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Labor and Delivery OB Faculty Responsibilities When on Call (2017)

Subject: Labor and Delivery OB Faculty Responsibilities when on call

Purpose: Clarify faculty role

Policy:

1. On-call faculty must be available within (30) minutes at the request of a resident.
2. On-call faculty will be in-house:
 - When a patient is admitted for induction of labor to confirm fetal presentation, cervical exam and induction management plan.
 - When a patient is in active labor (spontaneous or induction)
 - Patient with history of previous c-section admitted for TOLAC.
 - Patient on IV Pitocin.
 - Patient with postpartum complication.
 - Anytime upon the request of the resident.
 - Patient requiring epidural. Faculty may give the permission to proceed while en route to L&D.
3. Faculty will have a supervisory role for residents. In case of having the 9024 resident busy with other on call responsibilities, the faculty will take care of patients in Labor and Delivery until resident is available.

Patients coming to L&D

1. When a patient presents to Labor and Delivery, the resident carrying the 9024 pager will be notified and will see patient. Upon initial evaluation, the resident will call the OB faculty on call. If patient is in labor, resident will also send through text message FYI to PCP Faculty of admission with a return phone number. If PCP Faculty is coming, the PCP Faculty will call the resident at given phone number and notify resident of his/her decision. The on call resident will then notify the FM OB on call.
2. If the patient is admitted in labor and is a resident's patient, the 9024 resident will notify the COC resident of patient's admission.
3. If one of the residents' COC patients is in the hospital for induction or labor, the 9024 resident will manage the patient with the COC resident together.

Revised and approved by OB faculty at OB faculty meeting October, 2017

Resident Role in the Care of Obstetrical Patients (2018)

Subject: Resident role in the care of obstetrical patients

Purpose: The care of maternity patients is an integral part of resident training in the Family Medicine Program. As the primary care physician, the residents provide prenatal care, attend the labor and delivery, and follow the mother and infant in the postpartum and neonatal period. It may be necessary from time to time for the residents to leave their assigned services to attend to their patient in labor. In order to minimize confusion and stress on the assigned services, the following recommendations are made.

The residency goal is to provide core knowledge in obstetrical skills for all residents. According to our residency program requirements, residents must have 40 deliveries (30 of which need to be vaginal deliveries), including 5 continuity deliveries, prior to graduation.

Staff Level to Perform: Resident

Equipment: NA

Assignment of Maternity Care Patients

A prospective obstetrical patient who requests an unavailable resident will be contacted by that resident as soon as possible. Obstetrical care with another resident will be discussed and arrangements made. (If the requested resident is on vacation, the resident that is covering for him/her will contact the patient).

The OB list will designate the primary physician as **OB CALL** for all patients who will be assigned to be covered by the resident carrying the 9024 pager.

Residents will be assigned for faculty patients when they are on the maternal-newborn rotation during the month the patient is expected to deliver. Special considerations may apply.

Third-year residents will share obstetrical patients who have an EDD close to one month prior to the completion of residency. They will not see OBW during the last 4 months of their R3 years.

First year residents **will be able** to accept obstetrical patients **prior** to having completed their OB rotation.

Continuity Patient Definition and Responsibilities

In order for a patient to be considered a COC patient, the resident must:

- See the patient at least twice for prenatal visits/triages,
- Participate in labor management and delivery, and
- Either follows the patient for postpartum hospital care or for the postpartum outpatient visit.
- Continuity residents should be available to care for their patients when they are admitted in labor. They will be notified at time of patient admission. Residents must arrange coverage for maternity patients for planned absences. Residents may use a "team" approach for obstetrical care to provide coverage for vacations or may have the resident carrying the 9024 pager to cover for them.

When an initial OB visit is performed in clinic, the resident should add the patient information to the EPIC OB list.

When a resident sees the patient for the first OB visit, the resident will staff the patient and the **faculty will physically see the patient with the resident.**

When a resident is assigned as a continuity resident for a faculty patient, the resident's name will be added to the EPIC OB list. The resident should communicate with the faculty to assure that he/she will be able to see the patient for at least two prenatal visits.

The continuity resident should keep the EPIC OB list updated.

