ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG October 27, 2025
October 2025 MEC Meetings

Clinical Service Report and Rules and Regulations:

a. Medicine Service Report
b. Medicine Rules and Regulations and summary of changes

Credentials Committee:

a. Summary of changes: Primary Care Registered Nurse HTN Standardized Procedures
b. Summary of changes: Standardized Procedure Preamble
c. Summary of changes: Hospital Medicine Privileges

UCSF
University of California
San Francisco

ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Medicine Biennial Report 2024-2025

October 6, 2025

Topics

- Mission, Vision, and Values
- Organization and People
- Budget & Finances
- Clinical Services, Performance Improvement & Patient Safety
- Education and Training Activities
- Research Enterprise
- Summary: Strengths, Challenges, & Goals

Chief of Medicine Neil Powe with Chief Residents Tamara Sanchez-Ortiz, Harry Cheung, Pooja Lalchandani and Residency Ambulatory Site Director Ilana Garcia-Grossman

Mission and Vision

Mission: To advance health by developing and supporting innovators in patient-centered care, scientific discovery, medical education and public policy

We take pride in achieving worldwide renown for these equally valued and interrelated missions.

Ambition: Best internal medicine service in the U.S.

Vision: Transforming medicine through innovation & collaboration

Patient Care: Provide the highest quality clinical service that is the first choice for patients and referring physicians.

Research: Be the leading engine of scientific discovery to advance health and attract the world's best investigations.

Education: Be recognized as innovators in education, attracting & developing the next generation of leaders in medicine.

Public Policy: Be the most trusted & influential leaders in shaping public policy to advance health.

Values

We take pride in conducting ourselves and our business as professionals and with respect for our patients and colleagues

- 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 & timeliness
- Aligning incentives with best interests of our workforce
- Lifelong learning, mentoring and advocacy
- High ethical standards
- Caring, compassionate, commitment to social justice, and responsibility

We value the importance of **diversity**

Organization & People

How is our leadership structured?

ZSFG Medicine Division Chiefs n= 13

*Research focused divisions

Neil Powe
Chief of Medicine

Diane Havlir
- HIV, Infectious Diseases, & Global Medicine

E. Bimla Schwarz
- General Internal Medicine

Joel Ernst
- Experimental Medicine*

Margot Kushel
- Health, Equity, & Society*

Gina Solomon
- Occupational, Environmental, and Climate Medicine

Terry Friedlander
- Hematology-Oncology

Jackie Maher
- Gastroenterology

Delphine Tuot
- Nephrology

Brian Graham
- Pulmonary

Lisa Murphy
- Endocrinology

Jinoos Yazdany
- Rheumatology

Mary Gray
- Cardiology

Oanh Nguyen
- Hospital Medicine

Care.
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Women= 77%

ZSFG Medicine Leadership Team

Neil R. Powe
Chief

Division Chiefs n=13

Chief's Cabinet

Beth Harleman
- Vice Chief of Medicine, Clinical Services

Peter Hunt
- Associate Chief of Research

Elaine Khoong
- Director, Quality Improvement and Patient Safety

Larissa Thomas
- Director, Faculty Experience

Clinical Leaders

Beth Harleman
- Inpatient Services

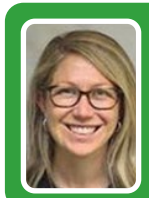
Monica Gandhi
- Director, Ward 86 Positive Health Program HIV Clinic

Emily Wistar
- Director, Richard Fine Peoples (GIM) Clinic

Shreya Patel
- Director, Subspecialty Clinics, ZSFG

Education Leaders

Joan Addington White
- Director, ZSFG Primary Care IM Residency Program



Rebeccah Brusca
- Inpatient Site Director Residency Program

Binh An Phan
- Site Director Medical Student Clerkship

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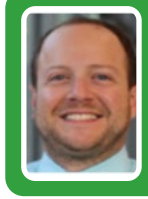
Administrative Leaders



Leonard Telesca
- Director, Administration and Finance

Christine Khuu
- Associate Director, Finance and Administration

Maura Temple
- Clinical Operations Manager

Raeni Miller
- Research Administration Manager

Division Administrative Team

Division Chief
n=13

Leonard Telesca
Director, Administration & Finance

Division Managers

Amy Akbarian
Gastroenterology & Rheumatology

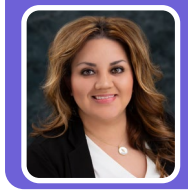
Eunice Chang
HIV, ID, and Global Medicine

Jenny Fowler
Cardiology & Pulmonary Critical Care

Gato Gourley
Health, Equity, and Society

Mary Ellen Kelly
Endocrinology & Hematology/ Oncology

Serena Lee
Occupational, Environmental, & Climate Medicine



Serena Loya
Nephrology

Fonda Smith
Experimental Medicine

Jennifer Thomas
General Internal Medicine

Justin Vang-Moore
Hospital Medicine

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UCSF

UCSF at ZSFG Medicine Primary Appointments

~880 Faculty, Non-Faculty Academics, and Staff (as of 7/17/2025)

304 Faculty

- 193 Salaried Faculty (93.5 Clinical FTEs)
- 96 Without Salary (WOS) Faculty (3.52 Clinical FTEs)
- 15 Recall Faculty (10 Salaried, 5 WOS)

27 Non-Faculty Academics

475 Staff and Student Employees

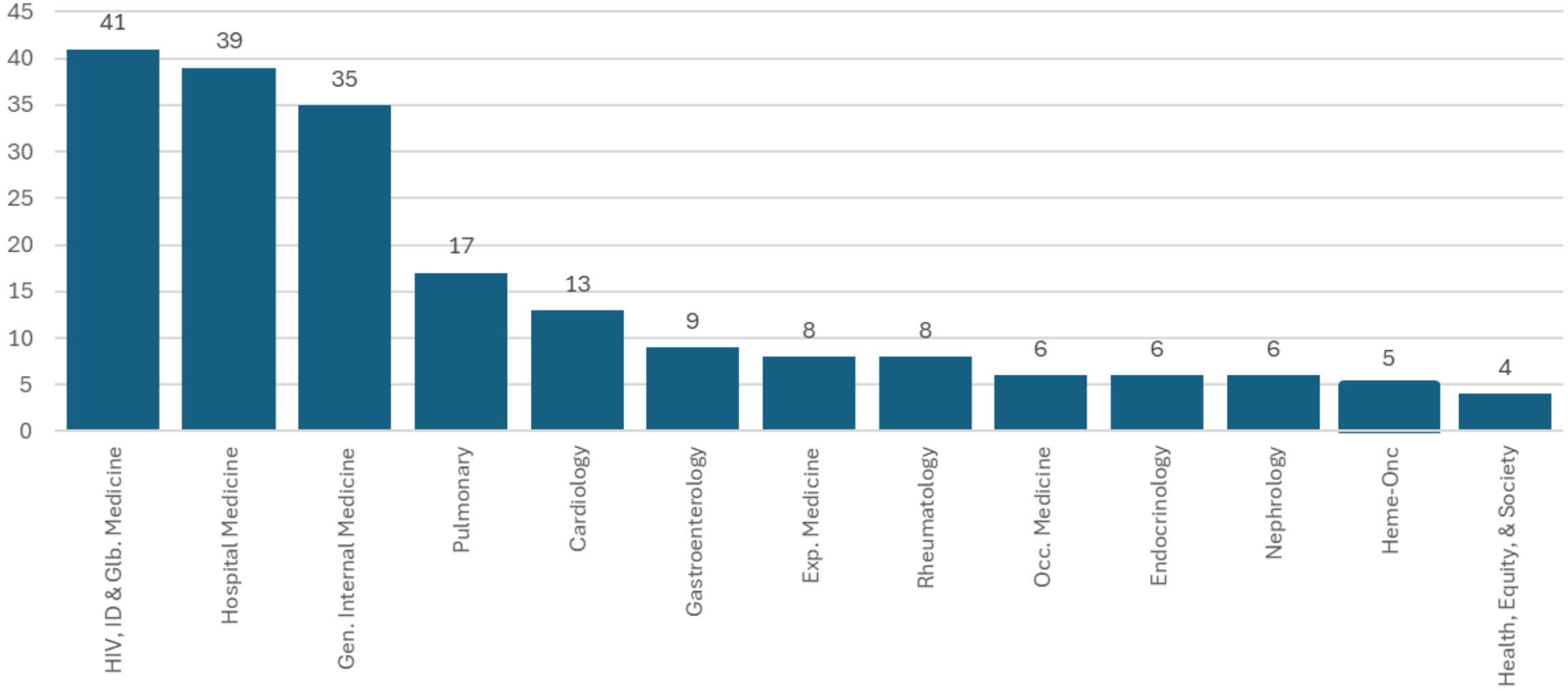
27 MSP Staff Physicians

26 Postdoctoral Scholars

Numerous Trainees (residents: 1º care, categorical IM, OEM)
(fellows: clinical specialties, NCSP)

Rank/Series	Ladder	In-Residence	Clin X	Clinical	Adjunct	Recall	Total	Rank %
Professor	4	29	29	19	3		84	**44%**
Associate		21	7	19	1		48	**25%**
Assistant		6	1	31	13		51	**26%**
Instructor							0	**0%**
Total	4	56	37	69	17	10	193	**5%**
Series %	**2%**	**29%**	**19%**	**36%**	**9%**	**5%**		**100%**

ZSFG Medicine Faculty by Division (n=197)



ZSFG Medicine Division Clinical Service Line Leaders

Division Chief | Division Manager

~ 40 Service Lines

Cardiology
Mary Gray | Jenny Fowler

- TBH – Director, Clinical Cardiology
- Jaya Mallidi- Director, Inpatient Service
- Mary Gray – Director, Cardiology Outpatient Clinics
- TBH – Director, Anti-coagulation & Heart Failure
- John MacGregor – Director, Cath Lab & Interventional
- TBH – Director, Cardiac Diagnostics ECG/Holters/Treadmill

Endocrinology
Lisa Murphy | Mary Ellen Kelly

- Sarah Kim - Diabetes Clinic Director
- Sarah Kim - Director, Obesity Clinic
- Sarah Kim - Co-Director, Pediatrics Obesity Clinic
- Lisa Murphy - Endocrine Clinic Director
- Lisa Murphy – Director eConsult
- Tom Bersot - Lipid Clinic Director

General Internal Medicine
E. Bimla Schwarz | Jennifer Thomas

- Bob Brody – Director, Health at Home
- Anna Chodos – Director, Geriatrics Consult Clinic
- Ilana Garcia-Grossman – Associate Director, RFPC
- Liz Goldman – Director, CalAIM; Lead Physician, ED Case Management Program
- Raphaela Lipinsky Degette – Associate Director, RFPC
- Scott Steiger – Deputy Director, Opiate Treatment Outpatient Program
- Emily Wistar – Director, Richard Fine People's Clinic (RFPC)

Gastroenterology
Jackie Maher | Amy Akbarian

- Justin Sewell – Director, Clinical Gastroenterology
- Mandana Khalili – Director, Clinical Hepatology

Heme-Onc
Terry Friedlander | Mary Ellen Kelly

- Nihirika Dixit – Director, Comprehensive Breast Cancer Program and Cancer Survivorship & Navigation Program
- Vacant – Director, Oncology Clinic
- Vacant – Director, Hematology

ZSFG Medicine Division Clinical Service Line Leaders cont.

