ADMINISTRATION

The University of North Dakota Center for Family Medicine, Bismarck, is a fully accredited residency training program that has graduated over 150 physicians. The Center is administered by the University of North Dakota School of Medicine and Health Sciences. We are a three-year program and accept five first year residents annually through the NRMP Match.

Our program is sponsored by both hospitals in the community —Sanford Health and CHI - St. Alexius Medical Center — and enjoys the tremendous support of the local teaching faculty.

FACULTY:

Program Director: Jeff Hostetter, M.D.

Associate Program Director: Jackie Quisno, M.D.

Assistant Program Directors: Shannon Sauter, M.D.
Swami Gade, M.D.
Joseph Luger, M.D. (Dermatology)
Brynn Luger, MA, LPCC, NCC (Clinical Counselor)
Rhonda Schafer-McLean, M.D. (OBGYN)

PART-TIME FACULTY

Joan Connell, M.D. (Pediatrics)
Kristin Melby, FNP
Laura Schield, M.D. (Psychiatry)

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Mission Statement and Aims of the Program

The mission of the Center for Family Medicine is to train competent, caring family physicians who will exemplify the ideals and values of family medicine, and who will provide high-quality, safe, and effective medical care for North Dakota communities.

Educational Aims of the Program

The Program will:

1. Maintain a training program in the specialty of Family Medicine that is ACGME-accredited and focuses on the teaching of effective, evidence-based, high-quality and safe medical care.
2. Develop and employ a medical curriculum that aims for all graduates to pass the ABFM board examination on their first attempt.
3. Design learning activities to expose residents to diverse experiences including providing medical care in rural, under-served areas in ND, and in providing care to under-served demographic groups in ND.
4. Complete regular evaluations of individual resident physicians in order to individualize learning plans for resident physicians with the goal of bringing all learners to a high level of competence.
5. Provide continuous learning opportunities to faculty physicians in order to keep their medical knowledge and practices updated to current standards of care.
6. Provide faculty to serve as role models for high standards of professionalism and excellence in medical care.
7. Provide a learning and working environment that exemplifies and promotes inclusion, cultural and ethnic diversity, and safety to medical learners at all levels, staff, faculty, and patients.

The Resident physicians will:

1. Learn to gather essential and accurate information from patients by utilizing effective listening and communication methods in order to formulate comprehensive evidence-based management plans.
2. Learn to manage and treat the majority of medical problems encountered in clinical practice in all patient care settings including acute and chronic medical conditions.
3. Gain sufficient knowledge and technical skills to competently perform procedures within the scope of family medicine.
4. Learn strategies in providing disease prevention and health promotion.
5. Critique and appraise information for its validity and clinical usefulness, and be able to incorporate the best medical evidence into patient care.
6. Practice professionalism including respect, compassion, integrity, responsibility, and commitment to the ethical practice of medicine.
7. Demonstrate an ongoing commitment to personal and professional development and the need to participate in life-long learning and improvement.

8. Understand the importance of physician well-being and resilience including physical and emotional well-being.
9. Learn skills needed to provide health care in rural, under-served areas, and to under-served demographic groups.
10. Learn to function effectively within the larger health care system coordinating the provision of quality, cost-effective care as a member of the health care team and serving as advocates for patients.

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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 ensures 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. 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.

Health Information/Medical Records
The Health Information/Medical Records department is responsible for all patient charts both electronic (EMR) and paper. Responsibilities include scanning of records into patient charts as well as destruction and retention schedules. This department is also in charge of HIPAA compliance as well as Release of Information.

Front Desk Receptionist/Schedulers
The receptionists are responsible for answering telephone calls that come into the clinic and maintaining the core switchboard, routing calls as appropriate. They are responsible for scheduling all patient appointments for physicians, nurses and ancillary support services. The receptionists are also responsible for collecting co-pays. The receptionists validate patient demographics and insurance information upon the patient's entry to the clinic system.

Radiology
The department is staffed with one full time registered and ND licensed radiologic technologist and a backup ND licensed 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, 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 in house is sent to our reference laboratory, Sanford Lab Bismarck. Turnaround time for most reference lab results is 12-24 hours. The lab is cross-

trained to assist radiology staff with several ancillary testing procedures. The Laboratory Director/Supervisor acts as a lead team member on the UND-CFM's Risk Management Committee and Quality reporting.

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
This department consists of a PharmD. The department is in charge of assisting the residents/faculty with any medication/prescriptions needs. 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 can be accessed by all residents, faculty, and staff at the UND CFM Bismarck website which can be accessed by choosing the "Residency Program" link at the URL for the **UND Center for Family Medicine**. A hardcopy of the manual can be found in office of the Risk Management coordinator.

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

http://www.cfmbismarck.und.edu

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 **University of North Dakota's School of Medicine & Health Sciences** Home Page is as follows:

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

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

The University of North Dakota's School of Medicine & Health Sciences **GME Residency Training Program** Home Page is located at

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

All UND residents and faculty Researches 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 DUTY HOURS POLICY

A. **Principles**
Physicians have a professional responsibility to appear for duty appropriately rested and fit to provide the services required by their patients.
The program is committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
The learning objectives of the program will be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events and must not be compromised by excessive reliance on residents to fulfill non-physician service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy.

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

B. **Application**

This policy applies to all residents in UND residency programs.

C. **Definitions** Duty hours are defined as time spent in all clinical and academic activities related to the program. Specifically, this includes time spent in patient care (both inpatient and outpatient), administrative duties related to patient care, the provision of transfer of patient care, time spent in-house during call activities, and scheduled educational activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

D. **Policy**
1. Duty hours must be limited to a maximum of 80 hours per week, averaged over any four-week period, inclusive of all in-house call activities and all moonlighting.
2. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
3. Duty periods of PGY-1 residents must not exceed 16 hours in duration.
4. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours continuous duty in the hospital. Residents are encouraged to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00PM and 8:00AM is strongly suggested. Residents may be allowed to remain on-site in order to accomplish effective transitions in care for no longer than an additional four hours.
5. For emergency medicine assignments, duty periods must not exceed 12 hours in duration.
6. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled duty period to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must appropriately hand over the care of all other patients to the team responsible for their continuing care; and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director will review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
7. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
8. PGY-1 residents and intermediate level residents (as defined by the Review Committee) should have 10 hours, and must have 8 hours free of duty between scheduled duty periods. Intermediate level residents must have at least 14 hours free of duty after 24 hours of in-house duty.
9. It is desirable for residents in the final years of education (as defined by the Review Committee) to have eight hours free of duty between scheduled duty periods. There may be circumstances (as defined by the Review Committee) when these residents must stay on duty to care for their patients or return the hospital with fewer than eight hours free of duty. These circumstances must be monitored by the Program Director.

10. Residents will not be scheduled for more than six consecutive nights of night float.
11. PGY-2 and above residents will not be scheduled for in-house call more frequently than every third night (when averaged over any four-week period).
12. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Time spent in the hospital by residents on at-home call counts as duty hours.

