Family Medicine Obstetrical and Newborn Service: Attending Service Manual

Updated Oct 2025

For questions about this document, please contact Jennifer Svarverud (jennifer.svarverud@fammed.wisc.edu). You can also contact Tom Hahn (thomas.hahn@fammed.wisc.edu)

Logistics:

The team room is on the 4th floor in the East Wing:

- The best way to get there is to take the East elevators (through the hallway with the tower elevators, take a left at the end of the hall) to the 4th floor, then turn left and follow the signs
- You can also get there by taking the North elevators to L&D, go through the area that use to be triage (now more L&D) through the doors to the end of the hallway and follow the signs

The code for the team room is **2-5-8.** Access to all other rooms is **3-5-7.**

You will generally be working with 2 residents – the "laborist" resident who is there all day and the "postpartum/newborn" resident who leaves for activities in the afternoon (clinic, conference, etc). The residents alternate between these roles. The resident who was involved in the delivery or saw the patient the day before should try to round on the dyads each morning if possible. If the laborist resident saw a dyad the previous day, they should see them during the morning if there is not active management on L&D or triage. Clearly this is not always possible, so the residents are encouraged to communicate with each other and the attendings.

There is also a "nighttime" resident who you may never see as they will sign out before you come and after you leave (6pm to 6am).

Important Phone numbers:

FMONS Residents/Team

- Service cell phones (*Preferred method of contact)* - Reminder--NO PHI should ever be texted or left on voicemail
  - Laborist cell phone: 608-843-4796
  - Postpartum/newborn rounder cell phone: 608-513-3926
- Residents' Vocera dial 608-417-8000 (just 7-8000 if you are in the hospital) and state "Family Medicine L&D Resident"
- Team Room: 608-417-5979

For families to **register newborns** to schedule a clinic visit, have them call Newborn Registration:

- Weekdays: 608-821-4819
- Weekends: 608-828-7603

To schedule **weekend follow** up for Meriter delivered/Quartz/GHC babies, call UNC UC Line: 608-828-7603

Primary responsibilities:

Your role is to support the residents in their care of all pregnant, postpartum and newborn patients. You may be actively supervising the residents in the management of patients who you are also caring for, supporting them in communicating with community attendings about their patients, and providing on the spot and formal didactic learning opportunities. At times this will feel like you are operating more like a senior resident than attending, this is on purpose! Specifically, your responsibilities include:

- Managing any DFMCH residency and Access FM patients with the residents including triage, L&D, post partum, and newborns
- Teaching the residents both "on the fly" and formally at about 11 am each day
    - When available, the Rural FMOB Fellow will teach on Mondays at 11am.
- Supporting the residents in finding the right attending/orders/nurse, thinking through cases (even if they are not our own, you should still help the resident think about the patient and prepare their presentation to the attending managing the patient), assuring that the residents make it to board rounds every day at 8AM. Encourage residents to also attend evening board rounds.
- Teaching/supervising residents in any procedures that they need help with, including on patients who we are not formally consulted on. This includes, but is not limited to, cooks catheter placement, IUPC/FSE placement, AROM, cervical checks, etc. See below.
- **Remaining in house with the residents until 1pm (and until 6pm if needed for any reason).**

The DFMCH community group, GHC group, and Wildwood are partner organizations with whom we have both financial and legal ties. You should not hesitate to follow a resident cervical exam, supervise a procedure (IUPC, FSE, cooks catheter, etc), or step in during an emergency for their patients. You should document in the chart the extent to which you were involved (ie "Supervised resident cervical exam only, agree with 2/60/-2"). We are the formal back up to all three of these groups when needed.

General daily schedule:

6 am - Residents arrive and sign out. The "laborist" and "postpartum/newborn" residents divvy up postpartum/newborn rounding and L&D responsibilities for continuity as needed (see Appendix A for postpartum rounding guidelines)

6:45 – You should get a text/call from the night call person to let you know anything that is going on at either hospital. You should also review the sign out line messages (608-829-5390, hit *, mailbox #263-5528, passcode 121244). The FMONs attending is "in charge" of the sign out line so should review all messages, delete as appropriate, and contact the St Mary's attending if there are any patients who need to be rounded on or managed at St Mary's. (see Appendix B for details on the St Mary's attending role)