Division Chief | Division Manager

~ 40 Service Lines

HIV, ID, & Global Medicine

Diane Havlir | Eunice Chang

- Monica Gandhi – Assoc Chief, Clinical Ops & Education; Medical Director, Ward 86
- Vivek Jain – Assoc Chief, Clinical Infectious Diseases

Nephrology

Delphine Tuot | Serena Loya

- Ramin Sam – Director Clinical Nephrology, Director Dialysis Center
- Ramin Sam – Director, Acute Nephrology Service

Hospital Medicine

Oanh Nguyen | Justin Vang-Moore

- Max Birger – Clinical Operations Lead, Faculty Inpatient Service
- Tessa Kaplan – Clinical Operations Lead, Faculty Inpatient Service
- Geetika Mehra – Clinical Operations Lead, Faculty Inpatient Service
- Marlene Martin – Director of Addiction Care Team
- Sandra Moody – Director of Palliative Care Service
- Edgar Pierluissi – Director, Acute Care for the Elderly Unit

Occupational Health

Gina Solomon | Serena Lee

- Timur Durrani – Medical Director, Occupational Health Service
- Monica Kaitz Tilly – Associate Medical Director, Occupational Health Service

Pulmonary & Critical Care

Brian Graham | Jenny Fowler

- Antonio Gomez – Co-Director, MICU
- Carolyn Hendrickson – Co-Director MICU
- George Su – Director, HSF Asthma/COPD and Sleep Medicine
- Neeta Thakur – Director Chest Clinic
- John Metcalfe – Director, Bronchoscopy

Rheumatology

Jinoos Yazdany | Amy Akbarian

- Mary Margaretten – Director Clinical Rheumatology
- Jonathan Graf – Director, Rheumatoid Arthritis Clinic

ZSFG Site Training Program Directors

(resident & fellow oversight)

11 ACGME • 2 Non-ACGME

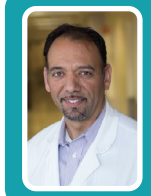
Uchenna Nwosu
- Nephrology

Pooja Dharwadkar
- Gastroenterology

Niharika Dixit
- Hematology Oncology

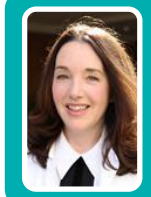
Jaya Malladi
- Cardiology

Kristine Gu
- Endocrinology



Antonio Gomez
- Pulmonary

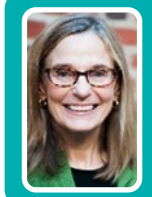
Monica Gandhi
- Infectious Diseases



Mimi Margaretten
- Rheumatology

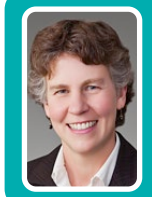
Paula Lum
- Addiction Medicine

E. Bimla Schwarz
- Primary Care Research Fellowship



Joan Addington-White
- ZSFG Primary Care IM Residency Program

Hilary Seligman
- National Clinician Scholars Program (UCSF-wide)



Gina Solomon
- Occupational & Environmental Medicine Residency

Key ZSFG Clinical Leaders from DOM

Bob Brody
- Medical Director, Health at Home

Jeff Critchfield
- Vice Dean, UCSF at ZSFG

Susan Ehrlich
- ZSFG CEO

Seth Goldman
- Informatics Director, Digital Health & Tech Integration

Antonio Gomez
- Associate Chief Medical Officer, Critical Care Services

Mary Gray
- Associate Director of Risk Management

Nicholas Iverson
- Medical Director of Patient Flow

Vivek Jain
- Co-Director, Infection Control

Lisa Murphy
- Director of Sub Specialty eConsults

Gabe Ortiz
- Chief Medical Officer

Amy Ou
- Associate Chief Medical Officer, Department of Care Coordination

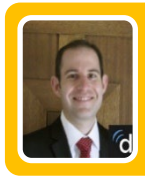
Shreya Patel
- Associate Chief Medical officer for Specialty Care and Diagnostics

Edgar Pierluissi
- Director of Acute Care of Elderly (ACE) Unit

Neda Ratanawongsa
- Chief Medical Informatics Officer

George Su
- Medical Director for Telehealth

Lisa Winston
- Hospital Epidemiologist and Associate CMO Medical Surgical Services



Luke Zier
- Cardiology PRIME and QIP

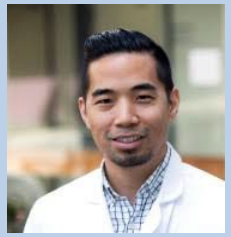
UCSF DOM at Large Leaders (at ZSFG)

Faculty Affairs

- **Urmimala Sarkar,** Associate Chair, Faculty Experience
- **Neil Powe, Chair,** Executive Promotions Committee

Research Affairs

- **Diane Havlir,** Associate Chair, Clinical Research



Education Affairs

- **Sarah Goglin,** Residency Associate Program Director, Subspecialty Education
- **David Chia,** Residency Associate Program Director of Inpatient Affairs
- **Vanessa Thompson,** DOM Pro-cess SFGH Site Lead; DOM Education Ombuds

Communication Strategies

- Email & Listserv
- Division Chief Meetings (twice/month: 1 formal; 1 informal)
- Division Meetings (monthly)
- ZSFG DOM Faculty Town Halls (Quarterly)
- Monthly Newsletter - Archives at (https://zsfgmedicine.ucsf.edu/about/news-letter
- Chief -Faculty Tea Talks
- Faculty and Staff Awards (Annually)
- Division Faculty Meetings (weekly-monhtly)

Newsletter *Vol. 7 / Issue 9 / March 2024*

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WOMEN IN ZSFG CLINICAL LEADERSHIP

As part of our Women's History Month, we celebrate the leadership of three extraordinary members of our faculty. They lead patient-centered teams, provide steady and creative guidance through challenging times, and help mentor the next generation of health care professionals. They also discuss some of the particular challenges for women in academic medicine, as well as transformational ideas for ensuring that everyone can contribute their talents to our mission-based work.

Building a Joyful Workplace

Patients who develop advanced kidney disease face difficult decisions: whether to pursue a kidney transplant, go on dialysis, or choose "conservative care" – taking medications to manage symptoms but declining more invasive treatment. At this challenging juncture, the ZSFG Renal Plus Clinic provides multidisciplinary support to help each patient make informed choices that are right for them.

Harini Sarathy, MBBS, MHS

"There's a lot of fear and anxiety for patients," said Harini Sarathy, MBBS, MHS, Assistant Professor in the ZSFG Division of Nephrology, who has directed the Renal Plus Clinic since 2019. "These discussions often require months of close contact, talking with them, supporting them, and helping them navigate."

Together with a nurse practitioner, physician assistant, nephrology fellow, dietitian, nurses and medical assistants, Dr. Sarathy and her team explain each of the options. If patients want a transplant, they refer them for an evaluation and help them fill out paperwork to get on the waitlist. They connect them with dialysis nurses who give them a tour of the dialysis clinic and explain the different kinds of dialysis. They also discuss what conservative care might look like for each patient, including life expectancy and quality of life, and partner with the palliative care team to help manage symptoms. The clinic team also helps manage overall health, providing injections to treat anemia, keeping track of needed immunizations, and providing nutritional guidance as patients' kidneys become less able to process salt and potassium.

"I'm immensely grateful for the people who work with me," said Dr. Sarathy. "They are always willing to go that extra mile if a patient needs something." Her team brings a broad range of skills to the work, including fluency in Spanish, Cantonese, Urdu and Hindi. "Although we are resource-limited in some ways, one of the joys of working at San Francisco General is having resources that really serve our patients, like staff who speak these languages," she said.

Always an Advocate

Dr. Sarathy grew up in India, earned her medical degree from Seth G.S. Medical College and K.E.M. Hospital in Mumbai, then completed her master's degree in genetic epidemiology at Johns Hopkins Bloomberg School of Public Health. She completed her internal medicine residency at the Albert Einstein College of Medicine-affiliated Jacobi Medical Center and her nephrology fellowship at UCSF. "My medical school and residency training were in safety net settings serving vulnerable, marginalized and uninsured people," she said. "San Francisco General feels like home to me."

She originally came to UCSF to pursue research with the San Francisco Veterans Affairs Medical Center-based Kidney Health Research Collaborative. However, immigration challenges affected

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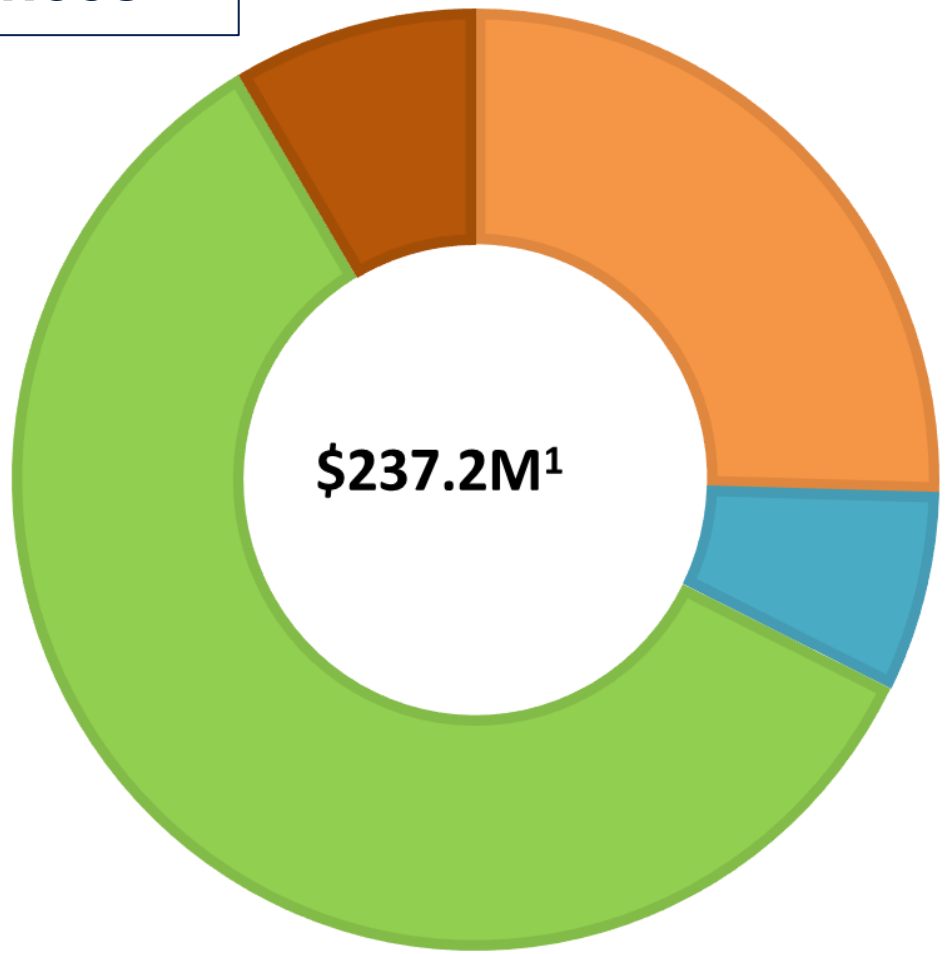
Budget and Finances

FY25 ZSFG MEDICINE REVENUE SOURCES

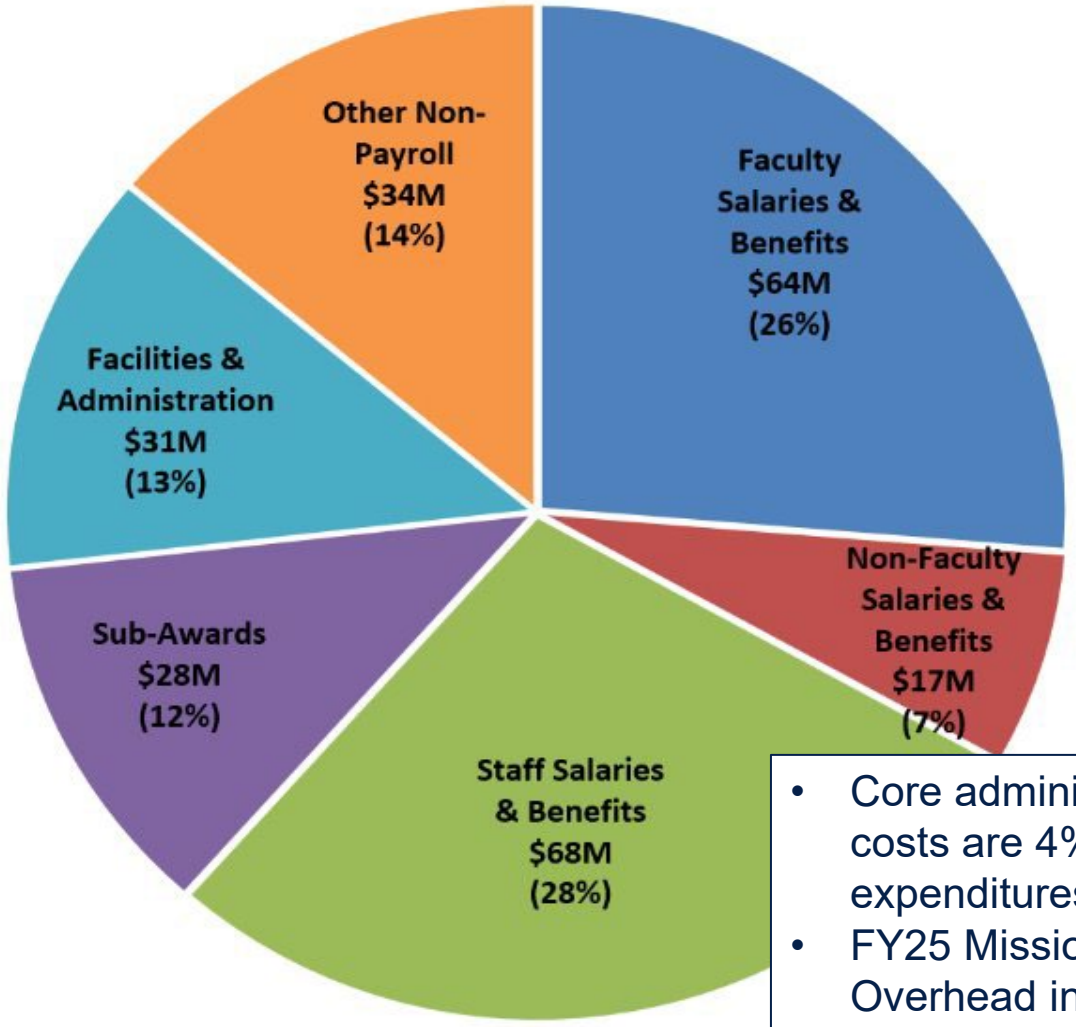


- SFGH Affiliation Agreement $60.4M (25%)
- Other Clinical Revenue $16.3M (7%)
- Sponsored Project Revenue $140.3M (59%)
- Other (State, ICR, Gifts, etc) $20.3M (7%)

