MEDICINE SERVICE
RULES AND REGULATIONS

2016-2018

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MEDICINE SERVICE RULES AND REGULATIONS

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I. ORGANIZATION OF THE DEPARTMENT

MISSION AND VISION

The Mission of the Medicine Service of San Francisco General Hospital is: To advance health by developing and supporting innovations in patient-centered care, scientific discovery, medical education and public policy with an emphasis on problems prevalent in vulnerable populations

VISION

Patient care: Provide the highest quality clinical service that is the first choice for patient and referring physicians in the safety net.
Research: Be the leading engine of scientific discovery to advance health for vulnerable populations and attract the world's best investigators.
Education: Be recognized as innovators in education, attracting and developing the next generation of leaders in medicine for vulnerable populations.
Public Policy: Be the most trusted and influential leaders in shaping public policy to advance health for vulnerable populations.

CORE VALUES

- **Creativity, fairness, respect for diversity and innovation**
- **Supportive and effective work life**
- **Teamwork and multidisciplinary approach**
- **Honest, open and truthful communication**
- **Transparency, accountability, fiscal discipline and timeliness**
- **Aligning incentives with best interest of our workforce**
- **Lifelong learning, mentoring and advocacy**
- **High ethical standards**
- **Caring, compassion and, commitment to social justice and responsibility**

A. SCOPE OF SERVICE

The Department of Medicine (DOM) provides physician and nursing services to adult medical patients along a continuum of care that ranges from prevention and health maintenance to acute inpatient and critical care to chronic care services. Medical services are organized among the following Department of Medicine Divisions and include evaluation and treatment of the following:

Cardiology

The Cardiology Division provides assessment, evaluation, consultation, and treatment of adult patients with cardiovascular disease through its three subdivisions: the adult cardiac laboratories (including invasive and noninvasive), the coronary care unit, and the outpatient adult cardiac clinic.

Clinical Pharmacology

The Clinical Pharmacology Division provides assessment, evaluation, consultation, and treatment of patients with toxicological conditions.

Endocrinology

The Endocrinology Division provides assessment, evaluation, consultation, and treatment of adult patients with conditions of the endocrine or metabolic systems.

Experimental Medicine

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The Division of Experimental Medicine conducts clinical and basic science research focusing on the pathogenic mechanisms of chronic infectious diseases, including the human immunodeficiency virus type 1 (HIV). The activities of the research group include recruitment of human subjects, implementation of research protocols, collection of data and biological specimens, processing and analyzing data and specimens, and presentation of findings.

Gastroenterology
The Gastroenterology Division provides assessment, evaluation, consultation, and treatment of adult patients with illnesses, injuries and disorders of the gastrointestinal tract, including performing diagnostic and therapeutic procedures.

General Internal Medicine
The Division of General Internal Medicine provides assessment, evaluation, and continuing treatment of adults. The ambulatory medical services are organized into medical screening, urgent, and primary care. Services are directed toward health maintenance, early diagnosis and treatment of illness, as well as managing complicated adult patients with multi-system diseases.

Hematology/Oncology
Hematology provides assessment, evaluation, consultation, and treatment of adult patients with diseases of the blood and blood-forming tissues. Oncology services employ a multidisciplinary care model and provide service in the outpatient clinic and hospital wards for patients with malignancies.

HIV JD and Global Medicine
The Division of HIV JD and Global Medicine provides assessment, evaluation, consultation and continuing treatment of adult HIV infected individuals through a multidisciplinary model of care involving medical, nursing, and psychosocial support services. The Infectious Disease specialists provide assessment, evaluation, consultation, treatment and isolation expertise in the care of adult patients with infectious conditions.

Hospital Medicine
The Division of Hospital Medicine consists of medical practitioners with a special interest in inpatient medicine. Acute Care for the Elderly (ACE), Palliative and Supportive Care, and the Faculty Inpatient Service are patient care services within this division.

Nephrology
The Nephrology Division provides assessment, evaluation, consultation, and treatment of adult patients with renal diseases.

Occupational Medicine
The Occupational Medicine Division provides assessment, evaluation, consultation, and treatment of adult patients with work-related injuries, illnesses, conditions, and diseases.

Pulmonary and Critical Care Medicine
The Pulmonary and Critical Care Division provides assessment, evaluation, consultation, and treatment of patients with conditions and diseases related to the respiratory system and provides intensive care for severely ill adult patients.

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The Infectious Diseases Division provides assessment, evaluation, consultation, treatment and isolation expertise in the care of adult patients with infectious conditions
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The HIV/AIDS Division provides assessment, evaluation, consultation and continuing treatment of adult HIV infected individuals. A multidisciplinary model of care involving medical, nursing, and psychosocial support services is provided for people with HIV.

Rheumatology

The Rheumatology Division provides assessment, evaluation, consultation, and treatment of adult patients with rheumatic diseases.

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, Article II, Rules and Regulations, and accompanying manuals as well as these Clinical Service Rules and Regulations.

MINIMUM REQUIREMENTS

At a minimum, all physicians applying for a Medical Staff appointment through the Medicine Service of SFGH must meet the following requirements:

The applicant must be fully licensed in the State of California.

The applicant must be board eligible, certified, or re-certified in the State of California. Minimum training requirements are Division specific and are listed in entirety within the Division privileges.

Current Basic Life Support Certification is required for all practitioners who hold the Procedural Sedation privilege.

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Valid DEA and secure safety scripts are required for all physicians holding medical staff membership.

A practitioner must possess a National Provider Identifier (NPI) or must have submitted an application for a NPI in order to be considered for appointment or reappointment to the Medical Staff.

C. MEDICAL SERVICE LEADERSHIP

The Medical Service is organized under the Bylaws, Rules and Regulations of San Francisco General Hospital. All fully licensed physicians and other licensed health care providers who are members of the Medicine Service at SFGH are bound by the Bylaws, Rules and Regulations and accompanying manuals of San Francisco General Hospital and the University of California, San Francisco. In addition, Medicine Service Rules and Regulations have been created to further delineate the proper conduct of medical staff professional activities at the San Francisco General Hospital.

1. Chief of the Medicine Service

The Hospital Chief of Staff, the duly elected Medical Executive Committee of the Medical Staff and the Governing Body of SFGH in accordance with the SFGH Medical Staff Bylaws, appoints the Chief of the Medicine Service at SFGH. The Chief of the Medical Service is subject to the Medical Staff process for reappointment to the SFGH Medical Staff every two years.

The Chief of the Medical Service at SFGH reports to the Executive Administrator of SFGH as well as the Chair of the Department of Medicine/UCSF and The Dean of the School of Medicine, and is responsible for:

a. Supervision and evaluation of clinical work performed by medical staff members of the Medicine Service.

b. Screening all applicants for clinical privileges in the Medicine Service and for recommending clinical privileges to the SFGH Credentials Committee. No appointment to the Medicine Service can be made without the recommendation of the Chief of Service.

c. Assuring that medical staff members of the Medicine Service practice within the limits of the clinical privileges assigned to them.

d. Assigning patient care responsibilities of any medical staff member who is unable to carry out these responsibilities due to disciplinary action, illness, or other causes.

e. Assuring adequate opportunities for continuing medical education (CME) for medical staff members of the Medicine Service.

f. Developing, maintaining and executing Medicine Service Quality and Utilization Management.

g. Receiving information, evaluating, and taking action, as may be appropriate, on issues of quality of care and professional standards regarding medical staff members of the Medicine Service.

h. Overseeing the development, management and implementation of the residency and fellowship training programs within the Medicine Service at SFGH and Department of Medicine at UCSF.

i. Calling for and presiding over meetings of the Medicine Service.

2. Vice Chiefs of the Medical Service

The Vice-Chiefs of the Medicine Service are appointed by the Chief of the Medicine Service and represent the Chief of the Medicine Service in his/her absence.

The Chief of the Medicine Service has currently appointed the following Vice Chiefs:

a. Vice Chief of Inpatient Medical Services – responsible for supervising the inpatient clinical programs at SFGH.

b. Vice Chief, Population Health – responsible for the coordination of patient care and research relative to the DPH population.

The Vice Chiefs of the Medicine Service are reviewed by the Chief of Medicine and as members of the SFGH Medical Staff. Their clinical work is evaluated every two years as part of the credentialing process at the time of reappointment.

3. Program and Residency Site Directors of Medical Service

Positions responsible for supervision and program oversight of the Resident training and education are as follows:

a. Residency Site Director - responsible for the supervision and guidance of the house staff during Residency-training on the Medicine Clinical Service at SFGH.

b. Associate Program Director (APD) for Residency Program – responsible for the oversight of programmatic development and curriculum innovation. There are 5 APDs across the SFGH, Parnassus and VA campuses. Each is in charge of different aspects of the residency program: APD for Inpatient Affairs, Ambulatory Affairs, Research and Academic Development, Curriculum and Special Projects, and Resident Evaluations and Wellbeing. Currently the APD of Curriculum and Special Projects is a member of the Department of Medicine at SFGH.

c. Program Director for SFGH Primary Care Medicine Residency Program - responsible for the supervision and guidance of the housestaff during Primary Care Residency-training on the Medicine Clinical Service at SFGH.

4. Division Chiefs

The Chief of the Medicine Service appoints Division Chiefs. Division Chiefs report directly to the Chief of the Medicine Service and are reviewed by the Chief of Service at the time of their annual academic review. As members of the SFGH Medical Staff, their clinical work is evaluated every two years as part of the credentialing process at the time of reappointment.
Division Chiefs are responsible for:

a. Supervising and evaluating the clinical work performed by the medical staff members of their division.

b. Screening all applications for clinical privileges in the division and making recommendations to the Chief of the Medical Service.

c. Assuring that medical staff members of the division practice within the limits of the privileges assigned to them.

d. Developing, maintaining and executing a divisional quality management plan

e. Administration of the division.

f. Assuring that faculty and staff in their division who are involved in patient care practice within the policies and procedures as set forth by SFGH.

g. Performing such tasks as assigned by the Chief of the Medical Service.

E. ATTENDANCE AND ADMISSION POLICIES

All Medicine Service Attending physicians and other individual licensed health care providers working in the Medicine Service and in outpatient clinics shall be responsible for providing the highest standard

of care to all patients at San Francisco General Hospital regardless of financial, social, or medical status. All health care providers are bound to follow the SFGH Medical Staff Bylaws, Rules and Regulations and accompanying manuals as they pertain to patient care. Each inpatient shall be seen daily by an Attending and a note shall be placed in the Medical record. This note shall reflect the involvement of the attending. Each Clinical Service that has a patient in the Hospital shall have an Attending present in house for some portion of each day and an Attending physician from the admitting Service shall be available on call twenty-four hours per day to meet the needs of the patient.

The Department of Medicine authorizes the UCSF Clinical Practice Group to bill for professional services delivered for inpatient services and selected outpatient services, e.g.hemodialysis, pulmonary function testing, cardiology and gastroenterology diagnostic services. The Department authorizes the trained professional coders to assign appropriate CPT codes based on the documentation provided in the clinical record.