On the first day of a new service, the resident will notify the attending/supervising physician(s) that he/she has a maternity patient due during the month assigned to the service. The resident will provide estimated date of delivery and keep the attending physician updated regarding anticipated date of delivery.

Residents should see their own continuity patients as many times as possible and residents should take the initiative to assist scheduling to optimize continuity. If the continuity resident is unable to see a patient, the patient should be scheduled with the maternal-newborn resident assigned to the month the patient is due.

Role of the Family Medicine Maternal-Newborn (9024) Resident

OB patients presenting to Labor & Delivery will be **triaged by the 9024** resident. The 9024 resident will decide whether the patient requires admission or discharge to home. The 9024 resident will call the responsible on call faculty and the primary continuity resident if the patient is admitted. The continuity faculty will be notified of admission with a FYI paging message.

Manage labor and delivery for all patients seen at non-FCC clinics (North Liberty, River Crossing, Scott Blvd Iowa City and the Free Medical Clinic).

Resident Expectations During Labor and Delivery:

Resident must notify faculty of admission and report any change of status. Faculty will be present if the patient is in active labor or anytime the resident requests supervision/assistance (see policy entitled "Labor and delivery Ob faculty responsibilities when on call").

The managing resident will assess the patient at a minimum every two hours. A note documenting patient status and plan will be written by the resident at this time. If there are any complications or changes in the plan, they will be documented in the chart by the resident.

A procedure note will be written after delivery to document delivery details.

The delivery resident will also start the discharge summary at the time of writing the delivery note to facilitate discharge planning.

Postpartum and newborn admission orders will be entered immediately after birth.

Resident Responsibilities for Postpartum Care

1. The delivering resident or the 9024 resident will round on patients with faculty and write notes each day while the mother and baby are hospitalized and will keep EPIC sign out list updated as well as communicating with the residents providing overnight coverage.
2. The delivering resident or the 9024 resident will arrange outpatient postpartum and newborn care appointments for mother and baby with him/herself or the continuity faculty or resident.

Reviewed: OB faculty meeting, 2018

Approved: OB faculty meeting, September 2011, February 2018

Faculty Obstetrical Sign-out Policy (2014)

Subject: Faculty obstetrical sign-out policy

Policy:

Procedure:

- Accurate hand-offs lead to improved patient care.
- FM OB Faculty day call runs Monday thru Friday 7:30 AM to 5:30 PM, except Holidays.
- FM OB Faculty night call is Monday thru Friday from 5:30 PM to 7:30 AM following day, except Holidays.
- The patient census can be found in Epic and is updated by the residents.
- Sign-out will occur at 7AM and 5 PM to allow the incoming person time to adjust their schedule as needed.
- OB day call faculty should sign out to next oncoming OB day call for better continuity of care. Examples of this would be when: 1) OB day call is split between two providers during the week 2) Sunday evening when weekend OB provider should sign out patients to on coming day call faculty on Monday in addition to the coverage Sunday night.
- Each shift will also be responsible to sign out to the next shift immediately following them.

Special Considerations:

- Faculty who delivers and follows a private patient should sign out to the OB Faculty on call to improve communication and patient care. The Faculty may decide whether he/she wants to be called with any issues regarding the patient or not. If this is the case, it should be specified in Epic.
- If at the time of sign out the faculty is in-house because of patient care responsibilities, he/she will wait until the faculty taking over is in-house.
- OB faculty only needs to be in house at the start of their shift if deemed necessary between the outgoing and incoming faculties.
- While sign-out to next provider is prompted by the outgoing provider, if a page has not been received for sign-out at the designated times (noted above), the incoming provider should check L&D board and page to see if they will be needed as acute situations on L&D could be preventing the outgoing provider from paging. This will help to ensure that providers are able to leave their shift as close to time as possible.