7 am - You arrive and should:

1. Get any updates from the residents about patients you are responsible for (residency clinic patients, antepartum patients, patients the community attending has turned over to the service, etc).
2. Find out how the team is dividing and conquering for the day - in particular how you can help support the intern.
3. Look at the list in Epic to confirm patients and double check with the postpartum/nursery census lists (ideally for Meriter and St Mary's) so that no one gets missed.
4. By 7:30 you should contact the St Mary's team regarding any patients that require management. The team room number is 608-258-6295 and you can find the St Mary's attending on service here: Ogenda SMH Faculty Link

Of note, during this time the residents will also be contacting the community attending regarding postpartum and newborn rounds and doing any rounding/meeting L&D patients they can before board rounds.

8:00 am - All head to board rounds. The residents present the patients they are managing and we should be there to support the residents and have an awareness of the activity on the floor. The format for the presentation is below:

LABOR AND DELIVERY

•Room __ is a __ year-old GxPy at __ wks who is admitted for ___.

Always Include:	If Applicable:
Fetal tracing category?	Hypertension severity
Stage of labor? Progression normal?	BMI >40
Operative delivery preparation?	Care Plan
Hemorrhage risk?	

8:15-11 – Rounding, seeing patients in triage, managing L&D. This is the time for you to supervise circs and see the residency clinic patients. For the intern in particular, you should be at their elbow actively supporting them in these activities. During the day when you are not actively managing a laboring patient/rounding you can also help the residents navigate who belongs in which group, introduce them to nurses/HUCS, suggest an order to triage patient needs, etc.

<u>Reoccurring teaching activities:</u>

- Mon/Tues/Wed/Fri: OB does teaching topics around 7:15am every day in the 5th floor sim lab which the residents are welcome to attend; however as this is prime community rounding time it is often not possible. I would encourage the senior to ask the OB residents/FMONs attending for the topics early in the week as they often have materials to review
- Mon 11am: If the Rural FMOB Fellow is available, they will do formal, case-based teaching with the team. A faculty member of the fellowship will also typically join. If the fellow is caught up in patient care activities at this time, they may reach out to find another time that work for the team that day or week.

- Thursday: no formal didactics currently, but working with peds to explore options

11 am – 12ish: Try to gather back in the team room to do some form of didactic. This time is not set in stone, if you find another time works better please use that for teaching. The senior should be encouraged to identify the goals and topics for didactics. This may include specific topics related to patients who are admitted, reviewing strips together, doing ALSO level ultrasound skills, using OB Teach Cards etc. This would be a good opportunity to review ACOG practice bulletins together or cover topics from the maternity care handbook (it has been saved on the 3rd computer station from the door on the desktop but can also be found by going to inside the DFM → residency → curriculum resources site (is in the left hand column) → inpatient → OB → resources, I suggest downloading the PDF if you go this route).

12 pm- 6pm: If there is nothing more going on you are free to leave at 1 pm, as long as there is a senior in-house, but you are still expected to be immediately available if needed by the resident or if a community faculty asks for assistance (sitting with an epidural, TOLAC etc). If the daytime resident is an intern, please plan to remain at Meriter to support the intern (following cervical exams as there are a lot of new nurses, supporting them in triage, discussing patient management, teaching basic ob skills) until 6 pm.

5:45 ish – Send a text/call the nighttime call person to let them know about anything going on. Leave a message on the OB call in line about updates.

6pm – You are gone but the residents sign out again and night board rounds are at 8 pm

Interactions with community attendings (see appendix C for more details about these arrangements):
The community attendings have various levels of attachment to primarily managing their patients vs utilizing our help.

- We have clarified with them that if they would like us to help manage one of their patients (including TOLAC patients or other indications for in house attending) that they do need to make an attending to attending call to express this and delineate the amount they want to continue to be involved (periodic updates from the resident, no updates until after clinic, notified of imminent delivery only (this should be discouraged in most situations).
- We are not expected to be the backup for postpartum/newborn rounding for the community attending, but if there is a circ to be done (if, for example, the community attending is running late because they let our resident do the circ) we can choose to help with their postpartum/newborn rounding to facilitate the resident involvement.

Please approach interactions with DFMCH community, GHC, and Wildwood with an attitude of “How can I help?”