For the purposes of payment, Evaluation and Management services billed by the attending physician require the attending to document at minimum that s/he either performed the service or was physically present during the key or critical portions of the service when performed by a resident/fellow. The attending provides such documentation in the attestation portion of the billing template and links his or her note to the resident/fellow note by indicating review of the note and discussion of the findings.

F. INFECTION CONTROL

Each member of the SFGH Medical Staff has a personal responsibility to prevent the transmission of infection in patients and staff. Basic infection control practices are an integral part of patient care and must be practiced by everyone per SFGH Hospital Policy No. 9.02 and 9.07. A detailed Infection Control manual is available electronically on the CHN website.

Each provider is required to complete annual training and testing as required by Joint Commission, the state of California, and other regulatory bodies.

G. INFORMED CONSENT

It is the responsibility of the Attending physician to ensure that informed consent is obtained for all procedures requiring patient consent and that hospital policy regarding patient identification is followed. The signed consent form will be placed in the medical record. Emergency procedures may be performed when signed consent has not been obtained if, in the opinion of the Attending physician, delay of a matter of hours may result in the loss of life, limb, or function. The need for the emergency procedure shall be documented in the medical record.

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H. CONFIDENTIALITY

In compliance with HIPAA regulations, "DPH Confidentiality Agreement" is signed prior to issuance of CHN numbers, allowing LCR access for faculty, housestaff, and students.

I. PROCEDURAL SEDATION

All members of the Medicine Service will abide by the "Sedation Guideline: Sedation Administration" of San Francisco General Hospital. The divisions Cardiology, Gastroenterology, HIV/AIDS, Oncology, and Pulmonary and Critical Care Medicine have developed and implemented Procedural sedation protocols and privileges, and are in accordance with the SFGH Sedation Policy 19.08.

J. ADVANCE DIRECTIVES

The Federal "Patient Self-Determination Act" enacted in 1992 makes it mandatory that all health care facilities that participate in Medicare or Medi-Cal programs give all adult inpatients information on state laws and the facility's policies regarding advance directives. California legally recognizes the Durable Power of Attorney for Health Care and a Declaration pursuant to the Natural Death Act as advance directives for adults as per SFGH Policy No. 1.8.

K. RESUSCITATION OF PATIENTS (CPR) POLICY

It is the policy of San Francisco General Hospital that all patients are presumed to be candidates for cardiopulmonary resuscitation unless a "Do Not Attempt Resuscitation" order has been written. Guidelines of the SFGH Resuscitation Policy No. 3.12 must be followed.

L. DISCHARGE OF PATIENTS

All medical records for patients hospitalized for longer than 48 hours require a discharge summary, which must be completed by a provider within 24 hours of discharge.

M. PROTECTION OF PATIENT PRIVACY

1. Members of the Medical Staff shall comply with the DPH Notice of Privacy Practices, the Hospital policies and procedures regarding patient privacy and the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA)

2. Members of the Medical Staff shall abide by the following:
   a. Protected health information shall only be accessed, discussed or divulged as required for the performance of job duties;

   b. Members shall not log into hospital information systems or authenticate entries with the user ID or password of another; and

   c. Members shall only install software on hospital computers that have been appropriately licensed and authorized by hospital Information Systems staff.

3. Members agree that violation of this section regarding protection of patient privacy may result in corrective action as set forth in Articles VI and VII of the Medical Staff Bylaws.

N. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

An appropriate screening exam shall be provided to all persons who present themselves to the Emergency Department, Psychiatric Emergency Service and designated urgent care centers in the hospital and who request, or have a request made on his/her behalf for examination or treatment of a medical condition. Where there is no verbal request, a request will nevertheless be considered to exist if a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment.

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O. NATIONAL PATIENT SAFETY GOALS

The DOM providers follow the National Patient Safety Goals and Joint Commission standards as instituted by SFGH.

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II. CREDENTIALING

A. INITIAL APPOINTMENTS

The process of application for membership to the Medical Staff of SFGH through the Medicine Service is in accordance with SFGH Bylaws Article II, *Medical Staff Membership* and SFGH Credentialing Manual, Article V, Section A-*Initial Appointments* and accompanying manuals as well as these Medicine Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of SFGH through the Medicine Service is in accordance with SFGH Bylaws, Rules and Regulations, Credentialing Manual, Article V, Section B- *Reappointments*, and accompanying manuals as well as these Medicine Service Rules and Regulations

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C. STAFF CATEGORIES

The members of the Medicine Service shall fall into the same staff categories that are described in Article III of the SFGH Bylaws, Rules and Regulations and accompanying manuals as well as these Medicine Service Rules and Regulations.

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DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Medicine Service privileges are developed in accordance with SFGH Medical Staff Bylaws, Article IV*: Clinical Privileges*, Rules and Regulations, and accompanying manuals as well as these Medicine Service Rules and Regulations.

B. ANNUAL REVIEW OF MEDICINE SERVICE PRIVILEGE REQUEST FORM

The division chiefs shall review the Medicine Services Privilege Request Form annually. Privileges and Standardized Procedures for Medical staff and Affiliated Providers can be found on the Medical Staff Lookup on the Medical Staff Office website.

C. CLINICAL PRIVILEGES

Medicine Service privileges shall be authorized in accordance with the SFGH Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations and accompanying manuals as well as these Medicine Service Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of the Medicine Service.

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D. TEMPORARY PRIVILEGES

Temporary Privileges shall be authorized in accordance with the SFGH Medical Staff Bylaws, Article V, Section 5.2, Rules and Regulations and accompanying manuals.

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IV. PROCTORING

A. PROCTORING REQUIREMENTS

Proctoring requirements for the Medicine Service shall be in accordance with SFGH Medical Staff Bylaws, Article V, Section 5.6 Rules, and Regulations and shall be the responsibility of the Chief of the Service and the Chief of each Division. (*Refer to Division Specific proctoring requirements in Divisional Criteria Based Privileges – Appendix A*)

Proctoring plans for attendings with clinical gaps shall be composed by the responsible service chief, or designee, with the approval of the San Francisco General Hospital Credentials Committee when indicated. Attendings with clinical gaps will adhere to the orientation practices described under Section X. In addition, these faculty may arrange for recurring meetings and/ or additional orientation with the Medical Service Vice Chief or designee.

B. ADDITIONAL PRIVILEGES

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Requests for additional and/or new privileges for the Medicine Service shall be in accordance with the SFGH Bylaws, Rules and Regulations and accompanying manuals. The request must be accompanied with documentation of training and/or experience related to that privilege.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges from the Medicine Service shall be in accordance with the SFGH Bylaws, Rules and Regulations and accompanying manuals. The request must be in writing and requires approval by the Division and Medicine Service Chief or Vice Chiefs.

V. MEDICINE SERVICE INPATIENT CONSULTATION CRITERIA

Consultations should be obtained whenever the consultation might reasonably be expected to assist in the patient's continuing care or is required by specific policies or procedures per SFGH Policy No. 9.12.

1. An emergent or urgent request for consultation must be responded to in person as soon as possible, and the initial respondent will be a resident, fellow, Attending Physician, or a qualified mid-level provider (nurse practitioner or physician assistant).
2. When a non-emergent consultation is requested, the patient should be evaluated within 24 hours.
3. If a full consultation report cannot be completed at the time of consultation, the consulting provider will write a brief note in the patient's medical record. The complete consultation report will be in the patient's medical record within 48 hours.
4. The written consultation must include the name of the requesting service and the name of the requesting attending. The consulting Attending Physician signs the initial consultation.
5. The referring provider is contacted by phone if the information must be shared immediately.

VI. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations and accompanying manuals will govern all disciplinary action involving members of the SFGH Medicine Service.

VII. PERFORMANCE IMPROVEMENT AND UTILIZATION REVIEW

(Refer to Appendix A– Medicine Service Performance Improvement & Utilization Review)

VIII. MULTIDISCIPLINARY CARE ROUNDS- Inpatient Medicine Service

Multidisciplinary Care Rounds are held each weekday to review patient progress and develop a comprehensive discharge plan for patients on the Resident Inpatient Service (RIS) and Faculty Inpatient Service (FIS). Members of the care team include physicians or mid-level providers caring for the patient, Social Services, Physical Therapy, Respiratory Therapy and Occupational Therapy.

IX. MEETING REQUIREMENTS

In accordance with SFGH Medical Staff Bylaws 7.2.I, all active members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff.

X. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

The Medicine Service has several functions that are specific to the department.

A. Operational:

1. The Medicine Service has created monthly orientations for new and returning inpatient attendings on the RIS; attendings for the month will attend the sign-In and sign-Out meetings described below. If attendings are unable to attend the scheduled meetings, they may request a separate sign-in orientation at a mutually agreeable time. The meetings are run by the Vice Chief of the Inpatient Medical Services

2. The sign-in meeting is held the first week of the month and its purpose is to provide an orientation and updates on performance improvement, billing practices, trainee supervision practices, and other pertinent hospital and service information. This is a time when faculty may ask specific questions and review any changes to policy since last attending.

   The sign-out meeting is held the last week of the month. The attendings reconvene to review any patient deaths that occurred while on service, provide feedback on the performance of members of their clinical teams, and note any systems issues in need of review.

3. The Medicine Service orients the housestaff on the first and 22nd days of each month.

B. Clinical:

1. Clinical care provided by the attending and the housestaff is documented in the electronic clinical documentation system, and charges for inpatient care aresubmitted for professional fee billing.
2. Primary Care Providers are contacted by the admitting clinicians when their patients are admitted to the Medicine Service.

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XI. EDUCATION – HOUSESTAFF TRAINING COMPETENCIES & SUPERVISION

The Medicine Service complies with the SFGH Graduate Medical Education Supervision Policy Objective: in order to maintain high clinical and educational standards and to assure compliance with applicable regulations in these areas, SFGH assures adequate housestaff supervision appropriate to each level of training, recognizing that graduate medical education is based on a system of graded responsibility in which the level of resident responsibility increases with years of training. *(Refer to Appendix B – Housestaff Educational Goals and Lines of Supervision)*

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XII. MEDICAL STUDENT TRAINING PROGRAM AND SUPERVISION

The Medicine Service complies with the SFGH Undergraduate Medical Education supervision Policy Objective: in order to maintain high clinical and educational standards and assure compliance with applicable regulations in these areas, SFGH assures adequate student supervision appropriate to each level of training. *(Refer to Appendix C – Medical Student Training Program and Supervision)*

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XIV. APPENDICES

Appendix A	**Medicine Service, Performance Improvement and Utilization Review**
Appendix B	**Housestaff Educational Goals and Lines of Supervision**
Appendix C	**Medical Student Training Program and Supervision**

APPENDIX A – MEDICINE SERVICE, PERFORMANCE IMPROVEMENT AND UTILIZATION REVIEW

A. DELIVERY OF INPATIENT CARE

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Twenty-four hour inpatient care is currently delivered by Medicine on units 4B, 4D, 4E, 5A, 5C, 5D, 5E, 5R, 6A, and 7D.

1. **CRITICAL CARE**

Units 5E and 5R (MICUs)
5E, an 8-bed intensive care unit, and 5R, a 6-bed intensive care unit, are dedicated to the care of adult patients with cardiovascular, medical, and respiratory dysfunction. These units also care for any critically ill adult patient requiring intensive care. Each is equipped with cardiac monitors, piped in oxygen and compressed air, wall suction, code blue buttons, nurses' call-system and a nursing work area. Overflow patients are cared for on the 4E Surgical ICU and PACU.

