FAMILY AND COMMUNITY MEDICINE CLINICAL SERVICE
RULES AND REGULATIONS
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APPENDIX A - DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE AT SFGH ORGANIZATIONAL STRUCTURE

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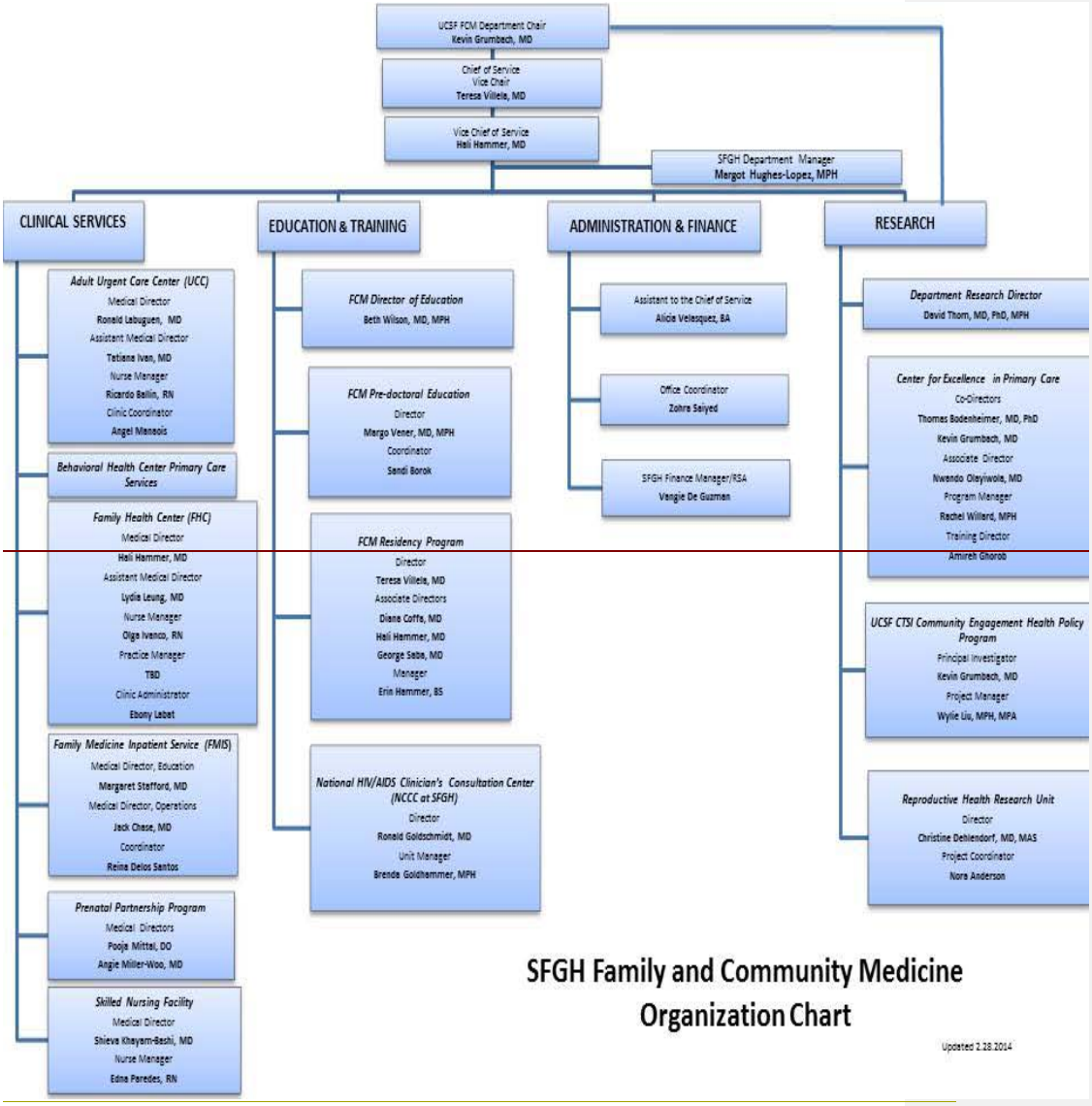

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San Francisco General Hospital and Trauma Center - Ongoing Professional Practice Evaluation (OPPE)

6 Month Date Range: Jan - June / 2013 ☐ No patient care and/or clinical teaching for this time period

(If checked, metrics need not be completed, but Y/N questions at bottom AND signature date are required)

Last, First, degree:_____ Status: _____ CHN #_____

Service: FAMILY & COMMUNITY MEDICINE

Home Dept / Div / Clinic if other than above: _____ Comments if Any: _____

OUTPATIENT SERVICES: Metrics for Medical Staff & Affiliated Staff	Acceptable	Marginal*	Unacceptable*	Metric Not Relevant During This Period	Comments
PRIMARY CARE PROVIDERS					
Active weighted patient panel as a % of target patient panel	☐ >80%	☐ 66%-79%	☐ <66%	☐	_____
Patients age 51-75 with up to date colorectal cancer screen	☐ >40%	☐ 25-39%	☐ <25%	☐	_____
Patients age 52-69 with mammogram screening every other year	☐ >60%	☐ 50-59%	☐ <50%	☐	_____
Patients with DM with LDL < 100	☐ >50%	☐ 35-49%	☐ <35%	☐	_____
Patients age 13 with up to date Tdap immunization	☐ >70%	☐ 60-69%	☐ <60%	☐	_____
NON PRIMARY CARE PROVIDERS					
If no primary care panel, clinical hours per month	☐ 4hrs	☐ 2-4hrs	☐ <2hrs	☐	_____
ALL PROVIDERS					
Patients seen who have medication allergies verified by provider *(with eCW implementation)*	☐ >80%	☐ 70-79%	☐ <70%	☐	_____
Cases of concern	☐ <2	☐ 2	☐ >2	☐	_____

*IN ANY ONE CATEGORY:

Two consecutive **marginal** ratings require Chief of Service's commentary

Three consecutive **marginal** ratings require FPPE and notification to the Credentials Committee Chair

Two consecutive **unacceptable** ratings require FPPE and notification to the Credentials Committee Chair

Updated : 2/26/2014

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1001 Potrero Avenue
San Francisco, CA 94110

San Francisco General Hospital and Trauma Center - Ongoing Professional Practice Evaluation (OPPE)

6 Month Date Range: Jan - June / 2013 ☐ No patient care and/or clinical teaching for this time period

(If checked, metrics need not be completed, but Y/N questions at bottom AND signature date are required)

Last, First, degree:_____ **Status:** _____ **CHN #** _____

Service: FAMILY & COMMUNITY MEDICINE

Home Dept / Div / Clinic if other than above: _____ **Comments if Any:** _____

INPATIENT SERVICES: Metrics for Medical Staff Only

Deaths attributable to practitioner	☐ Any 1A's or <2 1B's	☐ 2 1B's	☐ >2 1B's or any 1C's, 1D's	☐	_____
Length of stay	☐ <10 days	☐ 10-18 days	☐ >18 days	☐	_____
Readmissions within 30 days	☐ <20%	☐ 20-25%	☐ >25%	☐	_____
Procedure complications attributable to practitioner	☐ 0 or 1	☐ 1 - 2	☐ 3 or more	☐	_____
Cases of concern	☐ <2	☐ 2	☐ >2	☐	_____

***IN ANY ONE CATEGORY:**

Two consecutive **marginal** ratings require Chief of Service's commentary

Three consecutive **marginal** ratings require FPPE and notification to the Credentials Committee Chair

Two consecutive **unacceptable** ratings require FPPE and notification to the Credentials Committee Chair

REQUIRED FOR EVERY PRACTIONER ON ROSTER:

☐ Yes ☐ No Recommend continued current privileges

☐ Yes ☐ No Recommend a Focused Professional Practice Evaluation (FPPE). If YES, attach a detailed FPPE plan

☐ Yes ☐ No Recommend changes to current privileges:

_____

☐ Yes ☐ No To my knowledge, this practitioner does not have a medical/mental health condition that could affect clinical care or judgment. (If such a condition exists, please reference the plan for monitoring this condition)

Chief of Service (or designee) _____ **Date:** _____

(Electronic signature acceptable)

Practitioner Signature* : _____ **Date:** _____

(Electronic signature acceptable) * Required only if "marginal" or "unacceptable" notes above

Updated : 2/26/2014 S:\SFGH Medical Staff Office\OPPE\FINAL FCM OPPE Coversheet with metric thresholds_February 2014.FINAL.xls

I. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Family and Community Medicine Clinical Service (FCM) at SFGH has responsibility for ambulatory patient care delivered in the SFGH Family Health Center, ~~and~~ the SFGH Urgent Care ~~Clinic~~Center, medical services provided on the SFGH Skilled Nursing Facility and the Behavioral Health Center, inpatient care delivered on the SFGH Family Medicine Inpatient Service, ~~medical services provided on the SFGH Skilled Nursing Facility (SNF),~~ and inpatient obstetrical care provided through the Prenatal Partnership Program of the Family and Community Medicine Service. The Department of Family and Community Medicine sponsors the UCSF Family and Community Medicine Residency Program, which is based at San Francisco General Hospital.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in SFGH Medical Staff Bylaws, ~~and the~~ Rules and Regulations as well as these Clinical Service Rules and Regulations.

~~**1. APPOINTMENT REQUIREMENTS**~~

Initial appointment will be made on the basis of demonstrated competence in the candidate's previous training and practice. Board Certification or Board Eligibility in Family Medicine (or its equivalent for individuals in specialties other than Family Medicine) is required.

~~**2. DEA AND CPR CERTIFICATION REQUIREMENTS**~~

~~a. DEA Certification is required for all physicians.~~

~~b. CPR Certification is encouraged for all physicians, and required for those working in the Urgent Care Clinic.~~

C. ORGANIZATION AND STAFFING OF THE FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE

1. Organization

The Family & Community Medicine Clinical Service organization is presented on the attached organization chart (~~Attachment~~ Appendix **A**~~1~~). The officers of the FCM Clinical Service are the Chief of Service and the Vice-Chief of Service.

a) Chief of Service

The Chief of Service is appointed through the mechanism described in the Medical Staff Bylaws ~~involving~~ including concurrence at the hospital level, the Director of Public Health, and the Chairman of the Department of Family and Community Medicine at the University of California in San Francisco. The Chief of Service fulfills the range of duties described in the San Francisco Hospital Medical Staff Bylaws. The job description for the Chief of Service is detailed in Appendix **B**.

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b) Vice Chief of Service

The Vice-Chief of Service is appointed by the Chief of ~~Service, and serves~~Service, serves for an indefinite term, and serves as acting Chief of Service when the Chief of Service is away.

c) Director, Family Health Center (FHC)

Provide leadership and oversight of the FHC
Provide overall direction of clinical activities in the FHC
Develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary
Coordinate the FHC's participation in the Performance Improvement and Patient Safety Program relating to the FHC
Prepare budgets and other reports in collaboration with the Nurse Manager, MSO, and/or Chief of Service

d) Directors, Family Medicine Inpatient Service

Provide leadership and oversight of the FM Inpatient Service
Provide overall direction of the Inpatient Service, including clinical operations and educational activities
Develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary
Coordinate the FM Inpatient Service's participation in the Performance Improvement and Patient Safety Program

e) Directors, Prenatal Partnership Program (PPP)

Provide leadership and oversight of the PPP
Provide overall direction of the PPP, including clinical operations and educational activities
Develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary
Coordinate the PPP's participation in the Performance Improvement and Patient Safety Program

f) Director, Skilled Nursing Facility (SNF)

Provide leadership and oversight of the SNF
Provide overall direction of the SNF, including clinical operations and educational activities
Develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary
Coordinate the SNF's participation in the Performance Improvement and Patient Safety Program

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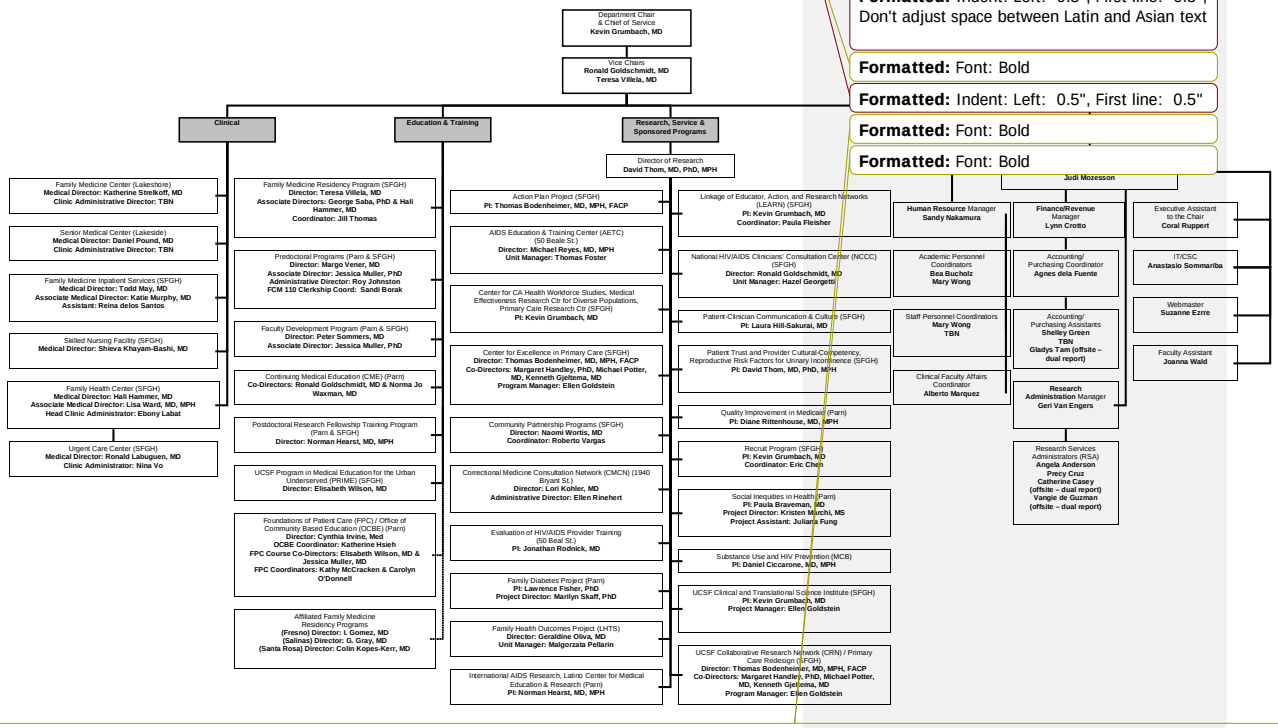
2. Clinical Services

~~ATTACHMENT 1~~

~~FAMILY & COMMUNITY MEDICINE ORGANIZATION CHART~~



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a~~1~~. The Family Health Center (FHC)

The Family Health Center (FHC) is an ambulatory care setting located on the SFGH campus on the first and fifth floors of Building 80 and first floor of Building 90. Care in the Family Health Center is delivered using a Family ~~Practice~~ Medicine model. ~~That is,~~ C~~c~~are is provided with concern for the total health care of the individual and the family, and th~~. Th~~e scope of practice is not limited by age, sex, organ system, or disease entity. Biological, clinical, and behavioral sciences are integrated in the care provided by ~~the~~ family physicians, ~~and~~ family nurse practitioners, and physician assistants at the FHC. ~~Patients are seen without regard to ability to pay, and the FHC participates in the indigent care system of SFGH.~~ The hours of operation for the FHC are 8:30 a.m. to 9~~5~~:00 p.m. Monday through ~~Friday~~Thursday, 8:30 a.m. to 5:00 p.m. Friday, and 8:30 a.m. to 12:00 noon on Saturday. ~~. Evening primary care will be provided until 9:00 Monday through Thursday, beginning January 2008.~~

Comprehensive continuity care is provided in the FHC with particular emphasis placed on preventive care and health maintenance. ~~Physicians and nurse practitioners in the Family Health Center serve as primary care providers for their patients.~~ All patients seen in the FHC have an assigned primary care provider who sees them for the majority of their visits. ~~Patients are encouraged to be seen with their family members at the Center.~~

Urgent care for FHC patients is available on site on a drop-in basis or by appointment during the hours of operation. After hours telephone advice is provided by ~~a second or third year~~ Family Medicine residents with supervision ~~provided~~ by a family physician faculty member. ~~The resident is on-call from 5:00 p.m. to 8:00 a.m. Monday through Friday and throughout the weekend.~~ Patients are encouraged to call for telephone advice during off hours, and ~~if a patient needs to be~~may be referred for evaluation at FHC, the ~~evaluated when the clinic is closed, he/she is referred to the~~ SFGH Emergency Department, Urgent Care Center, or Pediatric ~~Clinic~~ Urgent Care Center as appropriate.

b~~2~~. The Family Medicine Inpatient Service

The Family Medicine Inpatient Service is a non-geographic adult medical service which provides acute inpatient care to patients enrolled in the Family Health Center and designated clinics in the ~~Community~~ San Francisco Health Network. The Family Medicine Inpatient Service emphasizes ongoing communication with primary care clinicians during inpatient episodes of care for patients receiving continuity of care from these clinicians. The Family Medicine Inpatient Service is staffed by UCSF FCM residents and f~~F~~amily p~~P~~hysician attendings.

c~~3~~. SFGH Skilled Nursing Facility

The Skilled Nursing Facility (SNF) is an interdisciplinary unit with medical services provided under the supervision of the SNF Medical Director. The SNF Medical Director is a member of the Family and Community Medicine Service. Medical care is provided by the SNF Medical Director, ~~other~~ Attendings in the Family and Community Medicine Service, and Nurse Practitioners, in accordance with existing policies for the SNF.

d4. SFGH Urgent Care Center

The SFGH Urgent Care Center (UCC) provides urgent care for patients whose primary care home is in the San Francisco Health Network as well as patients without a primary care provider. The medical director of the UCC is a member of the Family and Community Medicine Service. ~~is administered by the FHC Management Team. There is a full-time Physician-in-Charge of the UCC who is the FHC Assistant Medical Director for Urgent Care Services.~~ Care at the UCC is provided by physicians, nurse practitioners, and physician assistants. ~~The UCC provides after-hours and weekend care for patients whose primary care home is in one of San Francisco's safety net health centers, as well as patients without a primary care provider. Run in close collaboration with the SFGH Emergency Department, the UCC offloads less acutely ill patients from the Emergency Room.~~

e5. The Prenatal Partnership Program

The Prenatal Partnership Program is administered through Family and Community Medicine to provide family-centered birth services at SFGH. Birthing services are provided by family physician attendings and residents in the Family and Community Medicine Service, and by attendings in the SFGH Community Primary Care Service. Family physician attendings in the Community Primary Care Services who participate in the Prenatal Partnership Program receive their privileges for inpatient obstetrical care through the Family and Community Medicine Service. ~~, which is responsible for medical staff credentialing, quality assurance / improvement for clinical care provided under these privileges.~~

f6. Attending Physician Responsibilities

Overall direction of clinical care is the responsibility of the attending staff of the Family & Community Medicine Clinical Service either directly or through supervision of residents, affiliated medical staff members or medical students. Requirements for attending medical staff for FCM clinical services are detailed in Appendices ~~**D**~~ **E** and~~,~~ ~~**E**~~**F**~~, H and I~~.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of SFGH through the Family and Community Medicine Clinical Service is in accordance with SFGH Bylaws, and the Rules and Regulations as well as these Clinical Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of SFGH through the Family and Community Medicine Clinical Service is in accordance with SFGH Bylaws, and the Rules and Regulations as well as these Clinical Service Rules and Regulations.