Revised and approved by OB faculty at OB faculty meeting June, 2011

Revised and approved by OB faculty at OB faculty meeting August, 2014

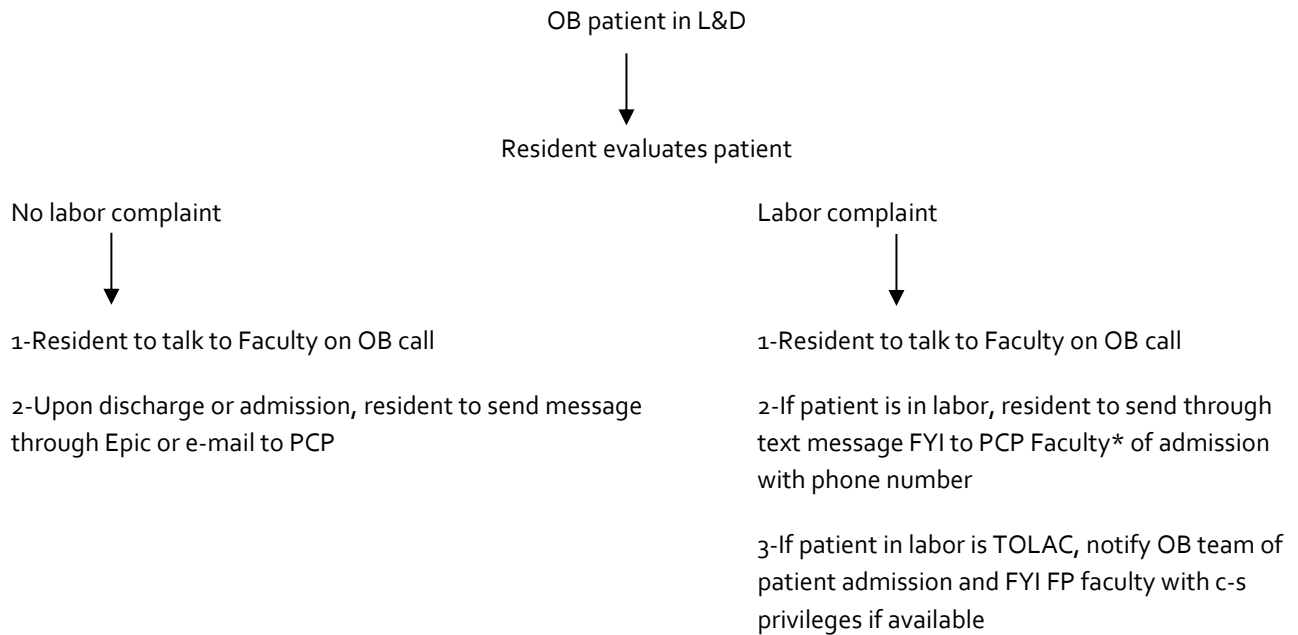
Faculty Notification of OB Patient in the Hospital

Subject: Faculty Notification of OB patient in the hospital

Purpose: Standardize communication and patient management between residents and Faculty

Procedure:

Faculty Notification when OB patient comes to L&D



* If PCP Faculty is coming, the PCP Faculty will call the resident at given phone number and notify resident of his/her decision. The on call resident will then notify the FM OB on call.

Department of Family Medicine and Department of Obstetrics and Gynecology (2016)

Subject: Department of Family Medicine and Department of Obstetrics and Gynecology

Purpose:

- 1- To clarify the working relationship between Obstetrics and Family Medicine
- 2- To optimize patient care through timely and appropriate request and provision of consultation.
- 3- To educate residents regarding the process of requesting and providing consultation.

1.

Policy: This is a Guideline

- 1- Antepartum and intrapartum care at UIHC
 - Family medicine physicians and obstetrical providers benefit from a mutually supportive relationship.
 - Family physicians and obstetricians provide options for patients and provide alternative sites for prenatal care.
 - Consultation allows us to work together to reduce obstetrical complications and decrease the number of emergency consultations.
 - Responsive and respectful interactions optimize patient care.
 - The guidelines are intended to provide a minimum standard. The level of care and interaction will vary on a case to case basis.
- 2- Definition of terms
 - **CONSULT:** a single visit to OB/GYN clinic or one visit on labor and delivery. An official consult will be placed in Epic. Consultation is intended to facilitate a working relationship. When placing consult to OB, include in your consult question family medicine's comfort level for continuing as primary. For example: "Patient on therapeutic Lovenox during pregnancy. I would like to keep her in family medicine for her obstetrical care if this is appropriate." Consult from OB will include recommendations for either transfer to the OB clinic vs rest of care in family medicine.
 - **CO-MANAGEMENT:** an ongoing relationship for care between family physician and obstetrician will occur. A consultation will be placed and will state that "co-management of care" is requested. A clear plan delineating who is responsible for components of care is essential. If disagreement regarding responsibility exists, a faculty to faculty discussion should occur. From an education perspective, co-management of care is an important skill. As an institution that trains physicians who may choose to provide care in rural and other settings, physicians must be prepared to collaborate with other physicians in co-management of care.