2. **NON-CRITICAL CARE**

Unit 4B
The 4B Progressive Care Unit is an approximately 20 bed Step-down unit dedicated to the care of adult medical, surgical, cardiac, and trauma patients who require nursing care at a level between critical care and general care. Telemetry is performed on this unit. The Acute Dialysis Unit, which provides renal replacement therapies to adults, is also located on 4B.

Unit 4D
Unit 4D is a medical surgical floor. Continuous pulse oximetry can be performed on this unit.

Unit 5A
This unit is an adult medical surgical unit. Palliative care patients and patients receiving chemotherapy are preferentially admitted to this unit.

Unit 5C
This unit provides care for Adult patients with general medical conditions. It also includes a 4-bed Psychiatric Area that provides care to medical patient requiring constant medical and psychiatric observation and treatment. The Acute Care for the Elderly (ACE) unit is located on 5C.

Unit 5D
The care delivery focus on 5D includes adult patients with cardiovascular and other general medical conditions. Telemetry is provided as needed. The Cardiac Acute Care for the Elderly unit is located on 5D.

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Unit 6A
6A preferentially cares for orthopedic and pediatric patients. Overflow acute Medicine patients may be cared for on this unit.

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Unit 7D
Medical care delivery services on 7D are dedicated to adult patients who are in Forensic custody of the Sheriff's Department.

B. DELIVERY OF OUTPATIENT CARE

Adult Medical Center (1M and Ward 92)
The Center offers a variety of clinical services to adults at two hospital-based clinic sites.

1M clinics include: Primary care (Richard H. Fine People's Clinic), and the specialty services of Cardiology, Anti-coagulation, Pulmonary, Diabetes and Bridge Clinic. The Bridge clinic is designed to support the recently hospitalized patient who needs an outpatient visit while awaiting a follow-up visit with their primary care provider.

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Ward 92 specialty clinics include: Dermatology, Endocrine, Lipid, Pain Consultation, Renal, and Rheumatology.

Ambulatory Treatment Center 4C
The Day Treatment Center cares for adult and pediatric patients (>12 years of age) with a focus on patients requiring intravenous therapy or nursing observation after an invasive procedureCare delivery services include cancer chemotherapy, antibiotic and antifungal infusion, blood and blood product transfusion, and invasive post-procedure observation.

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Unit 3D
A GI Diagnostic unit includes GI invasive procedures and Gastroenterology and Liver clinics. Ambulatory bronchoscopy by the Pulmonary Division is also done here.

Unit 5H
The Pulmonary Function Lab provides comprehensive Pulmonary Function Testing.

Units 4J and 5G
The Cardiology Lab provides Echocardiography, treadmill testing, cardiac catheterization, pacemaker placement and emergency angioplasty.

Hematology/Oncology Clinic (Ward 86)
Hematology Clinic provides consultation for and treatment of patients referred with hematological problems. Oncology services provide treatment of solid tumors and hematological malignancies as well as chemotherapy administration.

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HIV/AIDS (Ward 86)
The Positive Health Clinic provides primary medical care to approximately 2,500 HIV infected San Francisco residents. This clinic provides expertise in antiviral therapy and

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prophylaxis against opportunistic infections. The clinic provides access to care by providing drop-in services for acute medical needs, psychosocial, and social services.

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Occupational Medicine Clinics (Bldg. 9)
The Occupational Medicine Clinic provides urgent care/workers compensation care to injured workers employed by the City and County of San Francisco.

Renal Center (Ward 17)
Services include 13 hemodialysis stations, offers peritoneal dialysis, and nutritional consultation services for patients with chronic renal disease.

C. MEMBERS OF THE CLINICAL CARE TEAM

1. Staff physicians are responsible for oversight and coordination of the Medical team.

2. Medical Trainees include Fellows and Resident Physicians, and Medical Students.

3. Affiliated Staff including Nurse Practitioners, Physician Assistants, and Clinical Pharmacists.

D. CARE PROVIDER CREDENTIALING AND EDUCATION

1.
2. Affiliated professional staff in the Department of Medicine (Nurse Practitioners, Physician Assistants, and Clinical Pharmacists) must have a current California license and a protocol approved by the Committee on Interdisciplinary Practice, Subcommittee to the Credentials Committee. A member of the Department of Medicine directs their proctoring and evaluation as detailed in the SFGH Medical Staff Bylaws.

3. Educational requirements for Medical Staff physicians are defined in division specific criteria-based privileges. Each privileged provider is required to complete annual training determined by SFGH Housestaff and fellows practice within the scope of practice as defined by their training programs.

E. ACCOUNTABILITY AND RESPONSIBILITY

1. Departmental Level

The Department of Medicine administration oversees the performance improvement program. Responsible staff include: The Director of Performance Improvement and the Clinical Operations Manager for Inpatient Services, the Medical Director of Adult Medical Clinics for Outpatient Services, and the Vice Chief, Inpatient Medical Services

Coordination of Department of Medicine PI activities is the responsibility of the Medical Director of Performance improvement. The SFGH Department of Quality Management provides facilitation of and assistance with performance improvement activities as needed.

The Department of Medicine Inpatient Performance Improvement Committee is a multidisciplinary committee that meets regularly to review inpatient PI activities and to address patient safety and quality of care issues relevant to the medical patient. The Committee prioritizes department-wide concerns appropriate for the performance improvement process, in accordance with the hospital-wide Performance Improvement Plan. Members of focused task forces may include physicians, nurses, clinical pharmacists, social workers, dieticians, respiratory therapists, and others. These groups work with Quality Management staff and others to address specific performance improvement activities that require their expertise.

2. Division/Unit Level

On a yearly basis, each division is responsible for review and update of their individual PI plan that is comprised of:

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- Scope of Service
- PI Activities
- PI Reporting calendar

Each of the divisions and units included in the spectrum of inpatient and outpatient care is responsible for the measurement, assessment, and improvement of systems and processes to improve patient outcomes in their respective areas.

In addition to on-going PI activities, each division is responsible for proctoring new physician members, and assessing the current clinical competence of physicians applying for reappointment.

F. INTEGRATED PERFORMANCE IMPROVEMENT & PATIENT SAFETY (PIPS)

1. Performance Improvement Process

The goal of the Dept. of Medicine PIPS plan is to improve the overall outcome quality of patient care through continuous improvement of patient care processes and systems. The DOM promotes a coordinated and collaborative approach to performance improvement activities that is based on the combined efforts of multidisciplinary clinicians involved in the continuum of patient care delivery. The Department's PIPS process is supportive of the hospital's mission, goals, and strategic plan and participates in organization-wide performance improvement activities.

The performance improvement program within the Dept. of Medicine is comprised of multidisciplinary activities aimed at improving patient outcomes within the individual clinical divisions and nursing units. Performance improvement efforts are systematic and characterized by process improvement strategies such as FOCUS-PDCA: Find a process to improve; Organize to improve the process; Clarify current knowledge of the process; Understand the source of process variation; Select the process improvement; Plan the improvement; Do the improvement according to the process; Check the results; Act to hold the gain and continue to improve the process.

a. Objectives

Incorporate the needs, expectations, and feedback of patients, families, and staff into the design of new systems and the improvement of existing processes.

Determine the systems and processes that are the priorities for design and improvement of the Department of Medicine.

Conduct ongoing measurement, assessment, and improvement of the DOM's performance of selected patient care processes and outcomes.

Identify key elements of information, (e.g. indicators) required to support the performance improvement process.

Ensure compliance with requirements and standards related to accreditation and licensure.

b. Design of New Patient Care Processes

Processes that are new or require significant changes are designed in keeping with the mission and strategic plan of the hospital and the San Francisco Department of Public Health. The design of such processes addresses the expressed needs and expectations of patients and staff, and incorporates established practice guidelines and community performance standards.

c. Measurement of Performance

Measurement of performance, accomplished through the collection of data, is focused on functions and processes that are of integral importance to patient outcomes. Processes and outcomes of patient care that are high volume, high risk, or problem prone are priorities for analysis, so that stability, predictability, and opportunities for improvement can be determined. Specifically, data is collected to provide information on:

Productivity/Continuity of Care
Provider specific productivity is documented and measurement of continuity of care efforts are collected in accordance with the Medical Group Practice standards.

Clinical Indicators
Indicators are selected from identified aspects of care determined to be of high priority by the PI Committee, divisions, and nursing units. In addition to selecting indicators based on high volume, high risk, or problem prone aspects of care, indicators and outcomes recommended or mandated by regulatory bodies are monitored, as appropriate.

Use of Medications and Error Avoidance
The systematic measurement of the processes of medication use, including prescribing/ordering, preparing and dispensing, administering, and monitoring of medication effects on patients, is accomplished through department participation in multidisciplinary, cross-departmental study(s) that include the involved divisions and disciplines and pharmaceutical services. In addition to medications which are high volume, high risk, high cost, or problem-prone, those identified through review of Adverse Drug Reactions (ADRs) reported by the hospital Pharmacy and Therapeutics Committee, as well as those identified by the antibiotic order and ARV order sheet process, are of priority for measurement and assessment. The Department upholds the ADR Reporting Program and the Trigger Drug Program updated by the Pharmacy Service that has significantly reduced ADRs. Providers are informed and counseled if they are deemed noncompliant with SFGH Do Not Use Abbreviations and Medical Record policies. Persistent non-compliance is referred to the Division Chief and the Chief of Medical Service. The DOM encourages the development and implementation of computerized ordering to ensure medication use and patient safety. The department participates in the hospital-wide Medication Safety Project.

Use of Blood and Blood Components
The Hospital measures the processes associated with the use of blood and blood components. Performance criteria are addressed by the disciplines involved in each stage of the process, and include appropriateness, distribution, administration, and monitoring of patient outcome. Review of transfusions that do not meet Transfusion Committee guidelines are reviewed by the Dept. of Medicine PI Committee and with the Attending. Results of the review and action summary are kept in the specific Attendings' Performance Improvement file.

Radiation Oncology Services
The SFGH Cancer Committee reviews the performance improvement activities of the UCSF/SFGH Radiation Oncology Service where Department of Medicine patients requiring this service are referred for treatment.

Cardiology Surgical/Invasive Procedures
The Division of Cardiology reviews complications and the performance improvement activities of the UCSF/SFGH Cardiovascular Service when Department of Medicine patients requiring this service are referred for treatment during the Cath Conference discussion.

Patient Satisfaction
The needs and expectations of patients and families are incorporated into the overall performance improvement process within the Department of Medicine. The Department of Quality Management conducts patient Satisfaction surveys. Patient satisfaction is also monitored through data collected from patient grievances related to care received within the divisions of the department.

Utilization Review
Appropriate use of hospital resources by Department of Medicine patients is monitored through the hospital's Utilization Review Department. Utilization data collected is presented at the PI Committee and assessed for issues and trends. Areas for improvement are addressed in the Dept. of Medicine PI and Clinical Operations meetings.