1) Modification of Clinical Service

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The process for modification of clinical services for the Family and Community Medicine Service will be through the appropriate review process required.

2) **Staff Status Change**
The process for Staff Status Change for members of the Family and Community Medicine Services is in accordance with SFGH Bylaws, and the Rules and Regulations.

3) **Modification/Changes to Privileges**
The process for Modification/Change to Privileges for members of the Family and Community Medicine Service is in accordance with SFGH Bylaws, and the Rules and Regulations.

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~~C. PRACTITIONER PERFORMANCE PROFILES~~
~~Refer to Section IV~~

~~D~~C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals to SFGH through the Family and Community Medicine Clinical Service is in accordance with SFGH Bylaws, and the Rules and Regulations as well as these Clinical Service Rules and Regulations.

~~E~~D. STAFF CATEGORIES

The Family and Community Medicine Clinical Service staff falls into the same staff categories which are described in the SFGH Bylaws, and the Rules and Regulations as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT AND ANNUAL REVIEW OF PRIVILEGES ~~CRITERIA~~

Family and Community Medicine Clinical Service privileges are developed in accordance with SFGH Medical Staff Bylaws, and the Rules and Regulations, as well as these Clinical Service Rules and Regulations.

~~**B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM**~~

The Family and Community Medicine Clinical Service Privilege Request Form shall be reviewed annually by the Chief of Service.

~~C~~B. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

(Refer to Appendix ~~A~~C)

1. The Family and Community Medicine Clinical Service privileges shall be authorized in accordance with the SFGH Medical Staff Bylaws, and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Family and Community Medicine Clinical Service.

2. The process for modification/change to the privileges for members of the Family and Community Medicine Service is in accordance with the SFGH Medical Staff Bylaws, and the Rules and Regulation.

3. The Family and Community Medicine Clinical Service grants privileges to clinicians working in the SFGH Family Health Center, the SFGH Urgent Care Clinic, the Family Medicine Inpatient Service, the Skilled Nursing Facility, the Behavioral Health Center, the Birth Center, and the Nursery.

~~D DELINEATION OF PRIVILEGES~~
~~The Family and Community Medicine Clinical Service grants privileges to clinicians working in the SFGH Family Health Center, the SFGH Urgent Care~~

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~~Clinic, the Family Medicine Inpatient Service, the Skilled Nursing Facility, the Birthing Center, and the Nursery.~~

~~1.~~**a)** Request for clinical privileges will be evaluated by the Chief of the Family and Community Medicine Clinical Service. The initial determination of such requests shall be based on the applicant's education, training, experience, and demonstrated competence. The applicant shall have the burden of establishing his/her qualifications and competency for the clinical privileges requested.

b) ~~2.~~ Family and Community Medicine Clinical Service privileges permit practice within the Family Medicine Inpatient Service, the Family Health Center, the SFGH Urgent Care Clinic, the Skilled Nursing Facility, the Behavioral Health Center, the Birth~~ing~~ Center, and the Nursery, and related sites (e.g., patients' homes).

c) ~~3.~~ Evidence must be presented of having training and successful experience for each class of illness and procedure requested.

~~E~~C. TEMPORARY PRIVILEGES

Temporary Privileges shall be authorized in accordance with the SFGH Medical Staff Bylaws, and the Rules and Regulations.

IV. PROCTORING AND MONITORING

A. PROCTORING AND MONITORING ~~(PROCTORING)~~ REQUIREMENTS

Proctoring and ~~M~~monitoring ~~(proctoring)~~ requirements for the Family and Community Medicine Clinical Service shall be the responsibility of the Chief of the Service, with the primary review delegated to the Medical Directors of the Family Health Center, Family Medicine Inpatient Service, Urgent Care Center, Skilled Nursing Facility, and the Prenatal Partnership Program.

The scope of individual provider activity is determined by level of training~~,~~ and skill obtained from special procedure training. Clinical competence is monitored through direct observation, chart review, and practice audits. In general, the scope of provider activity is in keeping with that defined by the American Board of Family Medicine and the ACGME Residency Review Committee for Family Medicine. All care delivered by non-licensed residents is ~~closely~~ directly supervised~~monitored~~ by an attending physician in both the inpatient and outpatient settings. ~~Second~~ Licensed residents are indirectly supervised only after meeting criteria outlined by the FCMRP Clinical Competence Committee. ~~and third year residents are also supervised by attendings, although they are given greater latitude as their level of training progresses. There are generally two to three attending family physicians in the FHC, without their own scheduled patients, who provide preceptor supervision for residents and students working in the clinic.~~ Attending family physicians are the physician of record for the Family Medicine Inpatient service at all times.

B. PROCTORING AND COMPETENCY REVIEW

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1. INITIAL APPOINTMENT

Initial appointment will include review of qualifications, prerequisites, and previous experience for each privilege requested. The Privileges Request form (Appendix **C**) specifies the qualifications, prerequisites, and proctoring requirements for each privilege. Proctoring for initial appointment will include direct observation, case review, and review of the medical record. Forms used for documentation of case reviews are included in Appendix **D**.

~~**1.**~~ The Medical Directors of the Family Health Center, Family Medicine Inpatient Service and the Prenatal Partnership Program will perform or assign proctoring. In instances when these individuals are the candidates to be proctored, the Chief of Service or her/his designee will be assigned as proctors. The Chief of Service will be reviewed by the vice Chief of Service.

~~a. **Family Health Center Privileges**~~
~~i. Chart review: a minimum of 8 medical charts will be reviewed, using the guidelines for review in Attachment C.~~
~~ii. Direct observation: a physician supervising residents and students in the Family Health Center will be directly observed by attendings with full Family Health Center privileges during the physician's first month of activity.~~

~~b. **Urgent Care Clinic**~~
~~Because medical care provided to patients in the Urgent Care Clinic is classified as outpatient services, successful completion of proctoring for Family Health Center privileges will be considered sufficient for credentialing of Urgent Care Clinic privileges. UCC providers will be directly observed by the Physician in Charge or his designee during their first month of clinical service.~~

~~c. **Family Medicine Inpatient Privileges**~~
~~i. Chart review: a minimum of 12 medical charts will be reviewed, using the guidelines for review in Attachment E.~~
~~ii. Direct observation: an attending physician with full inpatient privileges will directly observe the clinical activities of newly appointed physicians for a minimum of 10 days during the first month of activity on the Family Practice Inpatient Service, including observation of bedside procedures that may be performed during this time.~~
~~iii. Other: data from clinical indicators such as all deaths and medical complications occurring during inpatient stays will be reviewed.~~

~~d. **Skilled Nursing Facility**~~
~~Because medical care provided to patients who are residents of the SNF is classified as outpatient services, successful completion of proctoring for Family Health Center privileges will be considered sufficient for credentialing of SNF privileges.~~

~~e. **Prenatal Partnership Program**~~
~~i. Chart review: a minimum of 3 medical charts will be reviewed.~~
~~ii. Direct observation: an attending physician with full prenatal partnership privileges will directly observe the first 5 labor and deliveries and associated procedures for newly appointed physicians.~~

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~~iii. Other: all data from clinical indicators for birth outcomes for all births during the initial proctoring period will be reviewed.~~

~~f. The Medical Directors of the Family Health Center, Family Medicine Inpatient Service and Prenatal PPartnership Program will will perform or assign proctoring. In instances when these individuals are the candidates to be proctored, the Chief of Service or her/his designee will be assigned as proctors. The Chief of Service will be reviewed by the Vice-Chief of Service.~~

~~g.~~ In the event that the minimum number of proctored cases is insufficient for making a valid determination of clinical competence, proctoring will continue until a valid determination of clinical competence is achieved. This determination will be made jointly by the proctor and the Chief of Family & Community Medicine Service.

~~h.~~ A summary proctoring report will be sent to the Chief of Family and Community Medicine for review and approval. ~~.~~

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~~**2. ADDITION OF NEW PRIVILEGES OR PROCEDURES**~~

~~Review will be required for the addition of new privileges or procedures.~~

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~~3.~~2. **REAPPOINTMENT**

a. Following initial appointment, review will be performed prior to each reappointment. The Chief of Service will be responsible for this evaluation. The evaluation will be based on a combination of concurrent assessment by the ~~Family Health Center~~ Medical Directors~~, the Director of the Family Medicine Inpatient Service, and Director of the Prenatal Partnership Program~~ and clinical data sources for ambulatory and inpatient care.

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b. Clinical performance data for review will consist of the following:

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i. Chart review: A minimum ~~of 3~~ number of cases and charts will be reviewed for each privilege ~~of the 3 major privilege areas (Family Health Center, Family Medicine Inpatient Service, Prenatal Partnership Program)~~ for which the clinician is credentialed. These are defined in the FCM Privileges Form (Appendix **C**).

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ii. Clinical indicators and practice profiles: These indicators will be reviewed for the entire population of patients for whom the clinician had primary clinical responsibility during the 2-year period preceding reappointment. They will be reported to the provider and the Medical Staff Office twice yearly as an Ongoing Professional Practice Evaluation.

iii. Case presentation: At least once during the reappointment period, ~~as scheduling permits,~~ each attending physician will present at ~~one of the weekly attending~~ faculty meeting~~s~~ of the Family and Community Medicine Service a case or cases for whom the attending is clinically responsible.

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iv: Other information as appropriate, including unusual incidence reports, adverse drug reaction reports, and similar information collected by SFGH committees.

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c. The Chief of Service will be reviewed by the Vice-Chief of Service.

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~~d. A summary monitoring report will be sent to the Chief of Service.~~

~~e. Reports of performance which are less than totally satisfactory will be investigated by the Chief of Service.~~

C. ADDITION OF~~AL~~ PRIVILEGES

Requests for additional privileges for the Family & Community Medicine Clinical Service shall be in accordance with SFGH Bylaws, and the Rules and Regulations.

D. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Family & Community Medicine Clinical Service shall be in accordance with SFGH Bylaws, and the Rules and Regulations.

V. EDUCATION ~~OF MEDICAL STAFF~~

The following Family & Community Medicine Service educational opportunities are offered on a regular, on-going basis through~~hout~~ the service:

Primary Care Grand Rounds – ~~Once a month~~Monthly
~~Monthly~~ Family and Community Medicine Clinical Staff Meetings – Monthly
M&M Conference –As warranted by clinical events
Family Medicine Board ~~Review –~~Review - Annually
Annual Review in Family Medicine - Annually
Monthly case conferences at attending faculty meetings
Faculty Development Sessions – 3 times per year
Other seminars and ~~case~~ conferences sponsored by the Family and Community Medicine Service

VI. FAMILY & COMMUNITY MEDICINE ~~CLINICAL SERVICE~~ HOUSESTAFF TRAINING PROGRAM AND ~~SUPERVISION~~ (SUPERVISION (Refer to CHN Website for House staff Competencies)

Attending faculty shall supervise house staff in such a way that house staff assumes progressively increasing responsibility for patient care according to their level of training, ability and experience.

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF:

House staff are trained in accordance with ACGME, American Board of Family Medicine, UCSF, SFGH, and California Medical Board guidelines.

B. EVALUATION OF HOUSESTAFF

House staff are evaluated in accordance with ACGME guidelines for both inpatient and outpatient care. The evaluation process consists of written rotation evaluations, written outpatient evaluations, and written evaluations of required didactic presentations~~,~~. ~~and discussions~~ T~~t~~he Residency Program ~~Director~~ Clinical Competence Committee reviews evaluations for each resident twice yearly and advises the Residency Program director through a summary evaluation and promotion recommendations. ~~conducts at scheduled Faculty Attending Meetings. Annually, the attendings evaluate each house staff in regards to promotion to the next level of training.~~

VII. FAMILY AND COMMUNITY MEDICINE CLINICAL SERVICE CONSULTATION CRITERIA

Consultation in all categories of privileges will be ~~required~~ expected for patients whose condition is critical, deteriorating, unresponsive to the therapy initiated, or when diagnostic problems remain unresolved.

VIII. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the SFGH Family & Community Medicine Clinical ~~Service~~Service. ~~.~~

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

The Chief of Service, or designee, is responsible for ensuring solutions to quality care issues. As necessary, assistance is invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

B. RESPONSIBILITY

Overall responsibility for performance improvement in the Family and Community Medicine Service lies with the Chief of Service. A Director of ~~Performance~~ Quality Improvement is appointed by the Chief of Service to supervise and coordinate performance improvement activities within Family and Community Medicine, and to serve as the Service's representative to the SFGH Performance Improvement and Patient Safety Committee. In collaboration with the Service's Director of Performance Improvement, medical directors of clinical programs within the Family and Community Medicine Service will be responsible for collecting and reviewing performance improvement indicator data for these programs and reviewing any adverse events. At least 8 times per year, a meeting of the clinical staff of the Family and Community Medicine Service will be devoted to discussion, review, and planning of performance improvement activities for the Service.

C. REPORTING

Performance Improvement/Patient Safety (PIPS) and Utilization Management activity records will be maintained by Family and Community Medicine Service. Minutes are submitted to the Medical Staff Services Department.

D. CLINICAL INDICATORS

In collaboration with the SFGH Performance Improvement and Patient Safety (QM) Department, a calendar of review of clinical indicators of patients is established for each year ~~is established~~. The QM Department monitors these throughout the year through chart reviews and panel reviews. ~~Additionally, some reviews are conducted by the residents as part of the curriculum. A faculty member meets with the residents once a month to review quality assurance, performance improvement, and patient safety issues.~~ This information, along with the information gathered from the PIPS Department is compiled and presented to the Performance Improvement and Patient Safety (PIPS) Committee.

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

In collaboration with the SFGH (QM) Department, Family and Community Medicine Clinical Service selects clinical indicators to collect at the level of individual attending physicians to monitor physician performance for all physicians with primary direct clinical responsibility for a population of patients. These Ongoing Professional Practice Evaluations (OPPE's; see Appendix **G**) ~~practitioner performance profiles~~ are ~~maintained~~ produced, reviewed, and disseminated to the individual provider by the Chief of the Service. They are compiled and presented to the Medical Staff Office twice yearly.

F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Family and Community Medicine Clinical Service monitors and evaluates each practitioner for appropriateness of patient care and the Chief of the Service maintains these records.

G. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

The Family and Community Medicine Clinical Service monitors and evaluates each practitioner and the Chief of the Service maintains these records. The clinical indicators and thresholds for the Ongoing Professional Practice Evaluations (OPPE's) are detailed in Appendix **G.**

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X. MEETING REQUIREMENTS

In accordance with SFGH Medical Staff Bylaws, all Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

Family & Community Medicine Clinical Services shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

As defined in the SFGH Medical Staff Bylaws, a quorum is constituted by at least three (3) voting members of the Active Staff for the purpose of conducting business.

~~XI. ADDITIONAL CLINICAL SERVICE SPECFIC INFORMATION~~

~~A. MEDICAL RECORDS~~

~~The Family and Community Medicine Clinical Service shall follow the SFGH Bylaws, and the Rules and Regulation of the medical staff and hospital in regard to medical records.~~

~~The Family Health Center will maintain a duplicate set of records to the hospital records in order to assure availability of critical information for non-scheduled patients. All information must be filed in the hospital medical record and only a duplicate kept in the Family Health Center. Neither the hospital nor the Family Health Center record can be removed from the premises of the institution.~~

~~All procedures in the inpatient or outpatient setting shall be noted in the medical record including date of procedure, medical staff member performing the procedure or supervising the resident performing the procedure, the indication for the procedure, report of the procedure, any complications or adverse reactions, and any required follow-up. An informed consent shall be obtained for those procedures required by Department and SFGH policy.~~

~~Discharge summary shall be entered in all patients' medical records leaving the Family Medicine Inpatient Service after consultation, when appropriate, with the admitting primary care physician. A copy of the discharge summary shall be sent to the clinic or primary care physician where the patient has been receiving care and/or will be responsible for the follow up.~~

~~**B. FHC INFORMED CONSENT**~~

~~Refer to Appendix F -- LIST OF APPROVED PROCEDURES AND INFORMED CONSENT~~

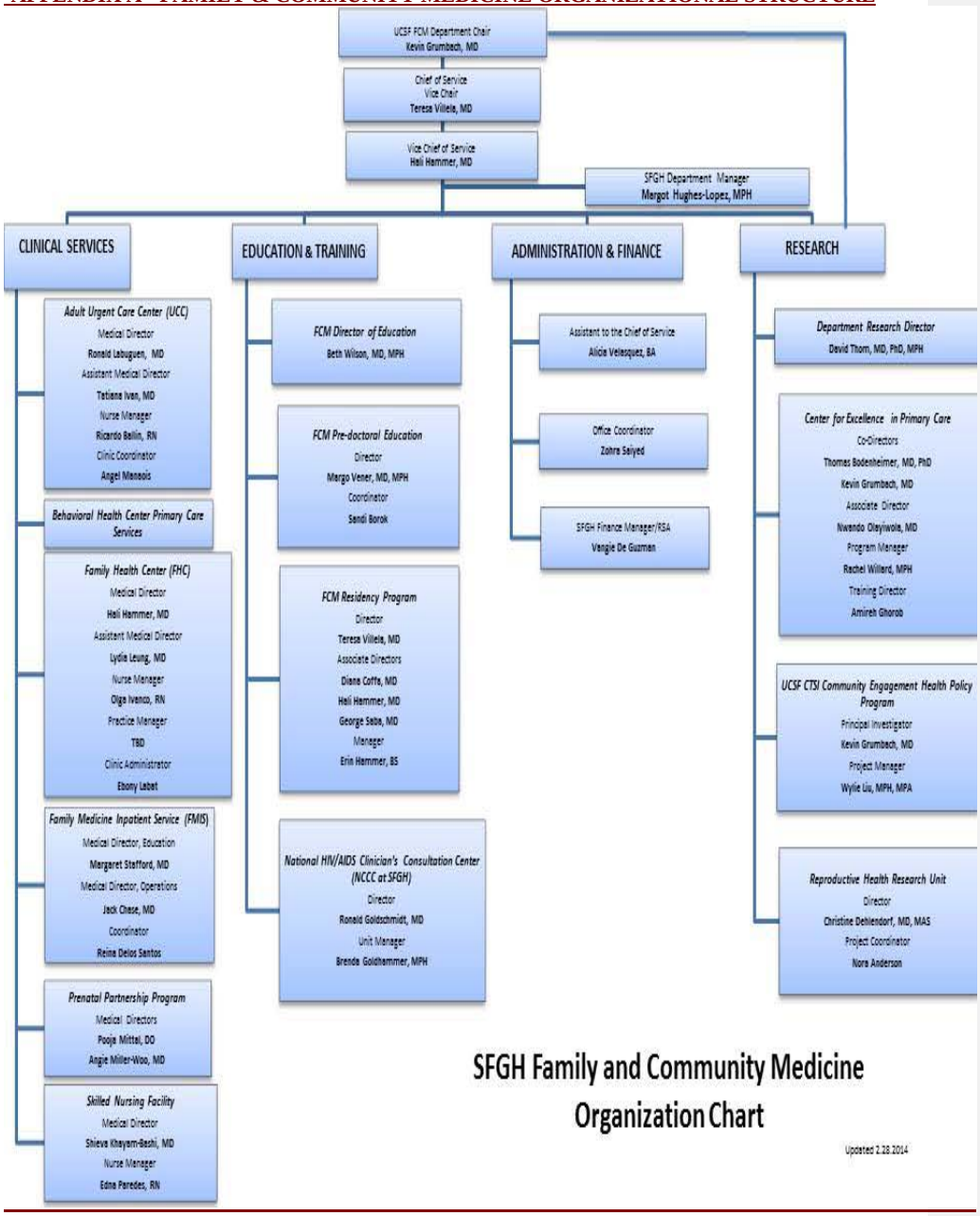
~~**C. FHC APPROVED PROCEDURES**~~

~~Refer to Appendix F -- LIST OF APPROVED PROCEDURES AND INFORMED CONSENT~~

~~XII.~~XI. ADOPTION AND A~~D~~MENDMENT

The Family and Community Medicine Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Family and Community Medicine Clinical Service annually at a Family and Community Medicine Clinical Service meeting.