Resident Recruitment Criteria

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

Policy: The UND Center for Family Medicine Bismarck 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, with a passing score.
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.
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 completed an observership at the UND Center for Family Medicine Bismarck.

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CFM Clinic Responsibilities

1. Clinic has priority over rotational responsibilities.

2. Notify the office manager and/or your nurse at the earliest possible time if you will be late/absent from clinic.

3. Morning clinic schedules ***begin promptly at 8:30 a.m.***

4. Afternoon clinic schedules daily, with the exception of Tuesday's begin promptly at 1:00 p.m.

5. Tuesday afternoon schedules begin after the resident 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 one-half day, unless a second preceptor is available.

7. Effective May 1st of each year, third year residents *may possibly* 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. For the first 6 months of the academic year, all PGY-1 clinic patient encounters need to be precepted by a CFM faculty member **BEFORE** the patient leaves the clinic. After this time, a minimum of every third clinic patient encounters needs to be precepted.

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. 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.

13. Clinic session will be scheduled as follows:
    a. 1 full day for PGY-1 residents.
    b. 2 full days for PGY-2 and PGY-3 residents.
    c. Whenever possible, clinic sessions will be FULL days in clinic opposed to 2 or 4 half days.
    d. Exceptions: NICU, ICU, FMTS and OB will not have full days, but rather half day sessions only

14. The current clinic preceptor will not be allowed to see scheduled patient visits during that clinic day unless it is a patient emergency.

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Clinic Chief Resident Responsibilities

Meetings and Conferences:

1. A. Chair the resident weekly business meeting or arrange for another 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.

   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 and completing consultations for 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 Didactics 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. The Senior resident is responsible for keeping the "Handoff List" for all patients on the FMTS up to date to facilitate sign out and team member changes.

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.

a. The Senior resident may be called for all CFM patients seen at both 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 without 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.

5. Senior residents are responsible for supervising and teaching PGY-1 residents assigned to the FMTS. Specifically,

A. The Senior resident is responsible for promptly reviewing (in person) all admissions done and consultations done by the PGY-1 resident to the FMTS.

B. The Senior resident is responsible to give the PGY-1 resident requested guidance regarding patient care.

6. Senior residents should assign case topics to residents and medical students based on interesting cases from clinic or inpatient experience or as needed.

7. Follow guidelines of Didactics Attendance Policy – please see policy for details.

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

_____ _____

Name Date

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Didactics Attendance

Purpose:
Didactic conferences are a significant portion of the learning residents receive, are essential for board preparation and future practice, and are required by the ACGME. Thus, attending as many of these sessions as possible should be a high priority.

Policy:
General guidelines:
1) Attendance at half-day didactic sessions is mandatory.

2) The only residents excused from the didactics are the Weekend Day Senior and one of the Weekday Interns on the FMTS.

3) The clinic will be covered by Kristin and one faculty. The Weekday Senior on the FMTS is "in jeopardy" and can be pulled from didactics to cover the clinic prn. If Kristin is gone, then the Weekday Senior on the FMTS will be in clinic.

4) The OB resident will have their clinic day switched to Friday morning, and thus on Friday's will not follow any patients on L&D after morning rounding and c-sections.

Other attendance considerations:
1) The following are situations where residents will also be excused:
   a. Away rotations like inpatient pediatrics and rural rotations
   b. Continuity deliveries
   c. If attendance will result in a violation of duty hours, or if you are too fatigued or ill to participate.
   Needs to be reviewed and approved by advisor or PD BEFORE the didactic sessions
   d. Leave/Vacation

2) Unexcused absences will result in the following consequences:
   First violation – Verbal warning
   2nd violation – Letter of Warning which goes in the resident file
   3rd violation – consideration for disciplinary action pursuant to University of North Dakota School of Medicine and Health Sciences Resident Fair Process and Grievance Procedure (https://med.und.edu/policies/_files/docs/gme-fair-process.pdf).

3) Tardiness
If more than 30 minutes late for the initial session, the resident will be marked as "unexcused" and will be required to meet with the advisor or PD to discuss reasons for tardiness.

4) Conferences will be recorded, **however**, in order to receive credit for viewing, residents will have to get written approval from their advisor or PD.
   *If the resident is approved to receive credit for viewing recordings, they must view the entire recording and then answer these questions via email to the Residency Coordinator:

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:

5) Professionalism
Didactics attendance will be reviewed and used by the CCC to evaluate resident professionalism during semi-annual reviews.

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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 for all rotations can be downloaded from the residency website by following the link below.

   https://med.und.edu/center-for-family-medicine-bismarck/bismarck-goals-objectives.html

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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

In-Training Exam (ITE) Performance

Introduction:
The American Board of Family Medicine (ABFM) In-Training Examination (ITE) is a nationally standardized instrument administered to all family medicine residents enrolled in ACGME postgraduate training programs given annually during the last week of October. The ITE has been shown to be a useful predictor of future success on the ABFM specialty examination. All residents are required to take the ABFM specialty examination in April or May of the PGY-3 year.

The ITE exam tests core knowledge and patient management skills in eight major areas: Internal Medicine, Surgery, Obstetrics, Community Medicine, Pediatrics, Psychiatry and Behavioral Sciences, Geriatrics and Gynecology.

All residents are released from other responsibilities in order to be present for the ITE examination, and no vacation or elective time off is allowed during the week of the exam. The examinations are scored by the ABFM and the results reported to the Program Director.

Purpose:
To encourage lifelong learning; to ensure residents attain and retain the requisite knowledge to safely advance through the residency program; and to achieve a 100% pass rate for first time takers of the ABFM specialty examination at the end of residency training.

Definition:
Using the Bayesian score predictor provided with the ITE, residents are expected to score at a level that is equal to or greater than 90% prediction of passing the certification exam. Residents who attain scores below this level for their training year have a significantly poor prediction for passing the ABFM exam.

Procedure:
A resident with low ITE performance will be identified by the program director and the resident's faculty mentor following the receipt of the ITE examination results.

PGY 1 - The first year resident will meet monthly with the advisor to review progress. The resident and mentor will develop an individualized strategy to prepare them for the next year's ITE. This may include:

- Reviewing the ITE exam results to identify areas needing improvement
- Going through all the ITE exam Qs/As in those identified areas and reviewing
- Reading the twice monthly American Family Physician journal and completing the AFP CME quizzes
- Complete 25 AAFP board review questions weekly; focus on topic areas for board questions based on ITE performance areas that were suboptimal

- Take practice quizzes from the ABFM app

PGY 2 – The second year resident will meet with the advisor. A strategy will be developed, which likely will may include:

- Those items listed under PGY 1 remediation above
- Completing the AAFP Family Medicine Board Review Self-Study course (available through the UND CFM residency).
- Enrolling in an additional Q-bank

PGY 3 – The third year resident will meet with the advisor. A strategy will be developed, and will include

- Taking a 1-month elective dedicated to board review which will include an "away" **live** board review course; the resident would be required to pay for this course out of pocket, unless they have remaining CME dollars available to use

Policy for Unsuccessful Remediation:
If remediation is unsuccessful and the resident fails to meet the standard set for performance in the remediation process ***and on the follow-up examination***, the resident may be placed on academic probation. Subsequent arrangements will vary and may include a second remediation program to dismissal from the program. The resident's duration of training could be extended by the time necessary to successfully complete the subsequent remediation.