Risk Management
Patient care issues or incidents with risk management implications are monitored internally, by the Department of Medicine, as well as by the hospital and UCSF Risk Management Programs. Sentinel events related to patient care, trigger an intensive, multi-disciplinary review and are assessed for any necessary action through the Risk Management Committee and the Dept. of Medicine Quality Improvement Committee. The QI Committee reviews the incidents and complications, which are documented during the following committee meetings: the weekly DOM Morbidity and Mortality conferences, the weekly Cardiac Catheterization meetings, and the other invasive procedure division meetings (Pulmonary and GI). These meetings are protected from disclosure under "Confidential Document" protected by California Evidence Code 1157".

The DOM adheres to ongoing HIPAA guidelines.

d. Assessment

The assessment process within the Department of Medicine includes the review of data collected to determine:

- Trends and patterns of performance over time within the department and in comparison to other areas of the hospital;

- Comparison of performance with community practice standards and guidelines (e.g. Core Measures, UHC). Community Acquired Pneumonia (CAP), Chronic Heart Failure (CHF), and Acute Myocardial Infarction are among the measures in which the Department and Hospital participate.

- Systems or processes which require improvement;

- Efficacy of newly designed or improved processes.

Intensive assessment occurs when patterns vary significantly from expectations or external standards, when the divisions/units wish to improve performance, or when sentinel events occur.

Assessment of clinical sentinel events and Unusual Occurrences (UO) are conducted as identified by the Hospital's Quality Management Department and are analyzed by the Department of Medicine's QI Committee and at the Morbidity and Mortality Conference. UO's are categorized and entered into a database for aggregate and systemic analyses.

e. Improvement

The Department of Medicine representatives participate in CHN improvement activities as outlined. In addition, improvement of patient care processes can occur within or among the Department of Medicine divisions, and involve other appropriate departments and/or disciplines as well. Potential improvements are identified during the assessment process, and changes in practice are initiated on a pilot basis in the appropriate areas. If data collected from the changed practice indicates improvement, the changed process is finalized and implemented on a division/unit, department, or hospital-wide level.

2. Program Reporting Structure

Reporting of the Department of Medicine's performance improvement (PI) activities takes place through an established committee structure:

Department of Medicine Inpatient QI Committee
The PQ Committee receives periodic summary reports on the status of performance improvement activities that have been undertaken in all of the department divisions/units. The committee also reports at the Departmental Service meetings and informs department members via email (*See PI Plan Accountability and Responsibility.)*

Hospitalists' Group
Faculty hospitalists and Inpatient Acute Medicine Nurse Practitioners in the Department of Medicine meet monthly to improve the quality of inpatient care and patient satisfaction. Hospitalists also serve on the Quality Improvement committee.

Nursing Quality Assessment
Clinical Nursing leaders participate in Nursing PI activities and as members of the PI Committee. They provide continuity and cohesiveness between clinical nursing efforts and Attending/Housestaff patient care. Issues and trends are identified and reported to PI Committee and may become interdisciplinary improvement activities.

Ambulatory Care Committee (ACC) of the Community Health Network
The ACC serves as a forum to identify and address operational and quality of care issues that affect the delivery of ambulatory care. Performance improvement activities created in response to these issues are evaluated by the Dept. of Medicine PI Committee, while concerns relating to services provided by the ambulatory care clinics, which are discussed at the department PI committee are reported to the ACC by the assigned Adult Medical Center representative. Issues that affect Medicine subspecialties are taken back to the appropriate division for action.

Performance Improvement and Patient Safety Committee
The Department of Medicine reports annually to the hospital's Performance Improvement and Patient Safety Committee (PIPS) through its appointed medical staff representative, and other participating department members. A summary of department PI activity is reported from PIPS to the Hospital Executive Committee and to the Governing Body through the Joint Conference Committee.

Reporting of PI activities includes a description of the process or function and/or indicator(s), results and analysis of measurement, and summary of actions taken and planned. Reports include a review of action plans, Rules and Regulations, Credentialing, and current indicators for all divisions and nursing units as well as other PI activities that may be interdepartmental or relate to a hospital-wide CPI project.

3. Program Evaluation

The Department of Medicine Performance Improvement Plan is evaluated regularly at the monthly QI Committee meeting with a complete, programmatic review and PIPS Plan review every year. The program is assessed in regards to:

1. Effectiveness in resolving problems as they relate to PI monitors;

2. Effectiveness in detecting and monitoring individual and generalized patient care problems and systems issues;

3. Problem solving ability.

Any problem that requires corrective action will be re-assessed, re-audited or monitored as stated to ensure that the desired results for high quality patient care have been achieved and sustained.

IN-PATIENT OPERATIONAL PERFORMANCE IMPROVEMENT PLAN

The following describes the Performance Improvement operational plan for the inpatient service of the Department of Medicine at San Francisco General Hospital. This plan includes monitoring the multidisciplinary care of patients in all the inpatient areas of the Department of Medicine at San Francisco General Hospital.

A. CONCURRENT REVIEW

1. Best practice treatments and complications will be discussed at Residents' Report on week days, as well as with participating members of the Faculty and Housestaff, held by the Vice Chief of Inpatient Medicine or designee.

2. Unexpected deaths and/or major complications will be reviewed weekly at the Wednesday Morbidity & Mortality conference. The Chief Residents will be responsible for keeping a log of cases discussed at each conference. Cases with medical error or performance improvement issues are reviewed by the PI Medical Director or brought to the PI Committee if necessary and communicated to the physician of record. The PI Committee also evaluates trends and system wide issues related to PI.

B. RETROSPECTIVE REVIEW PROCESS

1. The Department of Medicine's goal is to achieve comprehensive review and obtain worthwhile information that will note any trends in deaths and end of life care.

2. Faculty attending on the inpatient Medicine Service complete a Mortality Review for each patient death and are asked to present in the monthly Attending Sign Out meeting. All deaths where questions have been raised about the quality of care, systems issues, and/or iatrogenic occurrences are reviewed by the Medicine Director of PI and further action taken as appropriate. The DOM uses the hospital approved death reviews to gather the aggregate data for trend and systemic analysis.

3. All incident reports and Unusual Occurrences will continue to be logged and reviewed by the Medicine Director of the PI Committee. Management of Unusual Occurrences is in compliance with SFGH Hospital Policy.

4. As part of the individual attending performance evaluation, access to information gathered through the Resident and Student computerized evaluation system, E*Value is available to the Chief of Medicine and the Division Chiefs.

5. The Dept. of Medicine and the Quality Management Dept. of SFGH participate in independent medical review audits conducted by external peer reviews organizations such as the San Francisco Health Plan. The purpose is to assess care to inpatient Medicare beneficiaries for specific patient care issues and to compare outcomes with other facilities statewide. When necessary, improvement action plans may be required by the division or Department.

6. The other sources of data that the DOM uses to improve care are: Core Measures, UHC and Utilization Management.

C. EVALUATED ASPECTS OF CARE

Review of Clinical Pertinence:

PLAN: Each chart for patients admitted to the Medicine wards should contain clinically pertinent elements that document good patient care in an adequate manner. This documentation should be accurate, clear, and complete, including: accurate diagnoses, results of diagnostic tests, therapy rendered, conditions and in-hospital progress of the patient, condition of the patient at discharge, and plan for follow-up care.

MONITOR: Attending specific concurrent and retrospective chart reviews will be in accordance with Hospital Policy and Joint Commission guidelines and results kept in the physicians' files.

D. PROCTORING, EVALUATING AND REAPPOINTING

Proctoring, ongoing evaluation, and credentialing of staff physicians are a major part of the PI activities of the Department of Medicine and are an important part of ensuring quality of patient care.

1. Proctoring

   a. Proctoring of newly appointed members of the Department of Medicine is performed based on department proctoring forms designed for this purpose. Proctoring is also dependent on Division specific privileges and starts with appointment to Medical Staff.

   b. Proctoring will be completed in accordance with the Hospital Rules and Regulations.

2. Ongoing Evaluation of Appointed Members

   a. Ongoing evaluation of staff physicians will be accomplished by reviewing the physician-specific information generated by the above-mentioned monitoring processes; clinical teaching evaluations, and other divisional documented performance improvement issues.

3. Reappointments

a. Appointed members of the Department of Medicine will be reviewed bi-annually by the Division Chief and the Chief of Medicine for reappointment to the Medical Staff. Divisional and Departmental PI activities as well as provider specific peer review are considerations in the reappointment process.

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Approved and respectfully submitted by:

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Date

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Date

APPENDIX B - Housestaff Educational Goals and Responsibilities

The Medical Service at San Francisco General Hospital consists of five medical ward teams, four cardiology teams and one critical care team providing comprehensive inpatient care to acutely ill medicine patients.
The **Medicine Night float Intern and Resident** assist in providing care for patients on the Medicine Service and do overnight admissions, respectively.
The **Swing Resident** helps the post call team with work, admits patients from 4-9 PM, and helps the on-call team with work so that they can leave the hospital on time.
A **Medicine Consultant** provides consultative care to patients admitted to surgical or other non-medical services within the hospital.
Medicine residents and interns also care for patients in the Emergency Department and on elective rotations at San Francisco General Hospital.

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Housestaff training in procedures:
All interns have a half day of competency training in central line placement, which includes a didactic session, video, hands on central vein identification with ultrasound supervised by an attending. Most interns additionally have a month-long procedure rotation, where they learn the most common procedures done by internists while supervised by a proceduralist attending. All house staff rotate through the Moffitt ICU and have line placement supervision by an ICU attending; senior residents can take an elective in Interventional Radiology to increase procedural skills. Other procedures – e.g. lumbar puncture, paracentesis, and thoracentesis – are supervised by the senior ward resident on the team, who have demonstrated competency by performing a requisite number of procedures.

I. EDUCATIONAL GOALS

A. Critical Care Resident - Third-year house officer (R3) or Second-year house officer (R2) with prior ICU experience

By the end of the SFGH ICU rotation the R2 / R3 Resident will be able to:

Patient Care
- Evaluate and treat complex critically ill patients with illnesses including (but not limited to):
  - Infectious diseases (HIV, TB, community-acquired pneumonia)
  - Substance use and its sequelae, liver disease / cirrhosis
  - Acute complications of obesity-related diseases like diabetes
  - Illness in recent immigrants and homeless populations in the United States.
- Demonstrate competency in the acute management of respiratory failure, hemodynamic instability and life threatening metabolic and hematologic abnormalities.
- Demonstrate competency in the triage of critically ill patients and the appropriate use of critical care and step down units based on local staffing levels and expertise.

Medical Knowledge
- Demonstrate understanding of the basic pathophysiology of common critical care illnesses such as (but not limited to):
  - Severe sepsis
  - Upper GI bleed
  - Severe pneumonia and ARDS.
- Demonstrate an understanding of basic concepts regarding invasive and non-invasive mechanical ventilation, invasive hemodynamic monitoring and support.
- Demonstrate the ability to assimilate up-to-date research evidence and risk benefit analysis in making clinical decisions for critically ill patients.
- Show competency in basic ethical tenets and end of life care.

Practice-Based Learning and Improvement:

- Lead the team in reflection on the types and outcomes of cases admitted during the month and develop action items for changing future practice, using feedback from the ward teams, LCR data, and primary care physicians.

