
*Family Medicine
Maternal, Child, and Reproductive
Health Handbook*

Revised May 2014

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Contents

Family Medicine Maternal and Child Health (MCH) Service	4
MCH Service	4
MCH FAQs	6
FM Residency Maternity (OB) Requirements	7
Goals	7
Total Deliveries	7
Roles & Responsibilities	8
MCH Intern Responsibilities	8
PA Student Responsibilities	9
MCH Chief Responsibilities	9
Night Float Resident Responsibilities	10
Ambulatory Women’s Health Resident Responsibilities	11
MCH Fellow Responsibilities	11
Attending of the Day/Week Responsibilities	11
Overnight/Weekend Attending Responsibilities	12
Goals & Objectives	13
Goals	13
Objectives	13
Deliveries	15
General Information	15
MCH Intern Involvement with Resident Continuity Deliveries	16
MCH Chief Involvement with Resident Continuity Deliveries	16
Post-Cesarean Deliveries	16
Antepartum, Postpartum and Neonatal Admissions	17
Newborns	17
Immediate Postpartum Contraception	17
Abortion Care	19
Departmental Philosophy Statement	19
Opt-Out Letter/ Policy	19
Medication Abortion	20
Postpartum (Bilateral) Tubal Ligations for Family Medicine Patients (PPTL) ..	21
Prenatal Care	21
When Patient Admitted in Labor	22
After Delivery	22
After Tubal Ligation	22
Coverage of FM OB Patients	23
Who We Cover	23
Resident Continuity OB Patients	23
Prenatal Records	23
Education Seminars	24
MCH Tuesday a.m. Sessions	24
Breastfeeding Curriculum	25
Daily Didactic Teaching	25
MCH Core Didactics	25
MCH Practice Management	26
Colposcopy Training	26

Recommended FM MCH Textbooks	27
Core Books.....	27
Textbooks.....	27
Videos	27
Appendices	29
A. Guidelines for L&D Collaboration Between FM and Ob-Gyn Services	29
B. Memo Regarding Consultations and Cesarean Sections.....	31
C. Guidelines for coordinating continuity delivery and clinic/rotation responsibilities	33
D. Management of missed abortion (miscarriage) for Family Medicine patients.....	35
E. Shared Care Letter:	36
F. Guidelines for Supervision by MCH Attending in OB Triage.....	37

Family Medicine Maternal and Child Health (MCH) Service

MCH Clinical Director:

Larry Leeman, M.D., M.P.H. supervises the MCH clinical service, three resident rotations, and fellows.

MCH Education Director:

Sarah Gopman, M.D. supervises resident education and evaluation.

MCH Sub-I Faculty Supervisors:

Jennifer Phillips, M.D. & Larry Leeman, M.D., M.P.H.

Faculty MCH Clinic Coordinators:

FMC	Gopman
1209	Saavedra
SE Heights	Phillips
North Valley FC	Val-Spinosa
Edgewood FC	Sava
Alamosa FC	Tam
IHS	Snyder
South Valley FC	Chavez
Westside	Gopman
Los Lunas FC	Gopman
First Nations	Leeman
Cuba	Leeman
S. Broadway FC	Briones

MCH Service

Composition:

MCH chief resident
MCH intern
Sub-intern: 4th year medical student elective
MCH Nurse Practitioner
3rd year medical student on FM clerkship (observer status)
PA student on Women's Health rotation
Upper level residents on night float or covering weekends
Ambulatory Women's Health resident
MCH fellows
Attending of the week
Overnight/weekend attending
FM-OB operative backup/consultant

Call:

MCH resident on call will cover OB Triage, Mother-Baby Unit, Women's Special Care, newborns on GPU/Carrie Tingley, and Labor and Delivery patients. MCH resident admits all patients to MCH service unless continuity resident is present at time of admission to do admission.

MCH Service Daily Schedule

- 06:30** Day team residents arrive and receive brief sign out on overnight events.
- 06:30-07:30** Day team residents pre-round on patients, prioritizing laboring patients, sick patients, and discharges.
- 06:45-07:15** Attending-to-attending sign-out is completed by phone or in person anytime in this range.
- 07:00** Night float resident attends board sign-out. It is helpful for the night attending to be there as well, if possible.
- On Tuesdays, the Family Medicine resident should present first and the MCH Teaching Session should start at 07:05.
 - On Fridays, OB does board sign-out at 07:30.
- 07:15-07:30** Attending assumes care of service at 07:15 and should be in house and ready to work by 07:30.
- 07:30-07:45** Teaching occurs.
- 07:45-08:00** Brief sign-out, with everyone present except night attending.
- 08:00** Day team finishes pre-rounding. Night team signs out couplets they have seen to daytime attending. Notes should be written by 08:00.
- 08:30** Night team leaves, after assuring that patient list and delivery database are updated from admissions and deliveries overnight. Attending sees night-team patients.
- 09:00** Day team rounds with attending. Bedside or table rounds depending on team preference.
- 18:30** Day team checks out to night team. MCH Chief discusses with night team which patients to round on in the morning.

Additional Information:

*The Tuesday morning schedule is different due to the 7:00 a.m. teaching session. The teams will meet at 8:00 a.m. on these mornings for sign-out, following the teaching session. The day team should arrive at 6:30 to see patients before the teaching session starts. The Junior Night Float (Jr NF) resident should participate in these teaching sessions with the Senior Night Float (Sr NF) resident covering the service during that time. Tuesday morning teaching/case presentation will rotate in the following order, starting from the first day of the upper-level rotation: 1) the intern on service 2) the chief on service 3) the resident on the ambulatory women's health rotation (this could be a gyn case) 4) the Jr NF resident on the service- if no Jr NF, then the Sr NF resident.

* Weekends are covered by MCH attending with resident on MCH 24-hour call for Saturday, 12-hour call for Sunday. Chief and intern each pick either Saturday or Sunday to round, and then go home. Pre-rounds and transition from nights are similar to weekdays.

*Mondays at 7:00 a.m. there is a Family Planning Talk. MCH team is welcome to attend if patient duties permit. These are held outside of Jersey Jack's, in the lobby of the Pavilion.

*Wednesdays from 1:00 – 4:00 p.m. is Family Medicine Resident School. The MCH chief and intern are required to attend. The MCH attending carries the MCH pager and covers the service, with help from the MCH Nurse Practitioner for postpartum patients and the MCH fellow if needed. Residents can return for deliveries once core didactics are completed and can attend continuity deliveries during resident school.

*Fridays at 8:00 a.m. is Ob/Gyn Grand Rounds. MCH team is welcome to attend if patient duties permit. These are held in the Basic Medical Sciences Building on the 3rd Floor in the large lecture hall.

MCH FAQs

Hours:

Each resident (R1s-3s) must have an average of one day off per week over a 4-week rotation (they may not come in for rounds or assisting deliveries). There is no overnight call for interns or chiefs on this rotation. Chiefs cannot take call on the inpatient service during this rotation to avoid work hour issues. Night float residents and weekend/holiday overnight call residents (R2s and R3s) may work a maximum shift of 24 hours, with 4 additional hours for completion of patient care activities (no new patients may be seen in this 4 hour period). This gives an absolute maximum of 28 hours for a shift. Residents (R1s-R3s) must have a minimum of 10 hours for rest/personal activities between shifts/duties. The maximum work hours per week are 80.

- Time spent in the hospital for continuity deliveries counts toward the 80 hour per week duty hour maximum but does not reset the “clock” for when next shift/clinic may begin.

Vacation:

- 3rd year residents **may not** take vacation on MCH Chief rotation.
- Interns on MCH rotation may take a maximum of 1week vacation - limited to Wednesdays through Sundays - with a yearly maximum of four weeks for all interns.

Pagers:

- **MCH pager (951-1311):** Carried by an MCH resident and is **first call** to OB Triage and pages from pregnant patients via the hospital operator. ***Interns must immediately notify senior resident or attending when called for high risk patients (e.g. preterm labor, pre-eclampsia, twins, etc.).***
- **Reproductive Health Pager (951-0210):** Carried by MCH Ambulatory Women's Health resident for calls from medical abortion patients from Family Medicine Ultrasound/Options Clinic, Family Medicine sessions at Center for Reproductive Health, or women using misoprostol for medical management of miscarriage (from OB Triage or clinics). If assigned resident unable to answer calls (out of town, etc.), pager must be given to another resident who has already done the rotation.