`APPENDIX A - FAMILY & COMMUNITY MEDICINE ORGANIZATIONAL STRUCTURE



San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

APPENDIX B – CHIEF OF FAMILY AND COMMUNITY MEDICINE CLINICAL SERVICE JOB DESCRIPTION

Chief of Service

San Francisco General Hospital

Family and Community Medicine

Job Description

The primary responsibility of Chief of Service of Family and Community Medicine (FCM) is to assure the integrity and quality of the clinical services administered by the UCSF Department of Family and Community Medicine at San Francisco General Hospital (SFGH). The Chief of Service has direct accountability to the Chief of the SFGH Medical Staff and the UCSF Associate Dean at SFGH, in addition to the Chair of the UCSF Department of Family and Community Medicine and the SFGH Executive Administrator. The Medical Directors of FCM-administered clinical services at SFGH report to the FCM Chief of Service. The Chief of Service works in close collaboration with the other SFGH chiefs of service and SFGH nursing and administrative leaders to promote the collective excellence and accountability of SFGH services and programs.

The FCM Chief of Service, in consultation with the Chair of the UCSF Department of Family and Community Medicine, has responsibility for recruiting and supervising faculty members of the department who are based at SFGH. With the support of the department's manager at SFGH, the Chief of Service is responsible for managing the department's funds related to SFGH professional fee income, the Affiliation Agreement between UCSF and the City and County of San Francisco, other funds involving SFGH clinical operations, and such other funds as the Chair of the Department delegates to be principally managed by the Chief of Service.

The Chief of Service works closely with the Director of the UCSF-SFGH Family Medicine Residency Program to assure the integrity of the residency training program and the integration of the training program into the clinical services at SFGH, including assuring compliance with hospital rules and regulations, ACGME standards, and related policies and regulations. The Chief of Service also works closely with the department's Director of Predoctoral Education to assure successful operation of FCM medical student teaching programs at SFGH and works with educational leaders of the other UCSF health professional schools on issues relating to students' educational experiences on FCM clinical services.

The Chief of Service works in collaboration with the Chair of the UCSF Department of Family and Community Medicine to enhance the academic environment for the Department's programs based at SFGH, including research and community service.

The Chief of Service is expected to serve as an attending physician on the SFGH Medical Staff and perform direct patient care as part of the Family and Community Medicine Service. At a minimum, the Chief of Service is expected to have a continuity family medicine practice and supervise residents and medical students at the Family Health Center. Ideally, the Chief of Service will serve as an attending physician on the Family Medicine Inpatient Service and/or Perinatal Partnership Program family medicine obstetrical call group.

As a member of the UCSF faculty, the Chief of Service is expected to be involved in scholarly activities and contribute to the generation and translation of knowledge in areas of inquiry relevant to family medicine. The extent of involvement in research and scholarly activities will be based on the interests and qualifications of the Chief of Service.

The UCSF-City and County of San Francisco Affiliation Agreement and SFGH Medical Staff Bylaws fully delineate the responsibilities of chiefs of service, including the following:

A. Administration

1. General Responsibilities

a) Be responsible and accountable to the governing body through the Medical Executive Committee (MEC) for the clinical and administratively related activities within the clinical service;

b) Be a participating member of the MEC;

c) Be responsible for the integration of the clinical service into the primary functions of the organization;

d) Be responsible for the coordination and integration of interdepartmental and intra departmental services;

e) Provide administrative leadership for a culturally sensitive and competent program to the community served by SFGH;

f) Provide administrative leadership for a culturally sensitive environment for UCSF and SFGH employees and trainees.

2. Planning

a) Provide direction and participate in the planning, implementation and evaluation of the organization's plan for patient care;

b) Assess the effect of UCSF academic and program planning upon SFGH and directly communicate this information as part of the joint UCSF/SFGH program planning;

c) Stay abreast of changes in the health care industry, both locally as well as industry-wide, and demonstrate leadership by identifying and implementing appropriate changes;

d) Assist in the preparation of annual reports, including budgetary planning, pertaining to the clinical service as may be required by the Chief of Staff, the MEC, the Associate Dean, Executive Administrator, or the Governing Body.

3. Resource Management

Manage City and University resources, including revenue and expenses, appropriately and in a timely manner, as evidenced by:

a) Appropriate budget preparation and monitoring based on service goals;

b) Maximizing reimbursement and other revenues;

c) Ensuring compliance with third party billing regulations, including timely and appropriate documentation in the medical record;

d) Ensuring effective utilization of assigned clinical, administrative and research space;

e) Adhering to UCSF and SFGH financial policies;

f) Reporting and recommending to hospital management, when necessary, with respect to matters affecting patient care in the clinical service, including personnel, space and other resources, supplies, special regulations, standing orders and techniques;

4. Operations Management

a) Designate an acting chief when the Chief of Service will be absent for a period longer than 24 hours but less than thirty (30) days. After thirty (30) days, the process described in the Medical Staff Bylaws will be followed;

b) Assume responsibility for orienting new members and enforce the Medical Staff Bylaws, Rules and Policies, the clinical service rules and regulations, and the hospital's policies and procedures within the respective clinical service;

c) Participate in the administration of the Clinic Service through cooperation with the Nursing Service, Hospital Administration and all personnel involved in matters affecting patient care.

B. Communication

1. Communicate appropriately with hospital administration, the SFGH Dean's Office and Department faculty and staff;
2. Communicate information to faculty, housestaff and students;
3. Promote effective communication and collaboration among health care professionals;
4. Develop and maintain appropriate relationships within the San Francisco community.

C. Performance Improvement

1. Monitor and evaluate the quality and appropriateness of patient care provided within the clinical service, utilizing a quality improvement program that measures patient care outcomes;
2. Monitor the professional performance of all individuals who have clinical privileges in the clinical service, and report thereon to the Credentials Committee as part of the Reappointment process and at such other times as may be indicated;
3. Appoint ad hoc committees or working groups, as necessary, to carry out quality improvement activities;
4. Demonstrate the ability to assess issues and effectively solve problems;

5. Implement and monitor agreed-upon standards for program operations; address performance problems effectively and in a timely manner.

D. Medical Staff Credentialing and Privileging

1. Recommend criteria for clinical privileges in the clinical service;
2. Recommend sufficient number of qualified and competent individuals to provide care/clinical services;
3. Make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the clinical service;
4. Make recommendations to the Credentials Committee regarding the qualifications and competence of clinical service personnel who are affiliated professional staff;
5. Assume responsibility for the evaluation of all provisional appointees and report thereon to the Credentials Committee.

E. Education and Research

1. Be accountable to the Associate Dean and the UCSF Department Chair for the conduct of graduate and undergraduate medical education and UCSF-based research programs conducted in the FCM Clinical Service;
2. Assume responsibility for the establishment, implementation and effectiveness of the orientation, teaching, education and research programs in the Clinical Service;
3. Ensure the quality of resident teaching by monitoring outcomes.

Updated 2012

APPENDIX ~~A~~ C - FAMILY & COMMUNITY MEDICINE PRIVILEGES ~~REQUEST~~

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Privileges for San Francisco General Hospital

Requested Approved

Applicant: Please initial the privileges you are requesting in the Requested column.
Service Chief: Please initial the privileges you are approving in the Approved column.

FCM FAMILY AND COMMUNITY MEDICINE 2008
(10/08 MEC) (03/11 Admin.Revision)

FOR ALL PRIVILEGES: All complication rates, including problem transfusions, deaths, unusual occurrence reports and sentinel events, as well as Department quality indicators, will be monitored semiannually.

_____ _____ **14.00 OUTPATIENT CLINIC PRIVILEGES**

_____ _____ 14.01 Ambulatory Care Privileges for Family Medicine prepared physicians
Perform basic procedures within the usual and customary scope of Family Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for patients of all ages in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service, and may write informational notes in the SFGH inpatient medical record.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.

PROCTORING: Review of 5 cases.
REAPPOINTMENT: Review of 3 cases.

_____ _____ 14.02 Ambulatory Care Privileges for Internal Medicine or Emergency Medicine prepared physicians
Perform basic procedures within the usual and customary scope of Internal Medicine or Emergency Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service and may write informational notes in the SFGH inpatient medical record.

PREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Internal Medicine, the American Board of Emergency Medicine, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Review of 5 cases.
REAPPOINTMENT: Review of 3 cases.

_____ _____ 14.03 Behavioral Health Center Privileges
Concurrence of Behavioral Health Center Medical Director required:

_____
Signature, Behavioral Health Center Medical Director

Performs basic procedures within the usual and customary scope of Family Medicine or Internal Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Behavioral Health Center.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-certified by the American Board of Family Medicine, or the American Board of Internal Medicine, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Review of 5 cases
REAPPOINTMENT: Review of 3 cases

Privileges for San Francisco General Hospital

Requested Approved

14.10 INPATIENT CARE PRIVILEGES
Admit and be responsible for adult inpatient care on the Family Medicine Inpatient Service. Admissions may include medical, surgical, gynecological, and neurological problems, and medical complications in pregnant patients with obstetric consultation. May also follow patients admitted to critical care units in a consultative capacity.

14.11 Family Medicine Inpatient Service Privileges
Perform basic procedures within the usual and customary scope of Family Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adults hospitalized on the Family Medicine Inpatient Service.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.

PROCTORING: Review of 5 cases.

14.12 Skilled Nursing Facility Care Privileges
Concurrence of Skilled Nursing Facility Medical required:

_____
Signature, Skilled Nursing Facility Medical Director

Perform basic procedures within the usual and customary scope of Family Medicine or Internal Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the SFGH Skilled Nursing Facility (SNF).
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine, the American Board of Internal Medicine, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Review of 5 cases.
REAPPOINTMENT: Review of 3 cases.

14.13 Nursery Privileges
Render care to well newborns, including admitting and performing routine evaluations and management.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of a Clinical Service prior to 10/17/00.

PROCTORING: Case review for 3 newborn admissions

14.20 PERINATAL PRIVILEGES
Render care to women during the perinatal period, including specific privileges 14.21 - 14.24, if requested and approved below:

14.21 Normal Vaginal Delivery
Including administration of local anesthesia, performance of episiotomy, and repair of lacerations other than those involving the rectal sphincter.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.

PROCTORING: Case review and direct observation of a minimum of 3 deliveries.

Privileges for San Francisco General Hospital

Requested Approved

_____ _____ 14.22 Vacuum Assisted Deliveries (OB Consultation Required)
Concurrence of the Chief of OB/Gyn required:

_____
Signature, Chief of OB/Gyn

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.

PROCTORING: For applicants with documentation of prior successful performance of a minimum of 25 vacuum assisted deliveries: case review and direct observation of a minimum of 2 deliveries using vacuum assistance. For applicants with documentation of fewer than 25 vacuum assisted deliveries: case review and direct observation of 5 deliveries using vacuum assistance.
REAPPOINTMENTS: Case review of 1 delivery using vacuum assistance.

_____ _____ 14.23 First Assist in Cesarean Section (OB Consultation Required)
Concurrence of the Chief of OB/Gyn required

_____
Signature, Chief of OB/Gyn

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00 and documentation of prior successful performance of a minimum of 25 Cesarean Sections.

PROCTORING: Case review and direct observation of 5 Cesarean Sections.

_____ _____ 14.24 Ultrasound in Pregnancy
Limited to determination of fetal gestational age, confirmation of presentation, placenta locatin, amniotic fluid adequacy, and confirmation of fetal heart rate.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00 and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.
PROCTORING: For applicants with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (Residency or Medical Staff): case review and direct observation of 5 ultrasounds in pregnancy. For applicants without documentation: case review and direct observation of 25 ultrasounds in pregnancy.
REAPPOINTMENT: Case review of 2 ultrasound images.

_____ _____ **14.30 SPECIAL PRIVILEGES**
Physicians may apply for each of the following procedural privileges separately based on qualifications and scope of practice.

_____ _____ 14.31 Lumbar Puncture
PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).
PROCTORING: Review of 2 cases.
REAPPOINTMENT: Review of 2 cases.

Privileges for San Francisco General Hospital

Requested	Approved	
_____	_____	14.32 Paracentesis PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases. REAPPOINTMENT: Review of 2 cases.
_____	_____	14.33 Thoracentesis PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases. REAPPOINTMENT: Review of 2 cases.
_____	_____	14.34 Placement of central venous catheter, including femoral venous catheter PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases. REAPPOINTMENT: Review of 2 cases.
_____	_____	14.35 Intrauterine Procedures PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases. REAPPOINTMENT: Review of 2 cases.
_____	_____	a. Endometrial Biopsy
_____	_____	b. Insertion of Intrauterine Device (IUD)
_____	_____	14.36 Surgical termination of first trimester intrauterine pregnancy Perform surgical abortions in the first trimester of pregnancy at appropriate facilities at SFGH. PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00. Completion of at least 20 hours of formal training in surgical abortion, including first trimester ultrasound for confirmation of intrauterine pregnancy and determination of gestational age, during residency or a CME program, and documentation of 50 procedures. PROCTORING: Case review of 3 surgical terminations.
_____	_____	14.37 Vasectomy PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00. Completion, as a licensed physician, of a minimum of 20 vasectomy procedures under supervision of a privileged and Board Certified Urologist or Family Physician. PROCTORING: Review of 5 cases. REAPPOINTMENT: Review of 3 cases.
_____	_____	**14.40 LIMITED AMBULATORY CARE PRIVILEGES**

Privileges for San Francisco General Hospital

Requested	Approved	
_____	_____	14.41 Acupuncture Perform acupuncture, acupressure, and moxibustion in the Family Medicine Inpatient Service, Family Health Center (FHC), Skilled Nursing Facility, FHC Satellites and in the patient's home. PREREQUISITES: Successful completion, by a licensed physician of at least 200-hours instruction and didactic training course given by a UC or other nationally recognized university. PROCTORING: 5 direct observations and 5 cases to be reviewed by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. Direct observations and chart reviews may be on the same patient or on different patients. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for privileging recommendation. REAPPOINTMENT: Review of 5 cases by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for reappointment recommendation.
_____	_____	14.42 Dentistry Provide professional dental services to hospital and clinic patients; instruct patients in correct oral hygiene and dental care; treat mouth diseases; refer cases requiring oral surgery and medical attention to proper department. PREREQUISITES: Requiring completion of the curriculum of an approved school of dentistry and possession of the DDS degree. Requires possession of a valid license to practice dentistry issued by the State Board of Dental Examiners. PROCTORING: Review of 5 cases. REAPPOINTMENT: Review of 3 cases.
_____	_____	14.43 Clinical Psychology Provide individual and family counseling and therapy. PREREQUISITES: Clinical Psychologists must hold a doctoral degree in Psychology from an approved APA accredited program, and must be licensed on the basis of the doctorate degree in Psychology by the State of California, Board of Psychology. PROCTORING: Review of 5 cases. REAPPOINTMENT: Review of 3 cases.
_____	_____	14.44 Allergy and Immunology Work-up, diagnose, consult, treat, and interpret clinical findings of adult and pediatric patients in the ambulatory setting with allergy or immunologic diseases. Core privileges include allergy skin testing and interpretation. PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Internal Medicine and the American Board of Allergy and Immunology or special dispensation from the chief of service for equivalent training. PROCTORING: Review of 5 cases. REAPPOINTMENT: Review of 3 cases.

Privileges for San Francisco General Hospital

Requested	Approved	
_____	_____	**14.50 WAIVED TESTING**

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.
PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.
REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

_____	_____	A. Fecal Occult Blood Testing (Hemoccult®)
_____	_____	B. Vaginal pH Testing (pH Paper)
_____	_____	C. Urine Chemistrip® Testing
_____	_____	D. Urine Pregnancy Test (SP® Brand Rapid Test)
_____	_____	**14.60 STRAIN-COUNTERSTRAIN MANIPULATIVE MEDICINE PRIVILEGE**

Perform manipulation principally for the purpose of relief of primarily muscular pain on the Family Medicine Inpatient Service, Family Health Center, Skilled Nursing Facility, FHC satellites, and in the patient's home.
PREREQUISITES: Successful completion, by a licensed physician, of at least 30-hours instruction and didactic training course designed for health care professionals and authorized to provide CME or CE credits. In addition, five hours of supervised clinical practice, either during or after residency or completion of training in a Doctor of Osteopathy training program.
PROCTORING: 5 direct observations and 5 cases to be reviewed by a SFGH medical staff member who either maintains Strain-Counterstrain privileges or is a Doctor of Osteopathy who has received training in the Strain-Counterstrain technique.
REAPPOINTMENT: Review of five 5 cases.

