UNM HEALTH SCIENCES CENTER

Applies To: all OB-GYN department fellows who take primary L&D night call Responsible Department: OB/GYN Revised: 1/26/14

Title: **ROLES OF THE MFM TEAM**	**Policy**
Patient Age Group: (X) N/A ( ) All Ages ( ) Newborns ( ) Pediatric ( ) Adult	

PURPOSE: These guidelines serve to define the roles of the MFM team members to achieve excellent organization and communication between team members. This will allow provision of efficient, quality care to our patients and to actively engage as educators. These expectations should be reviewed with the new team at the beginning of each rotation.

FELLOW:

Wards:

-The primary roles of the wards fellow will be:

1) Overseeing rounds and providing input on the care plan for each patient.
2) Reading about the medical conditions which our patients have and teaching the team about what they have read, including new research.

-All transports or medically complex patients will be admitted to the ROB service on L&D and the MFM team will be consulted. The MFM team will write daily consult notes until the patient is stable for transfer to the floor, at which point the patient will be transferred to the MFM service.
-The fellow will write the initial MFM consult note on these patients.
-Subsequent consult/progress notes will be written by the residents.

-Consults from other services received during the day will be seen initially by the chief resident, who will then discuss the case with the fellow and/or attending.
-Subsequent notes on pregnant consult patients will be written by the fellow (whether on floor, SAC, or ICU status).
-Nonpregnant patients on whom we are consulting will have subsequent notes written by the residents (whether on floor, SAC, or ICU status).

-The wards fellow will be present in a timely manner for 07:00 L&D and OBSC rounds.
-The wards fellow will perform cerclages, amniocenteses, PUBS, Dopplers, and other necessary procedures on the floor patients when possible (this may require absence from clinic and coordinating with L&D).
-If the fellow is not available coordination with the MFM chief resident will take place.
-The wards fellow will attempt to make him/herself available for any complicated or interesting cesarean deliveries when possible; it will be up to the fellow to communicate their availability or unavailability to the HO3 on L&D.
-The wards fellow will call the referring provider to give updates on transport patients on the day of discharge.
-The fellow will discuss the patients on service with the chief (or covering) resident each evening prior to sign out to briefly receive updates and clarify the care plans overnight (the resident is responsible for contacting the fellow as noted below).
-The fellow will be present for the In & Out conference Monday mornings at 08:00, including leaving rounds early if necessary.
-The first year fellow will be responsible for presenting and discussing ultrasound images of patients on the special deliveries list and/or arranging lectures.

-The fellow will be available to review strips/evaluate patients (unless at an off-site clinic) if the residents have questions or concerns.
-The fellow will be available to assist the NP in covering the floor on Friday afternoons.
-The fellow will be the primary consultant on patients in the ICU and will be responsible for documentation.
-The fellow will see any consults received between 12:00-4:30 on Friday afternoon
    -The residents will see consults received before 12:00 on Friday, although if they are covering a busy L&D the fellow will be available for assistance.
-When the wards fellow is away on outreach or professional/annual/sick leave, there will be no fellow present for rounds; it is up to the fellow to notify the attending and chief resident on service of the planned absence in a timely manner.
-The wards fellow is responsible to carry out rounding responsibilities when post call. In this instance, the wards fellow must be dismissed by 9 AM.

Clinic:

-The clinic fellow will serve as a consultant in the MFM clinic and will be responsible to see most antenatal and preconception consultations. This will allow the MFM fellow to learn to function as a consultant.
-The fellow will have a parallel consult schedule in the Monday MFM clinic; if the fellow is not going to available for this clinic, it is up to the fellow to contact nursing and scheduling to cancel the clinic.
-There may be certain patients that the fellows wish to follow primarily; they may do so at their own discretion.
-**If additional help is needed to aid in the workload, both the wards fellow and the chief resident should make themselves available to help and an equitable division of labor should be agreed upon.**
-The clinic fellow will go to clinic as soon as possible after all responsibilities from rounds are completed. Floor work should be carried out by the Nurse Practitioner as much as possible.
-In clinics with concurrent ultrasound imaging (ie NWV and WFC), the fellow will also review ultrasound images and evaluate/counsel patients.
-When the clinic fellow is away for any reason, there will be no fellow coverage in clinic; it is up to the fellow to notify the attending and resident involved in order to plan for absence.

Ultrasound:

-The ultrasound fellow will see patients and perform ultrasound with Dr. Hall and the residents. Typically, the fellow will perform the more complex portions of the exam (ie echo, Dopplers, etc).
-The ultrasound fellow will not be pulled from ultrasound to cover clinics, wards, or other clinical responsibilities in the absence of another fellow.