O Drive:

Contains several folders as listed below. Accessed via "My Computer" on the desktop. You may need to re-log in to Novell by right-clicking on the red "N" at the right lower aspect of your screen. Only works on network computers, not workstations. To access the patient list from an outside computer, use the following link: <https://myportal.health.unm.edu/vo>. You will use your GroupWise login to enter the site. Please be certain to close the list/log out, otherwise others are unable to access the list.

- **Info:** Handbooks, clinical guidelines, protocols, consent forms, patient education materials are here (also found on the FCM residency wiki website).
- **Schedules:** MCH core didactics schedule, list of potential Tuesday a.m. education session topics, sub-intern schedule
- **Patient Lists:** delivery database, MCH inpatient list, discharge list, Cuba list

FM Residency Maternity (OB) Requirements

Goals

- All residents will be trained to be MCH Chief and be able to offer maternity care in their future practices, if desired.
- Residents will be formally evaluated to assess competencies.

Total Deliveries

- Our program goal is for all residents to have 75-100 deliveries during their 3 years.
- Year one: Goal of 30 deliveries during 2 rotations

- OB Labor & Delivery Service
 - 3 weeks supervised by OB faculty & residents
 - 1 week supervised by Midwives
- Family Medicine Maternal Child Health Service
- Year two: Goal of 20 deliveries
 - Junior Night Float (Jr NF) rotation on MCH (~10-15 deliveries over 4 weeks). Other locations (e.g. Hobbs) may be available.
 - R2Senior Night Float (Sr NF) (7-8 deliveries over 2 weeks)
- Year three: Goal of 15 deliveries
 - MCH Chief (7-8 deliveries over 4 weeks)
 - R3 Senior Night Float (7-8 deliveries over 2 weeks)
- Continuity prenatal & delivery expectations
 - Residents are expected to follow at least 20 continuity prenatal patients starting in February of their intern year and continuing throughout the rest of their training.
 - Residents must be present as the delivering physician for 10 of these continuity patients. Only one resident may count the delivery as a “continuity delivery”; other residents participating in the delivery may count this in their total deliveries.
 - Residents may co-follow prenatal patients with other residents at their continuity clinic to support access to prenatal care, maximize resident involvement in prenatal care and allow for individual flexibility in scheduling of rotations.
 - Each continuity clinic should develop site-specific expectations for residents’ participation in prenatal care that are at a minimum consistent with the above requirements and support patient access. Residents are expected to be active participants in their clinic’s practice plan. At clinics with a high volume of prenatal care, residents may be expected to follow more than the minimum number of prenatal patients; their delivery requirements would not be affected.
 - It is the responsibility of each resident in conjunction with their clinic faculty to monitor their progress toward completion of these requirements and notify the faculty and/or the residency office of potential problems.
- All deliveries, surgical assists, perineal repairs, and operative vaginal deliveries must be documented in a timely fashion in the resident’s procedure log on the New Innovations website.

Roles & Responsibilities

MCH Intern Responsibilities

- The intern is under close supervision from the MCH attending and MCH chief.

- When the MCH chief is unavailable and the intern is providing care, the MCH attending must see each patient in OB Triage, review NST and fetal monitoring, and supervise L&D care provided by intern. Interns cannot discharge a patient from triage until seen by an attending.
- Round daily with the team on MCH patients.
- Attend Tuesday a.m. teaching session even if post-call (this would only occur on the first day of the rotation).
- Be present whenever available for continuity/attending deliveries.
- Participate in Newborn Clinic patient encounters/observation as able, supervised by MCH attending.
- Sub-Intern rotating on the MCH service should be oriented to the service by the MCH chief, and has responsibilities similar to the intern, but with closer supervision. All sub-intern's orders must be reviewed and co-signed by the intern or MCH chief resident. Institutional guidelines regarding patient documentation by medical students must be followed.

PA Student Responsibilities

- Due to the short nature of this mini-rotation, the focus is postpartum care of mother and baby. The rotation is one week long.
- The students should initially shadow either the chief resident, midlevel provider, or attending for postpartum rounds, and toward the end of the week can round on and present some routine postpartum couplets to the attending. This can be done in conjunction with the chief or midlevel, who can be responsible for writing a note in the electronic record.
- Many of the PA students will not have used PowerChart prior to their MCH experience. They have all done their Family Medicine rotation and either Pediatrics or Behavioral Health prior to their MCH week.
- PA students may also be able to observe care on L&D, possibly including a vaginal delivery, however this will depend on patient preferences and team needs, and the student will not be the delivering provider. The student should be introduced to laboring patients by the attending before observing their care.
- PA students may observe and participate in patient care in OB Triage, however may not see patients in that setting independently.
- Dr. Gopman has arranged for the students on this rotation to have experience in the Lactation Clinic on Tuesday afternoons and Newborn Clinic on Thursday afternoons, as well.

MCH Chief Responsibilities

- Ensure all patients are placed on the MCH inpatient list on the O Drive, and that deliveries are entered on the delivery database.
- Attend Tuesday a.m. teaching sessions, organize the talks, and notify all MCH faculty and residents. Create an MCH Clinical Tip of the Week for your talk, or have the resident who gave the talk create one. Email the tip to Andrea Baca (MCH

Coordinator), MCH attending of the week, Sarah, Nicole, and Larry for review prior to sending out to faculty and residents.

- Ensure that a follow-up delivery and newborn care summary letter is sent home with each MCH Shared Care mother/baby at discharge (see appendix E).
- Chief will be aware of each patient, even if they are followed by their primary care physician (PCP). The PCP should inform the chief regarding whether he/she will be managing labor, present for delivery, and rounding on the couplet.
- The chief should have knowledge of any special problems/needs of moms/babies by the time the attending rounds with the team.
- Team will round with the attending of the day (after pre-rounding) to give the opportunity to assess communication and examination skills at bedside and witness the attending as a role model.
- Chief will be aware of babies in the neonatal intensive care units delivered by the MCH service, and report to the attending weekly. Document findings on the MCH inpatient list on the O Drive. Make social rounds on each infant at least once per week.
- Keep all pregnant patients who are undergoing fetal surveillance on the MCH sign out list.
- Keep all patients who are undergoing medical management of missed AB via OB Triage on MCH sign out list. (Patients managed via the FMC Options/Ultrasound clinic will be added to the list by the Ambulatory Women's Health resident).
- Maintain the delivery database.

Night Float Resident Responsibilities

- The resident night team usually consists of both a Junior and Senior Night Float resident ("Jr NF" and "Sr NF"). Occasionally a Jr NF resident will not be assigned, in which case only the Sr NF is present.
- The objective of the Junior Night Float (Jr NF) rotation is to gain skills in labor and delivery management, with the aim to be able to function more independently on L&D. To obtain these skills, the Jr NF resident should be primarily based in L&D managing labors and performing vaginal deliveries, with supervision by the Senior Night Float (Sr NF) resident.
- If there are no laboring patients or laboring patients are stable, the Jr NF resident should see patients in OB triage with the Sr NF resident.
- If there are > 5 patients/couplets on the patient list and there are no patients requiring attention on L&D, the night float residents should each round on up to 2 patients/couplets in the morning and staff these patients with the attending prior to leaving. If the midlevel provider is on vacation, the night float should round on couplets if there are greater than 3 on the patient list.

Ambulatory Women's Health Resident Responsibilities

- Monitor list of mifepristone/medical abortion patients with termination in process.
- Monitor list of patients receiving misoprostol for medical management of miscarriage through the FMC Options/Ultrasound clinic or family medicine sessions at Center for Reproductive Health. (If the patient was seen only in OB Triage, the MCH chief should continue to coordinate follow-up care.)
- Follow up on laboratory results, including RH status, of patients undergoing completion of miscarriage or elective termination of pregnancy.

MCH Fellow Responsibilities

- Fellows share back-up call for c/s's and other procedures: one fellow should be available for L&D consults at almost all times, and they should communicate with each other regarding times each will be unavailable (e.g. public health courses, attending educational conferences, on vacation, etc.). The fellow on back-up call is listed on AMION.
- Fellows should be notified when their continuity patients are admitted. Please notify whichever fellow is listed as being on back-up call on AMION.
- Fellows will assist with MCH service when needed due to high volume, and should round daily on complicated OB patients (pre- or post-partum). In general, the MCH chief will also round on complicated OB patients, and will staff them with the fellow. In the case of high volume on the service, the fellow may see these patients without the resident. The fellow who is rounding is listed on AMION. The management of these patients is often discussed with the FM-OB attending (Sarah, Nicole, or Larry).
- Fellows should be notified when a patient desiring PPTL is admitted/delivered.
- They can help arrange uterine aspiration procedures for patients requiring sedation at OSIS or in main OR.
- They will help organize bi-weekly reviews of co-follow list (list of patients with pregnancy complications), to ensure high quality of care for these patients—attended by fellows, Sarah, Nicole, and Larry. MCH chief and intern are also welcome, if patient duties permit. Usually twice per month on Wednesday a.m. at 7:00 a.m. in Larry's office in the department.