RESOURCES

American Family Physician (AFP) journal quizzes
AAFP website: www.aafp.org
Log in with your own username and password to obtain appropriate CME credit
Sign into the AFP CME quizzes
Complete the quiz twice monthly
Report CME from quiz completion on your AAFP CME site
Print a copy of your transcript from the AAFP website to place in portfolio for biannual review

AAFP Board Review questions
Enter AAFP website as above using your username and password
Sign into Board Review Questions
Complete 10 board review questions weekly; focus on topic areas for board questions based on ITE performance areas that were suboptimal
Print a copy of your transcript as above for your portfolio for biannual review

ABFM app
Free to download
Take practice quizzes; choose topic areas to focus on topic areas based on ITE performance as above

Healthtracks

This scheduled clinic (every Monday except Holidays that land on a Monday) is the responsibility of senior residents on a rotating basis. Similar to call, this scheduled responsibility may be traded between senior residents.

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 **Medhub** website or app.
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 may 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.

Resident Procedure Data Base Instructions

All residents are required to maintain 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.

All procedures are to be entered in the **MedHub** data base using the website or the app.

This information will 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 for both 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** notes.

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 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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RESIDENT SUPERVISION POLICY- Bismarck/Hettinger, Minot/Williston

Purpose:
The purpose of this policy is to ensure that the program will provide sufficient support, mentorship, and guidance in the supervision of physicians-in-training to facilitate education and the provision of safe and excellent patient care, while providing sufficient autonomy for residents to develop into independent practitioners

Policy:
1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each ACGME Review Committee) who is ultimately responsible for that patient's care.

A. This information should be available to residents, faculty members, and patients.
B. Residents and faculty members should inform patients of their respective roles in each patient's care.

2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident- delivered care with feedback as to the appropriateness of that care.

3. **Levels of Supervision**. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

A. **Direct Supervision** – the supervising physician is physically present with the resident and patient.
B. **Indirect Supervision with direct supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.:
C. **Indirect Supervision with direct supervision available** – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
D. **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

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

A. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
B. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
c. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

5. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

7. The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

8. **The guidelines and protocols for common circumstances requiring faculty involvement such as care of complex patients, ICU transfer, DNR decisions, etc:**

A. 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 Program Director.

c. If the 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.

d. The FMTS has a cap of 20 patients.

B. 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.

C. 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 Program Director.

D. Patient phone calls

When issues arise where there are 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 Program Director.

Hospital Admission and Care of Clinic and Nursing Home Continuity Patients

Purpose:

To maximize the continuity relationship between a UND CFM clinic patient and their primary care doctor when they are hospitalized, and maximize patient safety by limiting the number of hand-offs during their hospitalization to reduce the possibility of errors associated with excessive hand-offs.

Procedure:

1. When a hospitalized patients who has a resident from the UND CFM Bismarck assigned as their primary care physician (PCP) either in the outpatient clinic or in the nursing home, the FMTS team will admit the patient then consult the primary care doctor as follows:

a. Following admission, the FMTS senior or intern assuming care of the patient while hospitalized will notify the resident who is the PCP that their patient is admitted.

b. The resident who is the PCP will act as the primary care consultant, and will attend (in person or by phone) the next evening sign-out to provide collateral information. They will continue to do so daily until the patient is discharged.

*The PCP resident may call the FMTS senior earlier in the day to facilitate more prompt care depending on availability and urgency of information.

c. The primary care consultant will be responsible for physically rounding socially each working day of the patient's hospital admission (exclusion of weekends, holidays, sick or vacation leave).

1) They will continue to contribute significantly to the plan through verbal suggestion and placement of orders only as mutually agreed upon by the FMTS residents caring for the patient.

2) The primary care consulting resident will not, however, be responsible for daily note writing, specialty consultation calls, or placement of routine orders as the patient will be under the care of the FMTS team.

*If orders are placed by the primary care consulting resident, they must be discussed directly with the FMTS team to avoid duplication of orders, potential interaction of orders, or other unintentional harms.

d. Discharge orders and documentation will be the responsibility of the FMTS resident caring for the patient, not the primary care consulting resident.

e. Hospital follow-up appointments will be reasonably attempted to be made with the patient's primary care resident.

Home

Admission Order Signature Policy

Purpose:

1. To ensure admission orders are accurate and that patient safety is maximized.
2. To maximize the amount of learning experienced for PGY-1 residents on the UND FMTS from each hospital admission.

Policy:

1. All admission orders written by PGY-1 residents are to be reviewed and approved by a PGY-2 or PGY-3 resident BEFORE they are submitted to be implemented.

2. This only applies to the initial set of admission orders, not to orders for ongoing care.

Fatigue Mitigation

The UND and the program will provide all residents with educational activities to teach strategies that may be used to mitigate fatigue including, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

2. The program, in partnership with Sanford Health, CHI St. Alexius, and WRHS, will provide adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

3. If a resident is too fatigued to safely return home, they may take the following actions as they prefer:
    A. Sleep in call rooms that are available at the hospitals or at the Bismarck CFM.
    B. Ask attending to arrange a ride home for them
        1. This may be provided by faculty or CFM/hospital staff.
    C. Obtain a ride home using Uber, Lyft, or taxi.
        1. The resident is to inform the inpatient service attending or site director that they will be doing so BEFORE they leave the hospital.
        2. The program will reimburse the resident for the expense of the ride once they submit the receipt for the ride per UND policies and procedures.

Home

Patient Scheduling

1. First year residents are scheduled 3-6 patients per clinic session; half an hour per patient. Please discuss with a faculty member if more time per patient is needed or if more patients can be scheduled.

2. Schedules can be checked in Epic.

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 must notify the front desk and nursing staff so the that preparations can be made 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 8:30 AM. Those with afternoon clinic hours are expected to arrive at 1:00 PM and remain in the clinic until 5:00 PM to cover walk-ins and/or late scheduled patients.

6. If a physician is delayed for a scheduled appointment at the clinic, they must 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 residents on a rotating basis.

3. If a patient requests a pregnancy test but does not have a physician, the test is ordered under the clinic preceptor. If the test is positive the nurse will instruct the patient to see a physician as soon as possible. If the patient wishes to continue with the CFM and asks whom they should see, the patient is told to check with the reception staff to see which physicians are available.

Home

Rural Rotations

1. Rural rotations may be conducted in a community office outside of the Bismarck-Mandan area for a period of not less than two weeks and a maximum of eight weeks during the second and third years of residency.