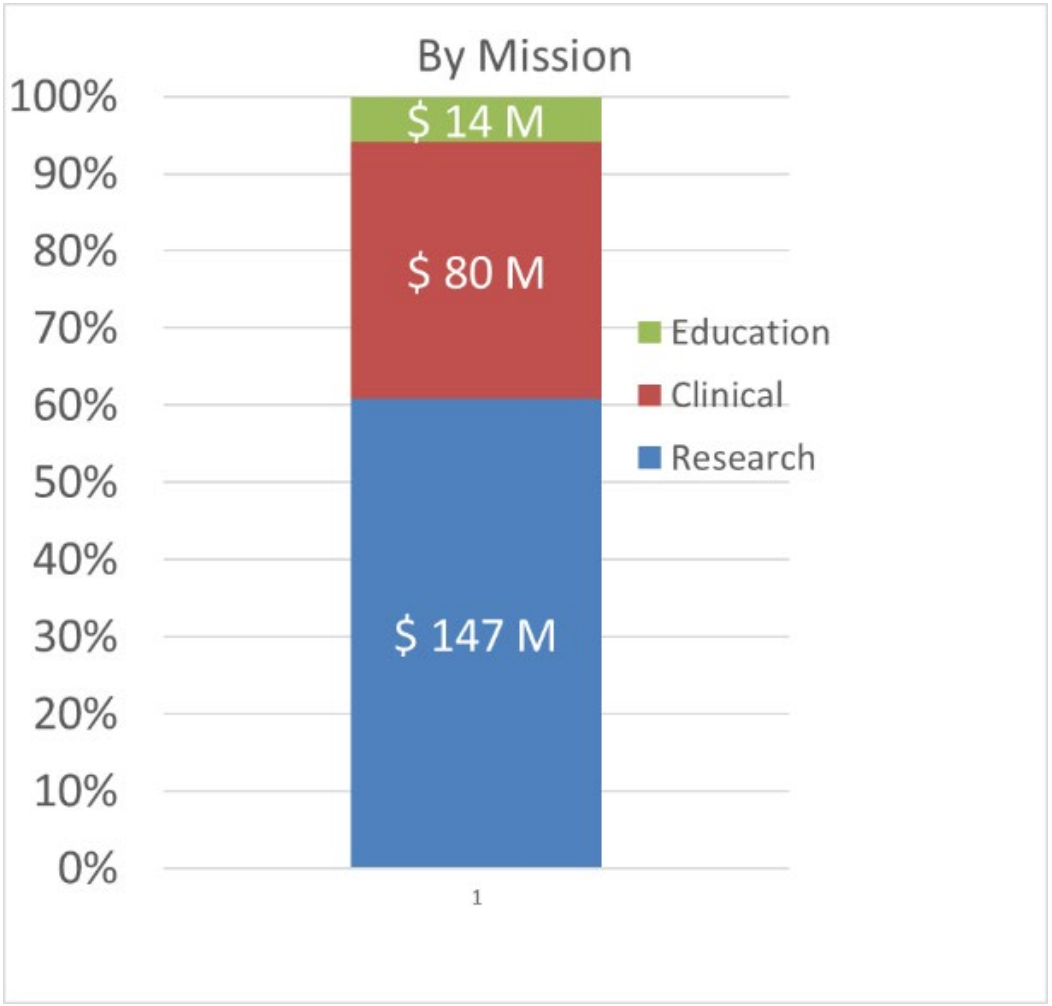
[1]27% of total Department of Medicine Revenue

Data pulled from SOM Dean's Office Financial Reporting Tool – Consolidated Budget Variance Report by Department

Total FY25 Expenses of $242M*



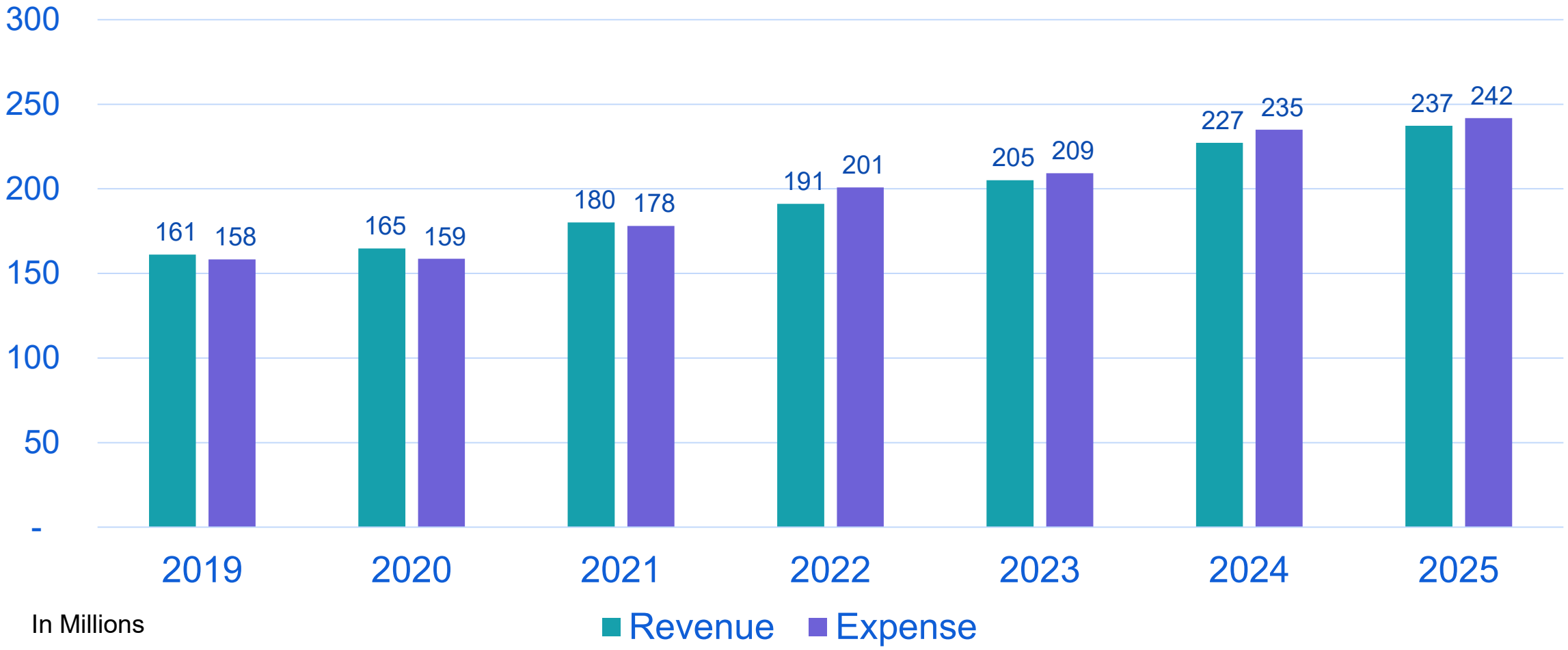
- Core administration staff costs are 4% ($9M) of total expenditures
- FY25 Mission and Clinical Overhead in Budget Model is $4M



*Expenses exceed revenue by $5M. Data reflects *current* year funding and does not include previous year carryover.

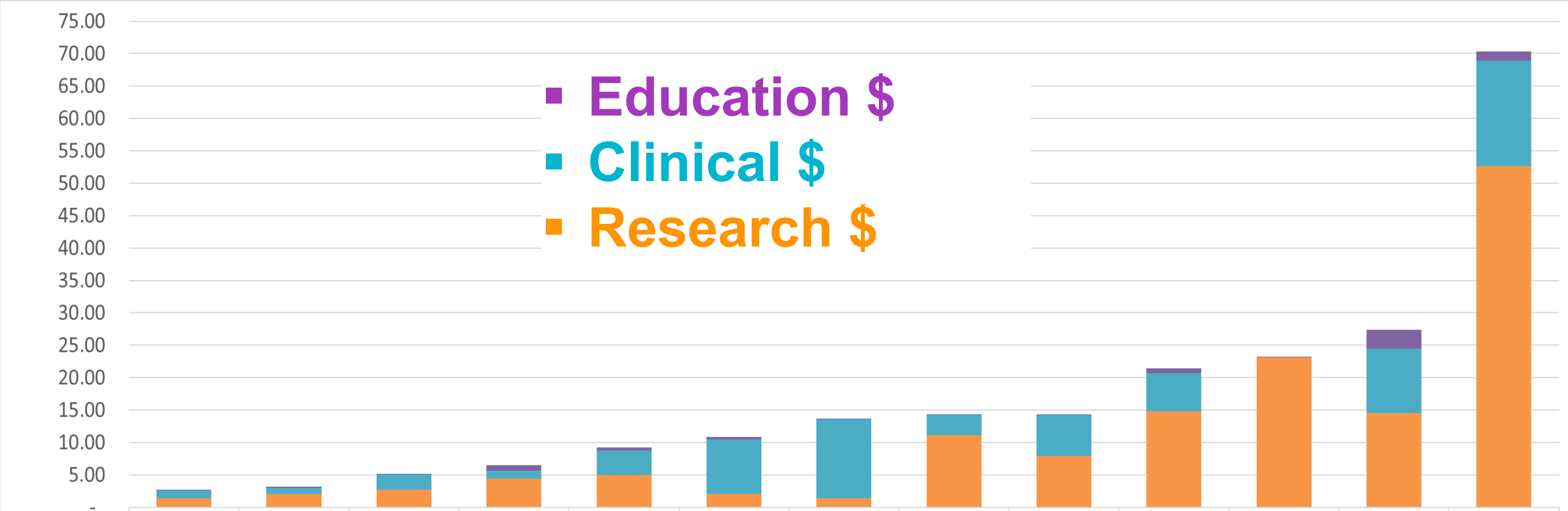
Data pulled from SOM Dean's Office Financial Reporting Tool – Consolidated Budget Variance Report by Department

DOM Revenue and Expenses 2019-2025



In Millions

FY25 Division Expenditures by Mission



	ENDO	RHEU	HMON	OCCM	GAST	NEPH	HOSP	DHES	CARD	PULM	EXPM	DGIM	HIVID
Education	0.05	0.25	0.01	0.81	0.51	0.40	0.01	0.05	0.09	0.67	0.08	2.97	1.48
Clinical	1.29	0.92	2.37	1.28	3.75	8.38	12.24	3.14	6.30	5.93	0.01	9.90	16.22
Research	1.36	2.06	2.66	4.39	5.00	2.08	1.36	11.09	7.93	14.78	23.11	14.52	52.64

In millions

Data pulled from SOM Dean's Office Financial Reporting Tool – Consolidating Mission Report by Department

Clinical Services

What services do we provide?