Attending of the Day/Week Responsibilities

- All MCH inpatients are seen by MCH attending (with exception of patients being rounded on by the MCH fellow). Guidelines for supervision of residents in OB Triage are as described in Appendix F.
- Utilize any opportunity to teach.
- Teach basic postpartum care of mother and newborn while on rounds.
- A formal didactic session is scheduled for Mondays, Wednesdays, and Thursdays, at 7:30 a.m. and Tuesdays at 7:00 a.m.. These are usually lead by the attending or chief resident. Progressive disclosure cases are also available on the O: drive, along w/

recommended readings to prepare for each case, and can be used to supplement other teaching sessions if time permits. The team should select the case they will use early in the week, to allow time to complete the preparatory readings if possible. The Friday 7:30 – 7:45 time slot should be used for brief, individual feedback sessions for the chief resident and intern.

- If you are the attending of the week, you must obtain checkout from the night attending between 6:45 a.m. and 7:15 a.m., and be in the hospital and ready for the teaching session at 7:30 a.m., with the exception of Tuesdays, when teaching begins at 7:00 a.m. Attendings should bring breakfast items for the team for the Tuesday morning teaching sessions.

Overnight/Weekend Attending Responsibilities

- Arrive for checkout and/or rounds as per above schedule
- Be present on HSC campus for
 - primiparous woman with regular contractions and at 5-6 cm cervical dilation or greater
 - multiparous woman with regular contractions and at 4-5 cm cervical dilation or greater
 - any patient with concerning fetal monitoring
 - any time MCH residents request faculty be in house--residents need to be encouraged to ask directly
- Faculty do not need to be in-house for early inductions getting misoprostol or cook/foley ripening, SROM with expectant management, or for early labor

Resident Documentation Guidelines for L&D

1. Patients in active labor **or** on magnesium sulfate are to receive progress notes every 2 hours. All other patients on L&D should have q 4-hour notes. There are specific guidelines for consultation of FP OB backup fellow or attending for prolonged labor or induction or for other morbidities such as development of preeclampsia with severe features, and residents as well as primary MCH attendings are responsible for facilitating these consultations.
2. The notes should be “submitted” as soon as each update is completed to allow attendings or others to see them. Just “saving” the note prevents others who may be following the patient’s progress from seeing the note.
3. Updates to notes should have the time and date typed in at the beginning of the new entry. A series can be done on a single note in a running fashion and can be used by multiple residents during **one** shift, and each entry should have the resident’s name typed at the bottom. The note cannot extend to another shift and should be “signed” at the conclusion of the shift.
4. **Please be careful with “cutting and pasting” from previous notes—if this is done, the note must be read and carefully edited to eliminate inaccurate information and that which is no longer timely before it is submitted/signed.**

Resident cervical exams will often be repeated by attendings, particularly when we are at turning points in patient care-- admission, initiation of labor augmentation, not making adequate progress, and prior to pushing. A recurrent scenario has been a patient who was felt to be fully dilated and pushed for some time before the incorrect exam was identified. Be careful about your exams, especially having any woman starting to push who does not feel the urge.

Though not part of the electronic medical record, the delivery database and MCH sign-out list must also be updated by the resident covering L&D or involved in the delivery. These are available on the O: drive as described above.

Goals & Objectives

New Innovations website is used for evaluation of residents. These are done both as routine assessments of residents on rotations, as well as “on the fly” evaluations of residents involved in continuity deliveries, etc.

Goals

The goal of the maternal child health curriculum is to provide FM residents with learning opportunities that will enable them to develop or refine knowledge, skills and attitudes necessary to:

1. Diagnose and manage common, low-risk perinatal presentations
2. Recognize, triage and coordinate consultation of complex and high risk obstetric conditions
3. Provide education and support for patients and families during the peripartum period
4. Effectively communicate with all members of the healthcare team
5. Develop a professional identity that emphasizes individual, practice and system improvement

Objectives

A. PATIENT CARE

The resident will demonstrate:

1. the ability to obtain, document and report an accurate cervical exam (10 supervised prior to promotion) R1
2. the ability to perform, document and report a routine vaginal delivery (10 supervised prior to promotion) R1
3. the ability to perform, document and report a newborn examination (5 supervised prior to promotion) R1
4. the ability to perform, document and report routine postpartum care R1
5. the ability to perform, document, and counsel women about breastfeeding R1
6. the ability to manage mild preeclampsia in labor (5 supervised prior to promotion) R2/R3

7. the ability to manage gestational diabetes in labor (5 supervised prior to promotion) R2/R3
8. the ability to evaluate and initiate treatment for preterm labor (5 supervised prior to promotion) R2/R3

B. MEDICAL KNOWLEDGE

The resident will demonstrate:

1. knowledge of antenatal, natal, and postnatal care based on written documentation and oral communication R1
2. recognition and interpretation of fetal strip reading using the DR C BRAVADO mnemonic of the ALSO course R1/R2
3. knowledge of evaluating SROM in triage (5 supervised prior to promotion) R1
4. knowledge of evaluating suspect labor in triage R1
5. knowledge of evaluating preeclampsia in triage (3 supervised prior to promotion) R1/R2
6. knowledge of indications for and performs labor augmentation and/or induction (5 supervised prior to promotion) R2/R3
7. knowledge of evaluating and treating postpartum hemorrhage using the "4 T's" of the ALSO course R1
8. knowledge, recognition and interpretation of neonatal jaundice R1
9. knowledge, recognition and interpretation of labor R1/R2/R3
10. knowledge, recognition and indications for appropriate use of operative vaginal delivery R2/R3
11. the ability to identify and manage fetal distress R2/R3
12. the ability to successfully complete the ALSO course R1
13. the ability to successfully complete the Newborn Resuscitation course R1

C. PRACTICE-BASED LEARNING AND IMPROVEMENT

The resident will:

1. recognize his/her own strengths and limitations.
2. apply medical evidence to inpatient clinical situations, using a logical approach that is inclusive of the individual patient.
3. use appropriate resources such as literature, consultants and peers to provide best patient care.
4. ask questions as an engaged, critical learner.

D. INTERPERSONAL AND COMMUNICATION SKILLS

The resident will:

1. make organized and effective oral presentations.
2. communicate with the patient, family and primary care physician in a timely, developmentally and culturally appropriate manner.
3. communicate clearly and respectfully with medical team members, consultants, nursing, social work, discharge planning, and other staff.

E. PROFESSIONALISM

The resident will:

1. accept responsibility for patient care.
2. never misrepresent patient care information.
3. be punctual, reliable and collegial.
4. demonstrate dress, hygiene and manner of speech that consistently reflect appropriate standards.
5. demonstrate sensitivity towards patients' and colleagues' gender, age, culture, disabilities, ethnicity and sexual orientation.
6. demonstrate sensitivity to the stressors and needs of the family with a new baby.

F. SYSTEMS-BASED PRACTICE

The resident will:

1. practice patient advocacy and use system resources to minimize discomfort or confusion.
2. recognize that the patient is part of greater system and provides care in a manner that supports continuity.

G. PROCEDURAL SKILLS

The resident will demonstrate **proficiency in:**

1. surgical skills competency as R1 (knot tying and suturing)
2. perineal repair (first degree, second degree) R1/R2

The resident will document/demonstrate **experience with:**

1. limited L&D/triage US supervised by upper level or attending (10 supervised prior to promotion) R1/R2
2. managing 1st trimester miscarriage R3
3. assisting at a cesarean delivery (5 supervised prior to promotion) R3

The resident will demonstrate **understanding of:**

1. perineal repair (third degree, fourth degree) R3

Deliveries

General Information

- Continuity residents must be notified by the admitting resident when their patients are admitted in labor.
- Continuity residents should be involved in management of labor; they should avoid arriving only for the delivery.
- MCH/continuity resident must discuss all labor management decisions with the MCH attending.
- When other duties conflict with the continuity resident's presence on L&D, the MCH attending can assist with prioritization and time management decisions.