L&D:

-The fellow on the L&D rotation will be present for board sign out in a timely manner at 07:00 each morning.
-When there is a fellow on the L&D rotation (typically 2 months per year), that fellow will write all consult and progress notes on the L&D patients.
-The fellow will be available throughout the day to discuss care/labor plans with the L&D team.
-He or she will be available to perform bedside ultrasounds on the laboring and floor patients.
-The fellow will help cover L&D on Friday afternoons when the residents are in resident school.

Research:

The research fellow is on protected research time and will not be pulled from ultrasound to cover clinics, wards, or other clinical responsibilities in the absence of another fellow.

OVERALL RESIDENT RESPONSIBILITIES:

Wards:

-The residents will see all floor/SAC status patients on the MFM service (including antepartum and postpartum) and write daily progress notes.
-If the residents are not able to see all patients due to heavy patient load, absences, etc, additional residents should be pulled to assist with rounds.
-The residents and fellows will see consult patients and ICU patients as outlined above.

-The residents are responsible for all floor work, including calling consults, putting in orders, discharging patients, reviewing NSTs, etc.
-A resident should be present for any MFM procedures (PUBS, amnio, cerclage, etc.), if possible.
-The residents should update the list daily (template below).
-The resident covering the service should be in close contact with the fellow and keep him or her apprised of any significant developments throughout the day.
-All transports should have an H&P written by an OB R2, R3, or R4 – not by an intern or by an off-service resident.

Clinic:

-The residents should see and document all patient encounters in clinic (fellows will primarily see/document patients in their continuity clinics only).
-The resident will not be required to document on patients he or she did not see in clinic.
-The MFM residents assigned to the clinics will be responsible for management of continuing prenatal care for patients who are receiving ongoing care in the MFM clinics.
-The second and third year residents assigned to clinic will be responsible to meet with the attending for chart review to ensure thorough review and update of each chart.

Chief Resident:

-While the chief resident has many tasks to perform, his or her primary responsibility is to manage the MFM service.
-The chief will be present for rounds. Chief resident absences from rounds, including walk rounds, should be rare.
-If the chief is scheduled to cover L&D (ie on Friday mornings, or due to the absence of the L&D R3), he or she should still do everything possible to be present for MFM rounds.
-The chief should know every patient on the service including care plan. His or her job is to manage the service and oversee the team; the fellow and attending will allow the chief to run the service to the extent possible/appropriate.
-The chief must know about all patients on the service, including labs, vitals, and any significant findings or changes to the patients' care.
-The chief resident will be responsible for seeing the sickest patients and writing notes on them.
-The chief will make him/herself available to see inpatient consults from other services received during the day; he or she will then discuss the case with the fellow and/or attending. The exception to this is Friday afternoons as noted above.
-The chief will cover the MFM service during the day including writing orders, reviewing NSTs, evaluating patients, calling consults, following up on labs, and discharging patients.
-The chief may delegate these responsibilities to junior residents or the NP, but in the end it is the chief's responsibility to ensure everything is completed in a timely manner.
-The chief should sign off on all morning NSTs by midday. If there are concerns regarding a strip, the chief should call the fellow to review it.
-The chief (or a junior resident when appropriate) will perform bedside AFIs, BPPs, etc.
-If the chief has any questions or concerns regarding a patient, he or she should call the fellow to discuss the plan.
-The chief should keep the fellow and attending apprised of any significant changes in patient status.
-The chief is responsible for contacting the wards fellow every day prior to signing out the service to the night team to briefly provide updates and clarify the care plans overnight.
-The chief will update the "alerts" board on L&D with any potentially problematic floor or ICU patients.
-The chief is responsible for overseeing the medical students.
-It is strongly recommended that the chief attend journal club and present an article if possible.

3rd year resident:

-The 3rd year resident's main goal is to achieve competency in obstetric ultrasound.
-The 3rd year resident will be present for rounds.

-He or she will be responsible for managing the inpatient ultrasound slots (2 daily), including submitting requests in Powerchart and communicating with the Women's Imaging staff.
-The 3rd year resident is responsible for presenting the hospitalized antepartum patients and the Special Deliveries List at the In & Out conference.
-He or she is also responsible for managing the special deliveries list and should be communicating with the genetic counselors regarding changes and updates to this list.
-If the 4th year resident on services has to cover L&D, it may be necessary for the 3rd year resident to perform walking rounds with the fellow and attending.
-In the case of prolonged hospitalization, the 3rd year resident will put in an interim summary and updated care plan on patients every 2 weeks.
-After rounds, the 3rd year will be in ultrasound with Dr. Hall as protected time and should not be pulled to help cover other clinical duties except in extenuating circumstances.
-The 3rd year resident will cover MFM clinic when the 2nd year is in PCC.
-In the absence of the chief resident, the 3rd year is responsible for the chief's MFM duties.
-It is strongly recommended that the 3rd year attend journal club and present an article if possible.