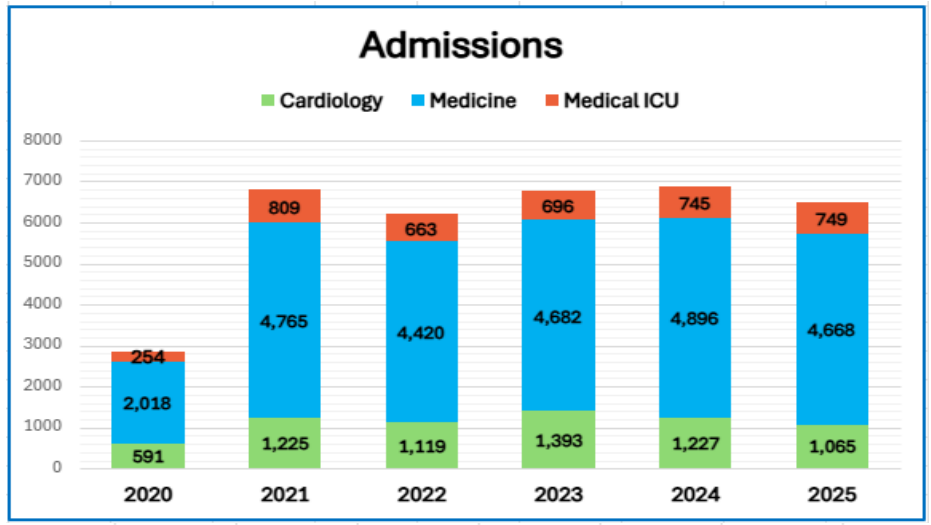
- **Inpatient Principal Care:**
  - General Internal Medicine: 5 resident/faculty (RIS) & 3 faculty only (FIS) teams)
  - Cardiology
  - Critical Care (MICU)
- **Inpatient Consultative Care (12 services)**
- **Primary Ambulatory Care (2 clinics)**
- **Specialty Ambulatory Care (18 clinics)**
- **Occupational Health Service**

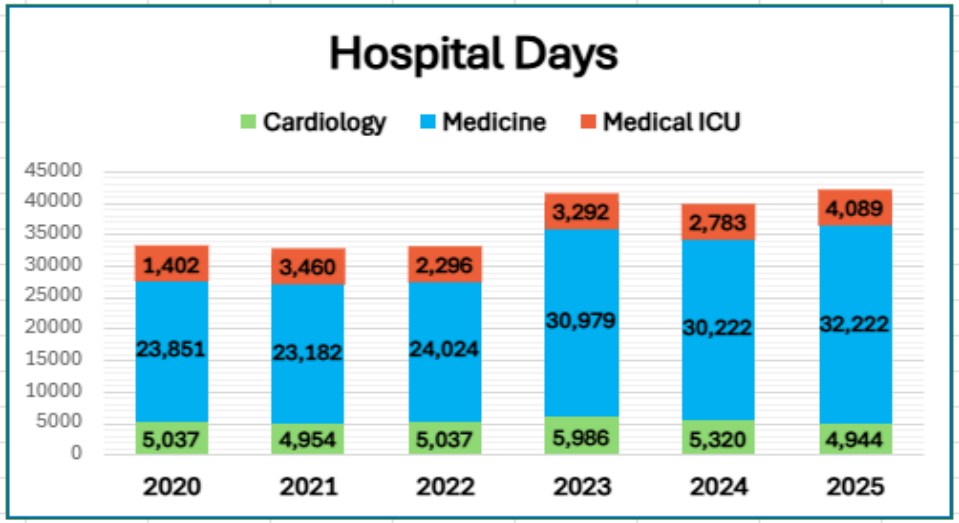
ZSFG Medicine represents:
21% ($80M) of total SOM Clinical Enterprise @ ZSFG Campus ($369M)

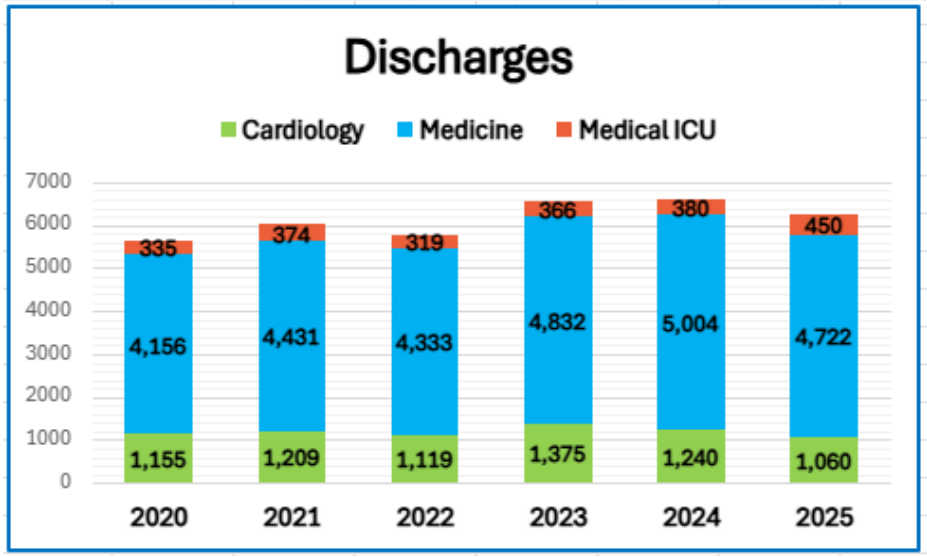
RIS = Resident Inpatient Service
FIS = Faculty Inpatient Service
MICU: Medical Intensive Care Unit

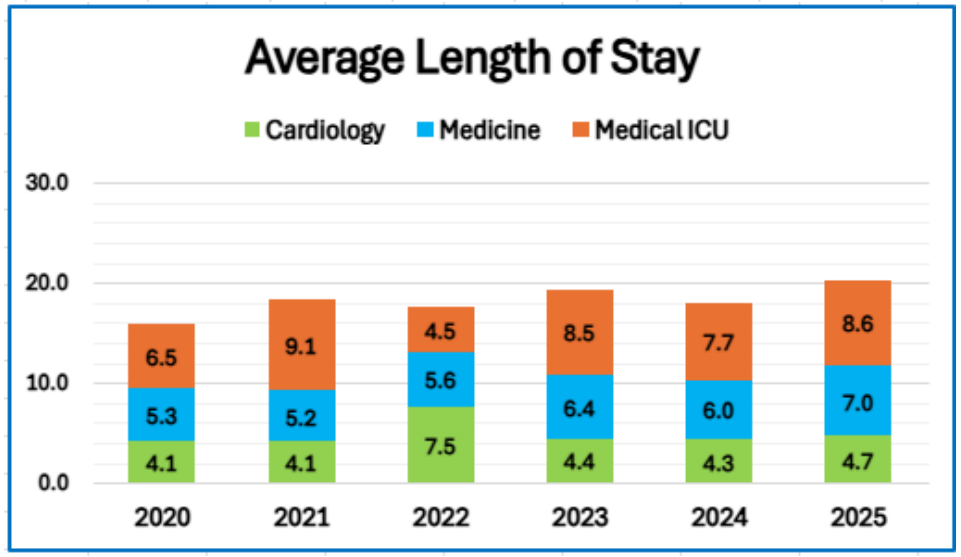
ZSFG Medicine Inpatient Volumes 2020-2025

Includes Resident Inpatient Service (5 teams), Faculty Inpatient Service (3 teams), Cardiology (1 team) and ICU (1 team)



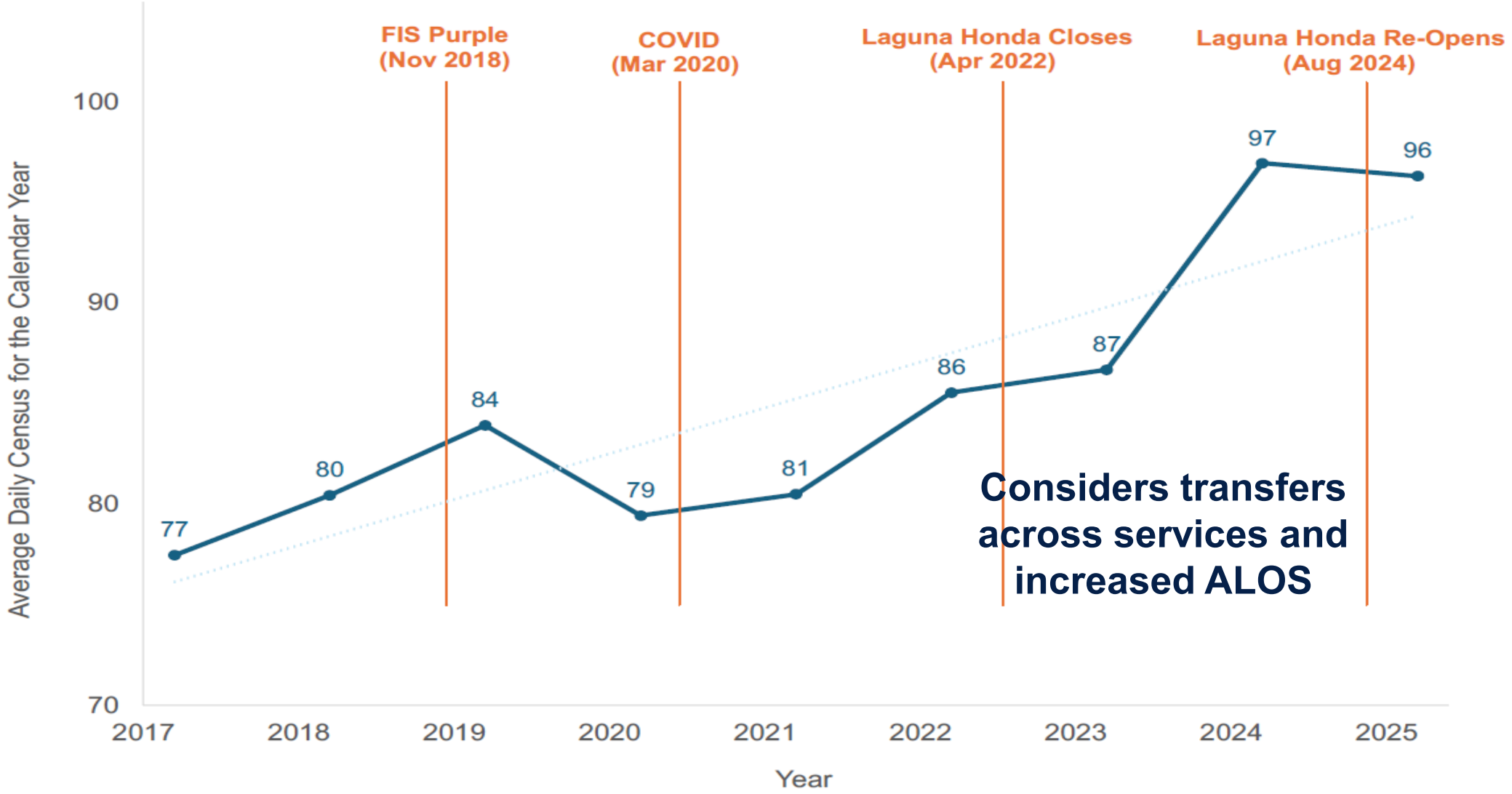






Data does <u>not</u> include 14 Inpatient Consult Services (Cardiology, Endocrinology, Gastroenterology, General Medicine, Geriatrics, Hematology, Infectious Disease, Rheumatology, Oncology, Med Toxicology, Nephrology, Palliative Care, Pain Med Mgmt, Pulmonary).

Average Daily Census on 5 Resident Inpatient and 3 Faculty Inpatient Medicine Services By Year (2017-2025)



ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

UCSF

Addressing the ZSFG Medicine Inpatient Census

Challenges/Drivers

- Medicine census has increased dramatically since 2017
- Census increase driven by increase in admissions as well as increased LOS
- Increased number of patients has contributed to burnout, moral distress, lower quality of care

Recent Countermeasures

- Developed job description, recruited and hired LLOC NP (Will Carpenter)
- Cohorted 10 LLOC patients on one team of NP, faculty attending, consistent SW support
- Developed resident surge moonlighter role
- Developed as needed overflow attending service

Palliative Care Service

Inpatient Consultation

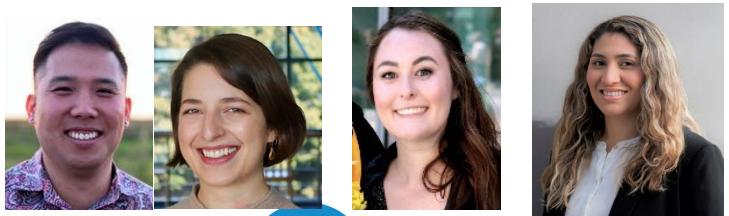
- Available for all patients in ICU, Medical-Surgical Units, and ED as of 05/08/2023.
- Onsite availability: 8:00 AM – 5:00 PM, Monday – Friday (not holidays)
- Available by pager (415-443-5548) evenings, weekends, and holidays

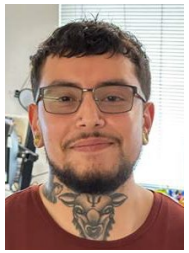
Outpatient Consultation

- Palliative Care Clinic in 4C (Tuesday 9:00 AM – 5:00 PM and Thursday 1:00 – 5:00 PM).
- Staff by NP only