MCH Intern Involvement with Resident Continuity Deliveries

- When the intern is available, they should assist the upper level residents, fellows, and attendings with the delivery of their continuity patients.
- Usually, both the continuity resident and intern can be gloved and assisting in the delivery and newborn care.
- The level of intern assistance during a resident continuity delivery will depend on the experience level of the upper level resident. At the beginning of the 2nd year, the upper level resident may want the intern to assist. However, by the end of the 2nd year, we want the 2nd year resident to be comfortable allowing the intern to be more hands-on.
- The intern should assist with deliveries during all weekdays and electively at other times. Interns desiring more experience can ask to be paged in from home as long as they are not in violation of resident duty hours regulations.

MCH Chief Involvement with Resident Continuity Deliveries

- If the chief resident has been involved in the management of another resident's continuity, then the continuity resident should allow the chief to continue to participate in the delivery if the MCH intern is unavailable.
- The MCH chief involvement is at the discretion of the continuity resident, however, if chief has been assisting with labor for hours, involvement is encouraged.

Post-Cesarean Deliveries

- Family Medicine patients with cesarean sections done by Larry Leeman, Sarah Gopman, Nicole Yonke, or the OB/GYN service are to be followed up by MCH service unless clinical status requires they be on MFM service.
- All surgical patients need a post-op note written at 6-12 hours following surgery (this includes PPTL patients, as well). Many patients will have SC enoxaparin started at 10-12 hours post op if they have risk factors and no concern for post-cesarean bleeding. See MCH clinical guidelines for criteria for post-cesarean enoxaparin. The FM obstetrical surgery team will discuss this at the conclusion of each cesarean.
- If surgical complications arise in a post-op patient, contact Larry Leeman, Sarah Gopman, Nicole Yonke, or the OB/GYN service if Larry, Nicole, or Sarah are unavailable.
- If surgical complications arise in the outpatient setting, consult Larry Leeman, Sarah Gopman, Nicole Yonke, or the Maternal and Fetal Medicine team's attending or resident, if Larry, Nicole, or Sarah are unavailable.

Antepartum, Postpartum and Neonatal Admissions

- Pregnant patients who need to be admitted for reasons other than labor should be admitted to MCH (i.e. mild pre-eclampsia, rule out severe pre-eclampsia, pyelonephritis, buprenorphine induction, asthma exacerbation—see FM-OB Guidelines).
- Postpartum patients admitted up to six weeks after delivery should be on the MCH service for problems such as postpartum endometritis, mastitis, delayed postpartum hemorrhage, or DVT. Non-pregnancy related admissions within the first six weeks are to be on the Family Medicine Inpatient Service (for cellulitis or pneumonia, etc.).
- Babies admitted within the first two months of life should be admitted to the MCH service for a diagnosis such as jaundice, failure to thrive, or neonatal infection.
- The MCH attending on call will be the attending for admissions, unless a continuity attending prefers to handle the admission. In this case, the on-call MCH attending is notified of the admission at the discretion of the admitting attending. Clear communication between attendings is important.

Newborns

- The delivering resident should admit the baby, perform newborn exam, and alert Newborn Nursery that this is a Family Medicine baby.
- Sign-out must be given to MCH team by the delivering continuity resident.
- If the delivery occurs after 8:00 p.m., a brief heart and lung exam is still indicated prior to the continuity resident leaving the hospital, but the newborn exam may be completed later by the night float resident (if the baby is stable).
- Night float MCH resident is also expected to do all newborn exams when they were involved in the delivery, regardless of hour of delivery.
- Babies who receive transition care in the ICN3 or NICU and are then transferred to MCH care in the Mother-Baby Unit will require an accept/progress note or an admission H&P, depending upon whether the ICN3/NICU team has done a full H&P or not. It is the resident's responsibility to review the H&P done by the transferring team or to complete one if it has not been done.

Immediate Postpartum Contraception

- New Mexico Medicaid/Salud plan covers post-placental IUDs and Nexplanons (Long-Acting Reversible Contraception—LARC) prior to discharge.
 - These devices must be obtained via the inpatient pharmacy

- To order the devices, there is a Power Chart Order for Immediate Postpartum IUDs and Postpartum Inpatient Nexplanons. They will be found under:
 - ParaGard - INPATIENT MEDICAID
 - Mirena - INPATIENT MEDICAID
 - Nexplanon - INPATIENT MEDICAID
- For IUDs: Once the order has been written in the Computerized Provider Order Entry (CPOE) system, the pharmacy will release the IUD in the Pyxis, which can take up to an hour. Order the IUD at admission for this reason, selecting “on call” for the “frequency.” **If the patient delivers prior to the order being profiled and the device released, the nurses have been instructed that they CANNOT borrow an IUD from the grant IUDs.** The patient will have to wait until her 6-week follow-up.
- For Nexplanons: The order should be entered when the patient is transferred to the postpartum unit or when the provider rounds on her on the floor. Again realize there is a delay built into the system. Select “**on call**” for the frequency of this order as well so that it is in the Pyxis when it is needed.
- Medicaid post-placental IUDs will be inserted on labor and delivery by the Ob/Gyn and MCH services based on having a trained attending or fellow from either department to facilitate.
- Medicaid Nexplanons will be inserted by the admitting service as long as the resident and attending physician or midwife are certified Nexplanon providers. The MCH team will also temporarily cover the Ob and CNM postpartum services for Medicaid Nexplanon if the Ob/Gyn attending or CNM is not Nexplanon certified. If there is not a certified OB attending on service, the OB resident should usually place the Nexplanon staffed by the MCH attending. If the OB resident is not available, the MCH resident may also place these instead.
- Women without a payor source (self-pay or EMSA) are eligible for LARC insertion via a resident training grant.
 - **EMSA/pending Medicaid does NOT cover LARCs from the pharmacy and the patient will be charged if it is ordered in this way.**
 - Women with Medicaid or other 3rd party coverage cannot obtain a LARC from the resident training grant supply-- **DO NOT “BORROW” ANY GRANT IUDS OR NEXPLANONS.**
 - **Grant IUDs:** Family Medicine grant IUDs need to have a family medicine resident involved with the placement of these IUDs, either inserting or performing the ultrasound during the procedure. These could be supervised by an MCH faculty/fellow or Ob/Gyn faculty/fellow. Ob residents have their own training grant for post-placental IUD insertions.
 - **Grant Nexplanons:** The MCH service will continue to cover Nexplanon insertions for medically indigent patients on all three services until we establish an Ob/Gyn resident training grant supply.

- **Women with 3rd party coverage other than Medicaid:** These women will need to plan for insertion at postpartum visits at their clinic or the UNM Center for Reproductive Health as **they are not eligible** for a Medicaid or resident training grant LARC.

Abortion Care

Departmental Philosophy Statement

Graduate medical education and service to the community are explicit in the mission of the University Of New Mexico Health Sciences Center. The provision of abortion services, including patient counseling, the provision of medical and surgical abortions, and the management of complications, is an important aspect of women's health care. Those residents in Obstetrics and Gynecology and Family Medicine graduating from the University of New Mexico who wish to provide these services to their patients must receive the training necessary to provide competent and safe medical and surgical abortions. As with any medical or surgical technique, extensive experience is necessary for the resident to become skilled in the procedures and in managing such complications that might arise.

Therefore, abortion services are an important aspect of the scope of care provided by the Obstetrics and Gynecology Department and Family Medicine Department. We provide these services not only as a component of comprehensive women's health care but in accordance with our mandate to provide comprehensive, high quality training to our resident staff.

Approved January 2001 by UNM Dept. of Family and Community Medicine & UNM Dept. of Obstetrics and Gynecology.

Opt-Out Letter/ Policy

Your Ambulatory Women's Health rotation includes training in pregnancy options counseling, first trimester dating ultrasound, and medical and surgical abortion. The training goals are for graduates to be able to:

1. Provide appropriate pregnancy options counseling and management of abortion complications.
2. Use ultrasound, cervical dilation and curettage and related gynecological skills in other areas of family medicine.
3. Provide first trimester medical and surgical abortion in their practices after graduation, if desired.

As 25% of pregnancies result in pregnancy termination and over 40% of women will have an elective abortion during their reproductive life, abortion care is an important part of primary care. The options counseling, pregnancy dating, and gynecology procedural skills

are extremely useful regardless of a resident's future plans regarding the inclusion of abortion services as part of their practice. The Family Medicine RRC considers the surgical management of an incomplete abortion a core skill.