Communication and Interpersonal Skills:

- Collaborate effectively with health care members from nursing, respiratory therapy, pharmacy, dietary and social work to elicit bedside data and establish shared daily goals and long-term care plan.
- Communicate effectively with other physicians such as consultants, emergency room and ward physicians to ensure the delivery of safe and expedient interventions and transitions of care into and out of the ICU.
- Appropriately counsel patients about the risks and benefits of tests and procedures.

Professionalism

- Demonstrate leadership and integrity, serving as a role model in the triage and management of patients across the hospital setting, including:
    - Responding in a timely and collegial manner to calls from ward and emergency department services.
    - Assisting and supervising procedures on other medicine services.
    - Assisting in the care of step-down (4B) patients.
    - Facilitating the transfer of patients with evolving needs to the appropriate clinical setting.
    - Providing effective handoffs to ward teams.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

System-Based Practice

- Understand and use hospital practice guidelines, protocols and forms to provide high quality care to critically ill patients.
- Provide critical care leadership with constructive feedback to the team regarding these practices when deemed necessary.
- Describe quality improvement projects that are ongoing in the ICU, including incorporation of cost-awareness principles into complex clinical scenarios.

B. Critical Care Intern (R1)

By the end of the SFGH ICU rotation the R1 Resident will be able to:

Patient Care:

- Demonstrate effective collection, synthesis, and presentation of data on complex critically ill patients from critically ill underserved populations including (but not limited to):
    - Infectious diseases (HIV, TB, community-acquired pneumonia)
    - Substance use and its sequelae
    - Liver disease / cirrhosis
    - Illness in recent immigrants and homeless populations in the United States
- Under the guidance of a senior resident and attending physician learn to evaluate and manage critically ill patients with respiratory failure, hemodynamic collapse and multi-organ dysfunction.

Medical Knowledge:

- Describe the basic pathophysiology of common critical care illnesses such as (but not limited to):
    - Severe sepsis
    - Upper GI bleed
    - Severe pneumonia and ARDS
- Describe basic aspects of triaging critically ill patients and differences in staffing and expertise present at different levels of care in the hospital.
- Understand indications for and basic interpretation of common diagnostic testing used in the ICU setting.
- Describe basic concepts regarding invasive mechanical ventilation and invasive hemodynamic monitoring and support.

Practice-Based Learning and Improvement:

- Seek feedback from ward medical teams after transfer from ICU about effectiveness of communication, quality of care plan, and areas for improvement, including timely and effective transfer summaries.
- Respond welcomingly and productively to feedback from all members of the health care team.

Communication and Interpersonal Skills:

- Collaborate effectively and effectively communicate plan of care to all members of the health care team, including nursing, respiratory therapist and other health care providers to elicit bedside subjective and objective data and establish shared daily goals and overall care plan.
- Deliver appropriate, succinct, hypothesis-driven oral presentations.

Professionalism

- Demonstrate integrity in the triage and management of patients across the hospital setting, including:
    - Responding in a timely and collegial manner to calls from ward, emergency department, and consult services.
    - Participating in the transfer of patients with evolving needs to the appropriate clinical setting.
    - Providing effective handoffs to ward teams.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.
- Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
- Recognize that disparities exist in health care among populations and that they may impact care of the patient.

System-Based Practice

- Demonstrate proficiency in applying and giving constructive feedback on hospital practice guidelines, protocols, forms, and quality improvement projects to provide high quality care to critically ill patients.

C. General Medicine Ward Resident (R2 or R3)

By the end of the SFGH medicine rotation the R2 / R3 Resident will be able to:

Patient Care:

- Provide compassionate, appropriate, and effective care to hospitalized underserved patients with diseases including (but not limited to):
    - Infectious diseases (HIV, TB, community-acquired pneumonia)
    - Substance use and its sequelae
    - Liver disease / cirrhosis
    - Acute complications of obesity-related diseases like diabetes
    - Illness in recent immigrants and homeless populations in the United States.
- Triage patients to the appropriate level of care (ward, 4B, ICU) based on their degree of illness.

Medical Knowledge:

- Demonstrate adequate knowledge to care for the patients with the above problems.

Practice Based Learning:

- Lead the team in reflection on the types and outcomes of cases admitted during the month and develop action items for changing future practice, using feedback from the Bridge clinic (Eliza Newbold), LCR data, and primary care physicians.
- Cite the literature to customize clinical evidence for an individual patient each admission cycle.

Communication and Interpersonal Skills:

- Provide effective teaching and leadership on daily work rounds, including bedside teaching, teaching to multiple levels of learners, and provision of feedback to learners about efficient presentation skills.
- Demonstrate sensitivity to differences in patients.

Professionalism

- Provide leadership for a team that respects patient dignity and autonomy, including recognizing and managing conflict when patient values differ from their own.
- Attend and participate as appropriate in 70% of required medical conferences which include: attending rounds, resident report, M&M, Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

Systems Based Practice:

- Demonstrate effective collaboration with multidisciplinary services during and outside of multidisciplinary rounds (MDR), including nursing, social work, utilization review, rehabilitation services, and pharmacy.
- Supervise and give interns feedback on discharge plan and medication reconciliation process.
- Supervise and give feedback to interns regarding:
  - Sign-out during shift changes, transfers between services, or end of month transfers.
  - Communication with outpatient primary care or subspecialist providers in the General Medicine Clinic, Ward 86, Community Health Network clinics, and other clinics.
  - Timely documentation of medications and discharge summary information in the Invision LCR system.

D. General Medicine Ward Intern (R1)

By the end of the SFGH medicine rotation the R1 Resident will be able to:

Patient Care:

- Provide compassionate, appropriate, and effective care to patients with diseases found in underserved populations including (but not limited to):
  - Infectious diseases (HIV, TB, community-acquired pneumonia)
  - Substance use and its sequelae
  - Liver disease / cirrhosis
  - Acute complications of obesity-related diseases like diabetes
  - Illness in recent immigrants and homeless populations in the United States

Medical Knowledge:

- Demonstrates adequate knowledge to care for the patients with the above problems.
- Cite at least one resource from the medical literature for patient care purposes in the chart each admission cycle.

Practice-Based Learning and Improvement:

- Incorporate feedback and communication with primary care providers into improving discharge planning for patients, including the creation of timely and effective discharge summaries.
- Meet at least every other week with supervising physician for feedback on ward performance.

Communication and Interpersonal Skills:

- Elicit information about the patient as a person – including cultural and socioeconomic background – to inform shared decision-making discussions.
- Communicate effectively with patients with limited English proficiency and/or low health literacy, including appropriate use of interpreter services and demonstrating sensitivity to how ethnic/cultural background influences health/illness.

Professionalism

- Treat patients with dignity, civility, and respect, regardless of race, culture, gender, ethnicity, age, or socioeconomic status, and recognize when it is necessary to advocate for individual patient needs.
- Attend and participate as appropriate in 70% of required medical conferences which include: attending rounds, interns report, M&M, Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

System-Based Practice

- Recognize awareness of common socioeconomic barriers that impact healthcare, and advocate for patients with complex psychosocial needs by identifying appropriate referral resources for access to health system and community resources, including Bridge clinic and Treatment Access Program (TAPS).
- Communicate and partner with multidisciplinary team above to identify appropriate referral resources for access to:
  - Subacute and long-term care
  - Medical and psychiatric care
  - Substance use intervention and treatment
  - Social support resources

- Seek out feedback from supervising physicians concerning sign-out during shift changes, transfers between services, or end of month transfers.

E. Cardiology Ward Resident (R2)

By the end of their SFGH Cardiology rotation, R2 / R3 will be able to:

Patient Care:

- Evaluate and treat patients with cardiac diseases found in underserved populations including (but not limited to):
  - Acute coronary syndromes
  - Congestive heart failure
  - Endocarditis
  - Cardiac complications of substance use
- Triage these patients to the appropriate level of care: floor, telemetry, CCU.
- Demonstrate and teach how to elicit important physical findings for junior member of the health care team.

Medical Knowledge:

- Formulate a differential diagnosis and outline a plan for evaluating and managing cardiology-related problems appropriate for each resident's level of training, including (but not limited to):
  - Management of acute coronary syndromes due to coronary artery disease from stimulant ingestion
  - Valvular heart disease
  - Congestive heart failure
- Achieve skills with competency and teaching in electrocardiogram interpretation.

Practice Based Learning:

- Learn to co-manage patients in a team-care approach on the cardiology service.

Communication and Interpersonal Skills:

- Facilitate and oversee effective communication among team members, including interns, residents, attendings, nurse practitioners, and primary care providers, to ensure effective continuity of care within the hospital and across transitions of care.

Professionalism

- Collaborate effectively with other hospital services to triage and assist in the management of patients with presentations concerning for cardiac disease, including ED nurses and attendings and non-medicine services requesting cardiology consultation during nights/weekends.
- Advocate for appropriate allocation of limited health care resources.
- Participate in organized teaching conferences for this rotation as well as required conferences for the SFGH medicine department such as M&M and Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

Systems-Based Practice

- Collaborate effectively with nurse practitioners to ensure appropriate transitions of care from the hospital setting, including medication reconciliation, follow-up care, and referral to community resources.
- Demonstrate the incorporation of cost-awareness principles into standard clinical decision-making.

F. Cardiology Ward Intern (R1)

By the end of the SFGH cardiology rotation the R1 Resident will be able to:

Patient Care:

- Under supervision of an attending cardiologist and resident, evaluate and treat patients with cardiac diseases found in underserved populations including:
  - Acute coronary syndromes
  - Congestive heart failure

- Endocarditis
- Cardiac complications of substance use

Medical Knowledge:

- Formulate a differential diagnosis and outline a plan for evaluating and managing Cardiology related problems appropriate for each resident's level of training, including (but not limited to):
  - Management of acute coronary syndromes due to coronary artery disease from stimulant ingestion
  - Valvular heart disease
  - Congestive heart failure
- Achieve skills with baseline competency in electrocardiogram interpretation.

Practice Based Learning:

- Learn to co-manage patients in a team-care approach on the cardiology service.
- Determine if clinical evidence can be generalized to an individual patient.
- Meet at least every other week with supervising physician for feedback on ward performance.

Communication and Interpersonal Skills:

- Elicit information about the patient as a person – including cultural and socioeconomic background – to inform shared decision-making discussions
- Communicate effectively with patients with limited English proficiency and/or low health literacy, including appropriate use of interpreter services and demonstrating sensitivity to how ethnic/cultural background influences health/illness

Professionalism:

- Recognize that disparities exist in health care among populations and that they may impact care of the patient, and treat patients with dignity, civility, and respect.
- Attend and participate as appropriate in 70% of required medical conferences which include: attending rounds, interns report, M&M, Grand Rounds
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

Systems-Based Practice

- Recognize awareness of common socioeconomic barriers that impact health care, and work with team resident to ensure appropriate transitions of care from the hospital setting, including medication reconciliation, follow-up care, and referral to community resources.