TRANSFER: when an obstetrical patient's care is transferred from family physician to obstetrician. All further care will become responsibility of the obstetrician unless or until a transfer back occurs.

	CONSIDER CONSULT	CONSULT	CO-MANAGE	TRANSFER
ANTEPARTUM				
Fetal anomaly in vital organ system, documented	X			
Fetal demise, second or third trimester		X		
Hx of recurrent pregnancy loss (either 3 consecutive abortions or 2 consecutive abortions, depending on pt's age)		X		
Poly and Oligohydramnios	X			
Isoimmunization: --RH and other with potential fetal compromise				X
Isoimmunization -- Minor antibodies, no potential fetal compromise	X			
IUGR	(Fetal Diagnostic Consult done when discovered on ultrasound. No need for additional consult to HROB unless further concern)			
Prior c-section, requesting repeat c-section		X		
Hx of prior midline skin vertical incision with unknown uterine incision, desiring TOLAC	X			
Hx of previous fetal or neonatal death with ongoing cause		X		
Multiple gestation --Di/Di twin		X		
Multiple gestation -- mono/di -- mono/mono -- > 2 gestation				X
Malpresentation >34 weeks		X		
Hx of major operations in uterus/cervix (cerclage, septum resection, myomectomy)		X		
Malignancy requiring treatment during pregnancy				X
Severe chronic medical disease (heart disease, SLE, etc)		X		
Hyperemesis gravidarum not responsive to therapy	X			
2 prior C-sections, wants TOLAC	X: if OB recommends C-section, consult with FM high risk OB for repeat C-section; If OB OK TOLAC, transfer or co-management but OB to deliver			
Diabetes type I				X
Pre-existing DM type 2		X		
Gestational diabetes requiring insulin		X		
Cholestasis of pregnancy	X			
Prior history of major operations in uterus or cervix		X		

	CONSIDER CONSULT	CONSULT	CO-MANAGE	TRANSFER
INPATIENT				
Bleeding due to placenta previa				X
Bleeding due to placenta abruptio		X		
Manual removal placenta	X			
Outlet forceps (for those with training)		X		
Vacuum extraction	X (notify OB team)			
Repair of vaginal, cervical and labial laceration	X			
3 rd and 4 th degree perineal laceration:		X Unless have privileges		
TOLAC		Notification to the OB team		
Preeclampsia without severe features	X			
Preeclampsia with severe features/eclampsia intrapartum				X
Post-partum preeclampsia with severe features		X		
Anomaly in vital fetal organ system	(Fetal Diagnostic Consult done when discovered on ultrasound. No need for additional consult to HROB unless further concern)			
NO cervical change despite use of pitocin and/or no fetal descent in second stage of labor for 4 hours	X			
Preterm onset of labor (less than 34 weeks)		X		
STD active or other infection potentially affecting fetus (HIV, herpes)	X			
Postpartum hemorrhage unresponsive to medical therapy			X	
Unscheduled c-section		X if FM high risk OB not available		
Eclampsia				X
Umbilical cord prolapse		X if FM high risk OB not available		
Amniotic fluid embolus				X
Any other questions or medical conditions not covered		X		

Written: Dr. Sara Mackenzie, November 2001 **Approved:** November 2001 by Dept of Family Medicine and Dept of OB/Gyn

Reviewed: November 12, 2014 at the OB Faculty Committee Meeting

Reviewed and approved: Reviewed and updated with OB January 14, 2016, approved by FAM OB faculty meeting 2/11/2016

Admission to the Maternal-Newborn Service (2018)

Subject: Admission to the Maternal-Newborn Service

Purpose: Identify patients that will be admitted to the Maternal-Newborn Service.