It is our expectation that all residents will receive instruction in contraception and abortion counseling techniques, and that residents will be able to perform abortions with appropriate faculty supervision. Training sites include:

- Planned Parenthood (Drs. Yonke, Hooper, Stromberg, Leeman, and Ob/Gyn faculty)
- UNM Family Medicine Center (Drs. Gopman, Lemon, , Grant, and MCH fellows)
- UNM Center for Reproductive Health (Drs. Leeman, Phillips, Hooper, Yonke, Tam, Espey, Singh, Pereda, & Ogburn)

It is not the department's policy that residents will be required to perform abortions. Residents with a strong religious or moral conflict with providing abortions may conscientiously object. A resident wishing to exercise this option will meet with Drs. Leeman or Hooper, co-coordinators of the ambulatory women's health rotation to design an alternative curriculum. All residents will be required to learn about medical and surgical abortion and be able to provide options counseling and management of patients following either procedure, including complications.

Residents may opt out of performing surgical or medical abortion. All residents need to be trained in options counseling and how to follow-up any complications after medical or surgical abortion.

Medication Abortion

- Each resident will have the opportunity to learn about medical abortion with mifepristone during their Ambulatory Women's Health rotation. Mifepristone and 1st trimester U/S are available through a Wednesday morning clinic at the Family Medicine Center and Monday/Thursday Family Medicine clinics at the Center for Reproductive Health. The physician prescribing mifepristone must be registered with the drug manufacturer and UNM pharmacy. For a woman to qualify she must not have reached her - 70th day of pregnancy. The treatment has strict criteria which must be followed to complete the pregnancy termination:
 1. The patient will receive a urine HCG test to confirm pregnancy if she has not had a home pregnancy test.
 2. She may have an U/S to confirm that she has not been pregnant for more than 70 days. This may be done in the clinic and mifepristone given that same day.
 3. Each woman must be fully aware of her options: adoption, parenthood, surgical abortion or medical abortion.
 4. The patient is given a 200mg dose of mifepristone po, in the presence of the MD. This dosage will terminate the pregnancy.

5. Within 24-72 hours, the woman will place 800mcg misoprostol buccally (or vaginally) at home. This dosage will expel the pregnancy.
 6. Within 1-2 weeks after taking the mifepristone, the patient will return for a follow-up ultrasound and/or HCG test. If the HCG results are <50% of the initial level, the termination is complete; if >50%, the termination is not complete. In cases where the termination is unsuccessful, the woman will have the choice to take more medication or to have a surgical abortion.
 7. Mifepristone is 97-99% successful, however, a small percentage of patients require uterine aspiration to stop excessive bleeding or due to an ongoing pregnancy.
 8. All patients are given information about birth control and emergency contraceptives (see detailed protocol distributed 7/1/02).
- A list of patients in process of termination with mifepristone should be maintained by the resident on the Ambulatory Women's Health rotation.
 - All calls from medical abortion patients are to be directed to the MCH reproductive health pager, with backup being the MCH on-call pager. This includes evenings and weekends. Residents who take vacation during their Ambulatory Women's Health rotation must arrange to have another resident who has already done the rotation carry the repro pager in their place.

Residents accepting calls from mifepristone or misoprostol patients should review management recommendations with the MCH attending on-call. If the MCH attending is unfamiliar with medical abortion, the call should be directed to Drs. Leeman, Gopman, Yonke, Lemon, Phillips, Hooper, or Grant.

Postpartum (Bilateral) Tubal Ligations for Family Medicine Patients (PPTL)

Prenatal Care

- All patients should have postpartum contraception discussed during prenatal care and all multiparous patients should be asked specifically about desire for tubal ligation by the time of the 20-week prenatal visit.
- Discuss all alternatives to tubal ligation including the use of the IUD.
- Have tubal federal consent papers signed at least 30-days prior delivery date (no later than 28-32 weeks). Sign even if patient is covered by private insurance.
- Make three copies of tubal federal consents: a copy for clinic chart, a copy for patient to carry, and a copy to go to OB Triage along with the prenatal records and/or to be scanned into Power Chart.

When Patient Admitted in Labor

- Confirm that the patient still desires postpartum tubal ligation.
- Locate copy of tubal federal consent papers and place them on the chart.
- Page Larry Leeman, Nicole Yonke, or Sarah Gopman to determine their availability for a postpartum tubal, and also notify the fellow on call (okay to leave voice mail between 7:00 a.m. and 10:00 p.m.).

After Delivery

- If an epidural is in place the patient may consider doing PPTL 2-4 hours after delivery and staying on L&D until surgery, and must remain NPO. L&D charge nurse and anesthesiologist approval is required. Severe pre-eclampsia, significant postpartum hemorrhage, and chorioamnionitis are contraindications.
- The patient should be NPO after midnight with maintenance IVF started when NPO.
- Postpartum Hct should be ordered.
- If the ob/gyn resident is to do the tubal with ob/gyn attending, then let the ob residents know so they can pre-op patient.
- If Larry, Nicole, or Sarah will do tubal with the ob resident, let resident know this and they will write pre-op note and have patient sign operative consent. Larry, Nicole, or Sarah should be paged to leave voice mail between 7:00 a.m. and 10:00 p.m.
- If Larry, Nicole, or Sarah will do tubal with MCH fellow/resident, the fellow/resident is responsible for writing pre-op note, having operative consent signed, and being available for the tubal.
- Pre-op evaluation increases knowledge of the delivery, medical problems, surgical history, medicines and drug allergies.

After Tubal Ligation

- Write brief operative note in chart, complete pathology slip, dictate operative note and write post-op orders.
- The patient may be discharged home as soon as 4-6 hours post-op if they are doing well. If discharged to home on the day of tubal ligation, then an FM resident needs to see the patient prior to discharge.
- Patient needs post-op check note on chart 4-6 hours after surgery regardless of whether staying or being discharged.

Coverage of FM OB Patients

Who We Cover

- Resident continuity prenatal patients (FMC, IHS, FC-SV, SEH).
- “Shared Care” prenatal patients (Milagro Clinics at FMC and SEH, all First Choice clinics except Belen site where all are CNM patients and CNM patients at Los Lunas site where MCH fellows and CNMs have practices, First Nations, Cuba, UNM Westside, UNM NEH).
- FM faculty continuity patients (not followed by a resident). MCH Residents will cover with FM faculty.
- For sites with prenatal care providers from multiple departments (Ob/Gyn, CNM's, and FM—e.g. Westside, LLFC, IHS), only patients who have established care with a FM provider prior to delivery will be delivered by MCH service, unless the MCH attending on call has been contacted with a request by the PNC provider for us to manage the patient. For example, a patient cared for by a nurse practitioner or midwife at IHS would not be admitted by MCH unless care had been transferred to a FM resident at IHS prior to delivery, or special arrangements were made with the MCH attending at the time of admission.

Resident Continuity OB Patients

- A faculty member at each site will oversee prenatal care and resident continuity experience and support each resident to balance continuity of care and a comfortable life-style.
- Residents will keep pagers on for their continuity patients from 37 weeks on. The MCH team will provide back-up prn.
- If a resident continuity patient comes in before 37 weeks, that particular resident should be paged, but MCH will cover if the resident is not available.
- The MCH attending should be involved in all management decisions for resident continuity patients.
- Residents are responsible for rounding on their own continuity patients, both moms and babies.
- Patients will be seen by the continuity resident before 8:00 a.m. attending rounds (unless other arrangements are made between primary and attending).
- The MCH team may assist in managing latent phases of labor, long antepartum stays, preterm labor, inductions, etc.

Prenatal Records

- For patients at non-UNM clinic sites
 - Ask the patient to bring in a copy of the first page of the written prenatal flow sheet at the time of each prenatal visit for updates to be added and to bring this to the hospital for the delivery.

- When the patient reaches 20 weeks, the primary prenatal provider needs to hand-carry a copy of the records to OB Triage and file them in the appropriate folder.
- An updated copy should be brought in at 34 weeks, and GBS results brought when available. Please include PPTL federal consent or immediate postpartum IUD consent, when applicable.

Education Seminars

MCH Tuesday a.m. Sessions

Teaching sessions are held each Tuesday morning from 7:00 to 8:00 a.m. in the L&D conference room. **Attendance is mandatory for all interns and residents** on MCH (including night float) and Ambulatory Women's Health rotations. The attending of the week will also be present. All FM residents and faculty are also welcome to attend.