Addiction Care Team ACT

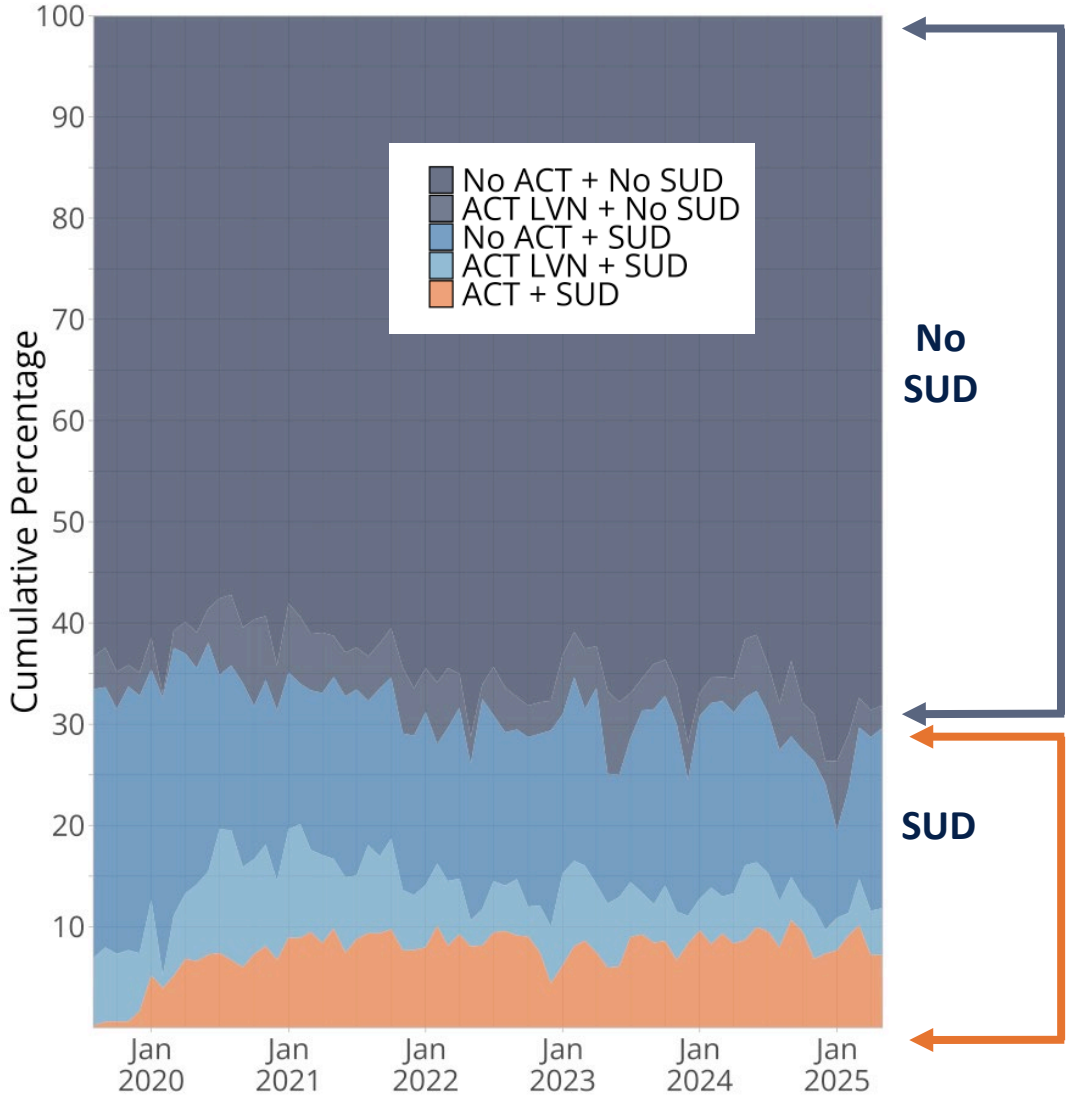
Clinical Services & Members



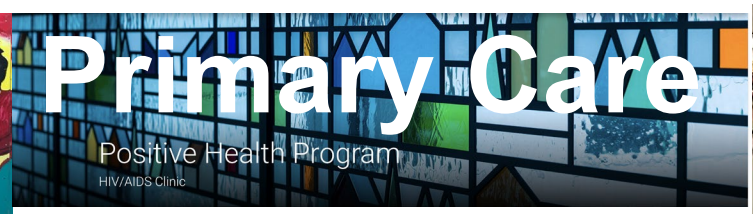


Marlene Martin, MD
Director

Alex Logan, MD
Associate Director



1 in 3 patients has an SUD and
ACT sees 1 in 3 of these



Richard Fine Peoples Clinic

- Est. 1970 as one of first outpatient clinics at a public hospital in the US
- Tradition of advocacy, activism, social justice
- Guiding principles of providing excellent, compassionate care to all; to be clinic, workplace of first choice
- Training site for 48 residents and fellows each year
- Mission-driven staff and NP, MD, and resident PCPs
- Experienced DGIM attendings practice and teach
- Medical directors are core UCSF clinician-educators (and SFPC alums!)
- Primary care, urgent care, and integrated behavioral health, nutrition, pharmacists, and interpreter services

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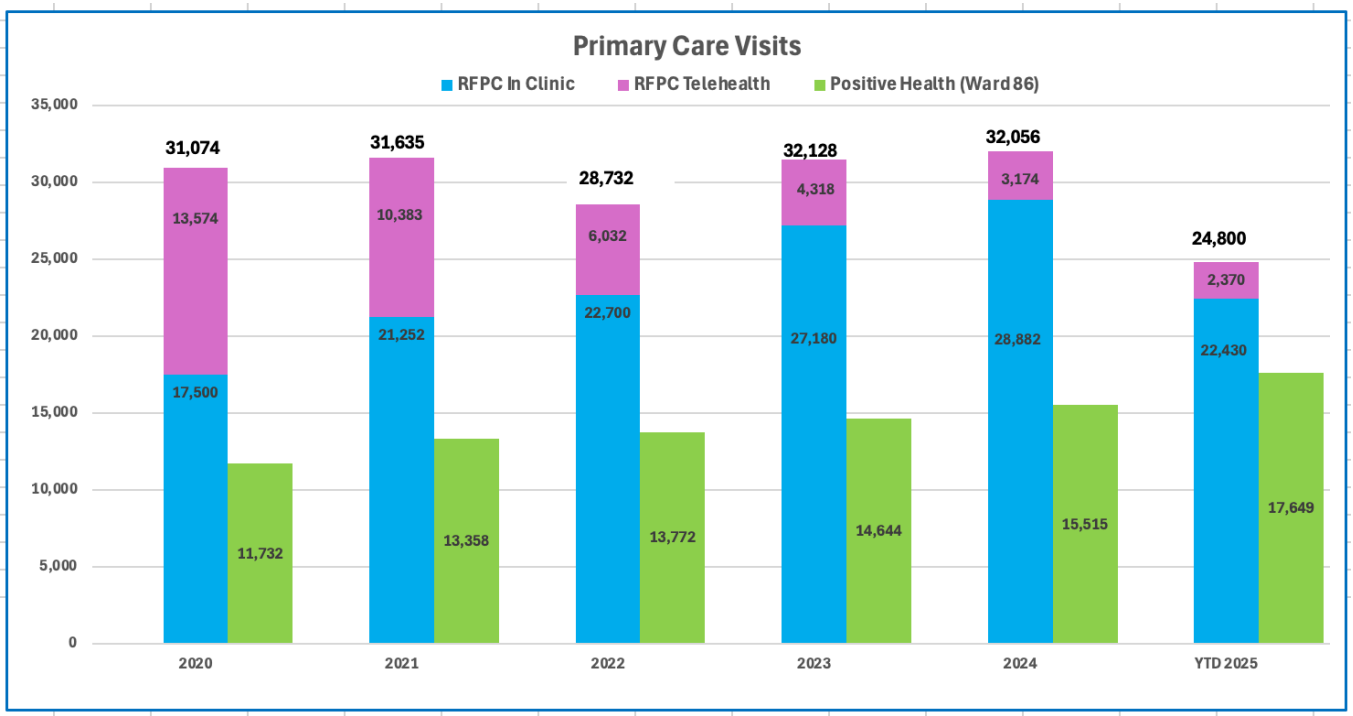
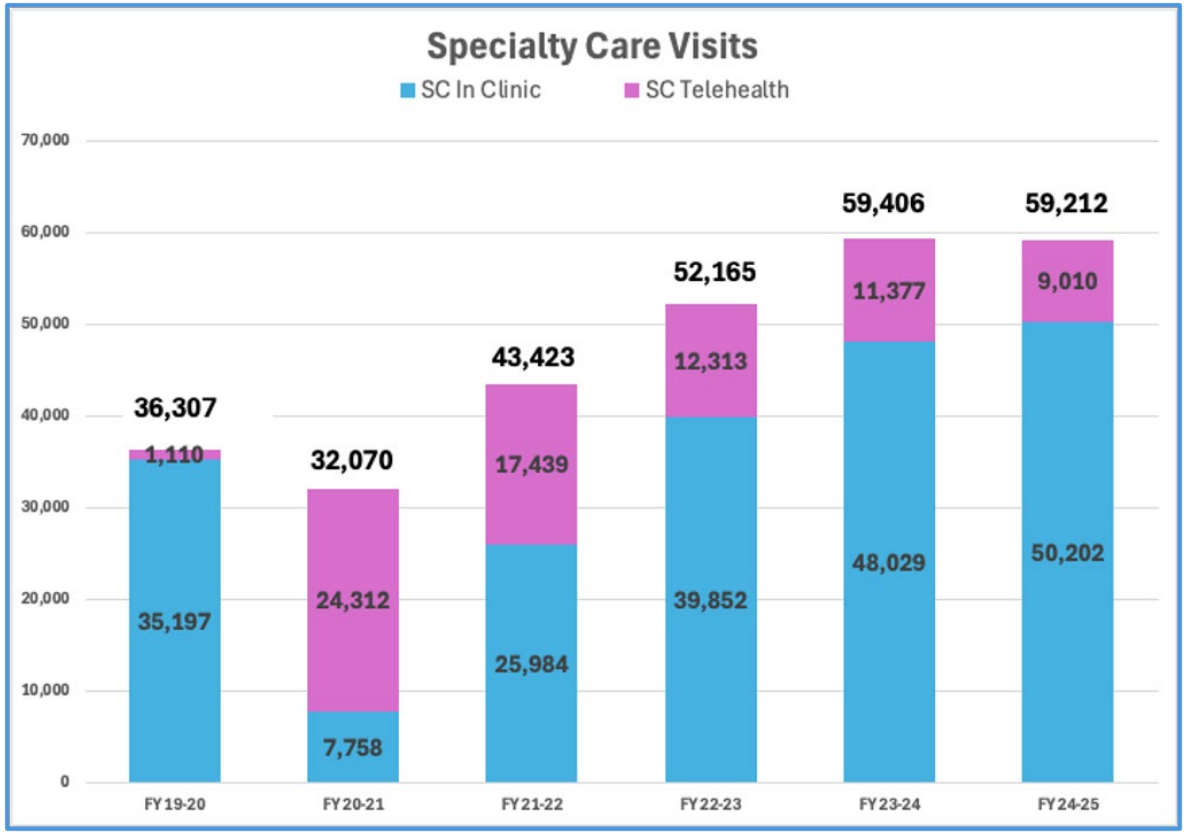
Positive Health Program (PHP)

- Est. 1983 as one of the first dedicated HIV clinics in U.S.
- Provides integrated primary and specialty care for SFHN HIV pts
- A comprehensive medical model that includes social services and case management
- Designated clinical programs include RAPID (same day therapy of diagnosis), PrEP (HIV prevention) program, SALUD clinic (Latino/a serving), Women's Clinic, Golden Compass (HIV and Aging program), POP-UP program (homeless with HIV program), SPLASH (long-acting ART/PrEP)