G. Medicine Night float Resident (R2/R3)

At the completion of this rotation, the Medicine Night float Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical and cardiac problems.
2. Demonstrate organizational skills necessary for the care of medicine and cardiac inpatients.
3. Efficiently and effectively document findings and clinical decisions in the medical record.
4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. Supervise the Medicine Night float Intern in management of acutely ill inpatients overnight. When indicated, residents should gain competence in supervising procedures performed by the Medicine Night float Intern including venipuncture, arterial puncture, lumbar puncture, paracentesis, joint aspiration, thoracentesis, placement of central lines, placement of nasogastric tubes, and placement of Foley catheters.

H. Medicine Night float Intern (R1)

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical problems.
2. Demonstrate organizational skills necessary for the care of medicine and cardiac inpatients.
3. Efficiently and effectively document findings and clinical decisions in the medical record.

4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. When indicated, R1's should gain competence in performing venipuncture, arterial puncture, lumbar puncture, paracentesis, joint aspiration, thoracentesis, placement of central venous catheters, placement of nasogastric tubes, and placement of Foley catheters by the completion of the R1 year. They should also be capable of explaining the indications, contraindications, and risks of these procedures.

I. Medicine Consult Resident (R2/R3)

At the completion of this rotation, the Medicine Consult Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse medical problems occurring on non-medical services.
2. Evaluate patients preoperatively and provide an assessment of their surgical risk.
3. Demonstrate knowledge of perioperative management of chronic medical conditions including coronary artery disease, pulmonary disease (COPD and asthma), diabetes mellitus, hypertension, and other medical conditions.
4. Demonstrate knowledge of post-operative medical complications and their management.
5. Function as an effective consultant to non-medical services.

J. Emergency Department Resident (R2)

At the completion of this rotation, the Emergency Department Resident should be able to:

1. Function as an effective leader and teacher of interns and students rotating through the emergency department and as an effective manager of the "patient flow" through the ED.
2. Discuss the differential diagnosis and direct the evaluation and triage of diverse urgent care and emergency medical problems. Residents will learn to accurately and quickly identify problems that are emergencies and to prioritize those diagnostic and life supporting measures that are most urgent. Specifically, residents will learn the initial management for patients with urgent and emergent conditions, such as, but not limited to diabetic ketoacidosis, acute coronary syndrome, respiratory diseases, sepsis, and altered mental status, and other medical problems. Residents will improve emergency technical skills such as central line placement as indicated.
3. Demonstrate baseline competency and improvement in physical diagnosis and medical interviewing skills, including performing a focused history and physical examination for a patient in the Emergency Department with an undifferentiated medical illness.
4. Demonstrate baseline competency and improvement in managing the wide range of medical conditions seen in the Emergency Department setting utilizing an evidence-based and humanistic approach.
5. Demonstrate baseline competency and improvement in knowledge and clinical skills relating to Emergency Medicine and Urgent Care.
6. Work effectively as a member of a health care team to ensure proper care and welfare of patients.
7. Demonstrate an ability to effectively and efficiently use consultants.
8. Learn to organize the care of multiple patients simultaneously.
9. Demonstrate appropriate use of body fluid substance precautions.
10. Learn to admit patients to the hospital appropriately and promptly.
11. Learn to organize and direct and medical resuscitation under the supervision of the Emergency Department attending physician.

K. Swing Resident (R2)

At the completion of this rotation, the Medicine Swing Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical and cardiac problems.
2. Demonstrate organizational skills necessary for the care of medicine and cardiac inpatients.

3. Efficiently and effectively document findings and clinical decisions in the medical record.
4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. When indicated, residents should further competence in performing procedures including venipuncture, arterial puncture, lumbar puncture, paracentesis, joint aspiration, thoracentesis, placement of central lines, placement of nasogastric tubes, and placement of Foley catheters.

II. TEAM STRUCTURE AND RESPONSIBILITIES

A. Team Structure:

The Critical Care team consists of one critical care attending, four residents, and three to four interns (two to three Internal Medicine, one Family Medicine R2 acting as an intern).

The five General Medicine Ward teams consist of one medicine attending, one resident, two interns, one to two third year medical students (MS3), and a sub-intern (MS4). A social worker is assigned to each team to aid in identifying and meeting discharge needs.

Division of Hospital Medicine attendings also admit patients to the Faculty Inpatient Service (FIS). A social worker is assigned to help care for patients on the FIS.

The Cardiology Ward team consists of one cardiology attending, two cardiology fellows; four teams consisting of one resident and one intern each, one to two third year medical students (MS3), and occasionally a sub-intern (MS4). A social worker is assigned to the team to aid in identifying and meeting discharge needs. One nurse practitioner assists in ensuring follow-up and access to follow-up testing after discharge.

A Night float Intern provides supervised coverage of the Resident Inpatient Service at night.

A Night float Resident and one hospitalist attending admit patients to the medicine service in the overnight hours (9 PM to 7AM).

The Medicine Consult team consists of one attending and one resident.

Medicine Residents rotating in the Emergency Department are a part of a multi-disciplinary team composed of attending and training physicians from both medical and other departments at UCSF, as well as numerous residents and interns from training programs outside of UCSF. The housestaff schedule is determined by the Department of Emergency Medicine at SFGH and varies according to the time of day and the time of year. There is always at least one Emergency Department attending physician present for supervision of patient care.

B. Critical Care Attending Physician:

1. Holds appropriate clinical privileges at SFGH with an academic appointment at the University of California, San Francisco (UCSF) School of Medicine.
2. Supervises and assumes ultimate responsibility for the care of inpatients admitted to the medical ICU, including appropriate continuing care, discharge planning or planning for transfer from the ICU, and medical follow-up. To achieve this, the attending should conduct daily management rounds that include the following:
    a) Interaction at regular intervals with ICU patients each day.
    b) Effective and frequent communication with the resident staff regarding management.

3. Conducts daily teaching rounds:

a) Rounds must consist of both patient-based and didactic teaching. Points for discussion include interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient, and appropriate use of technology and disease prevention.

b) The attending should work with the resident physicians to establish and achieve didactic goals for teaching rounds.

c) Teaching rounds must include direct resident and attending interaction with the patient. The teaching sessions must include demonstrations and evaluation of each resident's interview and physical examination skills, i.e. teaching rounds must include bedside teaching.

4. Oversees order writing, but residents and interns routinely write all orders for patients under their care. In those unusual circumstances when the attending writes an order on the team's patient, the attending must communicate his or her action to the resident in a timely manner.
5. Responsible for providing verbal feedback and written evaluation of the resident physicians participating in ICU care. Resident evaluations must include assessments of interview and physical examination skills, communication of treatment plans, and discharge planning.
6. Responsible for completing on-service and admission notes. Admission notes should be completed by the end of the day following admission. On-service notes should be completed daily.
7. Responsible for co-signing and ensuring dictation of discharge summaries for each patient in a timely fashion.
8. Responsible for signing orders relating to the withholding of resuscitative efforts (DNR orders).
9. The attending physician will be available by pager at all times.
10. Responsible for providing feedback and written evaluation on the performance of interns and residents.

C. Critical Care Resident - Third-year house officer (R3) or Second-year house officer (R2) with prior ICU experience

Under the guidance of the attending critical care physician, this resident directs the comprehensive ICU care of critically ill medicine patients. The Critical Care Resident also assists with the care of cardiology patients admitted to the ICU, under the guidance of the attending cardiology physician. Specific responsibilities include:

1. Responsible for coordinating the day-to-day function of the Critical Care Unit and directly supervising interns, and responsible for determining the assignment of critically ill patients to monitored beds in the ICU and step-down care unit.
2. Directs the admission and initial evaluation of patients to the medical ICU:
   a) The Critical Care Resident will oversee the initial history, physical examination and review of the laboratory data and medical records for all patients admitted to the medical ICU. The resident will write an admission note for all patients admitted to the medical ICU.
   b) The Critical Care Resident will be on-call every fourth night.
   c) The Critical Care Resident will provide assistance to the Medicine Night float Resident if needed.
   d) The Critical Care Resident will respond in person to “Code Blue” alarms and will function as the lead physician coordinating resuscitations. The Critical Care Resident will also document the events that occur during the code.
   e) Resident physicians will be responsible for ensuring that individual intern and sub-intern patient loads do not compromise patient care and educational goals.
   f) In the event that the Critical Care Resident is called to evaluate a patient whom they deem does not require ICU-level care, the Resident will leave a consultation note in the chart.
3. Directs the interns in providing continuing intensive care to all of the patients in the medical ICU:
   a) Oversees the daily interval history, focused physical examination, and new laboratory data for each patient on the team.
   b) Oversees the rational use of consultants and laboratory tests.
   c) Oversees the discharge planning and transitional care of all patients.
   d) Ensures compassionate communication with patients and families regarding the ongoing status and care of patients.
4. Ensures adequate communication of patient care issues among members of the team, including the attending physician, other Critical Care residents, and the interns.

5. Assists the General Medicine/Cardiology Resident with the admission and initial evaluation of patients to the Cardiac ICU and with the ongoing care of cardiology ICU (CCU) patients:
    a) The Critical Care Residents will participate in taking the initial history, performing a physical examination, and reviewing of the laboratory data and medical records for all patients admitted to the CCU.
    b) The Critical Care Residents will assist with placement of central lines for hemodynamic monitoring, and will be instructed in the use of ultrasound guidance for safe placement.
    c) Although the Cardiology Resident will have primary responsibility for making management decisions on Cardiology ICU patients, the Critical Care Resident team will assist as needed with bedside management and critical care decision-making. The Critical Care team will be responsible for ventilator management for intubated Cardiology ICU patients.
6. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents will need to demonstrate at least 70% attendance at each of the required conferences and will be expected to attend as many teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
    a) Weekly Morbidity and Mortality conference.
    b) Weekly Pulmonary/Critical Care conference.
    c) Weekly Grand Rounds.
7. Responsible for providing feedback and written evaluation on the performance of interns.
8. Responsible for providing written evaluation of attending physicians.
9. Residents will not work in excess of an average of eighty hours per week during any inpatient ward month.
10. Residents will have at least one day off per every seven averaged over the month.
11. Residents will have a break of at least eight hours between shifts.
12. The on call period will consist of 24 hours of patient care/new admissions, followed by no more than four additional hours for education and sign out.

D. General Medicine Ward Attending:

1. Holds appropriate clinical privileges at SFGH with an academic appointment at the University of California, San Francisco (UCSF) School of Medicine.
2. Supervises and assumes ultimate responsibility for the care of medical inpatients admitted to the medical wards and step-down unit, including discharge/transfer planning and medical follow-up. To achieve this, the attending should conduct daily management rounds that include the following:
    a) Interaction at regular intervals with medical ward patients.
    b) Effective and frequent communication with the resident staff regarding management.
3. Conducts teaching rounds:
    a) Rounds must consist of both patient-based and didactic teaching. Points for discussion include interpretation of clinical data, pathophysiology, differential diagnosis, and specific management of the patient, appropriate use of technology and disease prevention.
    b) The attending should work with the resident physician to establish and achieve didactic goals for teaching rounds.
    c) Teaching rounds must include direct housestaff and attending interaction with the patient. The teaching sessions must include demonstrations and evaluation of each trainee's interview and physical examination skills, i.e. teaching rounds must include bedside teaching.
4. Oversees order writing, but housestaff routinely write all orders for patients under their care. In those unusual circumstances when the attending writes an order on the team's patient, the attending must communicate his or her action to the resident in a timely manner.
5. Responsible for providing verbal feedback and written evaluations of the residents, interns, and students on the team. Evaluations of housestaff must include assessments of interview and physical examination skills, communication of treatment plans, and discharge planning.
6. Responsible for writing on-service and admission notes. Admission notes should be completed by the end of the day following admission. On-service notes should be completed daily.
7. Responsible for ensuring dictation of discharge summaries for each patient in a timely fashion.
8. Responsible for attending Multidisciplinary Rounds Monday-Friday.
9. Responsible for signing orders relating to the withholding of resuscitative efforts (DNAR orders).
10. The attending physician will be available by pager or cell phone at all times.