2. The Program Director or designee will coordinate, negotiate, and approve all rural rotations.

3. Rural rotations during the last two weeks of June and the first two weeks of July will not be granted.

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 at the University of Colorado Children's Hospital.
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 as well as provide housing during the rotation.

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. Either a faculty member or a PGY-2 or PGY-3 resident will be 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

Senior residents are allowed to moonlight if their medical licensure and visa status permits it. They much adhere to the following:

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

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

3. Residents must have **written** permission from the Program Director that approves they are allowed to moonlight.

4. Residents must log moonlighting hours in **MedHub**.

5. Resident moonlighting activity must adhere to the policies of the UND GMEC as delineated in the "Moonlighting Policy For Residents" at the UND SMHS GME policies website. (https://med.und.edu/policies/_files/docs/gme-moonlighting-2021.pdf)

Home

Effects of Leave on Completion of Residency - Bismarck/Hettinger

1. Purpose of Policy

This policy elucidates the details of the amounts of leave available to residents and the consequences of exceeding the amount of leave allowed in the completion date of all UND Family Medicine residencies.

2. Background

There are two entities that control resident time off: the ABFM and the UND. They both have separate rules and they do not match.

A. Per the ABFM, residents get 21 weekdays off per year for any reason.

Vacation, Illness, and Other Short-Term Absences Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one month per academic year. The ABFM defines one month as 21 working days or 30 calendar days.

https://www.theabfm.org/become-certified/residency-training-guidelines

B. Additionally, the ABFM specifies a leave category called "Family Leave" which can be taken for certain situations including:

1) The birth and care of a newborn, adopted, or foster child, including both birth- and non-birth parents of a newborn.
2) The care of a family member* with a serious health condition, including end of life care
3) A resident's own serious health condition requiring prolonged evaluation and treatment

The Family Leave policy specifies time can be taken for these situations without extending residency per the following guidelines:

"Family Leave Within a Training Year: *ABFM will allow up to (12) weeks away from the program in a given academic year without requiring an extension of training, as long as the Program Director and CCC agree that the resident is ready for advancement, and ultimately for autonomous practice. This includes up to (8) weeks total attributable to Family Leave, with any remaining time up to (4) weeks for Other Leave as allowed by the program.*
There is no longer a requirement to show 12 months in each PGY-year for the resident to be board-eligible; however, by virtue of the allowable time, a resident must have at least 40 weeks of formal training in the year in which they take Family Leave. This policy also supplants the previous 30-day limit per year for resident time away from the program.

Total Time Away Across Training: *A resident may take up to a maximum of 20 weeks of leave over the three years of residency without requiring an extension of training. Generally speaking, 9-12 weeks (3-4 weeks per year) of this leave will be from institutional allowances for time off for all residents; programs will continue to follow their own institutional or programmatic leave policies for this.*
If a resident's leave exceeds either 12 weeks away from the program in a given year, and/or a maximum of 20 weeks total, (e.g. second pregnancy, extended or recurrent personal or family leave) extension of the resident's training will be necessary to cover the duration of time that the individual was away from the program in excess of 20 weeks."

https://www.theabfm.org/sites/default/files/PDF/ABFM%20Family%20Leave%20Policy-5-21-2020.pdf

C. Per the UND residents get:

1) Vacation: Residents/Fellows shall receive 3 weeks (21 calendar days =15 weekdays + 6 weekend days) of paid vacation annually to be taken in periods of time mutually agreed upon by

resident/fellow, training site, and Program Director. Vacation is non-cumulative from one year to the next.

2) Meetings: Residents/Fellows may receive up to 7 calendar days (5 weekday + 2 weekend days) of paid leave for professional meetings, annually and non-cumulatively. Leave taken under this section *does not* count towards the thirty (30) days of allowable leave in Section 7 below.

3) Sick Leave: Residents/Fellows will be given 12 calendar days of paid sick leave per calendar year for personal and dependent illness. Sick leave is noncumulative from one year to the next. Residents/Fellows are responsible for notifying their program director of any absence because of illness. Residents/Fellows shall provide medical verification for absences due to illness when requested. Residents/Fellows who use all allotted sick leave may not meet ACGME or certification board requirements. Refer to Section 7 below. If incapacity results in more than 3 days, the UND Long-Term Medical and Family Leave Policy will be followed.

http://med.und.edu/policies/_files/docs/gme-leave.pdf

D. **Clarifications/FAQs**

1) Days off for interviews count as vacation days.
2) “Professional days" in resident contracts are for meetings. The leave for "Meetings” that the UND allows DOES NOT count toward the ABFM total days off.
3) Time off for community service count as vacation days.
4) There is no category for “personal days”. Absence for "personal business” (ABFM) count toward “vacation" days UNLESS they are “sick" days (UND).
5) There are more sick days allowed by the UND than the ABFM allows. If you use more than 6 sick days per year, you will have to extend your residency.
6) Days missed to take board exams DO NOT count toward any category since they are required duty assignments.
7) Time off for religious activities count as vacation days.
8) Per ABFM policy, unused days do not transfer to the next year; “use it or lose it” on July 1st.
9) Sick leave may be used for illness or other health related issues, maternity/paternity leave, funerals, or family emergencies.
10) Time off for religious activities or community service count as vacation days.
11) FMLA leave (different than ABFM Family Leave!) is available for qualifying situations. This is unpaid leave and can be taken for time off over and above the above limits.

3. Policy

If residents exceed more than 21 weekdays off per year for any reason other than for ABFM-approved Family Leave, their residency end date will be extended to allow them to be in compliance with ABFM policies on absence.

Home

Vacation/Leave Requests

Policy:

1. Leave 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 three faculty members. It will meet every two weeks to review leave requests.

2. The committee will use the following guidelines for approving leave:
   A. First come, first served.
   B. No leave allowed if resident is on **OB**, **Inpatient Peds**, **NICU**, 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 2 days of leave allowed. For a month rotation, only 5 days of leave is allowed.
   E. 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 availability to cover clinic and hospital patient services.

Procedure:

a) Arrange clinical coverage for the days off requested.
b) Submit request at least two weeks in advance by completing a Vacation Request in **MedHub**.
c) For situations involving emergency, health, family problems, or other special circumstances, please include an explanation requesting variance from the above policies to the leave request.
*Special circumstances will be considered, but are not a guarantee that approval will be granted.

CME Funds

1. Residents receive an allotted amount of funding to be used for CME activities**.**

2. The funds can be used during any year of residency.

3. All CME activities must be approved by the Program Director before the CME activity is attended. They will be approved based on how the CME furthers the professional goals of the resident beyond what is available in the local curriculum.

4. CME funds MAY be used to pay for the following expenses:
   a) expenses associated with live CME events including registration, travel expenses, and per diem.
   b) registration for online CME events
   c) USMLE Step 3 and/or ABFM board exam fees.