- The MCH Chief should oversee the weekly sessions during their rotation. The presenting resident rotates throughout the month.
- Resident Rotation: The responsibility for the case presentation will rotate in the following order starting from the first day of the upper-level rotations between: 1) the intern on service 2) the chief on service 3) the resident on the ambulatory women's health rotation (this would often be a gyn case) 4) the Junior Night Float resident on the service.
- The presenting resident should choose a case by Tuesday the week before and email the attending for the week of the presentation about which case will be presented and what the teaching issue will be, and a discussion should be had about whether the attending or resident will present the teaching points.
- Talks should be built around a clinical case. Most of these will include labor management, and a fetal heart rate tracing review should be included. The first 30 minutes are spent in review of the case, and the last 30 minutes in presenting relevant teaching points.
- On the Wednesday prior to the session, an email should be sent to Andrea Baca (MCH Coordinator) regarding the topic, so that it can be sent out to residents and faculty.
- A white board and projector are available.
- The MCH chief should obtain fetal heart rate tracings for the teaching sessions. For now, **strips must be requested approximately one week prior from the Medical Records Department at 2-0485**. Eventually they will be available via access to the QS system in the conference room.
- On Wednesday after the weekly seminar, the MCH Clinical Tip of the Week should be emailed to Larry, Nicole, and Sarah for approval, and to Andrea Baca for distribution. The tip should be a clinical pearl that is on a level to benefit attendings

as well as residents, not a summary of the standard management of a condition. Briefer is better.

Breastfeeding Curriculum

Faculty members from the departments of Family and Community Medicine, Obstetrics, and Pediatrics have collaborated to offer a curriculum for teaching breastfeeding concepts to medical students and residents in the respective disciplines. The educational guidelines are taken from the *Lactation Management Curriculum – A Faculty Guide for Schools of Medicine, Nursing and Nutrition*, sponsored by Wellstart International and University of California, San Diego, Dept. of Pediatrics.

Medical students and residents will be given clear objectives with the overall goal to be able to provide routine prenatal and postpartum counseling and management of common concerns and complications of the breastfeeding infant and mother dyad. They will also learn what resources are available and when to seek assistance.

In addition, residents and faculty will be educated on the principles and practice of the Baby Friendly initiative, an international program to encourage breastfeeding, which is underway at UHMH.

Daily Didactic Teaching

In addition to the formal MCH teaching session on Tuesdays at 7:00 a.m., a teaching topic is to be presented on Mondays, Wednesdays, Thursdays, and Fridays by someone on the team often the chief or attending, from 7:30 to 7:45 a.m. . Another option is to choose a journal article on a topic of interest to read the night before, with one member presenting a relevant patient case for discussion. These can be led by the attending, resident, intern, or sub-intern. Pre-prepared cases with associated recommended readings are available on the O: drive. These sessions do not replace “on the fly” teaching done to address specific educational issues that arise during patient care.

MCH Core Didactics

MCH core didactics occur during Family Medicine Grand Rounds the first week of the month from 1:00 to 3:00 p.m. The first hour will usually be a presentation by a faculty member. The second hour will vary between, MCH journal club and workshops/small group sessions. Each MCH chief is expected to present once or more during their residency at M&M and/or journal club. M&M discussions are held 3:00 – 4:00 p.m. on the first Wednesday of the month, with approximately 4 sessions per year covering MCH cases.

MCH Practice Management

The MCH chief is responsible for ensuring that the delivery database statistics are appropriately kept. Dr. Yonke and/or the MCH chief will present a summary once a month, usually at MCH resident school. This summary should include total deliveries, cesarean rate, induction rate and other appropriate information.

Colposcopy Training

Many family physicians offer colposcopy services, although the number of colposcopies is decreasing given the introduction of HPV testing for ASCUS paps, deferment of pap screening until age 21, and perhaps eventually due to the HPV vaccination program. Residents choosing to get trained to competency in colposcopy must be proactive in designing a training program. The key to this is identifying a mentor at the continuity clinic site and arranging for a colposcopy course.

The manual and visual skills of recognizing abnormal cervical lesions are only a part of training in colposcopy. A broad knowledge regarding HPV, dysplasia, epidemiology of cervical cancer, management of pap smears, and post-colposcopy follow-up and treatment are essential. Residents desiring colposcopy training should take a 2-4 day course as early in residency as possible. The residency does not pay for this but residents may use their CME funds. Courses are offered periodically in New Mexico through either IHS or ASCCP (see below), permitting residents to avoid travel expenses. However, availability in these courses cannot be guaranteed and courses often fill up quickly.

After completion of a course, residents should have approximately 30 supervised colposcopies, including at least 5 high-grade lesions, prior to offering this service independently. Colposcopy opportunities are limited, however, and residents must arrange a continuity experience to meet these goals. To be able to reach these training goals, residents must decide they are interested in colposcopy, arrange a training course, and start the precepting process as early in residency as possible. Although colposcopy exams are scheduled in the Wednesday morning Ultrasound/Options clinic at the FMC, residents should not plan to use the Ambulatory Women's Health rotation to meet their colposcopy goals. We do not have the ability to concentrate a large number of colpos in a block month, and therefore other training must be arranged.

For more information about colposcopy and training, please visit the American Society for Colposcopy and Cervical Pathology (ASCCP) website at www.asccp.org.

Recommended FM MCH Textbooks

Core Books

All paperback and readable

- Ratcliffe SD, Baxley EG, Byrd JE, Sakornbut EL, eds. Family Medicine Obstetrics. 3rd Ed. Saint Louis, MO: Hanley & Belfus; 2008. ISBN: 978-1-56053-359-7. (Purchase strongly recommended.)
- Parer JT. Handbook of Fetal Heart rate Monitoring. 2nd Ed. Saint Louis, Mo: W.B. Saunders CO.; 1997. ISBN: 978-0-7216-3639-9. (Recommended reading during Intern MCH rotation.)
- Thureen P, Hall D, Deacon J, Hernandez J. Assessment and Care of the Well Newborn. 2nd Ed. Saint Louis, MO: Elsevier Science Health Science Div; 2004. ISBN: 978-0-7216-0393-3. (Recommended purchase for Interns during NBN rotation.)
- Simkin P, Ancheta RS. The Labor Progress Handbook: Early Interventions to Prevent and Treat Dystocia. 3rd Ed. Williston, VT: Blackwell Pub.; 2011. ISBN: 978-1-4443-3771-6. (The art of labor management with emphasis on labor support, assessment of fetal position, and midwifery techniques.)

Textbooks

Reference Hardbacks

- Gabbe SG, Simpson JL, Niebyl JR, et al. Obstetrics: Normal and Problem Pregnancies. 6th Ed. Saint Louis, MO: Elsevier Science Health Science Div; 2012. ISBN: 978-1-4377-1935-2.
- Creasy RK, Resnik R, Iams JD, eds. Maternal-Fetal Medicine: Principles and Practice. 6th Ed. Saint Louis, MO: W.B. Saunders Co.; 2008. ISBN: 978-0-7216-0004-8.
- Posner G, Black A, Jones G, Dy J. Oxorn Foote Human Labor and Birth, Sixth Edition [Paperback] McGraw-Hill Professional 2013; ISBN-10: 0071740287
- Taeusch HW, Ballard RA, Gleason CA. Avery's Diseases of the Newborn. 9th Ed. Saint Louis, MO: Elsevier Saunders; 2011. ISBN: 978-1-4377-0134-0.

Videos

- Repair of Second Degree Perineal Lacerations
Rebecca G. Rogers, M.D.; Larry Leeman, M.D.; Maridee Spearman, M.D, 2001.
(Focuses on obstetrical perineal trauma presenting evidence-based methods of prevention and repair as well as a thorough review of perineal anatomy.)
- Repair of Obstetrical Anal Sphincter Lacerations
Rebecca G. Rogers, M.D.; Larry Leeman, M.D.; Maridee Spearman, M.D, 2001.
(Focuses on obstetrical lacerations and demonstrates alternative techniques for repairing 4th degree lacerations as well as a review of the anatomy of the anal sphincter complex.)