Staff to perform: Resident and Faculty

Procedure:

Any **pregnant patient** or **patient with postpartum complication** whose PCP is from the Department of Family Medicine and who requires inpatient care for any obstetrical and/or medical condition consistent with Family Medicine privileging will be admitted to and cared for by the resident and faculty on the Family Medicine Maternal-Newborn Service.

- 1- If patient is in the clinic or L&D, the provider will call 9024 pager and notify the FM-OB day call team.
- 2- If the patient is in the Emergency room, the Admission & Transfer Center (ATC) may routinely contact the Faculty and senior resident (pager 8096) on Medical-surgical call. Once the patient is identified as being pregnant, the senior resident will take down information and inform the ATC that they will contact the FM-OB team on call (9024 pager) to evaluate the patient. During the night and on weekends and holidays, the senior resident is on call for both teams and will notify FM-OB Faculty on call prior to evaluation.

All infants up to 3 months of age will be admitted to the Maternal Newborn Service.

- 1- All infants up to 3 months that are seen in any of UI Family Medicine Clinics will be admitted to the Family medicine Maternal-newborn Service.
- 2- For infants up to 3 months of age that may require admission from clinic or emergency Room, please page the Family Medicine faculty on OB call that day. Alternatively, the Family Medicine resident on OB call can always be reached on the 9024 pager. If the Faculty on Med-Surg call is contacted for admission, they will assist in transferring the call to the physicians in the Maternal Newborn service.

Approved at OB Faculty Meeting May, 2011

Reviewed/Approved: OB faculty meeting April, 2018

Obstetrics or Newborn Criteria for OB faculty case presentation at OB Faculty Meeting (2018)

Subject: Obstetrics or Newborn Criteria for OB faculty case presentation at OB Faculty Meeting

Criteria for case presentation

- Indications for review
 - Maternal or fetal death.
 - NICU/ICU admission.
 - Concern raised by Department of Obstetrics and Gynecology or family medicine faculty or resident.
- Optional:
 - 1 minute Apgar of 4 or less; 5 minute Apgar of 7 or less.
 - Unexpected labor complication (abruption, etc)
 - Delivery complications (4th degree lac, postpartum hemorrhage, etc)
 - Severe postpartum complications either with mother or with baby (preeclampsia, postpartum hemorrhage, etc)
 - Unexpected C-sections
 - Newborn readmissions during the first seven days of life, excluding hyperbilirubinemia.
 - Other incidents that have learning points

Procedure for Review

1. If a case meets one of the criteria above, the faculty involved should notify Family Medicine OB director
2. The case should be presented at the next regular ob faculty meeting by the supervising ob faculty involved with the case. Pertinent fetal strips and copies of all pertinent records should be available (with copies made if needed). (Copies will be placed in the shredder at the conclusion of the meeting, unless keeping certain documents for teaching purposes.)
3. The faculty member presenting the case should make recommendations for how to prevent a similar case in the future (if applicable) and provide the group with educational strategies if needed.
4. The group will also decide whether a formal review should be undertaken.

If a formal review is needed

1. The purpose of the review will be educational or for system-based improvement
2. Family Medicine OB director and an ad hoc committee of one to two other Family Medicine faculty members will independently review the medical record and meet within 14 days, along with the faculty member(s) involved in the case. If Family Medicine OB director was involved in the pertinent case, a third faculty member will be identified to participate in the review.
3. If the opinion of an Obstetrics/Gynecology trained physician is felt to be desired, Family Medicine OB director or department chair will request this and arrange to have someone from Ob/Gyn attend the group meeting with the 3 Family Medicine faculty reviewers, plus all faculty involved in the perinatal care of the patient(s).

Revised 11/21/06

Approved by Ob faculty at meeting on 11/22/06

Revised by OB faculty at meeting on 7/11/2018

Postpartum Rounds/Newborns Following with Family Medicine (2018)

Subject: Postpartum Rounds/Newborns following with Family Medicine

Purpose: Clarify patient care responsibility for postpartum and newborn rounds.