5. CME funds MAY NOT be used to purchase any “durable materials” like books, computers, software, or courses on disk, flash drive, or other media.

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Annual Program and Faculty Evaluation Surveys

Introduction:
1) The ACGME requires that all residents and faculty be given the opportunity to formally evaluate the program at least once a year.

2) The UND Statement of Resident Responsibilities (https://med.und.edu/policies/_files/docs/gme-resident-responsibilities-policy.pdf) states that resident must "Participate in the evaluation of the program and its faculty".

3) The ACGME and the UND are committed to making sure that evaluations can be done in an anonymous fashion to ensure that there is no possible retaliation against people completing evaluations.

4) UND SMHS Family Medicine residencies have received citations from the ACGME for not having policies and procedures to ensure that residents have the opportunity to evaluate the residency programs.

Purpose:
To ensure that the residents and faculty are given the opportunity to evaluate the program yearly, and that residents are given the opportunity to evaluate the faculty yearly.

Procedure:
1) The UND SMHS Family and Community Medicine Department will send electronic surveys annually (in the month of May) to all residency core faculty and resident physicians.

2) The residents will receive evaluation surveys of each core faculty member, and of the program.

3) The core faculty will receive evaluation surveys of the program.

4) The UND SMHS Family and Community Medicine Department will inform the program coordinator that the surveys have been sent.

5) The UND SMHS Family and Community Medicine Department will provide weekly reports for 4 weeks to the program coordinator of survey recipients who have not completed the surveys.

6) The program coordinator will remind these recipients to complete the survey.

7) After 4 weeks, the survey will close and results will be compiled and de-identified by the UND SMHS Department Family and Community Medicine non-residency faculty member.

8) The UND SMHS Family and Community Medicine Department will send reports of the surveys to the department chair within 2 weeks of the survey closure date and, once approved by the department chair, to the program directors.

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 documentation of each patient should include:
    A. Reason for the encounter and relevant history, physical examination findings and prior diagnostic results;
    B. Assessment, clinical impression or diagnosis;
    C. Plan for care;

2. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

3. Past and present diagnoses should be accessible to the treating and/or consulting physician

4. Appropriate health risk factors should be identified.

5. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

6. The CPT and ICD-10 CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record

Home

Dictation Time Limits

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

Procedure:
1. All physician and APP's will have 7 days after the date of visit to have a note for the visit dictated.

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

3. If documentation is delinquent, the medical records staff will inform the Program Director and the following will apply:

A. No additional patient visits will be scheduled beyond what is already on the provider's schedule.

B. Additional patient visits will not be scheduled until the provider has completed all delinquent documentation.

4. If dictation is delinquent for greater than 1 year from date of service, the note will be locked by Medical Records staff with the following statement added to the note.

> "This note has not been completed by the provider. It cannot be submitted for billing, and any additional information added by the provider would likely be inaccurate. Thus the note is being signed by clinic staff as an incomplete note in order to expedite administrative processes."

5. Although providers are strongly encouraged to complete and sign all documentation before going on vacation, the above time limits can be interrupted by vacation time without penalty. For example, if a provider goes on vacation five days after seeing a patient they will have an additional 2 days to complete their documentation upon returning to work.

Notification of Diagnostic Report Results

1. Notification of diagnostic results to patients is to be monitored to ensure 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 48 hours of receiving the report

B. Critical reports will be communicated ASAP from when the report was received.

2. Internal tracking of diagnostic tests will be done periodically by risk management (lab, xray, EKG, audiograms, Pap, biopsy). Providers will be reminded of outstanding reports are present in their Epic in-basket.

3. Notification and reading of results can be documented in Epic through the in-basket in the "Results" folder. Choose to notify either by telephone call, letter, result note, or MyChart notification. Mark "Done" after patient has been notified.

4. All paper diagnostic reports faxed or mailed to the clinic will be tagged for review and signature. Once signed return to medical records to be scanned into patient's chart. Then can complete notification steps as needed.

Home

Consent for Treatment

Informed Consent

I. 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.

1. 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. Nexplanon Insertion
8. Novasure
9. IUD
10. LEEP

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. Colonoscopy

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.

2. 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

3. 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.

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.

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.

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.

4. 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.

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.

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

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.

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 law permits the minor patient to obtain treatment without parental consent or the minor has requested a visit without parental/guardian consent. State of ND explains a minor to be ≥ 14 years and < 18 years of age for the following exceptions that can be treated without parental consent. The minor will need to sign the **Minor's Consent to Services** form.

1. Treatment of Minor for sexually transmitted disease
2. Emergency Care
3. Blood donations
4. Prenatal Care and other pregnancy care services
5. Unaccompanied homeless minor

A minor who has been deemed emancipated by a court of law may also consent for his or her own treatment.

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.

5. Refusal to be Informed

An exception to the informed consent process occurs when a patient refuse 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.

6. 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.
   Re-educate the patient when necessary.
3. 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.

Home

Transitions of Care/Hand off Policy

Purpose:
This policy establishes standards for transitions of care for Residents training in Accreditation Council for Graduate Medical Education (ACGME)-accredited Graduate Medical Education (GME) programs at all UND Family Medicine residencies

Definitions:
Resident: Any physician in an ACGME-accredited graduate medical education program, including residents and fellows.

Transitions of Care: the hand-off of responsibility for patient care from one provider to another, most commonly at the time of check-out to on-call teams, but also applicable in other transitional settings, including transfers between one clinical care setting to another or the scheduled change of providers (e.g. end-of-month team switches).

Hand-off: Transfer of essential information and the responsibility for care of the patient from one health care provider to another.

Patient Safety Practices: Habits and routines that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions.

HIPAA: Health Insurance Portability and Accountability Act, a 1996 federal law that restricts access to an individual's private medical information.

EHR: Electronic Health Record.

Policy:

All residents and faculty members must demonstrate responsiveness to patient needs and recognize that these supersede self-interest. This includes the recognitions that under certain circumstances the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

The following key Patient Safety Practices are critical to effective Transitions of Care:

- Interruptions must be limited
- Current, minimum content must be conveyed
- The opportunity to ask and respond to questions must be provided
- Hand-off documents must be HIPAA compliant.

A. Hand-off Participant Responsibilities:

1. **Minimize Interruptions:** Participate in hand-off communication only when both parties can focus attention on the patient-specific information (i.e. quite space).
2. **Current, Minimum Content:** Hand-off communication must include the following information:
   a. Patient name, location and a second chart-based identified (e.g. Date of Birth [DOB] or Medical Record Number [MRN]).
   b. Identification of primary team or attending physician
   c. Pertinent medical history including:
      1) Diagnosis
      2) Current condition
      3) Pertinent labs
      4) DNR status
3. **Anticipated Changes in Condition or Treatment:** Hand-offs should include:
   a. Suggested actions to take in the event of a change in clinical conditions (i.e. "if-then" discussion).
   b. Any elements that the receiving provider must perform (i.e. a "to-do" list).