Privileges for San Francisco General Hospital

Requested Approved

I hereby request clinical privileges as indicated above.

_____ _____
Applicant date

FOR DEPARTMENTAL USE:

_____ Proctors have been assigned for the newly granted privileges.
_____ Proctoring requirements have been satisfied.

_____ Medications requiring DEA certification may be prescribed by this provider.
_____ Medications requiring DEA certification will not be prescribed by this provider.

_____ CPR certification is required.
_____ CPR certification is not required.

APPROVED BY:

_____ _____
Division Chief date

_____ _____
Service Chief date

San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

Privileges for San Francisco General Hospital

Privileges for San Francisco General Hospital

Requested Approved

Applicant: Please initial the privileges you are requesting in the Requested column.
Service Chief: Please initial the privileges you are approving in the Approved column.

FCM FAMILY AND COMMUNITY MEDICINE 2008
(10/08 MEC) (03/11 Admin.Revision)

FOR ALL PRIVILEGES: All complication rates, including problem transfusions, deaths, unusual occurrence reports and sentinel events, as well as Department quality indicators, will be monitored semiannually.

14.00 OUTPATIENT CLINIC PRIVILEGES

14.01 Ambulatory Care Privileges for Family Medicine prepared physicians

Perform basic procedures within the usual and customary scope of Family Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for patients of all ages in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service, and may write informational notes in the SFGH inpatient medical record.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.02 Ambulatory Care Privileges for Internal Medicine or Emergency Medicine prepared physicians

Perform basic procedures within the usual and customary scope of Internal Medicine or Emergency Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service and may write informational notes in the SFGH inpatient medical record.

PREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the

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~~American Board of Internal Medicine, the American Board of Emergency Medicine, or a~~
~~member of the Clinical Service prior to 10/17/00.~~
~~PROCTORING: Review of 5 cases.~~
~~REAPPOINTMENT: Review of 3 cases.~~
~~14.03 Behavioral Health Center Privileges~~
~~Concurrence of Behavioral Health Center Medical Director required:~~
~~Signature, Behavioral Health Ctr Medical Director~~
~~Performs basic procedures within the usual and customary scope of Family Medicine or~~
~~Internal Medicine, including but not limited to diagnosis, management, treatment,~~
~~preventive care, and minor procedures for adult patients in the Behavioral Health Center.~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-certified by the~~
~~American Board of Family Medicine, or the American Board of Internal Medicine, or a~~
~~member of the Clinical Service prior to 10/17/00.~~
~~PROCTORING: Review of 5 cases~~
~~REAPPOINTMENT: Review of 3 cases~~

~~Privileges for San Francisco General Hospital~~

~~Requested Approved~~
~~**14.10 INPATIENT CARE PRIVILEGES**~~
~~Admit and be responsible for adult inpatient care on the Family Medicine Inpatient Service.~~
~~Admissions may include medical, surgical, gynecological, and neurological problems, and~~
~~medical complications in pregnant patients with obstetric consultation. May also follow~~
~~patients admitted to critical care units in a consultative capacity.~~
~~14.11 Family Medicine Inpatient Service Privileges~~
~~Perform basic procedures within the usual and customary scope of Family Medicine,~~
~~including but not limited to diagnosis, management, treatment, preventive care, and minor~~
~~procedures for adults hospitalized on the Family Medicine Inpatient Service.~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.~~
~~PROCTORING: Review of 5 cases.~~
~~14.12 Skilled Nursing Facility Care Privileges~~
~~Concurrence of Skilled Nursing Facility Medical required:~~
~~Signature, Skilled Nursing Facility Medical Director~~
~~Perform basic procedures within the usual and customary scope of Family~~

~~Medicine or~~
~~Internal Medicine, including but not limited to diagnosis, management, treatment,~~
~~preventive care, and minor procedures for adult patients in the SFGH Skilled Nursing~~
~~Facility (SNF).~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine, the American Board of Internal Medicine, or a~~
~~member of the Clinical Service prior to 10/17/00.~~
~~PROCTORING: Review of 5 cases.~~
~~REAPPOINTMENT: Review of 3 cases.~~
~~14.13 Nursery Privileges~~
~~Render care to well newborns, including admitting and performing routine evaluations and~~
~~management.~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine or a member of a Clinical Service prior to 10/17/00.~~
~~PROCTORING: Case review for 3 newborn admissions~~
~~**14.20 PERINATAL PRIVILEGES**~~
~~Render care to women during the perinatal period, including specific privileges 14.21 - 14.24,~~
~~if requested and approved below:~~
~~14.21 Normal Vaginal Delivery~~
~~Including administration of local anesthesia, performance of episiotomy, and repair of~~
~~lacerations other than those involving the rectal sphincter.~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.~~
~~PROCTORING: Case review and direct observation of a minimum of 3 deliveries.~~

~~Privileges for San Francisco General Hospital~~

~~Requested Approved~~

~~14.22 Vacuum Assisted Deliveries (OB Consultation Required)~~
~~Concurrence of the Chief of OB/Gyn required:~~
~~Signature, Chief of OB/Gyn~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.~~
~~PROCTORING: For applicants with documentation of prior successful performance of a~~
~~minimum of 25 vacuum assisted deliveries: case review and direct observation of a~~
~~minimum of 2 deliveries using vacuum assistance. For applicants with documentation of~~
~~fewer than 25 vacuum assisted deliveries: case review and direct observation of 5 deliveries~~
~~using vacuum assistance.~~
~~REAPPOINTMENTS: Case review of 1 delivery using vacuum assistance.~~

~~14.23 First Assist in Cesarean Section (OB Consultation Required)~~
~~Concurrence of the Chief of OB/Gyn required~~
~~Signature, Chief of OB/Gyn~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00~~
~~and documentation of prior successful performance of a minimum of 25 Cesarean Sections.~~
~~PROCTORING: Case review and direct observation of 5 Cesarean Sections.~~

~~14.24 Ultrasound in Pregnancy~~
~~Limited to determination of fetal gestational age, confirmation of presentation, placenta~~
~~location, amniotic fluid adequacy, and confirmation of fetal heart rate.~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00~~
~~and documentation of a minimum of 8 hours instruction and didactic training in ultrasound~~
~~technology and imaging.~~
~~PROCTORING: For applicants with documentation of satisfactory performance of at least~~
~~25 ultrasounds in pregnancy at another institution (Residency or Medical Staff): case~~

~~review and direct observation of 5 ultrasounds in pregnancy. For applicants without documentation: case review and direct observation of 25 ultrasounds in pregnancy.~~
~~REAPPOINTMENT: Case review of 2 ultrasound images.~~

~~**14.30 – SPECIAL PRIVILEGES**~~
~~Physicians may apply for each of the following procedural privileges separately based on qualifications and scope of practice.~~
~~14.31 – Lumbar Puncture~~
~~PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).~~
~~PROCTORING: Review of 2 cases.~~
~~REAPPOINTMENT: Review of 2 cases.~~

~~Privileges for San Francisco General Hospital~~

~~Requested Approved~~

~~14.32 Paracentesis~~
~~PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care~~
~~Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).~~
~~PROCTORING: Review of 2 cases.~~
~~REAPPOINTMENT: Review of 2 cases.~~

~~14.33 Thoracentesis~~
~~PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care~~
~~Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).~~
~~PROCTORING: Review of 2 cases.~~
~~REAPPOINTMENT: Review of 2 cases.~~

~~14.34 Placement of central venous catheter, including femoral venous catheter~~
~~PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care~~
~~Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).~~
~~PROCTORING: Review of 2 cases.~~
~~REAPPOINTMENT: Review of 2 cases.~~

~~14.35 Intrauterine Procedures~~
~~PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care~~
~~Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).~~
~~PROCTORING: Review of 2 cases.~~
~~REAPPOINTMENT: Review of 2 cases.~~

~~a. Endometrial Biopsy~~
~~b. Insertion of Intrauterine Device (IUD)~~

~~14.36 Surgical termination of first trimester intrauterine pregnancy~~
~~Perform surgical abortions in the first trimester of pregnancy at appropriate facilities at~~
~~SFGH.~~
~~PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the~~
~~American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00.~~
~~Completion of at least 20 hours of formal training in surgical abortion, including first~~
~~trimester ultrasound for confirmation of intrauterine pregnancy and determination of~~
~~gestational age, during residency or a CME program, and documentation of 50 procedures.~~
~~PROCTORING: Case review of 3 surgical terminations.~~

~~14.37 Vasectomy~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Family Medicine or a member of the Clinical Service~~

~~prior to 10/17/00.~~
~~Completion, as a licensed physician, of a minimum of 20 vasectomy procedures under~~
~~supervision of a privileged and Board Certified Urologist or Family Physician.~~
~~PROCTORING: Review of 5 cases.~~
~~REAPPOINTMENT: Review of 3 cases.~~

~~**14.40 LIMITED AMBULATORY CARE PRIVILEGES**~~

~~Privileges for San Francisco General Hospital~~

~~Requested Approved~~

~~14.41 Acupuncture~~
~~Perform acupuncture, acupressure, and moxibustion in the Family Medicine Inpatient~~
~~Service, Family Health Center (FHC), Skilled Nursing Facility, FHC Satellites and in the~~
~~patient's home.~~
~~PREREQUISITES: Successful completion, by a licensed physician of at least 200 hours~~
~~instruction and didactic training course given by a UC or other nationally recognized~~
~~university.~~
~~PROCTORING: 5 direct observations and 5 cases to be reviewed by a medical staff~~
~~member who maintains unproctored status for Acupuncture Privileges within the~~
~~CHN/SFGH system. Direct observations and chart reviews may be on the same patient or~~
~~on different patients. A summary monitoring report will be sent to the respective Clinical~~
~~Service to be forwarded to the appropriate committees for privileging recommendation.~~
~~REAPPOINTMENT: Review of 5 cases by a medical staff member who maintains~~
~~unproctored status for Acupuncture Privileges within the CHN/SFGH system. A summary~~
~~monitoring report will be sent to the respective Clinical Service to be forwarded to the~~
~~appropriate committees for reappointment recommendation.~~

~~14.42 Dentistry~~
~~Provide professional dental services to hospital and clinic patients; instruct patients in~~
~~correct oral hygiene and dental care; treat mouth diseases; refer cases requiring oral surgery~~
~~and medical attention to proper department.~~
~~PREREQUISITES: Requiring completion of the curriculum of an approved school of~~
~~dentistry and possession of the DDS degree. Requires possession of a valid license to~~
~~practice dentistry issued by the State Board of Dental Examiners.~~
~~PROCTORING: Review of 5 cases.~~
~~REAPPOINTMENT: Review of 3 cases.~~

~~14.43 Clinical Psychology~~
~~Provide individual and family counseling and therapy.~~
~~PREREQUISITES: Clinical Psychologists must hold a doctoral degree in Psychology from~~
~~an approved APA accredited program, and must be licensed on the basis of the doctorate~~
~~degree in Psychology by the State of California, Board of Psychology.~~
~~PROCTORING: Review of 5 cases.~~
~~REAPPOINTMENT: Review of 3 cases.~~

~~14.44 Allergy and Immunology~~
~~Work-up, diagnose, consult, treat, and interpret clinical findings of adult and pediatric~~
~~patients in the ambulatory setting with allergy or immunologic diseases. Core privileges~~
~~include allergy skin testing and interpretation.~~
~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the~~
~~American Board of Pediatrics or American Board of Internal Medicine and the American~~
~~Board of Allergy and Immunology or special dispensation from the chief of service for~~
~~equivalent training.~~
~~PROCTORING: Review of 5 cases.~~
~~REAPPOINTMENT: Review of 3 cases.~~

~~Privileges for San Francisco General Hospital~~

~~Requested Approved~~

~~**14.50 WAIVED TESTING**~~

~~Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.~~

~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.~~

~~PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.~~

~~REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.~~

~~A. Fecal Occult Blood Testing (Hemoccult®)~~
~~B. Vaginal pH Testing (pH Paper)~~
~~C. Urine Chemistrip® Testing~~
~~D. Urine Pregnancy Test (SP® Brand Rapid Test)~~

~~**14.60 STRAIN-COUNTERSTRAIN MANIPULATIVE MEDICINE PRIVILEGE**~~

~~Perform manipulation principally for the purpose of relief of primarily muscular pain on the Family Medicine Inpatient Service, Family Health Center, Skilled Nursing Facility, FHC satellites, and in the patient's home.~~

~~PREREQUISITES: Successful completion, by a licensed physician, of at least 30 hours instruction and didactic training course designed for health care professionals and authorized to provide CME or CE credits. In addition, five hours of supervised clinical practice, either during or after residency or completion of training in a Doctor of Osteopathy training program.~~

~~PROCTORING: 5 direct observations and 5 cases to be reviewed by a SFGH medical staff member who either maintains Strain-Counterstrain privileges or is a Doctor of Osteopathy who has received training in the Strain-Counterstrain technique.~~

~~REAPPOINTMENT: Review of five 5 cases.~~

~~Privileges for San Francisco General Hospital~~

~~I hereby request clinical privileges as indicated above.~~

~~Applicant date~~

~~FOR DEPARTMENTAL USE:~~

~~Proctors have been assigned for the newly granted privileges.~~
~~Proctoring requirements have been satisfied.~~

~~Medications requiring DEA certification may be prescribed by this provider.~~
~~Medications requiring DEA certification will not be prescribed by this provider.~~

~~CPR certification is required.~~
~~CPR certification is not required.~~

~~APPROVED BY:~~

~~Division Chief date~~

~~Service Chief date~~

~~Requested~~

~~Applicant: Please initial the privileges you are requesting in the Requested column.~~
~~Service Chief: Please initial the privileges you are approving in the Approved column.~~

~~14 FAMILY AND COMMUNITY MEDICINE~~

~~**14.10 BASIC PRIVILEGES - Family Physcians - Ambulatory and Outpatient Care**~~

~~MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Practice or a member of the Clinical Service prior to 10/17/00. Perform basic procedures within the usual and customary scope of family practice, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for patients of all ages in the Family Health Center (FHC), FHC satellites, the SFGH Skilled Nursing Facility (SNF), or the patient's home. May admit - BUT NOT MANAGE - adults on the Family Practice Inpatient Service (FPIS); may write informational notes in the SFGH inpatient medical record.~~

~~**14.20 BASIC PRIVILEGES - Physicians in Other Specialties**~~

~~MINIMUM CITERIA; Currently Board Admissible, Board Certified, or Re-Certified by specialty boards OTHER than the American Board of Family Practice or a member of the Clinical Service prior to 10/17/00.~~
~~Requires special supplemental review (waiver) from the chief of service specifying patient populations they are able to treat.~~

~~**14.30 INPATIENT CARE PRIVILEGES**~~

~~MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Practice or the Board of Internal Medicine or a member of the Clinical Service prior to 10/17/00. May admit and be responsible for adult inpatient care on the Family Practice Inpatient Service (FPIS). Admissions may include medical, surgical, gynecological, and neurological problems; and medical complications in pregnant patients with obstetric consultation. May also follow patients admitted to critical care units in a consultative capacity.~~

~~**14.60 BASIC PERINATAL PRIVILEGES**~~

~~MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Practice or a member of the Clinical Service prior to 10/17/00. Render care to women during the perinatal period, including normal obstetrical privileges 14.61 - 14.68, if requested and approved below:~~

~~14.61 Normal Vaginal Delivery: including administration of local anesthesia, performance of~~

~~episiotomy, and repair of lacerations other than those involving the rectal sphincter.~~

~~14.62 Application of Internal Fetal Monitor and Pressure Catheter~~
~~14.63 Administration of Oxytocin prior to delivery~~
~~14.64 Vacuum assisted deliveries (OB consultation required)~~
~~Concurrence of the Chief of OB/Gyn required~~

~~14.66 First Assist in Cesarean Section (OB consultation required)~~
~~Concurrence of the Chief of OB/Gyn required~~

~~Privileges for San Francisco General Hospital~~

~~Requested~~

~~14.68 Ultrasound in Pregnancy~~
~~Limited to determination of fetal gestational age, confirmation of presentation, placenta location, amniotic fluid adequancy, and confirmation of fetal heart rate. MINIMUM CRITERIA: 1) Must meet criteria for basic perinatal privileges and undergo minimum of 4 hours didactic training in ultrasound technonolgy and imaging, and successfully perform 5 proctored studies. OR 2) Must meet criteria for perinatal privileges and provide written evidence of satisfactory performance of at least 25 perinatal studies at another institution (Residency or Medical Staff), and successfully perform 5 proctored~~

~~**14.70 BASIC PRIVILEGES IN THE CARE OF HOSPITALIZED CHILDREN**~~
~~MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Practice or a member of the Clinical Service prior to 10/17/00. May admit - BUT NOT MANAGE - pediatric inpatients; may write notes in the medical record; and may consult with attendings and housestaff on the Pediatric Service regarding the management of their patients. Emancipated minors are admitted to the Family Practice Inpatient Service (FPIS) with appropriate consultation, if needed.~~

~~**14.80 NURSERY PRIVILEGES**~~
~~MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Practice or a member of the Clinical Service prior to 10/17/00. May render care to well newborns, including admitting and performing routine evaluations and management.~~

~~**14.90 ACUPUNCTURE PRIVILEGES**~~
~~MINIMUM CRITERIA: Successful completion, by a licensed physician, of at least a 200-hour course consisting of theory and training given by a UC or other nationally recognized university. May perform acupuncture, acupressure, and moxibustion in the Family Practice Inpatient Service (FPIS), Family Health Center (FHC), FHC satellites, and~~

~~**15.00 LICENSED CLINICAL PSYCHOLOGIST PRIVILEGES**~~
~~MINIMUM CRITERIA: Clinical Psychologists must provide documentation of appropriate training and continuing education in clinical psychology. May provide~~

~~individual and family counseling and therapy. Proctoring and peer review will be~~

~~**15.10 SURGICAL TERMINATION OF FIRST TRIMESTER INTRAUTERINE**~~

~~MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Practice or a member of the Clinical Service prior to 10/17/00. Completion of at least 20 hours of formal training in surgical abortion, including first trimester ultrasound for confirmation of intrauterine pregnancy and determination of gestational age, during residency or a CME program, and documentation of a minimum of 20 successfully performed abortions. Must complete proctoring of 3 surgical terminations. May perform surgical abortions in the first trimester of pregnancy at~~

~~**15.20 VASECTOMY PRIVILEGES**~~

~~MINIMUM CRITERIA; Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Practice or a member of the Clinical Service prior to 10/17/00. Completion, as a licensed physician, of a minimum of 20 vasectomy procedures under supervision of a privileged and Board Ceritified Urologist or Family Physician.~~

APPENDIX D – FHC: CHART REVIEW

Proctoring and chart reviews are conducted using the following forms:

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SFGH Family and Community Medicine Service • Family Health Center

CHART REVIEW REPORT-FHC PRECEPTORS WITH NO PATIENT PANEL

(Use this form for Privileges 14.01 and 14.02)

Reviewer	_____	Provider	_____ ☐ MD ☐ DO
CHN#	_____	CHN #	_____
Signature	_____		
Review Date	_____	Patient Name	_____
Review Type: ☐ Initial Proctoring ☐ Reappointment		Patient B#	_____

	Acceptable	Improvement Needed	Not Acceptable	Not Applicable
History is complete and accurate.	☐	☐	☐	☐
Physical exam is complete and accurate.	☐	☐	☐	☐
Lab studies are indicated and appropriate.	☐	☐	☐	☐
Assessment and problem identification are accurate and complete.	☐	☐	☐	☐
Plans are documented and appropriate.	☐	☐	☐	☐
Follow-up is appropriate for active problems.	☐	☐	☐	☐
Attending precepting note is legible.	☐	☐	☐	☐
Problem list is in LCR and is up to date.	☐	☐	☐	☐
Medication list is in LCR and is up to date.	☐	☐	☐	☐
Allergies are noted in LCR.	☐	☐	☐	☐
Health care maintenance is addressed.	☐	☐	☐	☐
Attending note reflects appropriate involvement in care of patient.	☐	☐	☐	☐

Please explain any "Improvement Needed" or "Not Acceptable" ratings.