11. Attends monthly sign-in and sign out session organized by the Vice Chief of service.

E. General Medicine Ward Resident (R2/R3):
Under the guidance of the attending physician, the R2/R3 directs the comprehensive inpatient care of acutely ill medicine patients on the wards and in the step-down unit and assists with patients admitted to the MICU. The specific responsibilities include:

1. Responsible for coordinating the day-to-day function of the team and directly supervising interns and sub-interns.
2. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents will need to demonstrate at least 70% attendance at each of the required conferences and will be expected to attend as many teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
    a) Weekly Morbidity and Mortality conference.
    b) Weekly Grand Rounds.
    c) Residents' Report
3. Directs the admission and initial evaluation of patients to the medical service:
    a) Oversees the initial history, physical examination and review of the laboratory data and medical records for all patients admitted to the team.
    b) Residents will take daytime call every fifth day (7am-6pm) of every call cycle. They will accept additional holdover patients admitted overnight on Days 2 and 3 of the call cycle, and will be eligible to receive post-call holdovers if they did not reach their cap on call. The medicine teams will admit all medical ward and step-down patients not admitted by the Faculty Inpatient Service (FIS) of attending hospitalists.
    c) Resident physicians will distribute admissions among members of their individual teams:
        i) Interns will be responsible for no more than five admissions per twenty-four hour period and no more than eight admissions per forty-eight hours.
        ii) Sub-interns will be responsible for no more than five admissions per twenty-four hours and no more than eight admissions per forty-eight hours.
        iii) Resident physicians will be responsible for admitting patients and writing detailed admission notes in excess of five admissions per intern or sub-intern per twenty-four hour period up to a maximum of ten new patients.
        iv) Total admissions per medicine team will not exceed seven per eleven hour call day; additional patients will be admitted by the hospitalists on the FIS and the Swing resident. If more than seven patients are admitted by swing resident and the FIS before 9 PM, a Jeopardy Resident may be activated.
        v) Resident physicians will be responsible for ensuring that individual intern and sub-intern patient loads do not compromise patient care and educational goals.
4. R2's/R3's direct the interns and medical students in providing continuing hospital care to all of the patients on his/her team:
    a) Oversees the daily interval history, focused physical examination, and new laboratory data for each patient on his/her team.
    b) Oversees the rational use of consultants and laboratory tests.
    c) Oversees the discharge planning and transitional care of all patients.
    d) Ensures compassionate communication with patients and families regarding the ongoing care of patients.
5. Ensures adequate communication of patient care issues among members of the team, including the attending physician.
6. Assumes primary responsibility for supervising sub-interns (MS4s) and will write admission notes for all patients admitted by sub-interns.
7. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents will need to demonstrate at least 70% attendance at each of the required conferences and will be expected to attend as many teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
    a) Weekly Morbidity and Mortality conference.

b) Weekly Pulmonary/Critical Care conference.
c) Weekly Grand Rounds.

8. Responsible for providing feedback on the performance of the interns, MS4, and MS3s.
8. Responsible for providing written evaluation of the attending physician, interns, MS4, and MS3s.
9. Residents will not work in excess of an average of eighty hours per week during any inpatient ward month.
10. Residents will have at least one day off per every seven averaged over the month and will be covered by the attending physician on those days.
11. Residents will have a break of at least eight hours between shifts.
12. The on call period will consist of no more than 16 hours of patient care, new admissions, education, and sign out.

F. General Medicine Ward Intern (R1):

1. All responsibilities and clinical privileges of the intern are under the guidance and supervision of the Attending and Resident physicians.

2. Responsible for patient care in concert with other members of the team.
3. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Interns will need to demonstrate at least 70% attendance at each of the required conferences and will be expected to attend as many additional teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
   a) Weekly Morbidity and Mortality conference.
   b) Weekly Grand Rounds.
   c) Monthly Intern Half-Days.
   d) Weekly Intern Report
4. Responsible for up to five admissions per twenty-four hour period, or up to eight admissions per forty-eight hour period.
5. Responsible for writing up to five admission notes; supervising residents will be responsible for admitting patients and writing admission notes in excess of five per twenty-four hour period.
6. Responsible for writing or co-signing medical students' daily progress notes.
7. Has primary responsibility for supervising MS3s.
8. Responsible for completing discharge summaries for each patient within forty-eight hours of discharge.
9. Has primary responsibility for writing orders in the medical record and will co-sign all medical student orders promptly.
10. Interns will not work in excess of an average of eighty hours per week during any inpatient ward month.
11. Interns will have at least one day off in every seven averaged over the month and will be covered by his/her supervising resident on those days.
12. Interns will have a break of at least eight hours between shifts.
13. The on call period will consist of no more than 16 hours of patient care, new admissions, education, and sign out.

G. Cardiology Ward Attending:

1. Holds appropriate clinical privileges at SFGH with an academic appointment at the University of California, San Francisco (UCSF) School of Medicine.
2. Supervises and assumes ultimate responsibility for the care of inpatients admitted to the Cardiac ICU, including appropriate continuing care, discharge planning or planning for transfer from the CCU, and medical follow-up. The cardiology attending also has primary responsibility for cardiology patients admitted to both the telemetry/step-down unit and the wards. The attending should conduct daily management rounds, which include the following:
   a) Interaction at regular intervals with CCU, telemetry, and ward patients.
   b) Effective and frequent communication with the cardiology fellows and resident staff regarding management.
   c) Review of electrocardiograms and other cardiac testing with the housestaff.
3. Conducts daily teaching rounds:

a) Rounds must consist of both patient-based and didactic teaching. Points for discussion include interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient, appropriate use of technology, and disease prevention.

b) The attending should work with the resident physician to establish and achieve didactic goals for teaching rounds.

c) Teaching rounds must include direct housestaff and attending interaction with the patient. The teaching sessions must include demonstrations and evaluation of each trainee's interviewing and physical examination skills, i.e. teaching rounds must include bedside teaching.

4. Oversees order writing, but housestaff routinely write all orders for patients under their care. In those unusual circumstances when the attending writes an order on the team's patient, the attending must communicate his or her action to the resident in a timely manner.
5. Responsible for providing verbal feedback and written evaluation of the resident physicians and interns participating in the care of cardiology patients. Resident evaluations must include assessments of interview and physical examination skills, communication of treatment plans, and discharge planning.
6. Responsible for writing or dictating on-service and admission notes. Admission notes should be completed by the end of the day following admission. On-service notes should be completed daily.
7. Responsible for co-signing and ensuring dictation of discharge summaries for each patient in a timely fashion. 8. Responsible for signing orders relating to the withholding of resuscitative efforts (DNR orders).

H. Cardiology Ward Resident (R2):

Under the guidance of the attending Cardiology physicians and the Cardiology fellows, the R2 directs the comprehensive inpatient care of acutely ill medicine and cardiology patients on the wards, in the step-down unit, and in the CCU. The specific responsibilities include:

1. Responsible for coordinating the day-to-day function of the team and directly supervising interns and sub-interns.
2. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents will need to demonstrate at least 70% attendance at each of the required conferences and will be expected to attend as many teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
   a) Weekly Morbidity and Mortality conference.
   b) Weekly Grand Rounds.
   c) Residents' Report.
3. Directs the admission and initial evaluation of patients to the medical and cardiology services:
   a) Will oversee the initial history, physical examination and review of the laboratory data and medical records for all patients admitted to the team.
   b) Residents will be on-call every fourth day and will admit all patients with primary cardiology issues.
   c) Will communicate frequently with the members of the Critical Care team, who will assist with the care of CCU patients.
   d) Resident physicians will distribute admissions among members of their individual teams:
      i) Interns will be responsible for no more than five admissions per twenty-four hour period and no more than eight admissions per forty-eight hours.
      ii) Sub-interns will be responsible for no more than five admissions per twenty-four hours and no more than eight admissions per forty-eight hours.
      iii) Resident physicians will be responsible for admitting patients and writing detailed admission notes in excess of five admissions per intern or sub-intern per twenty-four hour period up to a maximum of eight new patients.
      iv) Total admissions per admitting resident will not exceed ten per 24-hour call day; a Jeopardy Resident will be activated for any admissions in excess of eight per cardiology admitting resident per twenty-four hour call day; it is the responsibility of the Cardiology Ward Resident to notify the Chief Medical Resident on call in order to activate the Jeopardy system.
      v) Resident physicians will be responsible for ensuring that individual intern and sub-intern patient loads do not compromise patient care and educational goals.
4. R2's direct the interns and medical students in providing continuing hospital care to all of the patients on his/her team:

a) Oversees the daily interval history, focused physical examination, and new laboratory data for each patient on his/her team.
b) Oversees the rational use of consultants and laboratory tests.
c) Oversees the discharge planning and transitional care of all patients.
d) Ensures compassionate communication with patients and families regarding the ongoing care of patients.

5. Ensures adequate communication of patient care issues among members of the team, including the attending physician.
6. Assumes primary responsibility for supervising sub-interns (MS4s) and will write an admission note for all patients admitted by sub-interns.
7. Responsible for providing feedback on the performance of the intern, MS4 and MS3s.
8. Responsible for providing written evaluation of the attending physician, intern, MS4 and MS3s.
10. Residents will not work in excess of an average of eighty hours per week during any inpatient ward month.
11. Residents will have at least one day off in every seven averaged over the month and will be covered by the attending cardiology physician. Residents will have a break of at least eight hours between shifts.
13. The on call period will consist of 24 hours of patient care and new admissions, plus up to four hours for sign out and educational activities.
14. 13. Will carry a "Code Blue" pager and respond to all codes; will assist the critical care resident in these situations but does not have primary responsibility for leading the code.

I. Cardiology Ward Intern (R1):

1. All responsibilities and clinical privileges of the intern are under the guidance and supervision of the Attending and Resident physicians and the Cardiology Fellows.
2. Responsible for patient care in concert with other members of the team.
3. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Interns will need to demonstrate at least 70% attendance at each of the required conferences and will be expected to attend as many additional teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
   a) Weekly Morbidity and Mortality conference.
   b) Weekly Grand Rounds.
   c) Monthly Intern Half-Days.
4. Responsible for up to five admissions per twenty-four hour period, or up to eight admissions per forty-eight hour period.
5. Responsible for writing up to five admission notes; supervising residents will be responsible for admitting patients and writing admission notes in excess of five per twenty-four hour period.
6. Responsible for reviewing and co-signing medical students' daily progress notes.
7. Has primary responsibility for supervising MS3s.
8. Responsible for dictating discharge summaries for each patient within forty-eight hours of discharge.
9. Has primary responsibility for writing orders in the medical record and will co-sign all medical student orders promptly.
10. Interns will not work in excess of an average of eighty hours per week during any inpatient ward month.
11. Interns will have at least one day off in every seven averaged over the month and will be covered by the supervising resident
12. Interns will have a break of at least eight hours between shifts.
13. The on call period will consist of no more than 16 hours of patient care, new admissions, education, and sign out.