4. **Opportunity to Ask and Respond to Questions:** Allow adequate time for hand-off communication and maximize opportunities for face-to-face of verbal hand-offs:
   a. In-person, face-to face hand-offs are preferred
   b. If not possible, telephone verbal hand-offs may occur
   c. In either case, a hand-off document (written or electronic) must be available to the receiving provider
   d. Then hand-off must include an opportunity for the participants to ask and respond to questions.
5. **HIPAA Compliant Hand-Over Documents**
   a. All written or electronic hand-off documents must be compliant with HIPAA and local hospital policies.
   b. Each residency site is responsible to develop its own hand-off document in cooperation with resident and attending input.

Home

Patient Education

Purpose:

To provide accurate, evidence-based, culturally proficient, and meaningful patient education to the patient.

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. Materials should be appropriate for the reading and comprehension levels and the cultural and ethnic diversity of the patient population. Education materials need to support education provided and not take place of provider education.

When selecting materials:

- The type of resources that a patient or support person responds to varies from person to person. Using a mixed media approach often works best.
- Keep your assessment of the patient in mind. Consider factors such as literacy, numeracy, and culture as you develop a plan.
- Avoid fear tactics. Focus instead on the benefits of education. Tell your patient what to pay special attention to.
- Be sure to review any materials you plan to use before sharing them with the patient. Keep in mind that no resource is a substitute for one-on-one patient teaching.

Approved patient materials to provide education to patients can be found in EPIC. If other patient materials are to be given to patients the provider will review them for accuracy and relevant to the patient's needs

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.

Home

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 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.

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.

Other components and duties:

1) Select a patient for a home visit, and complete a minimum of one home visit per year.

2) Attend all nursing home care conferences for your nursing home patients
3) Communicate to the geriatric nurse any potential or new nursing home patients.
4) Promptly sign orders from nursing homes that are sent to residents at the clinic, and place them into the outgoing mail bin.
5) Communicate to the geriatric nurse when you are not able to attend any of the above-mentioned assignments.

Home

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. All required procedures logged in **MedHub**.
    a. Must have 30 vaginal deliveries and an additional 10 continuity deliveries
    b. ABG 10 procedures
    c. Foley Cath 10 procedures
    d. Pap Smear 10 procedures
4. Complete all ACGME patient visit requirements.
    a. 1,650 total continuity clinic patient visits
    b. 165 continuity clinic patient visits for patient under 10 years old
    c. 165 continuity clinic patient visits for patient over 60 years old
    d. 75 pediatric (<18 years old) ER visits
    e. 75 pediatric (<18 years old) hospital visits
    f. 40 newborn hospital visits
    g. 250 total pediatric (<18 years old) ER and hospital visits **combined**
    h. 750 adult (>18 years old) hospital visits
5. Have all clinic notes completed.
6. Pay all late Resident Dues
7. Have completed the Residency to Reality Series

To be turned in on last working day of work:

1. Practice Management Book Club Book
2. Key to clinic key
3. Beeper
4. Practice and Contact Address including new email

Reminder:

Apply for your own Medicaid ID number

Home

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 that the preceptor for the clinic is stationed in the preceptor office ("Fish Bowl") at all times during their assigned times unless they are precepting procedures or have other duties associated with precepting patients in the clinic.*
3. It is mandatory for all OB visits seen by a Resident be precepted with the Attending Physician.

Home

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 **MedHub** 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.

Home

Event Reporting

Purpose:
An event is an occurrence that is inconsistent with the routine operation of the clinic or the routine care of a patient. The event may or may not result in an injury or harm to a patient or visitor. IF no harm occurred, the event is considered a near miss. Near misses are important in event reporting because the potential for harm is present and needs to be addressed to prevent a similar occurrence which may lead to harm.

Policy:
For reporting system to be successful, it is important that a culture of safety is in place, recognizing that the patient safety is the top priority and encouraging staff member to report errors and near misses. It should not contain subjective narrative or attach blame to others.

Staff members should report all events on an incident form within 24 hours of the event. Event incident forms will be sent to the risk manager/business manager upon completion, and copies of the reports will not be included in the patient's medical record or personnel files.

Proper investigation of events is critical to understanding the cause(s) and to identifying areas for improvement. The report, which contains factual information around the event, will be used to initiate the investigation of the event. For serious events that cause injury, harm or additional medical intervention and treatment, a root cause analysis (RCA) will be performed. This process allows those involved in the event and others to participate in an analysis by reviewing the event, what led up to it, and the aftermath.

Tracking and trending reported information will assist the risk management committee to evaluate processes and care patterns within the clinic. Incident and complaint forms will be evaluated periodically and trends reported to the Business Manager and the Medical Director.

Event reporting is considered a quality improvement or peer review activity, and will follow state guidelines to protect the information in all the documents included in the reporting and investigation.

Statement of Confidentiality:
Data, records and knowledge, including minutes, collected for or by individuals to committees assigned peer review functions are confidential, not public records, and are not available for court subpoena in accordance with North Dakota NDCC 23-34.

Examples of Event Reporting opportunities:

- Near Miss
- Allergic Reactions
- Lack of adequate follow-up
- Surgical or procedural events
- Falls (any incident of an employee injury)
- Equipment failures or improper use of equipment resulting in injury
- Workplace Violence
- Improper Consent
- Procedures performed without informed consent
- Refusal of Treatment
- Refusal to be informed
- Lost or broken valuables
- Sanford Security called
- Patient leaving or signing out against medical advice-noncompliance
- Unanticipated patient outcome
- Missed or delayed diagnosis
- Specimen Labeling errors
- Critical results not communicated to the Provider
- Patient Complaints
- Complications following Treatment
- Wrong patient treated or wrong procedure performed.
- Medication-related occurrences (including near-misses)

Visitor events (for example, falls) should be reported to ensure that the important information is captured at the time of the event. If possible, tactfully take pictures of the fall area.

Document all patient involved events using the UND incident Report(link below) Forms are available from your Supervisor or Risk Management Coordinator. All in clinic and off site incidence will need to be reported by staff.

Employee Injury events will be recorded by following the guidelines from the University of North Dakota Safety website. The forms will include
https://campus.und.edu/safety/_files/docs/incident-reporting-form-persons.pdf

https://campus.und.edu/safety/_files/docs/incident-investigation-form-part-one.pdf

https://campus.und.edu/safety/_files/docs/incident-investigation-form-part-two

Home

Complaint Management

The Risk Management Team of UND Center for Family Medicine 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:
    A. Resolve complaint
    B. Complete complaint form including signature and date
    C. 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.

Home

Patient Satisfaction Survey

Purpose:
Patient Satisfaction Surveys reflect patient perceptions and expectations. Feedback, either solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service. In making UND Center for Family Medicine the healthcare facility of choice, we are committed to maintain the trust our customers have in UND and our Residency Program, and to insure we exceed our customers' expectations in the event dissatisfaction with service occurs. The patient satisfaction surveys will help us to create individual relationships with our customers and build a service recovery culture within our organization.