Corrective Action:
☐ **None Necessary** ☐ **Provider Counseled** ☐ **Topic Discussed in Staff Meeting** ☐ **Other:**

Comments

SFGH Family and Community Medicine ● Family Medicine Inpatient Service

REVIEW SUMMARY FORM

(Use this form for Privileges 14.11, 14.31, 14.32, 14.33, 14.34, 14.35)

Reviewer	_____	**Provider**	_____ ☐ MD ☐ DO
CHN#	_____	**CHN #**	_____
Signature	_____		_____
Review Date	_____	**Review Type:**	☐ Initial Proctoring ☐ Reappointment

	Proctoring	Reappointment Review
Evaluation Period		
No. of Charts: Inpatient Procedure		
No. of Charts: Outpatient Procedure		

Medical Record	**Evaluation**		
	☐ Acceptable	☐ Improvement Needed	☐ Unacceptable
	☐ Acceptable	☐ Improvement Needed	☐ Unacceptable
	☐ Acceptable	☐ Improvement Needed	☐ Unacceptable
Notes:			

Medical Record	**Procedure**	**Evaluation**		
		☐ Acceptable	☐ Improvement Needed	☐ Unacceptable
		☐ Acceptable	☐ Improvement Needed	☐ Unacceptable
		☐ Acceptable	☐ Improvement Needed	☐ Unacceptable
		☐ Acceptable	☐ Improvement Needed	☐ Unacceptable
Notes:				

San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

~~APPENDIX B – HOUSESTAFF COMPETENCIES~~

~~Competencies define procedures or activities that the resident can usually perform without on site supervision. The underlying patient condition and complexity of the procedure might dictate the need for direct supervision and physical presence of the attending physician.~~

~~Whenever a question arises about resident competency to perform a procedure independently, the attending physician should be consulted.~~

~~A = Adult Independent Competency~~	**~~AP = Adult/Ped Independent Competency~~**
~~P = Pediatric Independent Competency~~	**~~Blank = NOT Competent~~**

~~Indicate which Post Graduate Year a resident becomes a~~	~~Chief Resident (C); Fellow (F)~~							
~~Chief Resident with a "C" and a Fellow with an "F"~~				~~C;F~~				
	~~Resident Year~~							
~~PROCEDURES - Family Practice~~	~~Post Graduate Year~~							
	~~1~~	~~2~~	~~3~~	~~4~~	~~5~~	~~6~~	~~7~~	~~8~~
~~Airway Management, adult/pediatric, stable/unstable, trauma~~			~~AP~~	~~AP~~				
~~Anesthesia~~								
~~Local~~		~~AP~~	~~AP~~	~~AP~~				
~~Field Block~~		~~AP~~	~~AP~~	~~AP~~				

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~~Peripheral Nerve Block~~								
~~Ankle-Brachial Index~~		~~A~~	~~A~~	~~A~~				
~~Arterial Line - (Insert and Remove)~~	~~A~~	~~AP~~	~~AP~~	~~AP~~				
~~Arthrocentesis~~								
~~lower extremity~~		~~AP~~	~~AP~~	~~AP~~				
~~upper extremity~~			~~AP~~	~~AP~~				
~~Bladder Irrigation~~		~~AP~~	~~AP~~	~~AP~~				
~~Blood Gases (arterial)~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Bronchoscopy~~								
~~Cardiac Defibrillation~~				~~A~~				
~~Cardiopulmonary Resuscitation~~								
~~Closed~~		~~AP~~	~~AP~~	~~AP~~				
~~Open~~								
~~Cardioversion~~								
~~Cast/Splint (Apply and Remove)~~								
~~for fracture~~			~~A~~	~~A~~				
~~for immobilization/protection~~		~~A~~	~~A~~	~~A~~				
~~Central Venous Line (femoral/jugular/subclavian)~~								

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		~~Insert~~		~~A~~	~~A~~	~~A~~				
		~~Remove~~		~~AP~~	~~AP~~	~~AP~~				
~~Chest Tube~~										
		~~Insert~~								
		~~Remove~~								
~~Colonoscopy~~										
~~Compartment Pressure Measurement~~										
~~Conscious Sedation~~										
~~Cricothyroidotomy, emergency~~										
~~Cultures (urine/sputum/wound)~~			~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Cut down~~										
	~~Venous~~									
		~~Insert~~								
		~~Remove~~								
	~~Arterial~~									
		~~Insert~~								
		~~Remove~~								
~~Doppler study~~										

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~~Venous~~								
~~Arterial~~								
~~Graft/Fistula~~								
~~Drainage Tube (fluid/blood/pus – not chest or mediastinal)~~								
~~Insert~~								
~~Remove~~								
~~Drug Administration~~								
~~Intravenous~~		~~A~~	~~A~~	~~A~~				
~~Intra-arterial~~								
~~EGD – Esophagus Gastro Duodonoscopy~~								
~~Endotracheal Suctioning~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Endotracheal/Nasotracheal Intubation~~								
~~Foley Catheter – (Insert and Remove)~~	~~A~~	~~AP~~	~~AP~~	~~AP~~				
~~Gastric Lavage~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Incision & Drainage (abscess/fluid collection/cyst)~~		~~AP~~	~~AP~~	~~AP~~				
~~Laceration Repair~~		~~AP~~	~~AP~~	~~AP~~				
~~Laryngoscopy~~			~~A~~	~~A~~				
~~Long Intestinal Tube – (Insert and Remove)~~								
~~Lumbar Puncture~~		~~AP~~	~~AP~~	~~AP~~				

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~~Mediastinal Tube~~								
~~Insert~~								
~~Remove~~								
~~Nasal Packing~~								
~~Anterior~~		~~A~~	~~A~~	~~A~~				
~~Posterior~~								
~~Nasogastric Tube (Insert and Remove)~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Other Resuscitation~~								
~~Other Wound Care (not debridement)~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~(change/replace dressing; clean)~~								
~~Pacemaker/pacer wires~~								
~~Insert~~								
~~Remove~~								
~~Paracentesis/Acute PD Catheter~~		~~A~~	~~A~~	~~A~~				
~~Percutaneous Needle Aspiration (drainage/biopsy for fluid collection/cyst/abscess/mass)~~								
~~Perform/interpret lab tests (spin Hct/do UA/EKG/gram stain/~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~peripheral smear/etc.)~~								
~~Pericardiocentesis~~								

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~~Peritoneal Lavage~~								
~~Phlebotomy (including blood cultures)~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Pleurodesis~~								
~~Rectal tube (Insert and Remove)~~								
~~Remove Foreign Body~~		~~AP~~	~~AP~~	~~AP~~				
~~Sclerosis, other (e.g., seroma)~~								
~~Sigmoidoscopy/Anoscopy~~								
~~With biopsy~~		~~A~~	~~A~~	~~A~~				
~~Without biopsy~~		~~A~~	~~A~~	~~A~~				
~~Sutures/Staples (Insert and Remove)~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Swan Ganz Catheter~~								
~~Insert~~		~~A~~	~~A~~	~~A~~				
~~Remove~~		~~AP~~	~~AP~~	~~AP~~				
~~Thoracentesis~~		~~A~~	~~A~~	~~A~~				
~~Thoracotomy, emergency~~								
~~Tracheotomy, emergency~~								
~~Umbilical Artery Catheter~~								
~~Insert~~								
~~Remove~~								

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~~Venous Line (Insert and Remove)~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				
~~Wound Debridement~~	~~AP~~	~~AP~~	~~AP~~	~~AP~~				

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San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

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San Francisco, CA 94110

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APPENDIX DC – FHC: CHART REVIEW

FHCProctoring and chart reviews are conducted using the following forms:

UCSF ☼ CHN Family and Community Medicine ● Family Health Center

CHART REVIEW REPORT

Reviewer		Provider		☐ MD	☐ NP
CHN#		CHN #			
Signature					
Review Date		Patient Name			
Review Type:	☐Initial Proctoring ☐Reappointment	Patient B#			

	Acceptable	Improvement Needed	Not Acceptable	Not Applicable
History is complete and accurate.	☐	☐	☐	☐
Physical exam is complete and accurate.	☐	☐	☐	☐
Lab studies are indicated and appropriate.	☐	☐	☐	☐
Assessment and problem identification are accurate and complete.	☐	☐	☐	☐
Plans are documented and appropriate.	☐	☐	☐	☐
Follow-up is appropriate for active problems.	☐	☐	☐	☐
Therapeutic regimens meet accepted standards.	☐	☐	☐	☐
Patient education is documented.	☐	☐	☐	☐
Charting and documentation are complete and accurate.	☐	☐	☐	☐
Problem list is complete, accurate, and useful.	☐	☐	☐	☐
Medication list is complete, accurate, and useful.	☐	☐	☐	☐
Allergies are noted.	☐	☐	☐	☐
Health care maintenance is reasonably up to date.	☐	☐	☐	☐
Psychosocial factors are noted and included in plans.	☐	☐	☐	☐
Overall care meets high standards.	☐	☐	☐	☐

Please explain any "Improvement Needed" or "Not Acceptable" ratings.

~~Comments~~

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SFGH Family and Community Medicine Service

PERINATAL CARE PROCTORING FORM

(Use this form for Privilege 14.21 Vaginal Delivery)

Proctor Name	_____	Provider	_____ ☐ MD ☐ DO
CHN#	_____	CHN #	_____
Signature	_____		
Review Date	_____	Patient MRN	_____
		Patient Diagnosis	_____

Procedure:

Procedure Date:

CHART REVIEW	Acceptable	Improvement Needed	Not Acceptable	Not Applicable
1. History and physical exam	☐	☐	☐	☐
2. Use and interpretation of diagnostic testing	☐	☐	☐	☐
3. Management of labor:	☐	☐	☐	☐
4. Follow-up/reassessment of interventions	☐	☐	☐	☐
5. Timely and appropriate consultation	☐	☐	☐	☐
PROCEDURE REVIEW	**Acceptable**	**Improvement Needed**	**Not Acceptable**	**Not Applicable**
1. Pre procedure assessment and counseling	☐	☐	☐	☐
2. Operative management/technical skill	☐	☐	☐	☐
3. Post-operative management	☐	☐	☐	☐
4. Management of complications	☐	☐	☐	☐

ASSESSMENT (circle)	Acceptable	Improvement Needed	Not Acceptable	Reviewed with provider

Please explain any "Improvement Needed" or "Not Acceptable" ratings.

Comments

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SFGH Family and Community Medicine Service

PROCEDURE PROCTORING FORM

(Use this form for Privileges 14.24, 14.31, 14.32, 14.33, 14.34, 14.35, 14.36, 14.37, 14.60)

Reviewer	_____	Provider	_____ ☐ MD ☐ DO
CHN#	_____	CHN #	_____
Signature	_____		
Review Date	_____	Patient MRN	_____
		Patient Diagnosis	_____

Procedure Date:

Procedure (please check procedure box):
☐ Ultrasound in Pregnancy
☐ Placement of central & femoral venous catheter
☐ Surgical termination of 1st trimester of pregnancy at appropriate facilities
☐ Strain-Counterstrain
☐ Lumbar Puncture
☐ Intrauterine Procedure
☐ Paracentesis
☐ Thoracentesis
☐ Vasectomy

CHART REVIEW	Acceptable	Improvement Needed	Not Acceptable	Not Applicable
1. History and physical exam	☐	☐	☐	☐
2. Use and interpretation of diagnostic testing	☐	☐	☐	☐
3. Consent obtained and in chart	☐	☐	☐	☐
4. Appropriate documentation of procedure	☐	☐	☐	☐

PROCEDURE REVIEW	Acceptable	Improvement Needed	Not Acceptable	Not Applicable
1. Pre procedure assessment and counseling	☐	☐	☐	☐
2. Operative management/technical skill	☐	☐	☐	☐
3. Post-operative management	☐	☐	☐	☐
4. Management of complications	☐	☐	☐	☐

ASSESSMENT (circle)	Acceptable	Improvement Needed	Not Acceptable	Reviewed with provider

Please explain any "Improvement Needed" or "Not Acceptable" ratings.

Comments

San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

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San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

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San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

APPENDIX ~~D~~ E – ATTENDING PHYSICIAN RESPONSIBILITIES FAMILY HEALTH CENTER

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Clinical care in the Family Health Center is the responsibility of the attending staff of the Family & Community Medicine Clinical Service either through direct provision of service or through supervision of residents, affiliated professionals or medical students. ~~Responsibilities of attendings may fall into two general categories: clinical supervision of residents and students and administrative responsibilities of each day's attendings.~~ The FHC Medical Director will ensure that there is appropriate attending coverage is available during all hours of operation.

Guidelines for Family Health Center Attendings

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1) Before starting, you need

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- A UC appointment
- SFGH FCM outpatient privileges. Please see guidelines attached re: which special privileges to request and completing proctoring.
- A "CHN number," which is the 6 digit identification number you will use throughout SFGH
- An SFGH badge
- An "active directory log-in" which you get by calling the UCSF at SFGH Help Line: 206- 5126. This is the log-on you will need to be able to write LCR notes.
- One or more orientation session with Hali and other clinic attendings
- Correct information in the LCR. When logged on, click "Verify my Data" and make changes if incorrect.

2) Supervision and documentation

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a) Please be on time to your shift. Clinic can't open at 8:30, 1:00, and 5:30 until there's an attending here. Please let Ebony (206-6891 or 443-7412) or a Charge Nurse know if you will be late and they will find another attending to cover until you arrive.
b) Put your name and pager or cell phone number on the white board in the attending room when you arrive.
c) You are expected to attend a team huddle at the beginning of your morning or afternoon attending session. The 81 attending should go to the Red Team Huddle. The 85 attendings should split between the Green and Gold Team huddles. There will be a facilitator for each huddle, and as attending you should actively participate as well as use the opportunity to find out about staffing, anticipated issues with patients, etc. on the teams. The huddles start at 8:30 and 1:05 each day (except Thursday mornings when they start at 9:30).
d) It's a good idea to walk through the clinic 15-30 minutes after clinic starts to make sure all scheduled providers are there (unless you're sure the COD is doing this). It is primarily the responsibility of the MEAs to check this and page absent providers, but sometimes they don't do it. The MEAs will page late providers, and if they don't get an answer or find that a provider with scheduled patients is not coming, they will bring this problem to your attention. Please call or page Ebony or one of the chief residents if this happens: while you deal with patients waiting to be seen by an absent provider, they can be tracking the person down.
e) You must examine and write a note for every patient unless:
   i) The resident has a license

      AND

   ii) The resident has been cleared by the program directors to see patients without an exam and

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note by the attending. The Program Director will send an email out to all attendings telling them which 2nd year residents have been cleared to precept at their own discretion. Please keep this communication in mind (or on hand) when precepting with 2nd year residents. Because of the sensitive nature of this summary, we don't store it on our shared drives and encourage attendings to take care if they print it out.

Residents who meet only one of these criteria must continue to precept until both criteria have been met.

f) Ask the resident or student for the Attending Progress Note Form when they begin precepting. This is your note, and must be completely filled out, dated and signed.
g) Your note (and assessment and exam) is the note of record, and it must reflect a face-to-face encounter with the patient. You do not need to co-sign the learner's note.
h) The LCR has a good outpatient summary that you can use to "pre-round" on patients your residents or students are seeing. Click "Patient Overview," then "Outpatient Summary."
i) You will cosign all prescriptions for unlicensed providers, either while in the room with the student or resident or by checking your "unsigned prescriptions" list before you leave clinic.
j) Always check to see if you have any unsigned prescriptions before you leave clinic. Click "Verify My Data" and then "Unsigned Prescriptions."
k) Allergies (or lack thereof) and up to date problem and medication lists must be entered for every patient seen at the FHC. When you're precepting and looking at the patient's med list, please get in the habit of making sure allergies are entered and that the medication list is updated. Please also give residents feedback if they are not doing these and LCR problem lists. Appendix 4 is our FHC Chart Review Form for Preceptors. Please review this list to see expectations for preceptors.
l) You should not leave either 81 or 85 at the end of the day if there are still patients on the floor. Please make sure they're out the door before you head out. If you are attending and can't stay until 12:30 (morning attendings) or as late as 6:00 (afternoon attendings), please let Ebony know beforehand so she can identify someone else in case residents are not finished with patients.