2nd year resident:

-The primary responsibility of the 2nd year resident is MFM clinic.
-The 2nd year resident will be present for rounds.
-If there is not an intern on service, the 2nd year resident will be responsible for overseeing/updating the list.
-He or she will be present in every MFM clinic except when he or she is in PCC.
-In clinic, the 2nd year resident should be seeing the majority of patients and coming up with care plans for these patients; these should always be discussed with the fellow and attending.
-When there is no clinic scheduled, the 2nd year will have charting time and/or help cover L&D/OBT.
-The 2nd year will cover the floor on Thursday afternoons when the chief and 3rd year are in PCC.
-It is strongly recommended that the 2nd year attend journal club and present an article if possible.

Intern:

-The role of the intern is to assist upper level residents while learning the basics of managing complicated pregnancies.
-The intern will be present for rounds.
-The intern's primary focus in rounds will be to see postpartum patients or less complex antepartum patients.
-The intern will oversee/update the list.
-The intern will be present in MFM clinic except when in PCC.
-When there is no clinic scheduled, the intern will have charting time and/or help cover L&D/OBT.
-It is strongly recommended that the intern attend journal club and present an article if possible.

NP:

-The role of the NP is to provide support to the chief resident in managing the floor patients, assisting with discharges, orders, etc.
-The NP will pre-round and document on floor status patients as needed.
-The NP will attend the 08:00 multidisciplinary conference on MBU to discuss discharges for the day with the pediatrics team.
-The NP will call providers to give them updates on transported patients on hospital day 2.
-The NP may assist in obtaining follow up appointments for all patients.
-The NP will cover the floor on Friday afternoon during resident school.
-It is up to the NP to notify the team of planned absence and a plan to make up the time.

The List:

The following information should be included in the list:

Antepartum:

-HPI, i.e _ y/o G_ P_ @ _._ (EDD _ by _) txpted from _ with _.
*GA should be updated daily and double-checked at least weekly
-Most recent SVE (with date)
-Date steroids given
-Most recent ultrasound (with date and pertinent findings)
-PMH
-Meds
-OB Hx (brief)
-Delivery Plan
-Transport from (City & transporting doc)

Postpartum:

-HPI, i.e. _ y/o G_P_ PPD/POD _ s/p SVD/LTCS @ _ GA (date, time of delivery), for _ (reason for c/s).
*Should include the reason the pt is on the MFM service
-Delivery info (fetal weight, Apgars), EBL, lacs
-Blood type & Rh/Rub Imm status/Br or Bottle/PPBCM
-Any significant PMH, Meds, OB Hx, etc.
-Where she received PNC

BILLING

Billing should be filled out by the resident and reviewed by the attending.

General guidelines:

-Diagnosis codes:
-Up to 4 diagnosis codes should be selected, ranked in order of importance.
-Pregnancy (primagravida or multigravida) should NEVER be identified as the primary reason for the visit – this places the bill under the global fee and essentially ensures we will not be paid for the visit at all.
-Preference (ie list as #1) should be given to ICD-9 codes that start with a 6, and never one that starts with a v.

-New patient visits should be billed as an outpatient consult.
-This does require the name of the attending physician who sent the patient for consultation.
-The note should be dicatated as an MFM clinic letter (dictation code 122) addressed to the requesting provider.
-Avoid use of the word "referral" in your dictations.

-If the patient returns for intermittent visits (ie not receiving continued care from MFM), each visit should be billed as a consult note.
-Notes should again be dictated as letters to the requesting provider.
-Avoid use of the word "referral" in your dictations.

-Patients receiving all or the majority of their care in the MFM clinic (ie transfer of care) should have follow up visits billed as an established patient visit.
-Use of the prenatal visit flowsheet is appropriate in this case.

-Patients who have never been seen in the clinic before but have been admitted to the MFM service may not be billed as a new patient, as they have already established care. However, they may (and should) be billed as an outpatient consult, with the letter being dictated to the provider who transported the patient to us.

If you have any questions regarding billing, please ask a senior resident, fellow, or attending for help.

APPROVAL

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Approval: _____ 11/25/15
Chair, Department of Obstetrics & Gynecology Date

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