Definitions: OB faculty refers to the Family Medicine faculty member on OB call

Staff Level to Perform: Faculty

Equipment: NA

Policy:

1. When Resident delivers a COC Ob patient, he/she will be encouraged to round postpartum on the mom and baby at least once to meet the COC requirement. If the COC resident for that patient is not available, the resident carrying the 9024 pager will be responsible for rounding with the FM-OB faculty on call.
2. If parents of newborns delivered by one of the obstetricians wish to follow with any family medicine physician either here, or UICMS clinic or in the community, the newborn will be admitted to FAM newborn service.
 - a. The resident carrying the 9024 pager will admit the infant to the Nursery and will let the OB staff on call know that the baby is now a patient on the FP.
 - b. The resident carrying 9024 pager will call OB staff with any newborn admission after 10 PM. If the newborn needs immediate assessment by Staff, OB staff will see newborn upon admission. Otherwise, newborn will be physically seen by OB staff in the morning.
3. A family medicine faculty member who delivers one of their own continuity of care patients must “sign out” to Day Call faculty. The day call faculty is responsible for rounds until discharge, unless arranged otherwise.
4. As part of team effort to facilitate discharging patients from MBCU in a timely manner, here are some of the things recommended by the postpartum units:
 - a. Enter vaccines as needed when placing postpartum orders.
 - b. Anticipate discharge needs (prescriptions, follow up appointments) prior to the discharge day, especially if the discharge day falls on weekends.
 - c. Plan for procedures to be done the day before discharge when possible, such as nexplanon placement and circumcision.
 - d. Round on the patients who will be discharged that day **first**.

Written and reviewed: 2/28/02, Dr. Sara Mackenzie

Revised: 6/03/02 Dr. Sara Mackenzie and Rick Dobyns

Approved: June 2002, Drs. Sara Mackenzie and Rick Dobyns

Approved: 6/30/04, DFM

Updated: 3/28/2018, Dr. Wendy Shen

Approved: 4/11/2018, OB faculty meeting

Guidelines for Shared Prenatal Care (2017)

Subject: Guidelines for shared prenatal care.

Family Medicine prenatal care is currently performed at the Family Medicine clinic at UIHC location and many of our affiliated clinics.

Some providers provide prenatal care but do not participate in hospital care of obstetric patients.

Goals:

1. Provide optimal OB prenatal care for all patients.
2. Maximize communication between prenatal care only providers and prenatal care and hospital maternity care providers.
3. Promote continuity of care experiences for residents and patients from outlying clinics.

Definitions:

- Prenatal care only provider: provider does not provide in hospital maternity care
- In hospital maternity care provider: provider does in hospital maternity care (takes OB call)
- Shared care: Patient is seen by the prenatal care only provider and also seen by one of the in hospital maternity care provider at least once (after 32 weeks).

Procedure for pregnant patients seeing a prenatal care only provider:

1. At 18 weeks gestation, one of the following shall occur (according to patient/provider preference) to ensure that medical and social issues have been appropriately addressed and managed:
 - a. The patient will be seen in the same clinic by one of the hospital maternity care providers. Provider will ensure that pt is on shared OB list in epic.
 - b. If a visit with an in-hospital provider is not possible, the prenatal care-only provider will a chart review by one of the in hospital maternity care providers in the same clinic. If none available, the prenatal care only provider will ask the OB day call faculty to review the chart. Provider will ensure that pt is on shared OB list in epic.
2. Beginning at 30-34 weeks gestation until delivery, patient care will be managed in one of the following ways:
 - a. Transferring the patient to one of the in hospital maternity care providers in the same clinic or at UIHC (such as a Family medicine resident).
 - b. By sharing care with one of the in hospital maternity care providers from the same clinic or from the UIHC. This entails scheduling alternate visits with a provider who provides in hospital maternity care until the patient delivers.
3. In the event that a patient needs to come to the hospital for evaluation, the prenatal care only provider will communicate with the OB faculty physician on call.
4. The medical director of each clinic will be responsible to oversee the compliance with these guidelines.

Date written: February, 2014

Date reviewed and approved: OB faculty meeting February 2014, March 2014 and February 2017.