Even when we are not helping to manage the community doctor’s patients, we can use them as a jumping off point for discussion with the residents about induction techniques, labor management

strategies, EFM review, etc. It is also helpful to be available to discuss management plans with the resident to improve their understanding and confidence about the rationale for these interventions as they communicate with the community attendings (many of whom remain in clinic and don't have time to do robust teaching during the day).

To find out who is on-call for each group, you can look at the "on-call" Meriter website (found by going to the Citrix launch screen and clicking on "on-call"). You can also call the operator or look at the InsideDFMCH page under the faculty call schedules.

Antepartum Admissions

For UW DFMCH antepartum patients > 18 weeks, if you or the continuity attending for the patient are comfortable managing the patient, they will be admitted to our service. Otherwise, you would need to call OB/MFM for admission (or co-management). If they are admitted to our service, please ensure that the patient is added to the FMONs system list by asking the HUC to do this.

For patients < 18 weeks, UW OB is contacted and determines if these patients are appropriate for antepartum admission to the OB service. If it is primarily a non-OB issue, the patient will be admitted to the internal medicine hospitalist team (with an OB/MFM consult if needed, we are not a consultant team). FMONs may admit these patients to antepartum for a primary OB issue if contacted by the OB team. Wildwood and Community FMOB attendings may also admit patients to antepartum for OB related issues, however they may ask the FMONs attending to assume care for these patients, which is appropriate.

GHC currently does not admit antepartum patients. The policy for any of their patients is as follows:
For < 20 weeks gestation, the ER contacts UW OB for a consult, assessment, admission needs.
For >20 week concerns, the FMONS resident calls the GHC provider from Triage. Based on the acuity of the situation, they determine if the admission should go to MFM or UWOB. Then, there should be an attending-to-attending call based on that determination. ***These patients are not admitted to the FMONs service due to the negotiations between GHC and UW OB***

Re-admissions

Postpartum patients (up to 6 weeks postpartum who are DFMCH/Access/UW comm patients/Wildwood) **We do not re-admit GHC patients onto our service**

-If a patient was seen in the clinic that day and you determine that the patient needs to be admitted due to a postpartum issue, you can call Meriter and have the patient directly admitted.

-If the patient was not seen in the clinic and you are concerned about a postpartum issue, direct them to go to the ER.

If the ER determines that they need to be admitted, they will page/call the FMONs attending. The FMONs attending should go with the resident to see the patient in the ER to determine if they are an appropriate admission to the FMONs service (e.g. endometritis) or if the patient

should go to OB (e.g. preeclampsia with severe features requiring magnesium). If you are uncertain about whether the patient should go to OB, you can call the hospitalist to discuss the case to determine this and/or if the patient can be co-managed by FMONs and OB

Newborns

-FMONs does NOT admit for any newborn issues after initial discharge

-If a newborn was seen in clinic that day and you determine they need to be admitted, you can call SMH or UW to be directly admitted onto the family medicine pediatric service (as long as they do not need to go to the NICU)

-Any newborns should be directed to be taken to the SMH/UW ER if they had not been evaluated in clinic that day and you are concerned that they might need to be admitted. The family medicine service will then be notified if admission is deemed appropriate after ER workup/evaluation.

Other things to know

- If nursing has any concerns about newborns overnight, they should page the appropriate on-call attending. The attending may contact the resident to evaluate the newborn if they are available, but as there is only one resident overnight, this should not be an expectation. During the daytime, the first call goes to the resident, who can then assess and call the attending as needed.

- Babies needing bilirubin checks over the weekend should be directed to Union Corners on weekends (a chart can be created for newborn at urgent care--parents can call in advance to register the newborn prior to arrival using the above phone numbers).

"Dueling cervixes"

The FMONs attending will be contacted about triage/labor patients at St Mary' hospital during the day. When you get a call about a patient you should touch base with the St Mary's attending to determine who has the most "bandwidth" to manage this patient (and if this attending does OB).