J. Night float Resident (R2/R3):

1. Will arrive in the hospital at 8PM and leave at 10AM.
2. No resident will serve as Night float Resident for more than 6 consecutive days.
3. Will take sign out from the Swing Resident and cross-cover on those new admissions in addition to following up on any pending studies as directed by the Swing Resident.
3. The Night float Resident will admit general medicine and/or cardiology patients to the wards and step-down unit between the hours of 9PM-7AM.

4. Will assist the Night float Intern with any complicated patient care issues, and will supervise any procedures performed by the Night float Intern as necessary.
5. The Critical Care Resident is responsible for assisting the Resident Night float if necessary. If patient care issues or new patient admissions exceed the Night float Resident's ability to provide safe and comprehensive medical care to those patients despite the assistance of the Critical Care Resident and the FIS hospitalist attending, the Night float Resident will call the Jeopardy Chief Resident to activate the Jeopardy system.
6. The Night float Resident will personally sign out patients to the ward teams between 8AM-10AM.
7. Will attend morning report at 7:30AM if patient care allows.

K. Night float Intern (R1):

1. Will arrive at the hospital 8:00 PM or 9:00 PM depending on the role and leave at 7:30 AM or 10:00 AM depending on the role; the maximum shift length will be 14 hours.
2. No intern will serve as Night float Intern for more than 6 consecutive days.
3. Responsible for taking care of medicine or cardiology patients on the wards and in the step-down unit.
4. Will receive written sign-out on all patients.
5. Will check laboratory results, radiology results, monitor fluid status, etc. as specifically directed by the sign-out from the primary team.
6. Will respond to all nursing pages regarding patients under his/her care and will personally evaluate patients for whom there are any concerns.
7. If the Night float Intern is called to evaluate any patient who has had a significant change in condition, the Night float will clearly document any procedures, interventions, and/or studies in the chart.
8. The Night float Resident is responsible for assisting the Night float intern if necessary. If the Night float Intern requires assistance or supervision for a procedure, the Night float Resident should be called promptly.

L. Medicine Consult Attending:

1. Holds appropriate clinical privileges at SFGH.
2. Supervises and assumes ultimate responsibility for General Medicine consultations on inpatients.
3. Conducts daily teaching rounds with the medical consult resident.
4. Is responsible for completing of initial consultation templates and follow-up consultations.
5. Is responsible for providing verbal feedback and a written evaluation of the medical consult resident.
6. The medicine consult attending physician will be available by pager at all times.

M. Medicine Consult Resident (R2/R3):

1. **Will see all medicine consult patients, 7:30 AM to 5:30 PM Monday-Saturday.**
2. **Will discuss each case with the medicine consult attending or FIS hospitalist attending if urgent and the medicine consult attending is unavailable.**
3. **Will provide cross coverage for Critical Care Residents, Medicine Ward Residents, or Cardiology Ward Residents when needed.**
4. **Will write appropriate orders with agreement of primary team.**
5. **Will give written sign-out to the FIS nocturnist nightly.**
6. **Will initiate transfers to the Medicine Service when appropriate.**

N. Emergency Department Resident (R2):

1. Will work no more than 65 hours per week and will have at least one day off in every seven averaged over the month..
2. Responsible for directing patient care on the medical side of the Emergency Department including:
   a) Assisting the nursing staff with triage when appropriate.
   b) Responding promptly when called to the "Trauma Rooms" to care for the most acute patients.
   c) Managing patient flow through the Emergency Department and facilitating admissions and discharges.

3. Supervises and teaches interns and medical students who are working on the medical side of the Emergency Department. This includes overseeing the history, physical examination, review of laboratory data, and review of medical records for all patients evaluated.
4. Ensures that appropriate studies and necessary consultations are obtained quickly.
5. Discusses all patients with the Emergency Department attending.
6. Will learn to organize and direct and medical resuscitation.

O. Swing Resident (R2):

1. Will arrive at the hospital at 2:00 PM and leave by 12:00 AM.
2. Will assumes primary cross cover responsibilities until 9:00 PM for the non-call teams after receiving written sign out from the team intern or resident.
3. Will check laboratory results, radiology results, monitor fluid status, etc. as specifically directed by the sign-out from the primary team.
4. Will respond to all nursing pages regarding patients under his/her care and will personally evaluate patients for whom there are any concerns.
5. If the Swing Resident is called to evaluate any patient who has had a significant change in condition, the Swing Resident will clearly document any procedures, interventions, and/or studies in the chart.
6. Will alternate admissions with the Swing Hospitalist between 4-9 PM.
7. Will sign out admitted patients to the Night float Resident at 9 PM.

APPENDIX C – MEDICAL STUDENT TRAINING PROGRAM

SAN FRANCISCO GENERAL HOSPITAL

Medicine 110- Third Year Students

Commented [U3]: Likewise, it would be great if Margaret could take a quick look at this section to see if updates are needed.

Contents:

INTRODUCTION

Goals (or where to direct your energies)

1. Develop ease in dealing with sick persons and working with health care personnel in relation to delivering optimum medical care in an inpatient hospital setting.
2. Be able to obtain, organize, record and present (written and oral) a complete history, physical examination and diagnostic and therapeutic formulations. A complete differential diagnosis and understanding of the pathophysiology is more important at this stage than a complete therapeutic plan.
3. Continue to learn a body of knowledge in Internal Medicine.

HOW WILL YOU LEARN THIS?

1. General - Through close contact with patients.

   Digression #1 -

   Not all students will be exposed to the same types of patients, necessarily making the experience different for each student. Goals 1 and 2 can be realized through a variety of patients. Goal 3 will be accomplished through a combination of ward contact and didactic sessions (conferences and seminars) through which you will be exposed to at least a minimum amount of basic facts in Internal Medicine.

   Digression #2 -

   At all times, all patients must be treated with dignity and respect whether or not their personalities or attitudes coincide with yours. Less will not be tolerated.

   Patient care comes before education. Through this order of priorities will come your most important learning.

2. Specifics

A. Ward work - Each Medicine ward team consists of a PGYII/III medical resident, two interns, a 4th year student, one or two 3rd year students, and an attending (faculty) physician. Each team may have patients on one or more wards (4B, 5C, 5D, 5A, 4D, 6A). Each 3rd year clerk will be assigned to work with a specific team.

There are five Medicine teams. There is no overnight call. Overnight a covering resident team and a faculty hospitalist admits patients. Each team admits every fifth day ("long call"). Long call begins in the morning of call. Patients can be admitted to the long call team until 6pm. The team must sign out to the covering night team at 9 pm. All team members leave the hospital and return the next morning for their post-call day. Each team also admits holdover patients and patients admitted early in the morning ("short call" and "tiny call") on the third and fourth day of a five-day call cycle. There are four Cardiology teams, each with one resident (PGYII) and one intern. There is one Cardiology attending for all four teams. Cardiology teams take overnight call every fourth night. Third year students will spend six weeks on a Medicine Team and two weeks on a Cardiology team.

B. There is also an ICU (Intensive Care Unit) team. No students are on this team.

C. Conferences - There will be seminars most days, Monday through Friday, usually from 1:30 - 2:30pm or1:30 – 3:00pm in which topics basic to medicine will be discussed. Please see schedule outside of the Housestaff Coordinator's office (5H22) for specific topics and their dates. You will meet with Dr. Wheeler's for Patient Presentations Wednesdays at1:30pm. You will also meet with the Chief Residents for basic EKG instructions and Physical Diagnosis Rounds. YOUR PUNCTUAL ATTENDANCE AT THESE CONFERENCES IS IMPORTANT.

C. Standardized Patients - The School of Medicine has arranged for actors to play the part of patients in these half-day exercises. Sessions will be held on history taking and physical examination as well as discussion of advanced directives. These assignments will be based on call schedule and will come from Student Programs. If, for any reason, you are unable to attend this required program please call Lisa Carella at 476-1964.

D. BSCO (Brief Structured Clinical Observation) - Each student will be observed by their attending and a peer interacting with a patient. This exercise will include a part of the history and physical exam chosen by the student and attending, and should take no more than 10 minutes. These can be done as a separate exercise or in the course of normal clinical care such as during morning rounds. After the observed interaction the attending or peer will provide feedback to the student and fill out a form given to him/her by the student. Two BSCOs from an attending and one from a peer are required...The idea of this exercise is to increase the number of observed student-patient encounters. It does not count towards your grade, but you are required to turn in the BSCO cards to pass the course.

MS4 Sub-Internship Summary Page
San Francisco General Hospital

A major difference between your MS3 and MS4 experience is that you will truly be "learning on the job"- and you will really be assuming primary ownership of your patients. They will be YOUR patients (along with resident supervision). A new emphasis will be on your critical role in

- Communication (with your resident, consultants, patients and families)
- Coordination of care
- Information management (timely notes, verbal and written sign-out)

Goals:

- Assume primary responsibility for patient, including new emphasis on communication, coordination of care, and information management
- Develop comfort in being first-call for ward patients, including learning how to assess and manage common on-call issues that arise
- Develop efficiency and effectiveness in prioritizing tasks on multiple patients

Responsibilities at SFGH:

1. Call expectations:
   - On average, admit 3 patients on call, at discretion of supervising resident who understands the overall team/other intern census and complexity of patients
   - Expectation to pass the rotation is that you can admit and manage 2 patients a call night Daily census may range on average 3-6 patients, depending on call cycle
   - Go home post-call at same time as team; sign-out to covering intern with the rest of the team
   - No cross-cover; cover your patients only
2. Orders:

- Write admit and daily orders with your resident. The current electronic ordering system does not allow order entry by students. Legible co-signatures with "MS4" for each order
- (when written on 4B or other wards without electronic ordering)

3. Discharge summaries:
   - You are responsible for dictating discharge summaries at SFGH

- All patients must have discharged summaries in the LCR within 24 hours of discharge.
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4. Days off:
   - 1 day off per week; specific days are decided with your resident because the resident needs to consider days off/clinic days for other team members
5. Set expectations early with your team
   - Sit down with your resident and your attending to set up goals/expectations (yours and theirs)
   - As you know, every team has its own dynamic and expectations, so check in with your resident and attending at beginning, midway, and at the end
   - If you have a light census, ask your interns, MS3, and resident to see how you can help – they will appreciate your interest in helping the team
   - Midway through your rotation you will be required to have your resident and attending give you feedback on your performance. There is a Midpoint Feedback card that should document these conversations with items of feedback. If the resident or attending feel you are not able to fulfill the expectations of the rotation at the midpoint you should schedule an appointment with me immediately.
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Thank you for joining us, and we hope you learn a lot on your subinternship. Have a great month!

Please contact me, the House staff coordinator or the Chief Residents with any questions:

Deleted:

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Site Director, (415) 206-3457