Primary Care Visits are Growing

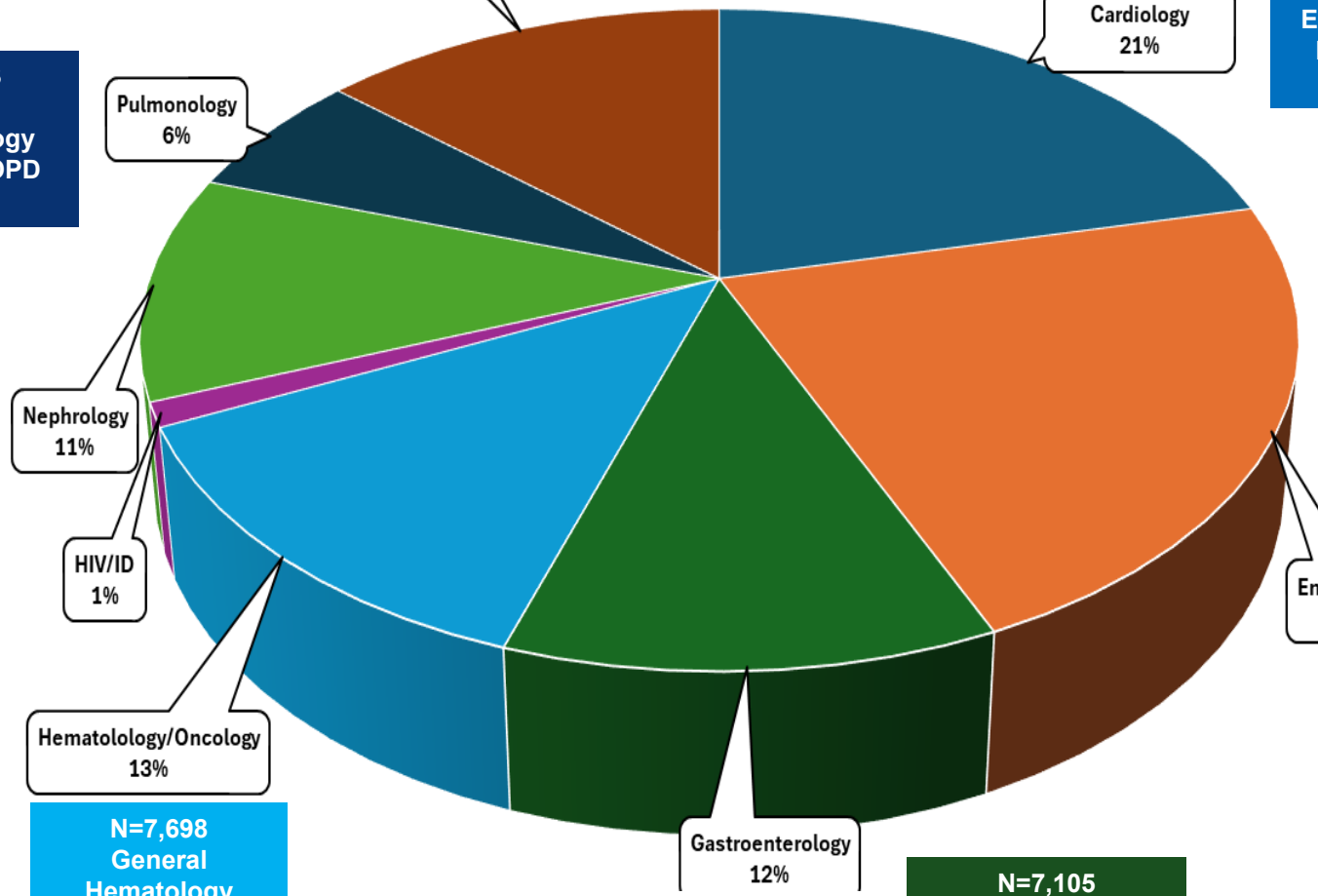


Ambulatory Specialty Care Visits are Accelerating



Ambulatory Specialty Care Clinic Visits FY 24-25

Total Visits = 59,221



N=8,289
General
Rheumatology

N = 12,434
General Cardiology
Heart Failure
Electrophysiology
Pulmonary HTN

N=3,553
General
Pulmonology
Asthma/COPD
Sleep

N=6,513
General
Nephrology
Renal Plus

N = 13,027
General
Endocrinology
Diabetes
Lipid
Weight Management

N=7,698
General
Hematology
General
Oncology
Breast Clinic
Sickle Cell

N=7,105
Gastroenterology
Hepatology

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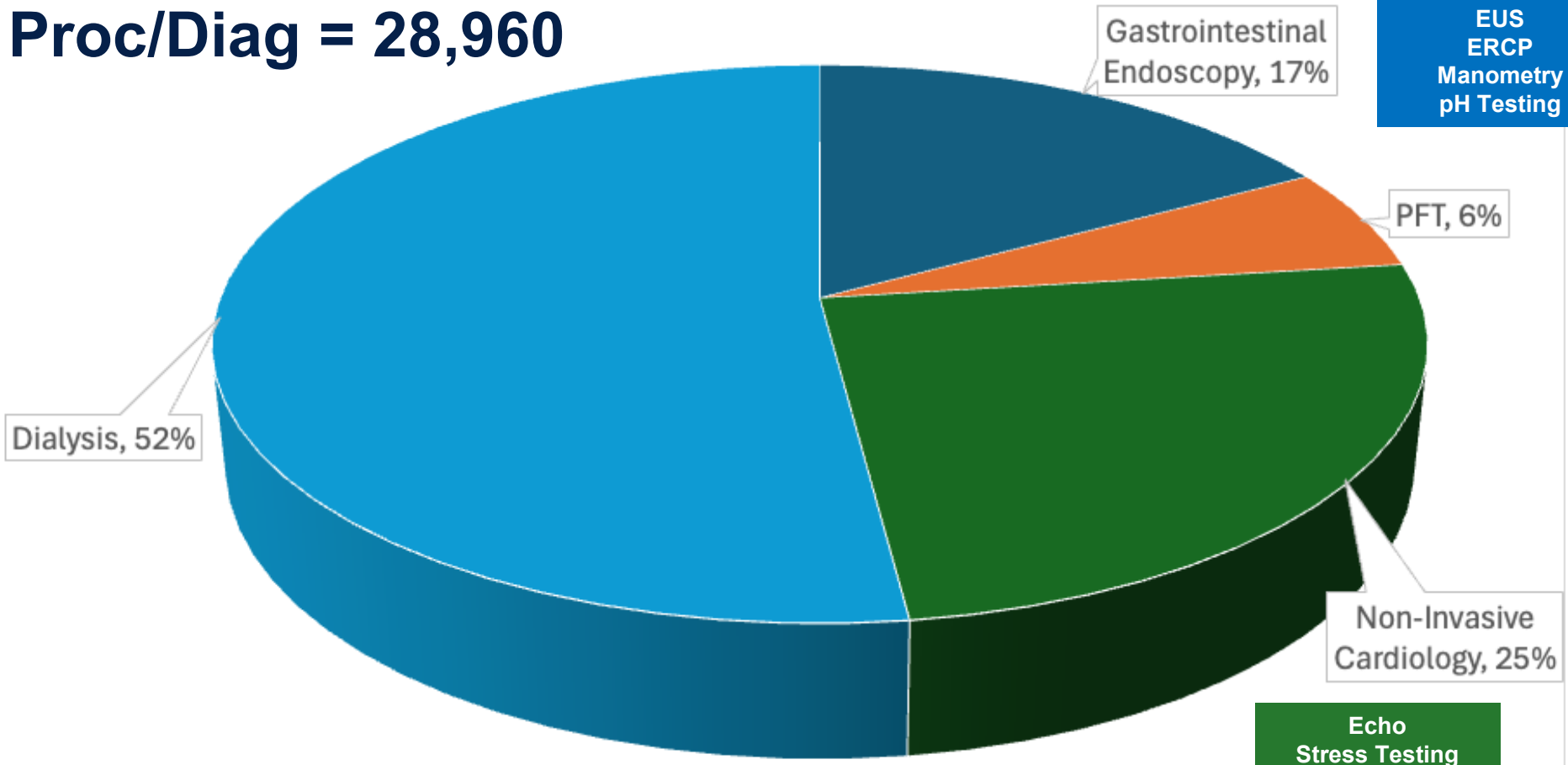
Specialty Care Procedures/Diagnostics FY 24-25
Inpatient and Outpatient

Total Proc/Diag = 28,960



EGD/Colonoscopy
EUS
ERCP
Manometry
pH Testing

Echo
Stress Testing
ECG monitors
Pacemaker

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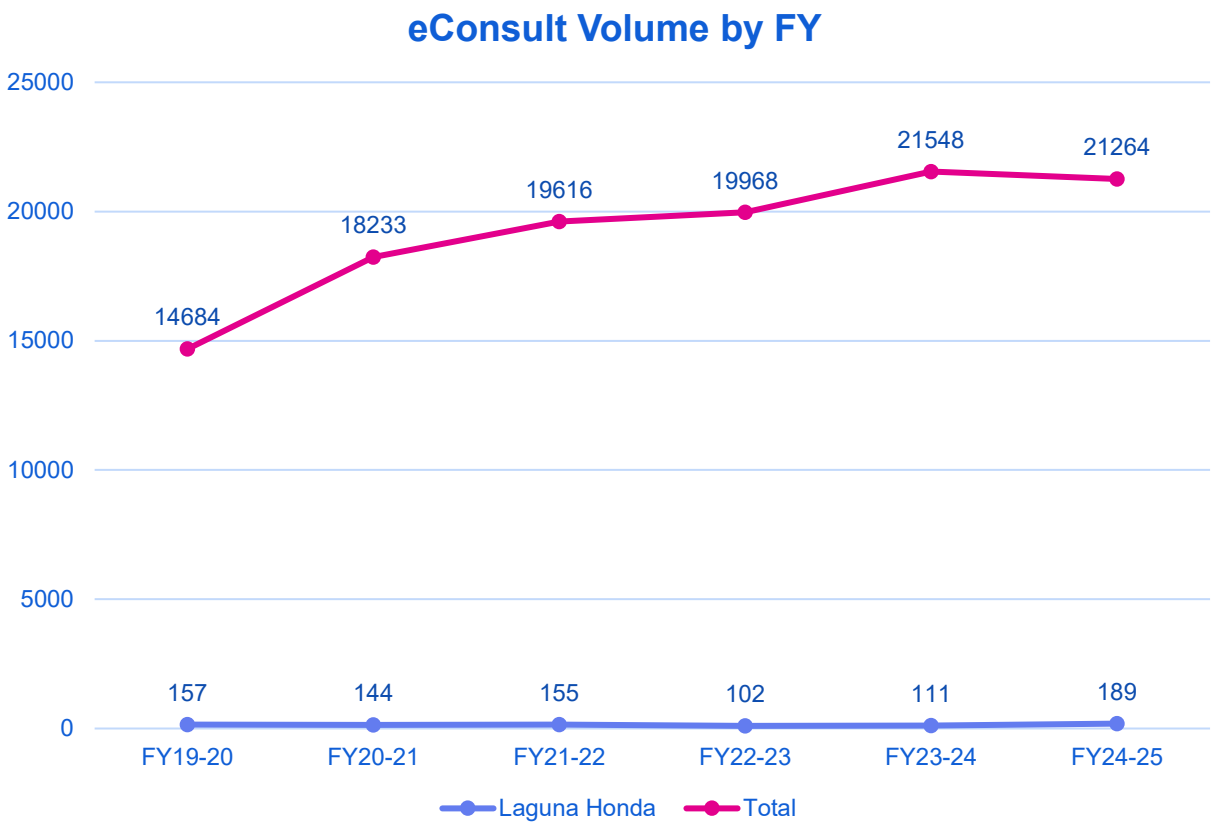
Hospital and Trauma Center

UCSF

Access to Care: eConsult Volume and Diversity



*Total includes both LHH and ZSFG

31 eConsult Service Lines

Endocrinology
- Endocrinology
- Lipid
- Diabetes Prevention
- Diabetes Clinic
- Weight Management

Infectious Disease
- Infectious Disease
- Long COVID
- COVID Outpatient Therapy
- General COVID-19 Questions
- HIV Pre-Exposure Prophylaxis
- Home and 4C based IV antibiotics
- LHH Infectious Disease

Oncology
- Hematology
- Oncology
- Cancer Genetics and Prevention
- Tumor Board
- Anal Dysplasia
- Palliative Care

Gastroenterology
- Gastroenterology
- Hepatology
- Direct Access Endoscopy

Cardiology
- Cardiology
- LHH Cardiology

Nephrology
- Nephrology
- LHH Nephrology

Pulmonary:
- Asthma COPD Group
- Pulmonary
- Sleep Disorder
- LHH Pulmonary

Geriatrics

Rheumatology

OCCUPATIONAL HEALTH SERVICES

Service to SFDPH and other city departments employees

2024 ACCOMPLISHMENTS

Physical examinations: 5,995

- Municipal transportation agency (Muni): 2,293 (38%)
- Department of Public Health: 1,777 (30%)
- SF Public Utilities Commission: 521 (9%)
- Department of Public Works: 436 (7%)

Employee COVID-19 diagnoses

- 3,823

Compliance with influenza vaccine health order:

- Overall: 72%
  - SFDPH: 51%
  - UCSF: 94%

Compliance with annual TB surveillance

- 47%
- 2022 policy was to ensure ALL staff underwent annual assessment
- Policy updated in 2023

2025 ACCOMPLISHMENTS (TO DATE)

Physical examinations: 4,506

- Municipal transportation agency: 1,208 (27%)
- Department of Public Health: 1,139 (25%)
- SF Public Utilities Commission: 577 (13%)
- Department of Public Works: 411 (9%)