- Use of Intradermal Waterblocks for Relief of Back Pain in Labor.
Larry Reynolds, MD
- Vaginal Breech Videos- contact Larry Leeman, MD, MP

Appendices

A. Guidelines for L&D Collaboration between FM and Ob-Gyn Services

Level 1 – Informal Interactions

1. Normal labor and vaginal delivery of term infant, (vertex presentation)
2. Fetal monitoring (internal or external)
3. Outlet or low operative vaginal delivery (if FP attending privileged)
4. Repair of 3 ^o (if FP attending privileged)
5. Gestational Diabetes, controlled by diet or oral medications
6. Induction/Augmentation of labor in term patient
7. Mild pre-eclampsia
8. Chronic hypertension (not requiring intrapartum IV antihypertensive medicines)
9. Chorioamnionitis

Level II – Formal consultation with FP Ob Fellowship trained faculty with operative privileges or Ob-Gyn Faculty

1. External cephalic version
2. Repair of fourth degree laceration (if FP attending privileged)
3. Active maternal use of cocaine, amphetamines, heroin or methadone
4. Amniocentesis for pulmonary maturity
5. Twin gestation
6. Postpartum tubal ligation (if FP attending privileged)
7. Need for abdominal delivery
8. Mal-presentation (breech, brow, transverse)
9. Vaginal Breech Delivery (if FP attending privileged)
10. Gestation diabetes, requiring insulin
11. Type 2 diabetes
12. Second or third trimester fetal demise
13. Preterm onset of labor (≥ 30 and < 34) **
14. Preterm rupture of membranes (< 32 wks) **
15. Chronic Hypertension requiring intrapartum IV anti-hypertensive ***
16. Severe pre-eclampsia by ACOG criteria ***

** If not delivered and managed conservatively consult with MFM service to see if should be admitted to MFM or FP antenatal service.

*** Inform MFM/Ob-Gyn of patient's presence on L&D

Level III – Formal Consultation with OB-GYN faculty

1. Midpelvic operative vaginal delivery
2. Third trimester bleeding from previa or abruption
3. Planned c-sections that are at high risk for hysterectomy or complex adnexal/pelvic surgery should have formal consultation prior to planned c-section with determination of the most appropriate surgical team for delivery. This would include patients with possible accreta, previa in patient with prior c/s so at risk of accreta, large fibroids in lower uterine segment, or adnexal pathology.
4. Preterm labor <30weeks
5. Preterm rupture of membranes <32 weeks

Level IV – Transfer of primary responsibility to Ob-Gyn Faculty or MFM Faculty

1. Eclampsia
2. Severe maternal morbidity as defined by ACOG

Items covered by credentialing process

- Vaginal Breech deliveries including the second twin
- Low and outlet vacuum deliveries
- Low and outlet forceps deliveries
- Repair of third or fourth degree episiotomies or lacerations
- Postpartum tubal ligation

Final Version 7/30/07

B. Memo Regarding Consultations and Cesarean Sections

From: Dr. Larry Leeman

UNM Family Medicine Faculty and Residents,

I am available for family medicine patients needing cesarean sections, postpartum tubal ligations, operative vaginal deliveries, repair of 3rd/4th degree perineal lacerations, vaginal delivery of twins, selected/approved vaginal breech deliveries, and consultation regarding prenatal and intrapartum obstetrical issues. Sarah Gopman and Nicole Yonke are available for cesarean sections, postpartum tubal ligations, vacuum-assisted vaginal deliveries, repair of 3rd degree perineal lacerations, and prenatal/intrapartum consultation. The following guidelines are to ensure a smooth integration with our Family Medicine OB attending system and the UNM OB/GYN service.

Cesarean sections and other procedures

Sarah, Nicole, and I would like to be involved with all family medicine patients needing a scheduled cesarean section for indications such as breech presentation, prior c-section requesting repeat cesarean and placenta previa. Faculty and residents should contact us to discuss the patient and we will then schedule the cesarean section. Consults may be scheduled for patients unsure about trial of labor versus repeat c-section.

Sarah, Nicole, or I may be called regarding FM patients needing non-urgent cesareans during daytimes, evenings, or weekends and will come in for these if available. Patients with non-reassuring fetal tracings/fetal distress/second stage bradycardia or other urgent problems should continue to be managed through the obstetrical residents/attendings if we have not been involved in the care. ***In an urgent case obstetrical care should not be delayed to consult us or await our arrival!***

We would like to have a resident or fellow from Family Medicine present at all scheduled FM cesareans as first or second assistant. This can be an MCH fellow, continuity resident, a resident on MCH, or another FM resident with specific interest in cesarean sections. Our goal is for FM residents to become skilled 1st assistants at cesarean sections. Training as primary surgeon will require post residency training (e.g. fellowship). The resident involved in the cesarean will be responsible for admitting the patient and can write an H&P in the clinic or on L&D. The FM continuity resident/faculty and the MCH team will follow the post-cesarean patient. Sarah, Nicole, and I will be available for postpartum consultation regarding post-cesarean complications, at the discretion of the MCH attending. Coverage of surgical complications of MCH post-op patients should be by consultation with the OB/GYN service if Sarah, Nicole, and I are unavailable. We may also be called to assist with vacuum extraction and repair of 3rd degree lacerations at the discretion of the MCH attending to facilitate FM residents and fellows gaining these important skills. Patients needing external cephalic version or third trimester amniocentesis can be referred to Sarah, Nicole, or me—we will arrange to do the procedure along with the fellow and/or primary. (Postpartum tubal ligations are addressed in another memo in the MCH handbook.)

Consultation

FM faculty and residents who would like to consult with us about prenatal patients can page or email Sarah, Nicole, or me. Family Medicine residents and faculty can also consult with us

regarding patients with intrapartum complications. The intrapartum consults should all be done at the **discretion of the MCH attending** following the patient. Patients needing a c-section for failure to progress, operative vaginal delivery for prolonged second stage/maternal exhaustion or patient in need of a third or fourth degree repair would all be appropriate for us to come and assist with if we are available (4th degree=Larry only). Early calls as a “heads up” to let us know a problem may be brewing will facilitate our involvement. If we become involved with a patient’s care during the day we will discuss with the MCH attending and /or resident whether to consult us during the evenings or weekend.

We can co-manage prenatal patients with complications such as breech presentation, twin gestation, gestational diabetes, etc. with primary physicians as desired. Depending on the primary resident or faculty’s desire we can co-manage the patient or they can be transferred to our care. We will refer to or consult with MFM as appropriate. If we co-follow a patient who is expected to have a more complicated delivery such as twins or marginal previa, then we can plan to come in during labor to assist if arranged in advance with the primary. -We would be the obstetrical back up for the primary physician and can be called anytime for these patients (along with the continuity physician). If we were unavailable then obstetrical backup would be the UNM OB resident/attending.

Larry Leeman, MD, MPH
Director of FM Maternity and Infant Care
Updated 5-5-14

C. Guidelines for coordinating continuity delivery and clinic/rotation responsibilities

Being present for a continuity prenatal patient during labor and delivery is a core component of FM training. Please recognize the importance of the continuity physician's presence during even "normal" labors and avoid routinely showing up for the delivery only. There is much to be learned from observing and supporting patients through labor transitions, reviewing fetal heart tracings, doing cervical exams, managing labor pain, and making even seemingly routine intervention decisions. However, a long L&D course and/or the resultant fatigue can interfere with other rotation duties and continuity clinic or personal responsibilities. The following guidelines are intended to help Family Medicine residents and attendings comply with the ideal of attending continuity deliveries and the mandatory ACGME duty hour rules.

Continuity delivery hours should be logged in NI, and they count toward all components of the duty hour rules.

- Do not violate duty hours for continuity deliveries. If there is a risk of a duty hour violation, you must decide whether to miss the continuity delivery or rotation/clinic.
- You must be present for a continuity delivery for it to count toward the 10 required; if you miss the delivery for any reason (including potential duty hour violation) you are still required to complete 10 continuity deliveries.
- If you must miss a continuity delivery for this reason, please coordinate care with the MCH team and update the NI Prenatal Patient Log to reflect that you missed due to avoiding a duty hours violation.
- If you are able to and choose to modify a rotation or clinic schedule to be present at a continuity delivery, you must notify as soon as possible the rotation, your clinic and the Residency Office.
- Use discretion and manage your time wisely and in collaboration with all who are involved. Use the faculty to help make these challenging decisions as needed.

RESIDENT RESPONSIBILITIES

Resident whose continuity prenatal patient is being admitted

When called about a continuity patient in labor or following a patient with a long labor, consider the patient's stage in labor, potential for complications, and your responsibilities in the next 24 hours. Discuss potential schedule conflicts with the MCH attending and strategize ways to minimize these conflicts. Discuss ways to stay involved during your patient's labor course, even if you are unable to be in the hospital continuously.