Procedure:
1. Each patient will be sent a survey, typically within 24 hours of their appointment.
2. Results of the survey will be shared with Residents during their semi-annual evaluations.

Home

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. Facsimile:
   a. Practice reasonable safeguards to avoid a misdirected fax by ensuring the correct fax number is used. Protect PHI by using fax machines that are located in secure places and using a cover letter every time a fax is sent.

   b. If documents including PHI are faxed to the incorrect fax number, a breach has occurred. Contact the HIPAA officer or Supervisor. Refer to UND CFM's Faxing policy for the complete guidelines to send and receive facsimile that include PHI.

3. 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 EMR patient portal will provide a secure means to communicate with patients.

4. 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.

5. 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.

6. 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.

7. 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.

8. 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.**

Home

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 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 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 must complete UND CFM's HIPAA training. A copy of the HIPAA completion certification must be kept on file.

3. Observers are not eligible for computer access.

4. Observers will wear an observer name tag while in the facility.

5. Observers may:
   A. Watch, listen, and ask questions of medical students, residents, and attending physicians.
   B. Attend journal clubs and conferences.
   C. Touch a patient only with the permission of the patient and presence of an attending supervisor.

6. Observers must:
   A. Be introduced to each patient they observe.
   B. Have each patient sign the Patient Consent for Presence of Student Observer form.

7. Observers may not:
   A. Write anything in any patient chart.
   B. Write any prescriptions.
   C. Give any orders, either verbal or written, to any other health care provider or patient.

Home

Credentialing and Privileging of Faculty Providers

Faculty Providers upon hire will need to provide the following information to obtain privileges at UND Center for Family Medicine Clinic. Include all procedure(s) you would like to offer to your patients.

Verify competency to perform any or all of the following:

Bone Marrow Biopsy
Botox Injection
Colonoscopy
Circumcision
Echocardiography
EGD
EKG Stress Testing
Endometrial Biopsy
Holter Monitor Interpretation
Implanon/Nexplanon Insertion
IUD Placement
Larynogoscopy
Nuclear Stress Testing
Pulse-Light Therapy of Skin Lesions
Language Certification
Vasectomy

Provide evidence of competency by providing a list and number of each performed in the last 3 years certification of training. Current privileging documentation from the hospital or clinic where you practice would fulfill this requirement also. Provide the same for all procedures not listed that are outside your standard training for your specialty.

a. All current faculty as of the effective date of this policy who perform any of the above procedures will be grandfathered with privileges to continue to performing the procedure.

b. Any new faculty or any procedure not listed above will be required to document training by one or more of the following to receive privileges to perform the procedure:
   1) Certificate of training
   2) Evidence of competency

c. The faculty will meet to review both the proposed procedure and the documentation of training, and determine the conditions under which the provider may perform the procedure; i.e. the faculty will serve as a credentialing committee for the clinic. The provider requesting privileges will be disqualified from the final vote/decision of the committee.

1. The hospitals will provide documentation of the credentialing done for the physicians. The hospital will send a letter to the physician confirming credential status. A copy of the letter will be placed in a file and updated as required.

2. A copy of the credentialing process for each hospital is kept on file.

3. Background checks of a physician will be completed following the guidelines of the North Dakota Board of Medical Examiners.

4. Quality review of charts will be done annually to document outcome of procedures for each faculty member.

Each Faculty will provide the following documents to the Residency Coordinator.

Physicians

a. Current letter from hospital (Credentialing/Privileging)
b. Current State License
c. Current DEA
d. Current malpractice binder
e. Certification for PALS, ATLS and ACLS
f. List of Procedures performed by each physician.
g. Verification of Signature

Nurse Practitioner:

a. Current state license ND Board of Nursing
b. Current ANCC certification
c. List of Procedures performed by nurse practitioner
d. Verification of Signature

Language Certification

To deliver quality interpretation to a limited English proficient patient, we offer Language Line Academy through Pacific Interpreters for interested Physicians and Nurses.

A Bilingual Fluency Assessment for Clinicians testing is needed to assess the level of fluency in English and the second language in a healthcare context setting, as well as medical terminology before the second language is used for patient care at the clinic.

Contact the Clinic Business Manager for more information about this certification.

Home

Peer Review

Purpose:
The Peer Review process is designed to evaluate the quality and appropriateness of the diagnosis and treatment provided by members of the medical staff with clinical privileges. The peer review process documents recommended corrective action, if necessary, and creates a framework for remedial action for deficiencies found. It will also be used as a tool to determine competency in granting and renewing privileges.

Definition:
Peer Review is a process by which a physician investigates the medical care provided by other physicians, nurse practitioners, clinical counselors and CRNAs in order to assess the quality of health care delivered and to determine whether accepted standards of care have been met.

Policy:
Peer review will be completed on patient care records that reflect the practice of our providers.

Peer review is meant to provide medical opinions conducted by an objective physician and relevant medical staff. Review should occur by another individual who has comparable levels of training, credentials, and experience. Review of the care provided by nurse practitioners is evaluated by a physician. An individual physician cannot conduct a peer review of his or her own cases nor can a non-peer perform the peer review. This is not meant to be a performance appraisal. Although the peer review process is on-going, data is monitored quarterly.

Procedure:
1. A predetermined number of medical records will be selected from each of the following areas for each provider practicing in the clinic to be reviewed externally applicable to that provider.

- Medical
- Procedural
- Obstetrics
- Dermatology
- Counseling

2. In addition, clinical records will also be selected from the following categories:

- Anesthesia- These records will be reviewed externally by an outside CRNA.
- Reported care-related complaints

3. Any additional cases flagged for review will be reviewed by the Medical Director. If it is determined to be a case that needs to be reviewed, the provider will be contacted and made aware. The Provider will then have time to review the case.

4. A peer review tool criteria will be selected and approved by Medical Director.

5. When the review is completed will be shared with the provider. The provider will provide comments.

6. The peer review tool along with the provider responses will be reviewed by the Medical Director.

7. A report of peer review activities will be provided to the Medical Director.

8. External Peer Review Guidelines

Sample of charts will be reviewed by an external peer.

- 10 clinic visit charts per faculty/attending provider per year.
- 5 procedure visit chart per faculty/attending provider per year.
- 10 obstetric visit chart per faculty/attending provider per year if applicable.
- 10 anesthesia procedures per CRNA per year.
- 10 clinic visit charts per nurse practitioner provider per quarter.
- 10 counseling visit charts per counselor per year.

Home

Disclosure

POLICY:

To maintain transparency and integrity in all of the UND Center for Family Medicine functions. It is appropriate to disclose adverse events, errors and/or unanticipated outcomes that could affect a patient's emotional or physical health. Discussion of unanticipated outcomes is based on strong communication processes, both before and after treatment or procedures.

An outcome may be negative and/or unanticipated, but not necessarily be the result of an error. The informed consent process should address possible risks, complications and adverse outcomes. A discussion about an unanticipated outcome that was addressed as part of the informed consent process is a much different discussion than disclosing an error.