3) Working with the Clinician of the Day

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a) The Clinician of the Day, also known as COD, is a new role filled by an NP/PA. Their primary responsibilities are outlined as follows:
   i) Management of clinic flow
   ii) Identifying providers who are backed up in clinic and redistributing their patients to other providers who have no-shows or have open slots. They should be speaking with the provider prior to redistribution of patients. They are actively trying to make sure residents see their target number of patients each session (see targets listed below).
   iii) Serve as consultants for drop-in triage RN to help identify open slots for same-day drop-in patients to the FHC.
b) CODs have to manage 2 floors and 4 teams of patients so they are quite busy. Your role would be to fulfill the above responsibilities if the COD was unavailable, busy or out sick.
c) If you are unable to complete the lab review or refills (see below), you may ask the COD for help with those.
d) The clinic schedule lists the COD (and ROD and drop-in resident) each day.
e) The 81 attending is responsible for consulting with the drop-in triage RN, who is located in 91.

4) Working with Resident of the Day

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a) There will be a Resident of the Day, also known as ROD, assigned to MOST clinic days.

The primary responsibilities of the ROD are:
i) See same day drop-in or urgent patients.
ii) See patients redistributed by COD or attending from providers who are backed up in clinic.

b) Since the ROD also serves as a "back-up" resident for the residency program, they are NOT always available to see patients in clinic. If the ROD is pulled to fulfill other clinical responsibilities for their colleagues, the COD and team leads (RNs) will be notified by either Ebony or the chief residents.

c) If the ROD is available and does not have patients (especially at the beginning of the session), please work with the COD to ensure the ROD sees their target number of patients during the clinic session.

5) Precepting tips

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a) Check in to find out if the trainee is a medical student, PGY1, 2, or 3. Adjust your questions and teaching based on the learners' year of training.
   i) For medical students: aim for 10-15 minute precepting in attending room, 5-10 minutes in clinic room closing out visit.
   ii) For PGY1: aim for 10 minute precepting in attending room, 5-10 minutes in clinic room closing out visit.
   iii) For PGY2: aim for 5 minute precepting in attending room. Allow resident to close out the visit as much as possible.
   iv) For PGY3: mostly serving as a consultant, do not need to see patient unless resident is unlicensed or requests for you to be in room with patient for an evaluation.

b) If you are meeting student or resident for the first time, it is a good idea to check in to see if they want you to pay particular attention to specific things they might be working on. For example, a lot of second-year residents struggle with managing clinic flow, completing notes while in the room, presenting more focused succinct presentations for the attendings.

c) We have target numbers (minimum number of patients) that residents should see each time they are in clinic: R1s 3-4; R2s 5-6; R3s 7-8 per session. Please keep this in mind and work in consultation with the COD to shift other patients to your residents if they have no-shows and are not hitting the target.

6) Special responsibilities of 81 attendings

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a) The 81 attending has 4 primary responsibilities:
   i) Supervision of the drop-in resident, who is the resident seeing same day, drop-in patients on a first-come, first-serve basis (in lieu of the old FHC Orange resident).
   ii) Supervision of the Red Team residents
   iii) Management of medication refill requests
   iv) Servicing as consultant for NP, PA, RNs and other staff.

b) Drop-in (DI) Resident:
   i) At the beginning of your session, please introduce yourself to the Clinician of the Day (COD) and Drop-in triage RN. The COD is an NP/PA whose main responsibilities (also see above) are to manage clinic flow, assist in distributing drop-in patients to the DI resident or other residents with open slots. The triage RN will mostly consult with the COD for triage or patient management questions. If the COD is not available, you will serve as the consultant for the triage RN and help to manage clinic flow.
   ii) Noon coverage of Drop-in clinic:
   aa. The morning attending is expected to be available until 12:30. If you know you have to leave at noon, please find someone to cover for you until 12:30 in case there are still patients being seen. The first people to ask are the 85 attendings. Ebony may also be able to help you locate someone to cover when you have to leave. If you anticipate having to

leave by noon, inform Ebony in advance of your precepting date so she can plan accordingly.
Afternoon and evening attendings must stay until residents and students are finished seeing patients.
bb. If there are no patients in rooms at noon, actively being seen, the resident and attending can leave the floor.
cc. If there is a patient still being seen who is sick or the possibility of a resident still needing to precept and you have to leave, you should make contact with an afternoon attending to see if they can come and relieve you. If none of them can, let Ebony know and she can try to find someone to cover.
dd. If you have to cover over the lunch hour because there are sick patients or residents needing to precept and you also are precepting in the afternoon, let Ebony know and she can help find coverage so you can get lunch and a bit of a break.
ff. If a patient's work-up was started and requires for continued evaluation in the afternoon, please make sure that the resident signs out the patient to the afternoon drop-in resident. You should also sign out the patient to the afternoon 81 attending and ensure that there is someone in the clinic who stays with the patient during the lunch hour.

iii) Drop-in patients who continue to need care after 5:00 should be signed out to an Urgent Care Center provider by the resident or sent to the ED. Patients sent to the ED must be have report given by the FHC attending to the ED attending. Call 206-8111 and ask for an attending who can receive sign out about a patient being transported.

iv) Pending labs or x-ray results should be signed out by the resident to that evening's FHC/L&D on-call resident.

c) Red Team:
   i) Patient work-ups from Red Team cannot be "held over" from the afternoon to the evening clinic. If a work-up is still in progress, the patient must be transferred to the ED or UCC.
   ii) Patients who may require hospitalization or ED transfer should not be given UR appointments in the evening. While this sort of triage is the responsibility of the triage nurses, they may consult you about a decision re: keeping a late drop-in patient in clinic to be seen at 5:30 or transferring the patient to UCC or ED. Only straightforward, non-acute patients should be given evening UR appointments.

d) Prescription Refills
   i) Prescription refills should be done on the LCR via e-fax. As you're going through the stack and doing them on the computer, you can send all the faxed papers to the shredder. No need to put those in the stack to be faxed back to the pharmacy.
   ii) If you have a question about a refill request that you can't answer by reviewing the LCR information, you may put the fax sheet in the provider's box with your question written on it. (Use slot underneath stack of faxes from pharmacy to send forms to providers' boxes). If you want this prescription to get attention within a week, you should email the question to the provider. Many FHC providers are only in clinic (and the building) once per week.
   iii) If you get a refill request for a controlled substance, look on the LCR to see if there's a clinical alert specifying the plan for refills. If there is not, check the "Reports/Notes" list to see if there's an on-line "Controlled Substance Agreement" or note of the plan. If there is not, fine to send these back to the PCP's box.
   iv) If you do not finish completing the refill requests by the end of the afternoon, please sign out to the evening clinic attending.
   v) On Fridays, all refill requests must be completed by the end of the afternoon session.

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Remember: you may ask the COD or 85 attendings for assistance if you are not able to get through the stack of refills. If there are still refills left when everyone leaves on Friday, you must make contact with the Saturday clinic providers and ask them to complete them.

vi) Refill requests for chronic medications should only be completed for patients actively being seen in the LCR. If the patient hasn't been seen in over a year or if there is a note that the patient is no longer being seen at the FHC, the request should be sent to the PCP and not filled by the attending. If that is not clear and the medication seems essential, a one month's supply can be given at the attending's discretion, with a note to the pharmacist to instruct the patients to return for care in order to get additional refills.

vii) Chronic medications can be refilled with a 90 day supply and 3 refills if the patient is actively receiving care at the FHC. Controlled substances should be filled with a one month supply only.

7) Special responsibilities of 85 attendings

The 85 attending has 3 primary responsibilities

a) Supervision of residents and students

i) This includes precepting residents who are seeing patients on Green Team who are receiving their refugee/asylee screening. These screenings include a first-time visit where residents perform an initial assessment, much like any other patient, but with special attention paid to mental health screening. There is a special state-mandated medical form that the residents must fill out. After the initial visit, there is a follow-up appointment. If you ever have questions about these particular screenings, the Newcomer's Program staff is a great resource. Their office is located directly across from the Green Team nursing room.

ii) Supervision of residents and students on Gold Team

b) Review of diagnostics for the day

Regarding review of diagnostic test reports, please see attached document "Guidelines for Review of Lab Reports."

If you are unable to complete the lab/radiology review at the end of clinic, please let Ebony know or bring the stack of labs/radiology reports down and hand off directly to the evening clinic attending. On Fridays, all diagnostic results must be reviewed by the end of the afternoon session. Remember: you may ask the COD or 81 attending for assistance if you are not able to get through the stack of diagnostic reports. If there are still labs to review everyone leaves on Friday, you must make contact with the Saturday clinic providers and ask them to complete them.

c) Acting as consultant for clinic NPs, PAs, RNs, other faculty in clinic, and other clinic staff.

8) Special responsibilities of evening attendings

a) If you are not going to be in the building and ready to start at 5:30, please let Ebony know as early as possible so she can get someone to cover for you.

b) Students and residents tend to have many urgent care, transfer, and new patient appointments scheduled in the evenings. Take a look at the schedules before clinic starts so that you can start planning for moving patients around in case one provider gets backed up. Move adults from one provider to another before you move kids. It's a good idea, in general, to ask providers before you move a patient to another person in case they know the patient and intend to see them.

c) It's very important to stay on top of flow in the evenings so that patients are out the door by 9:00.

d) Evening attendings, please get in the habit of checking the 81 med refills tray and the 85 lab pile when you start. Evening attendings often have downtime and are expected to finish the refills and labs if the afternoon people didn't get to them.

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e) Nursing and security staffing is only available until 9:00. Patients should be out of the building by 9:00. Please anticipate if a patient work-up is going to take longer, initiate transfer to the ED or UCC starting at 8:30.
f) There may be leftover labs and refills from the afternoon to review. Please let Ebony know if you don't complete the review.

9) Evaluation of learners
a) On-the-fly evaluation of residents
i) Please evaluate residents with whom you precept on more than 4 patients.
ii) Attached are instructions for on-the-fly evaluations in the e-value system.
iii) There are paper on-the-fly evaluations if you are not able to log on to the system.
iv) If you have concerns about a resident (performance, professionalism) please contact Teresa Villela, George Saba, Diana Coffa or Hali Hammer asap.
b) Students' notes
i) You must write a preceptor note and examine every patient seen by a student.
ii) You are expected to review students' notes and give feedback. There are paper feedback forms in the 81 and 85 attending rooms. Alternatively, you can give feedback in real-time if the students are able to complete their notes prior to leaving clinic.
c) Evaluation of students
i) If you work with a student more than twice, you will be asked to evaluate the student.
ii) Margo Vener is FCM Predoctoral Director. Please contact Margo if you have concerns about an individual student.

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~~**A. ATTENDING RESPONSIBILITIES**~~

~~1. Attendings are responsible for being physically present in the Family Health Center during assigned patient care sessions. Morning sessions begin at 8:30 a.m. and conclude after the last patient is seen approximately at noon. Afternoon sessions begin at 1:00 p.m. and conclude after the last patient is seen approximately at 5:00 p.m. Attendings who are not available at conclusion of the clinical session beyond noon or 5:00 p.m. may require support from other attendings. Attendings, the Medical Director or the Outpatient Chief Resident should, when appropriate, arrange coverage in advance. Clinic sessions are held on Wards 81, 85, and 91.~~

~~2. Attendings are responsible for supervising all medical care during assigned clinic sessions. Supervisory responsibilities can be divided into the following basic areas:~~

~~a) Direct consultation with unlicensed providers (PGY 1s, medical students, or other assigned students) for each of their patients. Supervision of medical students and PGY 1s will include the direct observation of the medical students with patients or reviewing directly with patients significant aspects of the history and confirmation of the physical examination. Supervision of these unlicensed providers also includes reviewing and co-signing their medical records. In addition, the attending must complete a progress note which attests to the billable level of service provided by the attending. Nurse practitioner students at the FHC are directly proctored by licensed PGY 3s.~~

~~b) Direct consultation to all PGY 2 and PGY 3 house staff and other postgraduate trainees around the management of their continuity clinic patients. This may focus on aspects of diagnosis or management and other related practice management topics, (i.e., how frequently to re-evaluate and see a patient for a follow-up visit).~~

~~c) Attendings routinely monitor clinic flow (i.e., residents are behind schedule) and when appropriate, provide consultation regarding how to keep an appropriate pace while maintaining expected levels of patient care.~~

~~d) Provide direct consultation to the Orange Team (Acute Care Clinic) triage nurse and resident. This is usually the responsibility of the assigned first floor Attending. However, all attendings are requested to assist when needed. Duties include routine case consultation, evaluation of triage flow, identification of triage bottlenecks which may require facilitation of triage provider focus to or identification of alternative providers to see patients, immediately assessing all acutely ill patients, and facilitating admissions and other transfer to the hospital. All admissions must be presented to an attending physician.~~

~~e) Attendings are responsible for laboratory review. The algorithm for review of labs is:~~

~~1) Unreviewed laboratory results are delivered to the Ward 85 Attending Rooms by clerical staff. Attendings are required to document that results have been reviewed by placing their name and the date of review on the laboratory results. Labs should be divided into the following categories:~~

~~(a) Urgent Results (i.e., positive culture or K+ = 1.8 mg/dL): These laboratory results require immediate attention. Attendings may manage these cases by arranging appropriate clinical follow-up (such as scheduling an appointment), they may order medications and call them to a pharmacy, they may page primary care providers to formulate a follow-up, and/or they may review the medical record to determine if follow-up has been completed. If the provider is not reachable and follow-up is not documented, attending physicians are required to initiate follow-up.~~

~~(b) Abnormal (non-urgent) Results: These are results which should be addressed in the short-term future (i.e., within 2 weeks of result date): These results will be placed in the provider's mailbox. As is appropriate, attendings may schedule follow-up appointments for patient follow-up and/or call the primary care provider to make them aware of the abnormal results.~~

~~(c) Normal Results or Abnormal Results Requiring Follow-Up at the Next Scheduled Visit: All reports of abnormal results will be placed in the appropriate basket so that clerical staff will pick them up and return them to the mailbox of the primary care provider. Reports of normal laboratory results are not routinely placed in the PCP's~~

~~mailbox. All other normal results of diagnostic tests (cytology, radiology, etc.) are given to the PCP for review.~~

~~2) Providers will review all their own laboratory results delivered to their mailboxes and respond appropriately. Providers who are on vacation or leave will post a notice on their mailbox indicating the provider who will be covering their patient care corrrespondence in their absence.~~

~~3) All laboratory results (with the exception of DEXA scan results) are documented in the LCR.~~

~~4) Providers may record laboratory results in the written medical record as clinically appropriate.~~

~~f) Attendings provide consultation to nursing staff for questions arising from nurse visits, medication refill requests, and other nursing functions.~~

~~g) Attendings provide consultation to registered nurses for diabetes care and prenatal care.~~

~~h) Attendings provide consultation to Refugee Clinic staff as needed.~~

~~B. DIRECT PATIENT CARE~~

~~Attendings may need to assess patients directly without the involvement of a resident or nurse practitioner. This may occur if there are simultaneous emergencies in the clinic and an inadequate number of providers are available to handle them. It is expected only under rare circumstances that the attending ssugned to supervisory duties will be a direct provider without the concurrent involvement of a resident or nurse practitioner.~~

~~C. ADMINISTRATIVE CLINICAL RESPONSIBILITIES~~

~~The physicians attending in the Family Health Center on Ward 81 and Ward 85 are responsible for overseeing all patient care emergencies and for carrying out specific administrative functions relating to patient appointments and scheduling, patient flow, etc. Specifically:~~

1. ~~The attending physician responds to all clinic emergencies. Therefore, it is required that the attending physician be on the SFGH campus and available for immediate response to emergencies. There also must be an attending physician available at all times while patients are present in the clinic. The morning attending staff may sign out active patients to the afternoon attending staff verbally at anytime that is mutually convenient. In the unusual event that neither the morning nor afternoon physician can be on the campus over the noon hour, then another attending present at the FHC must provide clinical supervision during their absence.~~

2. ~~The attending physician is required to deal with pressing administrative problems that arise.~~

   a. ~~The most common situation is facilitating a medical visit for a patient who has been scheduled to see a physician at a time when the physician is not in clinic. The attending physician should speak briefly with the patient to ascertain if there is an urgent need to be seen. If not, the patient should be given a choice between being rescheduled to see his/her primary provider or seeing an alternative provider that day. Any patient who was given an appointment and wishes to be seen must be seen that day. This does not require that a comprehensive visit be provided, however. Time limitations, patient need, and reinforcing the primary provider role should be taken into account. Many scheduling errors are made so even if the patient does not have an appointment slip, the likelihood is that the mistake was ours. The priority in seeking alternative providers is as follows:~~

      1) ~~Medical students who have no shows or empty patient slots.~~

      2) ~~Triage of patient to Open Access slots on clinical teams or in Orange Team Urgent Care as is appropriate.~~

      3) ~~Continuity providers with open slots.~~

      4) ~~Continuity providers with no shows.~~

      5) ~~Nurse practitioner students who don't have enough patients. How much is enough should be agreed upon by you, the student, and the resident preceptor.~~

6) Outpatient chief resident if available.

7) You, if it does not seriously interfere with teaching and supervisory responsibilities, i.e., when there are few providers' and/or multiple attendings.

8) If none of the above, be creative. Please note: attendings should prioritize their supervisory and teaching responsibility as more important then seeing patients for direct care except in a clinical emergency.