If the St Mary's attending is not available or able to manage a laboring patient and there is a PGY-1 alone at Meriter, the FMONS attending should take the following steps to find back-up coverage:

1. Clinic faculty: Call the UW Family Medicine faculty who was following the patient in clinic to see if they would be available to follow the patient while in labor.
2. Coverage at Meriter: See if there is another UW Family Medicine attending following a patient at Meriter who could supervise the intern so that the UW Family Medicine Attending at Meriter could follow the patient at St. Mary's
3. SSM St. Mary's Obstetrician: Ask the OB doctor at St. Mary's to take over care of the patient. If there is a situation where a UW Family Medicine patient is transferred to SSM OB, SSM OB will follow the patient for the remainder of the labor until delivery.

Backup

In the event the FMONs Attending becomes ill or has a family emergency, a backup system is in place; every week there will be at least one faculty person who does OB assigned to one of our non-OB services (SMH, UW and back-up). The FMONs Attending should check the Family Medicine Attending schedule and identify who has been assigned as the FMONS Backup. This does NOT change the current plan for backing up an actual delivery (see “dueling cervixes” above).

- Scenario A: The FMONs attending is sick or unable to come in for some reason: for every week of the year, there will be at least 1 person assigned to non-FMONs services that does OB(SMH, UW or departmental back up).
    1. If the departmental back-up does OB, that person should be the 1st choice to come in and cover FMONs.
    2. If the departmental back-up does NOT do OB, then either the SMH or UW attending (whichever does OB) would go over to FMONs and then the departmental back-up would step in to cover the inpatient service.

- Scenario C: we are down 2 attendings between SMH/UW/FMONs. We call around and scramble for coverage however we can.

APPENDIX A

Family Medicine Obstetrics and Newborn Service (FMONs)

During the day, there are 2 residents, one of whom is the "laborist" (following the active laborers) and the other is the postpartum/newborn rounder. The residents alternate between these roles. However, if there are any postpartum patients/newborns who were delivered by the "laborist" on a prior day, the "laborist" should ideally try to round on these patients and the postpartum/newborn rounder will see the remaining patients to promote continuity. The night resident can do postpartum/newborn rounds prior to 7am on patients they delivered if this is not disruptive to the patients.

The goal of this service is to round on the mother-baby dyads delivered by family medicine residents Priority for rounding should be given to the following groups:

1. Residency patients. Continuity DFMCH patients will usually be seen by continuity residents and the FMONs attending. The postpartum/newborn resident does not have to round on these patients unless they delivered them and the continuity resident is not rounding.
2. Access family medicine patients, including newborns regardless of whether they were delivered by family medicine, OB, or midwives
3. DFMCH community/Wildwood/GHC patients delivered by family medicine residents.

NOTE: Residents are NOT expected to round on non-Access and non-residency babies that they did not deliver (AKA: do not have to round on UW community, GHC, Wildwood babies they did not deliver).

In order to facilitate rounding with potentially multiple attendings in the morning, residents are encouraged to call/text the attendings at 7am to coordinate the morning rounding with as many attendings as possible.

Community DFMCH, GHC, Wildwood

The postpartum/newborn rounder should aim to round on the dyad with the family medicine attending on patients that were delivered by family medicine residents. If rounding with the family medicine attending is not possible, the resident may round prior to the arrival of the family medicine attending. If the Family Medicine attending has already written a note on the patient, the resident does not have to see that patient and write a duplicate note. However, if you delivered the patient or were involved in postpartum care you are encouraged to see the patient and write a social rounding note in this case.

APPENDIX B

St Mary's Attending Role

Intro: The St Mary's attending is an integral part of the pregnancy care team. We have prioritized faculty that do both OB and Med-Peds to attend at St Mary's hospital. The attending list for patients that we care for on newborn/FCS is the same as the admission list for adult-peds at St Mary's.

Roles for St Mary's attending:

1. Round on any postpartum and newborn patients at St Mary's hospital including providing circumcisions. The St Mary's attending will be alerted to any patients who need to be rounded on by the FMONS attending who will monitor the sign out line. The St Mary's attending should also consider routinely reviewing the newborn/FCS list daily to assure there are no patients who were overlooked.
    a. The attending may round on these dyads with the continuity resident, family medicine team, or independently depending on the business of the St Mary's Service.
    b. The attending may also engage the resident on peds to round on babies who were delivered by OB/CNM but will be followed at our clinics
2. Manage labors at St Mary's as determined by conversation with the FMONS attending
    a. The FMONS attending will take the first call on all triage/labor patients at St Mary's. If they need to be admitted for labor the FMONS attending and St Mary's attending should discuss management of the patient determined by how busy each service is
    b. The St Mary's attending should routinely follow all labors at St Mary's on Wednesday as there is a PGY-1 alone at Meriter
3. Admit any antepartum or postpartum patients who are cared for by our residency or Access clinics. The St Mary's attending may be contacted directly by the ED or by the FMONS attending about these patients.
    a. If there is a clear surgical issue (ie retained products of conception, miscarriage requiring surgical management) it may be appropriate for the patient to be admitted to OB directly from the ED. The St Mary's attending should use their judgement to advise the ED accordingly