- You may be able to come to the hospital some time after your patient is admitted or go home to sleep at night during early labor with the MCH service providing coverage.
- You may be able to come to L&D periodically during a day to do exams and be involved in management decisions.
- Avoid socializing on L&D late at night or simply staying up when not evaluating your patient or providing necessary labor support.
- If you are able to sleep in the hospital during your patient's labor and can have the MCH service assume primary responsibility for care, the time you spend sleeping does not count as "on duty" with respect to duty hours as long as you are not responding to pages (consider turning your pager off and setting an alarm for a pre-arranged time to "return to duty").

- If you are unsure about when you need to be physically present on L&D (versus sleeping) or how frequently to evaluate your patient, discuss with your attending.
-

Residents covering MCH call or MCH Night Float

You are already awake or scheduled to be on call. Especially between the hours of midnight and 5:00 a.m., consider following a patient admitted in early labor and delaying your call to their primary physician. Exceptions to this might be in the case of a patient with unique psychosocial needs or labor complications requiring more complex decision-making (or if a resident or attending requests to always be notified immediately when their patients are admitted). Talk to the MCH attending on call about a patient to be admitted before calling the primary resident if the patient is in early labor.

FACULTY RESPONSIBILITIES

On call MCH attending responsibilities

Encourage all of the above. Discuss the issue of “when to call” the primary resident when patients are admitted late at night and be willing to follow patients in early labor with the on-call resident. Help primary residents think ahead about conflicting responsibilities and prioritize their activities to avoid duty hours violations and minimize clinic cancellations. Prompt residents to go home or go to bed to avoid unnecessary continuous hours sitting on L&D. If a resident is unable to be with their continuity patient continuously, help them think about how they can stay involved (come over at lunch to do the next cervical check and review the fetal heart tracing) and discourage “perineal obstetrics” (coming in for the delivery only) unless there is no other choice.

Continuity clinic attending responsibilities

Support a resident’s presence at continuity deliveries and be available to discuss anticipated conflicts with clinic responsibilities. Ask the resident if they have discussed canceling their clinic with the MCH attending (or contact the MCH attending to confirm). Be willing to review the resident’s clinic schedule over the phone to involve the resident in triaging patients that must be rescheduled. Encourage the resident to be flexible/creative in accommodating these patients themselves.

D. Management of missed abortion (miscarriage) for Family Medicine patients

There are four options for Family Medicine patients with missed abortion (early pregnancy loss) at 10 weeks or under gestational age:

1. **Expectant management** is successful in over 90% of women, but may require several weeks. Some women will select surgical or medical treatment to complete the miscarriage process and this decision should be respected.
2. **Manual vacuum aspiration** under local paracervical block at the joint Ob-Gyn/FM Center for Reproductive Health. Electric suction D&C in main OR or OSIS attended by Larry Leeman, Nicole Yonke, or Sarah Gopman, with MCH fellow/FM resident. If Larry, Nicole, and Sarah are unavailable, this may occur through Gyn service.
3. **Misoprostol** for medical completion of a missed abortion will be successful in over 85% of women. Main disadvantage is 7-14 days of bleeding, although most of heavy bleeding is within first few days or week.

Patients desiring expectant management may be followed through their usual clinic or referred to Wednesday morning Options/Ultrasound Clinic at the Family Medicine Center per provider choice. They may have an U/S at this clinic to determine if they have completed their miscarriage.

For women desiring aspiration procedure at Center for Reproductive Health (CRH) call 925-4455 or complete ad hoc referral at night to CRH. If aspiration to be done in in OR/OSIS, please contact Larry Leeman, Nicole Yonke, or Sarah Gopman.

For women desiring to use misoprostol for completion of a missed abortion, please use the protocol and patient information sheet available on the O: drive and department wiki. The 3rd year FM resident on the Ambulatory Women's Health rotation carries the repro pager (951-0210) and should be informed of all women using misoprostol. This rotation includes training in management of early pregnancy loss. Calls during the evenings or weekend may also be referred to the MCH resident on call at 951-1311.

E. Shared Care Letter:

Your patients were recently cared for on the Family Medicine Maternal-Child Health Service. The following provides a summary of their hospital stay. Thank you for allowing us to share in the care of your patients.

MOTHER: Name: _____ DOB: _____
 G: _____ P: _____ →: _____ OB Dates @ Admit: _____ Admit Date: _____ D/C Date: _____

INTRAPARTUM CARE: **PRENATAL CARE SITE:** _____
 Labor: Spontaneous _____ Augmented/Induced _____ N/A _____
 Anesthesia: None _____ Parenteral _____ Epidural/Spinal _____ Other _____
 Labor Complications/Coexisting Conditions:
 GDM _____ PIH _____ Preeclampsia _____ Oligo/polyhydramnios _____ PTL _____ PROM _____
 Chorioamnionitis _____ TOLAC _____ Other: _____

DELIVERY:
 Vaginal: _____ C/S: _____
 _____ Normal Spontaneous _____ Classical
 _____ Extraction Assisted: Vacuum/Forceps _____ Lower Uterine: Transverse/Vertical
 Complications:
 Laceration(s): 1 _____ 2 _____ 3 _____ 4 _____ Perineal Vaginal Cervical
 Postpartum hemorrhage _____
 Other: _____

POSTPARTUM CARE:
 Postpartum HCT: _____
 Maternal-Infant Psychosocial Adjustment: Good _____ Fair _____ Poor _____
 Rubella Immune: Yes _____ No _____ (If No, Immunization given? Yes _____ No _____)
 Other: _____
 Birth Control: _____ Depo _____ BTL performed on: _____
 _____ OCPs _____ Desires 6-week post-partum IUD _____ Declines all-Please address at 6-week check
 Plan: _____ 6 wk post-partum check _____ 1 wk wound check _____ Fe for anemia _____ PNVs while breastfeeding
 BABY: Male _____ Female _____

DOB: _____ Time of Birth: _____ Apgars: _____ Birth Wt: _____ D/C Wt: _____

FEEDING:
 Bottle _____ Both _____ Breast (Good _____ Fair _____ Poor _____)

HOSPITAL COURSE:
 Coombs: _____ RPR: _____ D/C Bili: _____
 Hearing Screen: Pass _____ Fail (f/u _____)
 If male, circumcision performed? No _____ Yes _____ (Date of circ: _____)
 PKU#1 performed on all babies prior to discharge _____
 Hepatitis B#1 given prior to discharge? Yes _____ No _____

COMPLICATIONS: _____

FOLLOW-UP: _____ 7-10 day newborn check _____ Breastfeeding check _____
 _____ PKU#2 at newborn check _____ Bilirubin check _____

On: _____ At: _____
Date Location

UNM FP MCH ATTENDING _____ RESIDENT _____

F. Guidelines for Supervision by MCH Attending in OB Triage

All patients who present to the triage area should be initially evaluated by the chief resident or night float resident, if possible. Interns can be assigned to see patients at the attending/chief's discretion. The resident is then responsible for notifying the appropriate attending prior to the decision to admit or discharge the patient.

The attending should see all patients who are being DISCHARGED to home who meet the following criteria:

1. Any patient that the resident requests that the attending see
2. Patients at less than 35 weeks with history or exam consistent with
 - Preterm labor (attending needs to confirm the cervical exam in all patients less than 34 weeks estimated gestational age)
 - Preterm premature rupture of membranes when the correct diagnosis remains unclear.
3. Post-partum patients with
 - Wound or perineal laceration/episiotomy infections
 - Abnormal vaginal bleeding, pain, fever, or unexpected blood pressure issues
4. Any patient with non-reassuring fetal monitor tracing
5. Any patient with a potentially life-threatening condition including
 - Ectopic pregnancy
 - Placenta previa
6. Unexplained, unresolved abdominal pain or unexplained vaginal bleeding at any gestational age

The attending should see all patients who are admitted to L&D or Women's Special Care. Any stable patient who is admitted can be seen by the attending after admission.

The attending needs to see all patients who deliver prior to being admitted (home deliveries, precipitous deliveries in OB Triage, etc.).

The attending does not need to see any patient with a non-OB complaint (cold/allergy symptoms, tooth pain, etc.) at any gestational age who is discharged to home, unless the resident specifically requests that the attending evaluate the patient.