9) If it appears that a preventable scheduling error has been made please try to document what happened on an unusual occurrence form or any other convenient way and place it in the medical director's box.

b. Another common occurrence is when a resident who is scheduled to be in clinic becomes ill, late, lost, or occupied on labor and delivery. If a provider is unable to attend clinic for any reason, the clerks should contact the attending physician immediately. Patients that arrive in clinic should be treated as outlined above but as many patients as possible should be called and rescheduled prior to their arrival at the FHC. The clerical supervisor's role is to delegate and supervise the rescheduling. Other staff that may be of assistance are the Outpatient. Chief Resident and the FHC scheduling administrator who can facilitate clinic calendar changes and locating an absent resident.

c. If the resident is more than 10-30 minutes late without notifying the attending physician and clinic staff, the attending physician should attempt to locate him/her. Page them first. If you get no response ask the Schedule Coordinator, x6891, or the Outpatient Chief Resident to find out which clinical rotation they are on. Call directly to the wards where they are likely to be found. Next call their home. Home and mobile phone numbers are available from the receptionist, x8611. At the same time, the attending physician must manage the back-up of patients as above. Finally, please leave a phone message for the Medical Director regarding all providers who have missed a scheduled clinic.

d. Residents may occasionally need to leave a regularly scheduled clinic for a prenatal delivery. This should be negotiated with the Outpatient Chief Resident. The Chief Resident's role is to facilitate the use of the back-up resident system to cover the clinic for the resident who has left, decide when the resident shall leave and return to clinic, and to inform the appropriate staff of changes. Manage the patient flow as above until the back-up resident has arrived.

e. The last common problem is to deal with disgruntled patients, providers, or other staff members. Find out what the problem is and do what you can to address the concern or conflict immediately. Intermediate and a long term follow up may be handled by you or referred to the Medical

~~Director. Please do not hesitate to seek the assistance of any core faculty (medical director, nursing supervisor, or another attending physician) for matters of policy or procedure which are unfamiliar to you.~~

~~D. TRIAGE~~

~~Triage can get very busy. If nurses come to you in the middle of a session to ask for help, determine whether the bottleneck is resolvable with the current providers (i.e., simple complaints, addressing how to move this along faster) or whether additional help is needed. Additional patient slots may be available on the clinical teams where there are medical students, residents with no-shows, or Open Access appointments. If no clinic appointment is available, it is reasonable to ask patients who are not acutely ill to schedule appointments at a later date. Always check in triage regularly. This is especially important about 45 minutes before the end of a session, when clearing patients out becomes a priority. Again, seeing patients yourself without a resident is an option but not preferred. It should be the exception, not the rule.~~

~~Dealing with the inexperienced resident can be challenging. Diverting their waiting patients to speed up clinic must be balanced with teaching them time management strategies, nursing needs, and patient satisfaction. When additional help is needed, it is strongly recommend that alternative providers be utilized rather than the attending to ensure that supervision and teaching are maximized. Inexperienced or slow residents, chronically late residents and other problems should be brought to the attention of the Medical Director by memo or phone, or at attending meetings where they can develop a strategy for providing additional teaching about time-management strategies. Problems sometimes go unidentified because many different attendings may see the same behavior once, with each attending assuming it was an isolated event.~~

~~E. ATTENDING~~

~~Most times, there are several attending physicians working at any given time; however, all core faculty are required to be reasonably available to fill in should a regularly scheduled attending not be present or if the clinic is exceptionally busy. Please consider being flexible enough to work as the attending physician in the rare event that the scheduling coordinator calls to request additional attending coverage.~~

~~F. CLOSING THE CLINIC~~

~~Before leaving the clinic, check on any remaining patients and providers in clinic. Medical students should never be left alone in the clinic while they are still with a patient, even if they have already consulted with you. Morning residents who are running late can page the attending physician if they need assistance over the noon hour. If you and the afternoon resident are both comfortable that attending consultation will not be needed, you can leave, but it would be helpful to identify someone available by pager should a problem arise.~~

~~G. COMMUNICATION BETWEEN ATTENDING PHYSIAN STAFF AND ATTENDING SCHEDULE CHANGES~~

~~If you know well ahead of time that you won't be able to be present on your regularly scheduled day, notify the Medical Director or her administrative assistant, the scheduling~~

~~coordinator immediately. Please attempt to find someone to replace you from within the group if it is less than one week's notice of the change. If notification is more than one week prior to the scheduled time, the schedule coordinator will identify an attending physician to cover the clinic. If you find a substitute for yourself anytime before the monthly schedule is out (usually the last week of the preceding month), notify the Medical Director or the scheduling coordinator so that the change will be entered in the schedule.~~

~~Changes after the schedule is out are more complicated. If an attending physician is unable to be present on a scheduled day, please notify the FHC Medical Director or the scheduling coordinator as soon as possible. The scheduling coordinator will notify the clinic personnel of the change. A current copy of the attending schedule is posted at each of the four nursing stations, on Orange Team, and in all three attending rooms. If you cannot identify a replacement, then notify the scheduling coordinator to make a plan for replacement.~~

~~H. COMMUNICATION OF YOUR ATTENDING SCHEDULE NEEDS~~

~~If you wish to change your regularly scheduled attending time, please contact the Medical Director or the scheduling coordinator as soon as possible so that the necessary changes can be made. Usually the attending schedule is drafted 4-6 weeks prior to the monthly schedule, and if you can anticipate your needs in this time frame, it will assist us in finding coverage.~~

~~I. COORDINATOR OF ATTENDING RESPONSIBILITIES~~

~~As noted earlier, the designation of attending physician responsibilities must be divided so that precepting and teaching, laboratory review, time management, and patient complaint responsibilities are all completed during the clinic. The division of these responsibilities should be negotiated and communicated between the attending physician staff scheduled so that at any given moment all attending functions are covered without interruption.~~

San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

APPENDIX F~~E~~ - ATTENDING PHYSICIAN RESPONSIBILITIES ON THE FAMILY ~~PRACTICE~~ MEDICINE INPATIENT SERVICE

The Family ~~Practice~~ Medicine Inpatient Service Attendings are responsible for all patient care activities on the service. They ~~do so~~ provide ~~through~~ direct patient care as well as supervision and teaching of the Family ~~Practice~~ Medicine Inpatient Service house staff.

Family Medicine Inpatient Service
Attending Physician Expectations
Revised 2/2014

Patient Care

All attending physicians are expected to:

- Provide high quality patient care based on evidence-based principles and guided by the patient and family's values and preferences.
- Involve specialist services when appropriate, including mandatory consultations by the team with the Neurology service for patients with stroke, the Hematology service for patients with acute sickle cell crisis and the Obstetrics service for pregnant patients. Attending physicians are responsible for direct consultation with the Cardiothoracic Surgery service.
- Assess all patients on their team six days a week (and assist with weekend coverage of the opposite team's patients to ensure seven day attending assessments for all patients).
- Recognize that ultimate responsibility for care of all patients on the service belongs to the attending physician.

Teaching

All attending physicians are expected to:

- Provide case-based teaching in admission rounds.
- Provide informal teaching in work rounds in a manner that supports the growth and independence of their senior residents while also being mindful of time constraints.
- Perform, on average, one attending rounds per week. The attending will work with the inpatient chief resident to select a topic based on patients recently admitted to the service and guided by the core topic curriculum.
- When appropriate, participate in the creation and implementation of an educational remediation plan for learners in difficulty.
- Recognize that compliance with the ACGME duty hours guidelines is an essential priority and play an active role along with the senior residents to facilitate compliance.
- Supervise and mentor the chief residents in their role as the residents' first-line consultants and during their weeks attending on the service.

Evaluation

All attending physicians are expected to:

- Meet with all team members to provide performance feedback and to solicit feedback on their own performance.
- Complete formal evaluations in a timely fashion.
- Notify the inpatient service directors if a resident or student is performing below the expected competency level and is in need of an educational plan.

Documentation

All attending physicians are expected to:

- Complete admission History and Physical attestation notes on the day of service. These notes must be completed and in the medical record by no later than the morning following admission. The Family Medicine Inpatient Service analyst or your team will file these notes during the week. On the weekends, the attending physician is responsible for filing admission notes in the medical record.
- Generate a daily progress note on all patients seven days per week
  - You can attest resident notes by writing on and signing the physical note. Medical students' patients need progress notes written separately; the FMIS analyst will create templates for these notes.
- Document any and all procedures they have supervised by writing a "Procedure Note" using the templates provided.

Professionalism

All attending physicians are expected to:

- Model compassionate, ethical and culturally sensitive care of patients and their families.
- Model respectful and collegial behavior towards all members of the SFGH staff.

Practice Improvement

All attending physicians are expected to:

- Report and review cases with the inpatient service directors when there is a concern that the care provided to a patient requires additional review (e.g. a Morbidity and Mortality case review).

~~**Proctoring/Reappraisal Criteria**~~

~~The following components of patient care are reviewed:~~

~~a. Clinical Care~~

~~1) History: Has an accurate history of the chief complaint and other essential information been taken? Has this information been adequately transmitted to the House Staff?~~

~~2) Physical examination: Are pertinent positive findings on examination identified?~~

~~3) Diagnostic assessment: Are abnormal laboratory results identified and acted upon? Are the tests ordered appropriate but not excessive?~~

~~4) Overall assessment: Is the assessment sufficiently accurate to guide further diagnostic and therapeutic strategies? Has the assessment been discussed with House Staff?~~

~~5) Plan: Does the plan include essential diagnostic procedures and appropriate therapeutic options?~~

~~Has there been discussion of plans of action with House Staff and attending?~~

~~6) Use of consultants: Is use of consultants appropriate?~~

~~7) Adequacy of discharge planning: does discharge plan make the best use of available resources?~~

~~8) Relationship with patient: Does the professional relationship with the patient foster confidence and lead to collaboration between the doctor and patient in care plans.~~

~~b. Supervision and Teaching of House Staff~~

~~1) Communication with House Staff: Are the guidance and teaching of House Staff accurate, helpful, timely and provide practical guidance?~~

~~2) Leadership: Do patient care and teaching provide a role model for House Staff?~~

~~c. Procedures~~

~~Procedures performed: Was the procedure appropriate, informed consent properly obtained?, and the procedure performed correctly? A full discussion of the procedure (date, results, complications, etc.) will be included in the comments sections of the Proctoring Reappraisal form.~~

~~d. Review of Provider Specific Information from PIPS/QI Activities~~

~~Any information showing provider specific performance will be reviewed.~~

~~APPENDIX F – LIST OF APPROVED PROCEDURES AND INFORMED CONSENT~~

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~~Informed consent should be obtained in the method required by Medical Staff Bylaws, Rules and Regulations and SFGH Hospital policy, for procedures requiring informed consent.~~

~~It is the policy of SFGH's Family Health Center that the following procedures may be performed at the FHC. Any procedure not listed below may be done with the approval of the FHC Clinic Medical Director and/or the Chief of Staff in consultation with the Nursing Supervisor:~~

~~The following procedures performed on the Family Health Center Service do not require informed consent:~~

- ~~Anoscopy~~
- ~~Arterial Puncture~~
- ~~Arthocentesis~~
- ~~Casting and splinting~~
- ~~Cauterization~~
- ~~Colposcopy~~
- ~~Condylomata treatment~~
- ~~Foreign Body Extraction; eyes, ears, noses, subcutaneous~~
- ~~Incision & Drainage of Abscess~~
- ~~Indirect Laryngoscopy~~
- ~~Injection of Tendon Sheath or Ligament Trigger Points~~
- ~~Insertion of peripheral venous catheter~~
- ~~Intravenous therapy~~
- ~~Liquid nitrogen therapy~~
- ~~Nail Avulsion~~
- ~~Nasal packing~~
- ~~Phlebotomy~~
- ~~Spirometry~~
- ~~Urethral Catheterization~~
- ~~Venipuncture~~
- ~~Wound Debridement~~

~~The following procedures performed at the Family Health Center require written informed consent:~~

- ~~Biopsy: Subcutaneous – Excisional and Incisional~~
- ~~Biopsy: Skin – Excisional and Incisional~~
- ~~Biopsy: Exo- or Endocervical~~
- ~~Biopsy: Endometrial~~
- ~~Cervical Polypectomy~~
- ~~Circumcision~~
- ~~Insertion of central venous catheter~~
- ~~IUD Insertion and Removal~~
- ~~Joint injection~~
- ~~Laceration Repair with or without anesthesia~~
- ~~Lumbar puncture~~
- ~~Paracentesis~~
- ~~Thoracentesis~~

~~Vasectomy~~

~~The following procedures performed on the Family Health Center Service require verbal informed consent:~~

~~HIV Antibody Testing~~

~~The following procedures performed on the Family Medicine Inpatient Service do not require informed consent:~~

- **~~Arterial blood gas determinations~~**
- **~~Arthrocentesis~~**
- **~~Incision and drainage of abscess~~**
- **~~Insertion of peripheral intravenous lines~~**
- **~~Lumbar puncture~~**
- **~~Anoscopy~~**
- **~~Venipuncture~~**

~~The following procedures performed on the Family Medicine Inpatient Service require informed consent:~~

- **~~HIV Antibody Testing (verbal consent)~~**
- **~~Laceration repair with or without local anesthesia~~**
- **~~Paracentesis~~**
- **~~Punch biopsies of skin~~**
- **~~Sigmoidoscopy~~**
- **~~Thoracentesis~~**
- **~~Insertion of central venous catheter~~**

~~Consent for operative or other invasive procedures performed on Family Medicine Inpatient Service patients by other specialists in other services is obtained by the operator (surgeon) or individual performing the invasive procedure (e.g., cardiologist obtains consent for cardiac catheterization).~~

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~~**APPENDIX G – FHC CLINICAL RESEARCH POLICY**~~

APPENDIX G – OPPE FORM AND THRESHOLDS

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San Francisco General Hospital and Trauma Center - Ongoing Professional Practice Evaluation (OPPE)

6 Month Date Range: Jan - June / 2013 ☐ No patient care and/or clinical teaching for this time period

(If checked, metrics need not be completed, but Y/N questions at bottom AND signature date are required)

Last, First, degree:_____ Status: _____ CHN # _____

Service: FAMILY & COMMUNITY MEDICINE

Home Dept / Div / Clinic if other than above: _____ Comments if Any: _____

OUTPATIENT SERVICES: Metrics for Medical Staff & Affiliated Staff	Acceptable	Marginal*	Unacceptable*	Metric Not Relevant During This Period	Comments
PRIMARY CARE PROVIDERS					
Active weighted patient panel as a % of target patient panel	☐ >80%	☐ 66%-79%	☐ <66%	☐	_____
Patients age 51-75 with up to date colorectal cancer screen	☐ >40%	☐ 25-39%	☐ <25%	☐	_____
Patients age 52-69 with mammogram screening every other year	☐ >60%	☐ 50-59%	☐ <50%	☐	_____
Patients with DM with LDL < 100	☐ >50%	☐ 35-49%	☐ <35%	☐	_____
Patients age 13 with up to date Tdap immunization	☐ >70%	☐ 60-69%	☐ <60%	☐	_____
NON PRIMARY CARE PROVIDERS					
If no primary care panel, clinical hours per month	☐ 4hrs	☐ 2-4hrs	☐ <2hrs	☐	_____
ALL PROVIDERS					
Patients seen who have medication allergies verified by provider *(with eCW implementation)*	☐ >80%	☐ 70-79%	☐ <70%	☐	_____
Cases of concern	☐ <2	☐ 2	☐ >2	☐	_____

*IN ANY ONE CATEGORY:

Two consecutive marginal ratings require Chief of Service's commentary

Three consecutive marginal ratings require FPPE and notification to the Credentials Committee Chair

Two consecutive unacceptable ratings require FPPE and notification to the Credentials Committee Chair

Updated : 2/26/2014

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~~San Francisco General Hospital offers an ideal setting for clinical research. Opportunities for research may be offered in both the FHC and on the Family Medicine Inpatient Service (FMIS). All research protocols must be previously approved by the Institutional Review Board of the sponsoring institution.~~

~~In the outpatient setting of the FHC, patients may be recruited as candidates in research studies. Any research investigation must be presented to the Medical Director and the Management Team of the FHC prior to initiation. All materials associated with the research including recruitment materials, surveys, patient information, and consent forms must be approved by the Institutional Review Board of the sponsoring institution which may or may not be the University of California or San Francisco General Hospital. In addition, contact with and consent of the primary care physician is strongly encouraged and may be required. We particularly encourage research targeted at the socially and culturally diverse populations seen at the Family Health Center. See attachment – for a list of criteria that must be met for research studies involving FHC patients or staff to be approved.~~

~~In the inpatient setting of the Family Medicine Inpatient Service, there are also opportunities for patients to enter into research studies. However, the Family Medicine Inpatient Service admits patient from multiple primary care sites. Therefore, consideration must be given to the primary care relationship. Most patients on the Family Medicine Inpatient Service (FMIS) are patients in an outpatient continuity relationship with a primary care physician or nurse practitioner in the community. The providers for these patients admit their patients to FMIS with the understanding that FMIS will provide the most appropriate care for their patients. After more than a decade of cooperation, a mutual trust has developed between the Family Medicine Inpatient Service and these community providers. Offering their patient enrollment in a research protocol is desirable, but has the potential for upsetting this delicate balance. Therefore, the Family Medicine Inpatient Service has developed the following guidelines:~~

~~1. If a patient is an appropriate candidate for a research protocol, investigators will discuss the potential for the research with the Family Medicine Inpatient Service team (house staff and attending physician).~~

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~~2. The primary care provider will be informed on the potential for the research by either the Family Medicine Inpatient Service team or the investigator or both. Discussion of the importance of the research as well as the potential impact on the patient and the primary care provider patient relationship will be discussed.~~

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~~3. If there is agreement to offer the research protocol, the researcher will obtain informed consent from the patient. That discussion will include statements about the primary care provider's opinion of the appropriateness of the research protocol. The primary care provider will be invited to participate directly in the informed consent process.~~

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~~4. If the primary care provider does not agree that the research should be offered, the investigator will not proceed with offering the research opportunity. Further discussion between the investigator and the FMIS Attending Physician can be used to discuss problems and future coordination of research program with FMIS care.~~

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~~5. If the patient has no previous primary care providers, the Family Practice Inpatient Service Attending (for designees) will be considered the primary provider.~~

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~~APPENDIX H – CHIEF OF FAMILY AND COMMUNITY MEDICINE CLINICAL SERVICE JOB DESCRIPTION~~

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~~Chief of Family and Community Medicine Clinical Service Job Description~~

~~Position Summary:~~

~~The Chief of the Family and Community Medicine Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of San Francisco General Hospital (SFGH) and the Department of Public Health (DPH). The Chief also insures that the Service's functions are integrated with those of other clinical departments and with the Hospital as a whole.~~

~~Reporting Relationships:~~

~~The Chief of the Family and Community Medicine Clinical Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the SFGH Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.~~

~~Position Qualifications:~~

~~The Chief of the Family and Community Medicine Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at SFGH.~~

~~Major Responsibilities:~~

~~The major responsibilities of the Chief of the Family and Community Medicine Clinical Service include the following:~~

~~Providing the necessary vision and leadership to effectively motivate and direct the Service in developing and achieving goals and objectives that are congruous with the values, mission, and strategic plan of SFGH and the DPH;~~

~~In collaboration with the Executive Administrator and other SFGH leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement, reviewing and approving Service policies and procedures, identifying new clinical services that need to be implemented, and supporting clinical services provided by the Department;~~

~~In collaboration with the Executive Administrator and other SFGH leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and~~

~~supervising the selection, orientation, in-service education, and continuing education of all Service staff;~~

~~Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and~~

~~Performing all other duties and functions spelled out in the SFGH Medical Staff Bylaws.~~