Supervisory FM-OB Call for New Faculty (2019)

Subject: Supervisory FM-OB call for new faculty.

Procedure:

A faculty member who joins the department and will participate in the FM-OB call schedule will take supervised call with one of the FM-OB faculty on a weekly basis during their orientation period.

Each new faculty will take supervisory call at least weekly until:

- 1) he/she has been the physician responsible for at least 10 deliveries
- 2) satisfied all criteria established by FM-OB faculty to be able to take call independently
- 3) All new faculties will be assigned to do 3 weeks of supervised FM-OB day call during the first 6 months.

New faculty are expected to meet this expectation within the first 6 months of employment.

During this time, the supervising FM-OB faculty will be in house for deliveries and at any time requested by the new faculty. The supervisory FM-OB faculty will be always available on pager for any other matters. The new faculty will call the supervisory FM-OB faculty when appropriate for him/her to come to the hospital.

When the supervising FM-OB faculty participate in the care of a patient (such as for vaginal deliveries) the compensation will go to him/her.

Criteria which must be met to take FM-OB call independently:

- Accurate assessment and management of indication for admission (labor, induction, medical complication, etc)
- Accurate assessment and management of fetal heart rate monitoring and labor
- Accurate assessment and management of perineal lacerations and repairs and management of postpartum care.
- Appropriate communication and interaction with the team (residents, nursing staff, other Faculty)
- Overall assessment and care of newborn
- Maintain current certification on NRP (every 2 years), ALSO (every 3 years) and Fetal heart Tracing (every 5 years).

The supervising FM-OB faculty will evaluate the new faculty and provide feedback to him/her.

The supervising FM-OB faculty will communicate the assessment at one of the FM-OB Faculty Meeting and to the Director of the FM-OB services. The decision to take call independently will be made by the director of FM-OB Services in collaboration with the head of the department of family medicine and the FM-OB committee members.

Reviewed and approved by FM-OB faculty at FM-OB faculty meeting June, 2011

Reviewed and Revised: FM/ OB faculty meeting, March, 2019

Approved: April, 2019

Notification of Urgent OB Ultrasound Findings to Dept. of Family Medicine (2018)

Subject: Abnormal OB ultrasound notification

1. Family Medicine physicians caring for obstetric patients request same day notification for the following urgent obstetric ultrasound findings in their pregnant patients:

- Cervical length < 2.5 cm
- Cervical funneling
- Dilated cervix
- In utero fetal demise
- Major structural anomaly
- Breech presentation after 37 weeks
- Oligohydramnios after 37 weeks
- Fetal growth restriction after 28 weeks
- Anything else that needs immediate management in the next 24 hours or re-evaluation of care management before the patient's next scheduled appointment.

2. For notification:

- 1) Sonographer to page #9024 and talk to Family Medicine OB resident carrying this pager. He or she MUST triage the ultrasound findings with their staff physician timely and make the decision as to how to proceed according to the findings. The resident will also need to generate documentation in Epic.
- 2) -If the ultrasound findings are not urgent, the sonographer will follow instructions about patient disposition according to what the ordering physician stipulated in the order (3 options: send back to clinic, call physician with results, or discharge home and ordering provider will contact patient)

Written: Drs. Andrea Greiner and Sandra Rosenfeld, 2018.

Reviewed and approved: by OB through email 6/2018 and FAM OB faculty meeting, 7/2018

Management plan for FM patients with previous cesarean (2018)

Subject: FM patient with previous cesarean delivery

Previous cesarean section: The Ob/Gyn Department highly recommends a UIHC ultrasound at 20 weeks to rule out placenta previa, accreta, or fetal anomalies. The Family Medicine physicians will provide appropriate and up to date counseling on the risks/benefits of repeat cesarean section vs. TOLAC. In addition, it is the responsibility of the Family Medicine OB service to consent for sterilization or for contraception such as post-placental IUD placement (at least 30 days prior to delivery).

Planned cesarean patients are to have a one-time consult in in the OB/Gyn Department between 32-34w where the OB/Gyn consultant (either Continuity of Care or Private Ob/Gyn) schedules the CS and provides preop instructions. Patients will then complete their prenatal care and postpartum visit with Family Medicine. The OB/Gyn service provides in-hospital postop care/rounding on the OB service.