Employee COVID-19 diagnoses

- 1,520

Compliance with influenza vaccine health order:

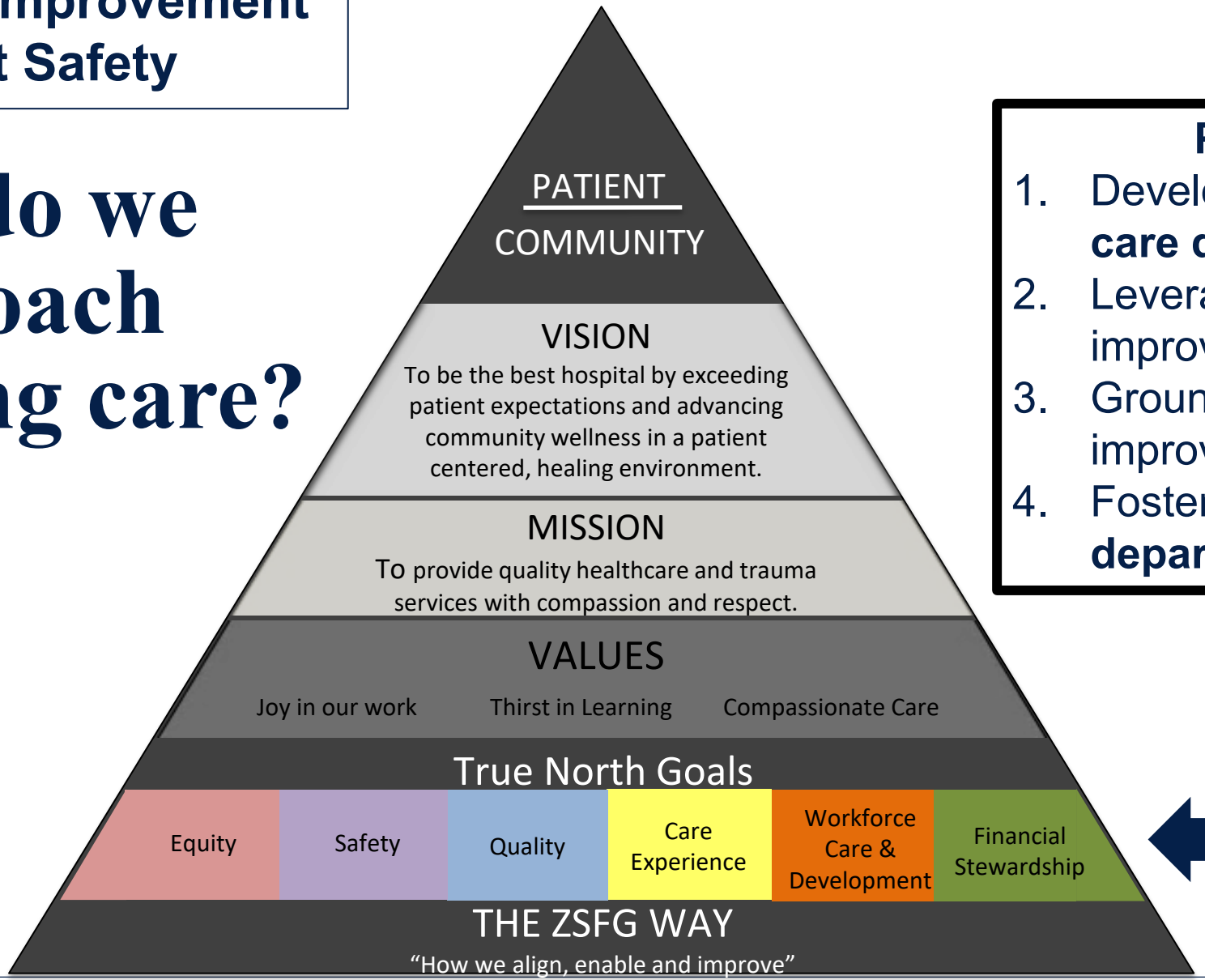
- Overall: 5,236 of 7,411 (71%)
  - SFDPH: 1,879 of 3,479 (54%)
  - UCSF: 3,357 of 3,932 (84%)

Compliance with annual TB surveillance

- 578 of 683 (85%)
- New policy: mandatory annual surveillance limited to groups at higher risk of TB exposure

Performance Improvement & Patient Safety

How do we approach improving care?

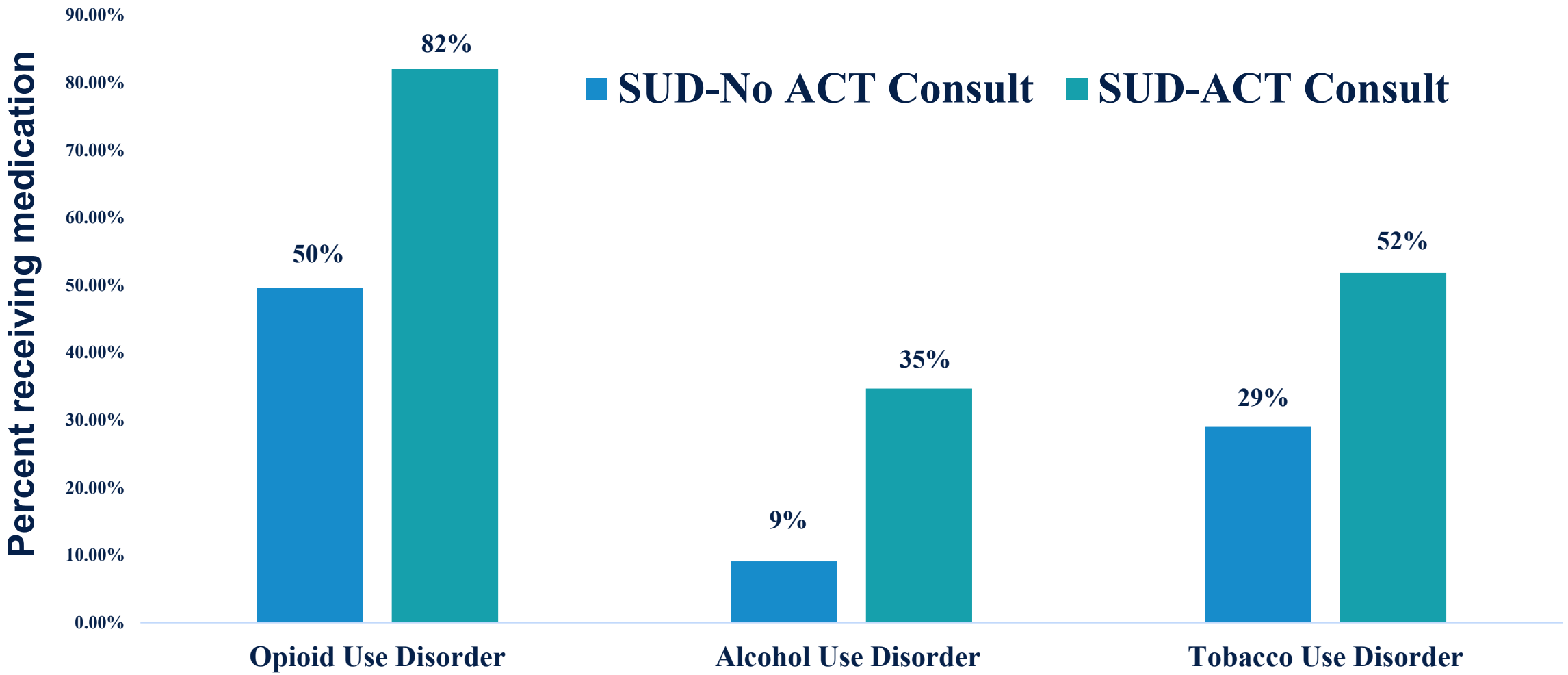


Priorities

1. Develop **novel clinical care delivery** programs
2. Leverage **EHR** to improve quality
3. Ground performance improvement in **equity**
4. Foster **cross-departmental** projects

See Appendix for expanded list of projects

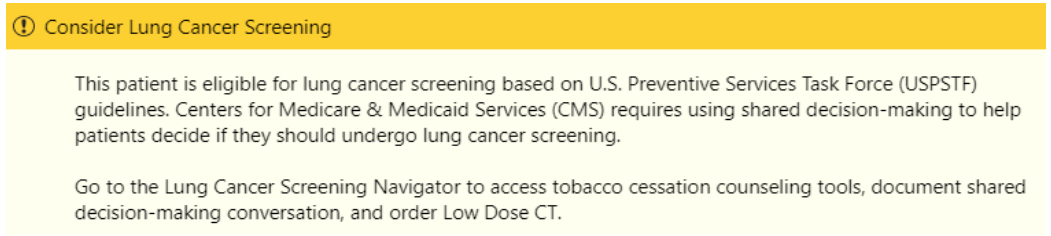
Novel Clinical Care Delivery: Addiction Care Team (ACT) Increases Rates of Medication Assisted Treatment for Persons with Substance Use Disorders (SUD)



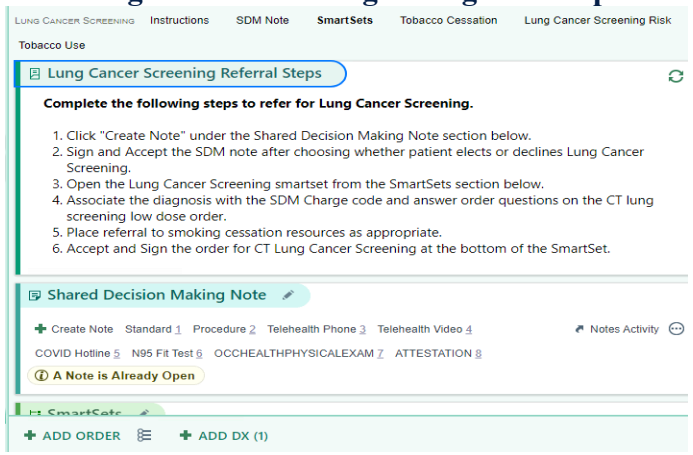
Leverage EHR: Decision Tool Optimizes Lung Cancer Screening

QI Intervention: Epic Build

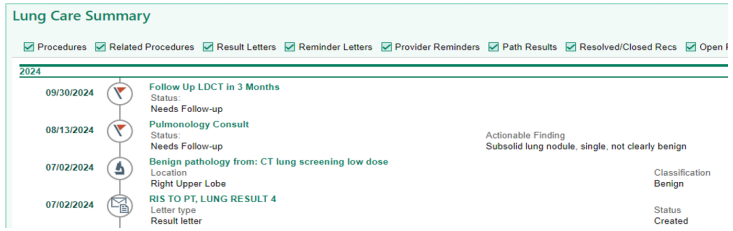
Automated eligibility assessment



Lung cancer screening "navigator" to provide guidance to PCP



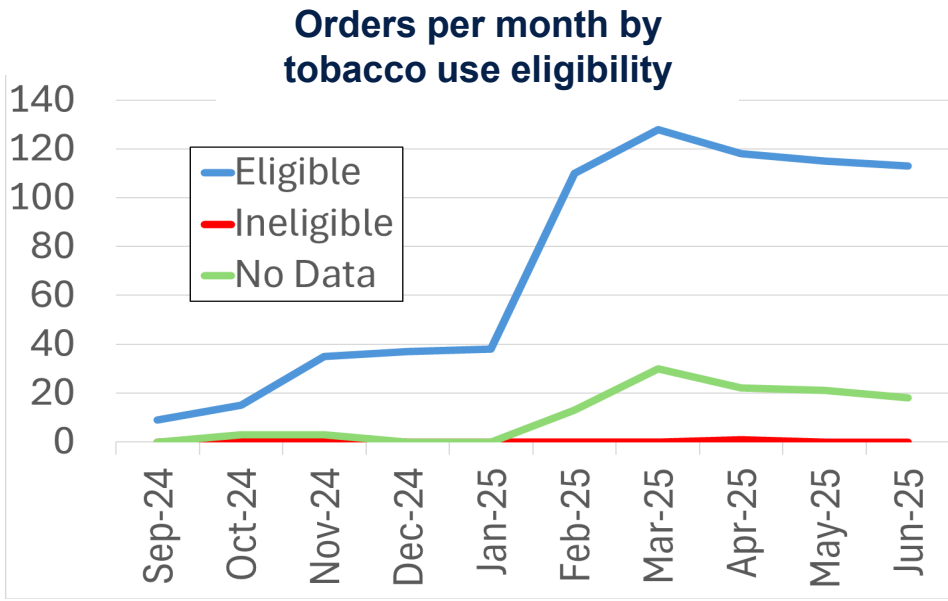
Lung cancer screening care summary

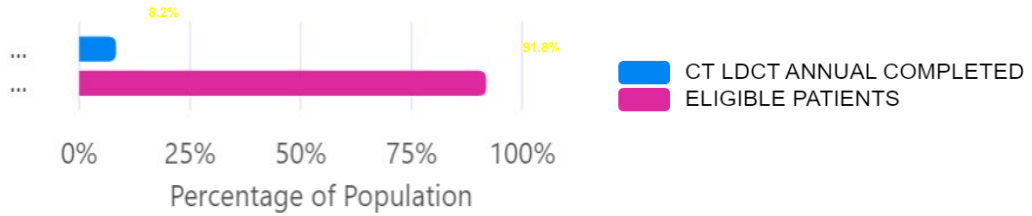


SFHN Lung Cancer Screening Rate (8.2% compared to <1% CA state average)