~~APPENDIX I – OTHER JOB DESCRIPTIONS~~

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~~MEDICAL DIRECTOR~~

~~*Family Health Center*~~

~~*Department of Family and Community Medicine*~~

~~*Community Health Network of San Francisco*~~

~~The Family Health Center (FHC) was established in 1972. It is the largest primary care site of the Community Health Network (CHN), with approximately 40,000 patient visits per year. It is the principal training site for the UCSF/SFGH Family and Community Medicine Residency Program. Services offered include cross-cultural, family-centered primary care; perinatal, well-child, and adolescent care; family counseling; home care; family planning; nutrition counseling; and health education. Urgent care and minor procedures services are also provided. The Refugee Health Center is an integral part of the FHC and the Residency Program. It provides screenings for newly arrived immigrants. Patients include refugees from Asia, Africa, Eastern Europe, and the former Soviet Union. The clinic provides full interpreter services for immigrants served by the clinic.~~

~~The Family Health Center Medical Director ("Medical Director") is a full-time position within the Family and Community Medicine Service of San Francisco General Hospital. The Medical Director holds a salaried faculty appointment within the Department of Family and Community Medicine (FCM) at the University of California, San Francisco, and is an employee of the University.~~

~~The Medical Director is responsible for FHC patient care services and for FHC educational functions. The Medical Director reports directly to the Chief of the SFGH Family and Community Medicine Service, who has overall responsibility for the patient care and educational functions of the Family Health Center. The Medical Director maintains a working collaboration with both the administration of SFGH and the SFDPH Community Primary Care service to ensure that all hospital and Department of Public Health patient care policies and procedures are effectively implemented and monitored. The Medical Director also collaborates closely with the Director of the UCSF/SFGH Family and Community Residency Program and the FCM Coordinator of Pre-Doctoral Programs to insure that FHC educational functions are effectively implemented and monitored.~~

~~The responsibilities of the Medical Director fall within four categories: administration of FHC patient care services; coordination of FHC educational functions; teaching and scholarly activities; and direct patient care. Specific responsibilities in each of these four categories are outlined below.~~

~~A. Administration of FHC and UCC Patient Care Services (.40 FTE)~~

1. ~~Develops and evaluates all FHC clinical services goals, objectives, policies, procedures, standards, and clinical practice guidelines.~~
2. ~~Designs, implements, monitors, and appropriately modifies all FHC and UCC patient care systems.~~

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3. ~~Meets regularly with SFGH administration and SFDPH community primary care administration to ensure that patient care services are consistent with SFDPH patient care objectives and that resources essential to meetings those objectives are made available to the FHC and UCC.~~
4. ~~Chairs the FHC Management Team and collaborates with the team to manage patient marketing and recruitment, patient utilization of services, patient appointment systems, patient flow systems, patient satisfaction, medical records, and patient care information systems.~~
5. ~~Collaborates with the FHC Management Team to manage all FHC patient care clinical units and programmatic components including:~~

   - ~~Continuity practices on Red, Blue, Green, and Gold teams~~
   - ~~Acute Care and Urgent Care services~~
   - ~~Refugee Medical Clinic and Newcomers Health Program~~
   - ~~Home Care service~~
   - ~~Prenatal service~~
   - ~~Diabetes Education Program~~
   - ~~Counseling services~~
   - ~~Nutrition services~~
   - ~~Patient education and support group services~~
   - ~~CHDP Program~~
   - ~~Family Planning Program~~
   - ~~Procedure Clinic~~

   ~~FHC Women and Infants Clinic~~
   ~~Bay Area Family HIV Clinic~~
   ~~Oral Health Screening Clinic~~
   ~~Pharmacy Consultation and Refill Clinic~~
   ~~FHC Pain Management Clinic~~
6. ~~Collaborates with the FHC Management Team to develop and revise position descriptions for all nursing and clerical personnel and to supervise/evaluate the work of all nursing and clerical personnel.~~
7. ~~Collaborates with the FHC Management Team to design and implement a comprehensive Performance Improvement and Patient Safety system, including formal evaluation of structure, process, and outcomes of patient care in the FHC. The Medical Director must approve any research studies that relate to the FHC.~~
8. ~~Collaborates with the FHC Management Team to oversee implementation of the MediCal Managed Care Program.~~
9. ~~Supervises the proctoring of all physicians practicing in the FHC.~~
10. ~~Designs standardized procedures for nurse practitioners and completes annual performance evaluations for nurse practitioners.~~
11. ~~Supervises all after-hours patient care systems, including after-hours call systems.~~
12. ~~Acts as FHC liaison to FHC Emergency Department, Consultation Services, Laguna Honda Hospital, Health at Home, Family Medicine Inpatient Service, and other DPH clinical and support services.~~
13. ~~Oversees patient scheduling for all providers, including physicians, nurse practitioners, residents, medical students, nurse practitioner students, and clinical pharmacy students.~~

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14. ~~Regularly participates in DPH Primary Care Medical Directors meetings, Ambulatory Care Committee, Primary Care Quality Improvement Committee, and San Francisco Health Plan Peer Review Committee.~~

~~B. Coordination of FHC Educational Functions (.10 FTE)~~

1. ~~Collaborates in the development and evaluation of all instructional programs and formats related to the education of residents, medical students, nurse practitioner students, and all other trainees, including attending and precepting formats, direct observation formats, and patient management seminars.~~
2. ~~Approves the placement and scheduling of all trainees within the FHC.~~
3. ~~Plans and oversees orientation of trainees to the FHC.~~
4. ~~Selects, approves, schedules, and evaluates all teaching attendings/preceptors within the Family Health Center.~~
5. ~~Evaluates trainee performance in the FHC.~~
6. ~~Participates in all curriculum development efforts involving the FHC.~~

~~C. Teaching and Scholarly Activities (.30 FTE)~~

1. ~~Maintains ongoing responsibilities for teaching residents and students within the educational programs of the UCSF Department of Family and Community Medicine and the University, including:~~

   ~~• FHC precepting and direct observation/feedback sessions~~
   ~~• Facilitation of patient management seminars~~
   ~~• Didactic presentations, Grand Rounds, and M&M presentations~~
   ~~• Small group teaching for UCSF medical students~~
2. ~~Has responsibility for curriculum development within a defined "area of expertise."~~
3. ~~Engages in formal scholarly activities within an "area of expertise" and/or in collaboration with University faculty colleagues. Scholarly activities include formal development and evaluation of curricula, research, and publication of manuscripts in peer-reviewed journals.~~

~~D. Direct Patient Care (.20 FTE)~~

1. ~~Maintains a primary care practice in the FHC.~~
2. ~~Practices obstetrics as a member of the Prenatal Partnership Program.~~
3. ~~Participates in managing the care of patients admitted to the Family Medicine Inpatient Service.~~
4. ~~Participates in providing preventive and illness care to residents of the SFGH Skilled Nursing Facility and Mental Health Rehabilitation Facility.~~
5. ~~Participates in night and weekend call responsibilities for all FCM clinical services.~~

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San Francisco General Hospital and Trauma Center - Ongoing Professional Practice Evaluation (OPPE)

6 Month Date Range: Jan - June / 2013 ☐ No patient care and/or clinical teaching for this time period

(If checked, metrics need not be completed, but Y/N questions at bottom AND signature date are required)

Last, First, degree:_____ Status: _____ CHN # _____

Service: FAMILY & COMMUNITY MEDICINE

Home Dept / Div / Clinic if other than above: _____ Comments if Any: _____

INPATIENT SERVICES: Metrics for Medical Staff Only

Deaths attributable to practitioner	☐ Any 1A's or <2 1B's	☐ 2 1B's	☐ >2 1B's or any 1C's, 1D's	☐	_____
Length of stay	☐ <10 days	☐ 10-18 days	☐ >18 days	☐	_____
Readmissions within 30 days	☐ <20%	☐ 20-25%	☐ >25%	☐	_____
Procedure complications attributable to practitioner	☐ 0 or 1	☐ 1 - 2	☐ 3 or more	☐	_____
Cases of concern	☐ <2	☐ 2	☐ >2	☐	_____

*IN ANY ONE CATEGORY:

Two consecutive marginal ratings require Chief of Service's commentary

Three consecutive marginal ratings require FPPE and notification to the Credentials Committee Chair

Two consecutive unacceptable ratings require FPPE and notification to the Credentials Committee Chair

REQUIRED FOR EVERY PRACTIONER ON ROSTER:

☐ Yes ☐ No Recommend continued current privileges

☐ Yes ☐ No Recommend a Focused Professional Practice Evaluation (FPPE). If YES, attach a detailed FPPE plan

☐ Yes ☐ No Recommend changes to current privileges:

_____

☐ Yes ☐ No To my knowledge, this practitioner does not have a medical/mental health condition that could affect clinical care or judgment. (If such a condition exists, please reference the plan for monitoring this condition)

Chief of Service (or designee) _____ Date: _____

(Electronic signature acceptable)

Practitioner Signature* : _____ Date: _____

(Electronic signature acceptable) * Required only if "marginal" or "unacceptable" notes above

Updated : 2/26/2014

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~~MEDICAL DIRECTOR~~
~~SKILLED NURSING FACILITY~~
~~SAN FRANCISCO GENERAL HOSPITAL~~
~~COMMUNITY HEALTH NETWORK OF SAN FRANCISCO~~

~~STATEMENT OF POLICY~~

~~The Medical Director of the Skilled Nursing Facility (SNF) at San Francisco General Hospital (SFGH) is a full-time position within the Family and Community Medicine Service of the Community Health Network of San Francisco (CHN). The SNF Medical Director holds a salaried faculty appointment within the Department of Family and Community Medicine at the University of California, San Francisco, and is an employee of the University. The SNF Medical Director is also an active member of the CHN/SFGH Medical Staff.~~

~~The SNF Medical Director reports directly, and is fully responsible and accountable, to the Chief of the CHN Family and Community Medicine Service. The SNF Medical Director also maintains an ongoing working relationship with the Director of Nursing for the SNF Unit, the Medical Director for Primary Care, the Director of Rehabilitation Services, and the Medical Director for Health at Home.~~

~~The SNF Medical Director has overall responsibility for the medical care of patients/residents admitted to the SNF. The SNF Medical Director is responsible for the policies, procedures, standards, coordination, surveillance, and quality improvement of the medical care in the SNF. The SNF Medical Director must approve all admissions to and discharges/transfers from the SNF.~~

~~ROLES, RESPONSIBILITIES and DUTIES~~

~~A. **Skilled Nursing Facility**~~

~~1. **Provision of SNF Medical Care Service**~~

~~The SNF Medical Director is responsible for the medical care of residents admitted to the SNF, and consistent with that responsibility, the SNF Medical Director or designee:~~

~~a. Approves all admissions to and discharges/transfers from the facility.~~

~~b. Is responsible for all medical care of SNF residents, and, as such:~~

~~1. Performs or supervises all resident evaluations including a written history and physical examination within 72 hours of admission.~~

~~2. Provides resident diagnosis, treatment plan and determination of level care.~~
~~3. Signs all orders for diagnostic procedures and treatment, including medications, diet, activities, and rehabilitation therapies.~~
~~4. Completes progress notes at each visit with a signature and date.~~
~~5. Reviews each resident's total plan of care, including medications and treatments, at each visit and informs the resident of any changes in his/her health at least every 30 days.~~
~~6. Discharges residents, providing plans for the continuance of care at home or elsewhere.~~

~~Supervises the medical care of SNF residents provided by any physicians or nurse practitioners assigned to the SNF.~~

~~c. Arranges for 24-hour physician coverage at all times.~~

~~d. Develops procedures for emergency treatment of residents.~~

~~e. Oversees the orientation of new physicians and nurse practitioners to the distinctive policies and procedures of the SNF.~~

~~f. Reviews the monthly pharmaceutical services report per State regulations.~~

~~g. Remains knowledgeable of public health policies and programs that may influence resident care services.~~

~~**2. Coordination of Care within the SNF**~~

~~The SNF Medical Director is responsible for coordinating medical care with all resident care services in the SNF, including:~~

~~a. Coordinating medical care with SNF team members, including SNF Director of Nursing, Nursing Staff, Staff Educator/CNS, Social Workers, Physical Therapists, Occupational Therapists, Clinical Pharmacists, Substance Abuse Consultation Services, Director of Activities Program, Nutrition Services Coordinator, Pain Management Nurse Clinician, Psychiatry Liaison, and others as appropriate.~~

~~b. Meeting weekly with team members in the SNF Interdisciplinary Care Planning Conference to develop an interdisciplinary care plan for each resident.~~

~~c. Collaborating closely and meeting weekly with the SNF Director of Nursing to coordinate medical care consistent with the overall care plan for SNF residents.~~

~~d. Meeting regularly with the SFGH/CHN Director of Rehabilitation Services to coordinate medical care and physical medicine services in the SNF.~~

~~e. Participating in SNF in-service training programs.~~

~~f. Working with the Director of Nursing to insure compliance of SNF employees with health status surveillance guidelines.~~

~~g. Reviewing written reports of surveys and inspections and presents recommendations to the SFGH Executive Administrator.~~

~~**3. Program Planning and Policy Development**~~

~~The SNF Medical Director collaborates fully in the development, review, approval and revision of plans, policies, and procedures pertaining to the SNF:~~

~~a. Collaborates and meets periodically with the SNF Director of Nursing, the SNF Staff Educator/CNS, and other designated personnel to develop, review, approve, and revise all plans, policies, and procedures pertaining to the SNF.~~

~~b. Collaborates in monitoring and revising all criteria for SNF admissions, including procedures for pre-admission screening by case managers.~~

~~c. Participates on all committees pertaining to operation and management of the SNF and MHRF, including the Joint Resident Care Policy Committee (JRCPC), the SNF Resident Policy Committee, the SFGH Quality / Utilization Managers, and any ad hoc committees related to the admission, care, and discharge of SNF residents.~~

~~**4. Coordination and Liaison Responsibilities within SFGH and CHN**~~

~~The SNF Medical Director will regularly coordinate with SFGH Acute Care Services, SFGH Emergency Department, SFGH Psychiatry Service, CHN Primary Care Services, the Laguna Honda Hospital, and Health at Home to insure that the admission of residents to the SNF, the medical care of SNF residents, and the discharge/transfer of SNF residents is optimal at all times, including:~~

~~a. Developing and monitoring formal linkages with/and minimal criteria for admission of residents to SNF from the SFGH Family Practice Inpatient Service, SFGH Medicine and Neurology Services, SFGH Trauma Service, SFGH Orthopedics Service, SFGH Plastics Services, and other appropriate services.~~

~~b. Developing and monitoring formal linkage with/and minimal criteria for transfer of SNF residents to the SFGH Emergency Department.~~

~~c. Collaborating in the development of interdepartmental care policies for patients admitted to the SNF who have special problems, including:~~

- ~~residents with substance abuse~~
- ~~residents exhibiting potentially violent behavior~~
- ~~residents on hemodialysis~~
- ~~residents with special neurological care problems~~
- ~~residents with special infection control needs~~

~~**5. Quality Assessment and Improvement**~~

~~The SNF Medical Director plays a central role in ongoing objective assessment of all aspects of care to SNF residents and participates fully in planning, monitoring, reporting, and correcting of problems identified, including:~~

~~a. Attending the Quarterly SNF Quality Assessment and Improvement meetings.~~

~~b. Collaborating with the SNF Director of Nursing, and the SNF Staff Educator/Clinical Nurse Specialist to develop, maintain and evaluate the SNF Quality Assessment and Improvement Program.~~

~~c. Reporting all Quality Assessment and Improvement activities to the SFGH Performance Improvement and Patient Safety Committee (PIPS) per the reporting schedule.~~

~~d. Collaborating in developing clinical practice policies and standards for SNF care consistent with State and Federal regulations.~~

~~e. Collaborating to develop/implement remedial action plans for all areas of care that do not meet clinical practice policies and standards.~~

~~f. In addition to formal quality assurance and improvement plans, regularly reviewing all unexpected deaths, all unexpected morbid events, and all transfers to the SFGH Emergency Department, providing regular written reports pertaining to these occurrences, and reporting these findings in writing to the SFGH PIPS Committee.~~

~~**6. Educational Program Development and Clinical Teaching**~~

~~The SNF Medical Director will have significant responsibilities for educational program development and clinical teaching within the Department of Family and Community Medicine.~~

~~**a. SNF Educational Programs for Family Practice Residents**~~

~~The SNF Medical Director will have overall responsibility for developing a SNF Curriculum for the CHN/UCSF Family Practice Residency Program. This curriculum will build skills in the care of SNF residents with a focus on five areas: interdisciplinary team care, physical and rehabilitation medicine, wound care, pain management, and discharge planning.~~

~~**c. Clinical Teaching in the Family Health Center**~~

~~The SNF Medical Director will regularly participate in teaching residents and students in the SFGH Family Health Center.~~

~~**d. In-service Education**~~

~~The SNF Medical Director participates regularly in SNF In-service Education programs and activities.~~

San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

APPENDIX H – FHC CLINICAL RESEARCH POLICY

San Francisco General Hospital
Family Health Center
Date Adopted: 5/02
Reviewed: 2/08; 5/10
Revised: 12/12

TITLE:*Criteria for Approval of Research Studies at the Family Health Center*

STATEMENT OF POLICY**: It is the policy of the Family Health Center to require researchers conducting studies which involve FHC patients to meet hospital and clinic guidelines**

POLICY: For research to be conducted at the FHC the following requirements must be met:

1. Minimal additional administrative work for FHC staff or providers.
2. No obvious duplication of patient contacts by concurrent research studies.
3. Letters to patients are not signed by FHC staff or providers, unless special permission is given. There is no implication of FHC provider involvement, unless permission is given.
4. Providers are given patient lists for review prior to patient contact.
5. Study is relevant to our patients, and appropriate patient incentives are included.
6. Research group will present outcome of study for FCMRP/FHC during noon conference, Provider Meeting, or All Team Meeting.
7. Study must be approved by UCSF IRB and approved by SFGH.
8. The FHC requests that all studies involving FHC patients make a voluntary donation to the clinic. The suggested donation range is $50-$500, depending on the total study budget. If this presents a hardship, this requirement can be negotiated. These funds are used to support FHC staff development and team-building activities.

Researchers will follow these steps, as appropriate:

1. Initial contact by research study group to Medical Director.
2. Letter sent to research group which outlines FHC criteria for approval of research studies.
3. If study group believes they do or can meet all criteria, protocol is sent to FHC Medical Director.
4. Protocol is reviewed by Management Team with consultation by Chief of Service, if needed.
5. Research study group gives lists of potential patient contacts to primary care providers for review.
6. Final list of contacts is given to Medical Director.
7. Study proceeds.
8. Study group gives presentation to FCMRP/FHC of outcome of study.
9. Conference will be scheduled by the research group in coordination with the Family Medicine Chief Residents and/or Medical Director.

Approved by: _____ Date: _____
Hali Hammer
Medical Director, Family Health Center

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