General Principles

A. **Events to be disclosed** — This includes adverse events, unanticipated outcomes, and occurrences in which patients are significantly harmed or have the potential to be significantly harmed.

B. **To whom disclosure will be made** — Make disclosure to the patient and, only when appropriate, to the patient's family, significant other or patient advocate.

C. **Timing of disclosure** — Disclose adverse events as soon as possible after the identification that an adverse event has occurred. If event analysis is incomplete within the first 24 hours, then sharing only partial factual information is more important than waiting until all details of the event have been factually ascertained. If the patient is not able to comprehend the information, it should be disclosed to the patient advocate, depending on the severity of the occurrence and his/her need to know the information.

D. **Honest disclosure** — Tell the patient the facts as known, and assure the patient that you are committed to obtaining and providing all available information as it becomes known. Consider the use of support services (e.g., social worker, mental health therapist), as appropriate.

E. **Cultural sensitivity** — Demonstrate respect for individual cultures and provide interpreters for non-English speaking or cognitively impaired patients.

F. **Who will disclose events** — Disclosing adverse events is primarily the attending physician's responsibility. When it is impractical or unreasonable for the physician to do so, a designee may be used. If the physician is uncertain regarding the event and/or the obligation to disclose or finds it difficult (is unable) to disclose the event to the patient, the physician will consult with the practice administrator and/or the office manager to determine who will disclose the events. The practice administrator and/or office manager, in consultation with the physician, may disclose the adverse event to a patient, if a physician cannot or does not inform the patient in a timely manner.

G. **Events for which disclosure may be discretionary** — Disclosure of certain events is a matter of clinical judgment. Errors that do not harm a patient and do not have the potential to do so may not require disclosure to patients.

H. **Mechanism to assist with the disclosure process** – The physician practice administrator and/or office manager may provide assistance to physicians regarding disclosure. These individuals have the authority to help clinicians make decisions about which adverse events need to be reported and disclosed and to help make decisions about disclosure when the most responsible clinician fails to do so or is unable.

I. **Beneficial consequences of disclosures (and error reporting)** –

1. Patients receive prompt care for injuries suffered and are fully informed to assist in further decision-making and treatment planning.
2. Errors are opportunities to learn how to improve patient safety.
3. Lessons learned from error reporting will serve to correct system problems.

IV. Procedure

A. Staff Member and Physician Actions

1. Take immediate actions to safeguard the patient, as needed.

2. If the adverse event is of a serious nature, notify the office manager and/or the

physician as soon as possible. Complete an incident report and inform the patient's attending physician.

3. Document the event in an objective and factual manner in the patient's record as soon as possible after the event.

4. In consultation with risk management, discuss the factual details and sequence of what occurred with the healthcare team and attempt to reconcile any differing perceptions of what occurred.

5. Determine how the details of the event, the outcome and the treatment plan will be explained to the patient and his/her family members. Decide which member of the healthcare team (generally the physician) will discuss the event and with whom (patient and/or family member). Designate a family contact person.

6. Be accessible for questions. Repeated requests for an explanation of the event are a common reaction when patients and family members are informed of an adverse event or medical error.

7. If the event involved a medical device or piece of equipment, preserve these materials for investigation. Do not clean or alter the device or equipment in any way and contact the office manager and/or the physician. Do not return defective devices or equipment to a manufacturer.

8. Notify your malpractice insurance carrier of the event in a timely manner and obtain guidance, as applicable.

9. Defer to the office manager and/or the physician to determine when and if patient billing should occur. Follow compliance policies.

B. Communication Framework for Disclosure

1. Have the attending physician and/or a leadership staff member meet with the patient (and family members as appropriate) as promptly as other duties permit. Delays should be avoided.

2. Present the nature, severity and contributing cause (if known) of the adverse event in a straightforward and nonjudgmental manner.

3. Avoid attributing blame to yourself or to specific individuals or to the organization as a whole. Serious adverse events are rarely due to the sole action or inaction of one person. Do not criticize the care or response of another provider.

4. Disclosure is a process; be sure the disclosing medical providers avoid speculation and focus on what is known at the time of the discussion, what happened, what led to the event, and the recommended course of action.

5. To avoid the appearance of contradicting information, provide a caveat that as information becomes available, further discussion will take place.

6. If further treatment is necessary as a result of the adverse event, describe what can be done, if anything, to correct the consequences of the adverse event.

7. Identify someone (staff member or physician) to have ongoing communication with the patient and/or family members.

8. Convey empathy and use language that is understandable to the patient. Make eye contact and concentrate on presenting your body language in an open and caring manner.

9. Apologizing for the observed occurrence of the adverse event is appropriate. This aspect of communication is separate from discussing ascertained causes of the event. A sincere show of concern can increase the rapport between the patient and provider.

C. Withholding of Information

1. Sometimes the outcome information can put a patient at risk of harm either due to psychological trauma or exposure to physical harm. In such situations, clinical judgment regarding disclosure should be exercised.

2. If information is withheld, document the reasons for such. It may be appropriate to have a mental health provider conduct an assessment to determine concurrence.

D. Reporting and Accountability

Prompt and thorough reporting and disclosure of events by the physician and staff members will be managed by Risk Management and individual provider accountability. The practice will address patient safety concerns through the medical staff peer review process and/or human resource procedures when the investigation reveals a serious lack of provider knowledge, skill deficit, unawareness of the hazard, oversight, or negligent or reckless disregard for patient safety.

E. Documentation

1. Document facts objectively, completely and contemporaneously, including that a discussion of the unanticipated event took place.

2. Ensure that the documentation is dated, timed and signed at the time of the entry.

3. Avoid writing any information unrelated to the care of the patient (e.g., incident report filed or legal office notified) in the medical record.

4. Do not alter any prior documentation or insert backdated information.

5. Record the name and relationship of those present.

6. Include documentation of any questions posed by the patient/family members and indicate that answers were provided by the caregiver.

7. While an addendum to the record may be made, consider carefully whether this information is relevant to the patient's clinical management. Accepted reasons for an addendum are for the correction of facts (i.e., persons involved, time of event, sequence of events) and for the addition of facts or clarifying information. If you participated in the care, but were unable to access the record until a later date, you may provide added information. Do not use an addendum to state your opinions, perceptions or defenses.

8. Assign the most involved and knowledgeable staff member(s) to record the factual statement of the event in the patient's record, as well as any follow-up needed or done as a result of the event.

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ABBREVIATIONS AND SYMBOLS; "DO NOT USE"

Resource:
https://www.jointcommission.org/facts_about_do_not_use_list/

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "every other day"
Trailing zero (X.0 mg)*	Decimal point is missed	Write X mg
Lack of leading zero (.X mg)		Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate"
MSO_4 and $MgSO_4$	Confused for one another	Write "magnesium sulfate"

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*__Exception:__ A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Home