supervisor as soon as possible. The mobile provider will need to be called to deactivate the phone. If a PHI breach is a concern the HIPAA officer will need to notified of the breach.

b. Applications are available for devices that can locate the lost device and the phone can be remotely locked or the information can be deleted from the phone. i.e. Find My iPhone. It is recommended that electronic mobile devices have this or a similar application.

7. Termination or Resignation of Employment:
All employee access to current software applications and devices will be deactivated.

For complete UND policy see the office of Human resources and Payroll Services Annual Notification of Policies.

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Clinical observer/shadowing policy

Purpose:
To establish a policy and procedure for short-term visiting residents (international or US medical graduates) who are not eligible to provide clinical services.

Policy:
Observers, or shadowers, will not have any clinical responsibilities but must complete institutional documentation requirements in order to avoid liability and confidentiality issues. These are HIPAA requirements.

1. Observers, or shadowers, are non-employees. An onsite observation agreement must be completed prior to the shadowing experience. The completed application must be kept on file.

2. Observers, or shadowers, must complete UND CFM's HIPAA training. A copy of the HIPAA completion certification must be kept on file.

3. Clinical observers/shadowers are not eligible for computer access. Clinical observers/shadowers, will wear an observer name tag while in the facility.

4. A clinical observer may:
   a. Watch, listen, and ask questions of medical students, residents, and attending physicians.
   b. Attend journal clubs and conferences.
   c. Use the medical library.
   d. Touch a patient only with the permission of the patient and presence of an attending supervisor.
   e. A clinical observer must:
      1) Be introduced to each patient they observe.
      2) Have each patient sign the Patient Consent for Presence of Student Observer form.
   f. A clinical observer may not:
      1) Write anything in any patient chart.
      2) Write any prescriptions.
      3) Touch any patient, or talk to any patient without a supervisor being present.
      4) Give any orders, either verbal or written, to any other health care provider or patient.

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