TOLAC: Family Medicine patients attempting TOLAC are to have an OB consult upon admission to L&D. Family Medicine will inform the Ob/Gyn service whether or not they are able to provide Labor and Delivery and in hospital care for the patient. Requirements to provide this care are (1) to have a FM resident on L&D at all times during the labor, (2) have an in-house FM-OB attending present at UIHC at all times during the labor, (3) provide q 2 hour updates to the Ob/Gyn chief resident and attending regarding plans and progress of labor, and (4) have both the resident and the attending for each shift attend AM and PM check-in rounds on 6 JPP. If Family Medicine is unable to provide the required level of care, the patient will be transferred to the Ob/Gyn service upon admission to L&D.

Written: Drs. Stephanie Radke and Wendy Shen, 10/2018.

Reviewed and approved: by OB through email 10/2018 and FAM OB faculty 10/2018

Obstetric Continuity of Care Delivery Definition (2019)

Subject: Definition of resident OB COC delivery.

Our goal is to foster an environment for residents to develop obstetrical skills to provide comprehensive, continuous and patient focused care over time to at least 5 COC patients during their training period. Our culture is that we are there for our patients and their families. To help foster patient focused care over time, an OB patient will become a COC patient for a resident when a resident has seen the patient during 2 prenatal visits, managed the labor and seen the patient during one postpartum visit.

At least 2 prenatal visits

- In the clinic: Resident sees the patient at least twice during her prenatal visits. Resident interviews the patient, staffs the patient with faculty, develops a plan of care and does documentation.
- In Labor and Delivery: Patients seen in L&D: these encounters are primarily aimed to capture patients as COC patients from outlying clinics at River Crossing, North Liberty, Free Medical Clinic, Scott Boulevard and Muscatine Clinics. Resident interviews the patient, does the exam develops a plan and completes documentation. *This is intended to be used by residents on the 9024 and night float rotation that may see patients more frequently for triage. Residents should not claim a COC patient after one triage visit and then request residents to page them for the triage.*
- Only one resident can claim the patient per visit (2 residents cannot claim as COC patient from a single visit).

Participation in Labor management

- The COC resident will be notified when their COC patient is admitted for labor by the on-call resident. The COC resident should be present after the patient is admitted to manage the labor and provide support to their patient. The COC resident should also be present for the beginning of an induction.

Participation in delivery

- The COC resident is the responsible provider during delivery. In case of a c-section, assist in the c-section and/or participate in newborn evaluation in OR.

Postpartum follow up

- COC resident needs to follow up patient during postpartum care in the hospital and/or seeing the patient at the 6 weeks postpartum visit in the clinic.
- **Planned and unplanned c-sections**
- Sometimes a woman may require a planned (does not desire TOLAC) or unplanned c-section (breech presentation, labor dystocia, etc). In these circumstances, if resident has 1) seen the patient for at least 2 prenatal visits with 1 of these visits occurring in third trimester, and 2) is present for the newborn resuscitation during the c-section and 3) provides postpartum follow up, this can count as a COC delivery.

Protocol for Standard Notification of COC Residents about COC Patients

1. After a COC patient has presented to L&D and been initially evaluated and a plan has been discussed with staff, an FYI page will be sent to the COC resident informing them.

- a. If there is the possibility of an admission (for rupture, for labor, etc.) then this should be sooner than later
 - b. If it appears to be something for which the patient has been ruled out and will be discharged, the page can be sent once the patient has been discharged
2. If the COC patient is admitted, then the COC resident should be paged again with this information.
3. A decision/plan will be made between the 9024/on-call resident and the COC resident on when they will come in. **It is the COC resident responsibility to be present during labor and to make the decision of when to arrive to LDR.**
4. Residents need to clarify with current rotation assignment if they are available to be relieved to manage and attend the delivery of their patients.
5. The understanding is that if staff does not feel that the COC resident adequately managed labor, or if the COC resident arrives too late, then the resident will not be able to count the delivery towards their COC numbers.

Reviewed and Approved by Thoma, Rosenfeld June 20, 2014

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