Please contact Jennifer Svarverud with any questions.

APPENDIX C (Last update 2021 - will update to include Wildwood in June 2023 but not yet reviewed)
Intro: The DFM-Residency attendings provide "back-up to GHC back-up" coverage for labor and delivery services at UPH-Meriter Hospital. This is a rarely used system that serves to support the sustainability of the smaller, community-based, continuity practice at GHC. Conversely, the GHC providers participate actively in residency training. There is also a reimbursement agreement between the organizations.

GHC-DFM Back-up system for routine coverage of Labor and Delivery:

1. The GHC primary FMOB attendings cover more than 90% of their own labor and deliveries.
2. If the primary GHC FMOB attending is not available, often an immediate GHC practice partner covers the labor and/or delivery.
3. If an immediate GHC practice partner is not available, the GHC Back-up provider covers the labor and/or delivery. Although the GHC Back-up provider is usually available for coverage, due to the small size of the GHC group, the GHC Back-up provider is not required to be available 24/7.
4. If the GHC Back-up provider is not available, the DFM-Residency attending on service or on-call (depending on time of day) will provide coverage for labor and/or delivery.
5. If the DFM-Residency attending is occupied at SSM St. Mary's Hospital, they will contact the DFM-Community Back-up provider for coverage at Meriter.

*Note that in emergency situations, the UW OB/GYN department provides coverage for GHC FMOB patients.

<table>
<tr><th colspan="5">DFM Service coverage guide</th></tr>
<tr><td></td><td>Resident</td><td>DFM- Residency Attending location</td><td>Coverage provided by DFM resident</td><td>Coverage provided by DFM-Residency attending</td></tr>
<tr><td>Weekday</td><td>A PG2 or PG3 is in-house with the PG1.</td><td>The attending is available 7am to 6pm, though may leave the hospital after 1pm, unless needed.</td><td rowspan="2">● Triage
● Labor/Delivery mgmt.
● AM rounding
● Newborn acute assessments
● Post-partum acute assessments
● Communication and coordination of care with the GHC attending</td><td>The DFM-Residency attending is available to supervise the residents with all services when the GHC attending is not available for any reason.</td></tr>
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Weekends and Evenings	Sat: PG2/3 Sun: PG2/3	In-house for AM rounding, then remote unless needed.	Same as weekdays, except that the DFM residents are not responsible for newborn acute assessments. Newborn acute assessments are called to the GHC Peds On-Call provider who might consult the Pediatric resident.	The DFM attending is available to accept GHC patient when the GHC back-up attending is not available for any reason.

Additional notes for cross coverage:

- Attending to attending communication is required for all coverage requests and transfers of care.
- GHC FMOB providers are expected to contact the DFM-Residency attending as early as possible when a coverage need is identified. Short notice requests are also accepted when an unforeseen coverage need arises, particularly during an evolving clinical situation.
- For the sake of general awareness, the DFM attending could scan the patient board for GHC laboring patients. However, DFM coverage would only be expected after an attending to attending phone call.
- During phone calls, the two attendings should discuss mutual expectations for coverage (part of labor only, or through to delivery).
- On nights and weekends, if a GHC provider requests coverage, the decision to cover through to delivery (rather than just part of labor) depends on the DFM attending's preference.
- If the DFM-Residency attending is occupied at SSM, there is a DFM-Community provider available for service back-up at Meriter.
- AM rounding responsibilities for residents include coverage of the DFM-Residency Group patients and any GHC patients delivered by the residents. They are not obligated to round when the GHC rounding attending is a CNM.

- Between our groups, residents and attendings should never text each other regarding coverage or emergent clinical situations.