Reduction in radiology unscheduled work queue (June 2025: 211 unscheduled ~50% decrease from >~400)

Reduction in inappropriate orders (June 2025: 86% eligible, 0% ineligible, and 14% no data)





Equity: Culturally concordant group classes improve knowledge and efficacy about steatotic liver disease (SLD)

Table 2. SLD Knowledge, Beliefs About SLD, Barriers to SLD Care, and Confidence to Adhere to Provider Recommendations Before and After SLD Education ($N = 296$)

Domains and subdomains	Preeducation score	Posteducation score	Change (in score)	*P* value
Domain 1: Knowledge [max. score 10]	5.8 ± 2.6	7.7 ± 2.0	2.0 ± 2.5	**<.001**
Domain 2: Beliefs about SLD				
(a) Perceived severity (mean ± SD) [max. score 4]	1.6 ± 1.1	2.5 ± 1.0	0.9 ± 1.3	**<.001**
(b) Treatment efficacy (mean ± SD) [max. score 2]	1.0 ± 0.5	1.1 ± 0.5	0.1 ± 0.6	**.001**
(c) Self-efficacy to discuss SLD (%) [max. score 1]	58.6	68.0	9.4	**<.001**
(d) Perceived susceptibility to disease risk (mean ± SD) [max. score 2]	1.3 ± 0.6	1.8 ± 0.5	0.5 ± 0.7	**<.001**
Domain 3: Barriers to SLD care (mean ± SD) [max. score 15]	2.2 ± 2.0	1.9 ± 1.7	−0.3 ± 2.0	**.003**
Outcome: Confidence to adhere to provider recommendations regarding SLD care (mean ± SD) [max. score 4]	2.4 ± 1.4	2.7 ± 1.4	0.3 ± 1.5	**.004**

Boldface values indicate $P < .05$.
SD, standard deviation.

PMID: 39931048

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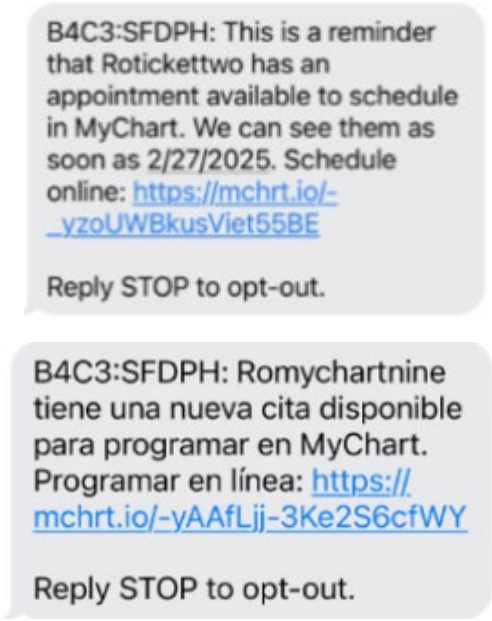
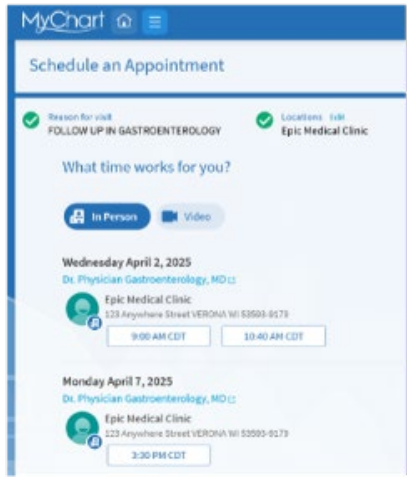
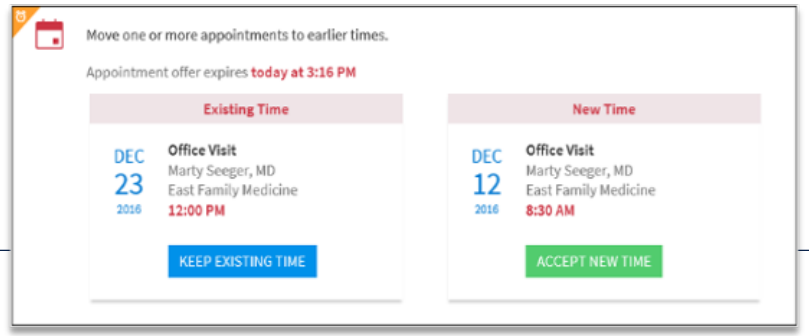
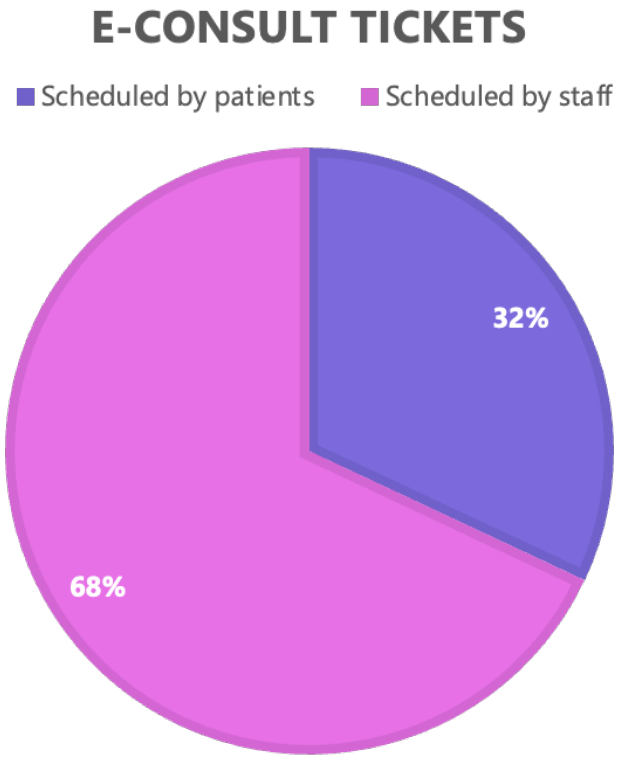
Innovation/Access in Care: Self-Scheduling and Template Optimization

- **Template optimization and patient-facing tools to improve access including self-scheduling, wait list features, reserving urgent slots**









Pilot clinics (GI/Liver + 5M): September 2025

Equity | Safety | Quality | Care Experience | Workforce Care & Development | Financial Stewardship

UCSF

Cross Departmental: Multidisciplinary Approach Improves Gastric Cancer Care

Category	Specific Goal	PRE	*Target*	POST	
Tumor Board	Increase the % of cM0 cases presented at Tumor Board	36% (n=11)	***>90%***	**86% (n=14)**	**p= 0.033**
Endoscopic ultrasound (EUS)	Increase the % of cases referred for EUS for clinical T and N staging (if CT is negative for distant metastases)	9% (n=11)	***>90%***	**64% (n=14)**	**p= 0.017**
Emergent metric: nodal staging with EUS or PET		27% (n=11)	***N/A***	**79% (n=14)**	**p=0.030**
Neo-adjuvant chemotherapy	Increase the % of eligible patients (cT2+ or N+) receiving peri-operative (i.e., neo-adjuvant) chemotherapy	20% (n=10)	***>80%***	**80% (n=10)**	**p=0.007**
Surgery documentation	Improve documentation of lymphadenectomy type (i.e., D1 or D2)	25% (n=8)	***100%***	**100% (n=7)**	**p=0.015**
Pathology reports	Improve synoptic reporting and definition of margin status in pathology report	N/A	***100%***	**100% (n=7)**	**-**
Time to PET/CT	Decrease time from Dx to PET/CT at UCSF for patients without cM1 disease (median / mean)	8.9 wks / 8.1 wks	***<5 wks***	**7.1 wks / 6.6 wks**	**p=0.268**

Leadership Communication and Responsiveness

Challenges/Drivers

- Perception that division and department leadership (and UCSF) could better partner in advocacy to improve clinical workload
- Desire for dept leadership to meet, share with and educate on-the-ground faculty
- Sense that senior (Dean's Office/C-suite) leaders would benefit from more awareness of on-the-ground challenges related to clinical work and staffing
- Frustration with business plan process to right-size affiliation agreement staffing and promote innovation

Countermeasures

- Town halls attended by hospital and health system leaders to hear from faculty and communicate changes made
- Tea sessions with Chief: small groups to hear directly from faculty at all career stages
- Departmental leadership direct-to-faculty email communications about important changes
- Department leadership meeting summaries shared with chiefs for dissemination to faculty
- Researcher affinity and work-life integration groups
- Support for faculty involved in business plan submissions
- Creation of departmental ambulatory leadership group

Recognizing Excellence: ZSFG Medicine Faculty Awards 2024-2025

- **Performance/Quality Improvement Award:** Lucas Zier, Anne Rosenthal
- **Henry F. Chambers, MD Medicine Subspeciality Consultant Award:** Sarah Kim, Sandra Moody
- **Care Experience Award:** Jaya Mallidi, Lurit Bepo
- **Clinical Innovator Award:** Elizabeth Imbert, Seth Goldman
- **Distinction in Medical Education Award:** Alex Logan, Lisa Ochoa-Frongia
- **Outstanding Early Career Investigator Award:** Matt Durstenfeld, Leslie Suen
- **Professional Altruism Award:** Justin Tien, Vanessa Thompson
- **Mentoring Award:** Jinoos Yazdany, Alicia Fernandez
- **John Murray, MD Award for Excellence in Internal Medicine:** Neeta Thakur, Mary Gray
- **Robert Lull, MD Non-Internal Medicine Consultant Award:** Adnan Alseidi (Gen Surg), Elaine Dekker, RN (Infection Control)
- **Bailowitz Volunteer Faculty Award:** Ramona Doyle, Elizabeth Abbs
- **Clinical Fellow Award:** John Landefeld, Cody Cichowitz
- **Diversity, Equity, and Inclusion Award:** Katherine Lupton, Marlene Martin

Celebrating Excellence: 2024 ZSFG Department of Medicine Faculty Awards

Celebrating Excellence: 2025 ZSFG Department of Medicine Faculty Awards

ZSFG Medicine Award Recipients, first row, left to right: Marlene Martin, MD, Leslie Suen, MD, Elaine Dekker, RN, Anne Rosenthal, MD, Sandra Moody, MD. Back row: Beth Harleman (Chair of Selection Committee), Cody Cichowitz, MD, Elizabeth Abbs, MD, Alicia Fernandez, MD, Mary Gray, MD, Vanessa Thompson, MD, Lurit Bepo, MD, Lisa Ochoa-Frongia, MD, Seth Goldman, MD, Neil Powe (Chief of Medicine).

Recognizing Excellence: ZSFG Medicine Staff Awards 2024 and 2025

- **Excellence in Administrative Service:** Vanessa York, Jennifer Lau, & Eva Lo
- **Excellence in Leadership:** Elizabeth Gutierrez & Justin Vang-Moore
- **Excellence in Research:** Jillian Kadota Tomlinson, Mary Beth Moreno, Celeste Enriquez, & Robin Fatch
- **Excellence in Patient Care:** Wendy Ching, Johanna Sluser, & Mary Shields

16 UCSF DOM Master Clinicians – Professional Excellence

Joan Addington-White, MD
- General Internal Medicine

Soraya Azari, MD
- General Internal Medicine

Chip Chambers, MD
- Infectious Disease

Monica Gandhi, MD
- HIV, ID, & Global Medicine

Jonathan Graf, MD
- Rheumatology

Sarah Goglin, MD (2025)
- Rheumatology

Antonio Gomez, MD
- Pulmonary & Critical Care

Mary Gray, MD
- Cardiology

Beth Harleman, MD
- Hospital Medicine

John Imboden, MD
- Rheumatology

Mimi Margaretten, MD
- Rheumatology

Marlene Martin, MD (2024)
- Hospital Medicine

Lisa Murphy, MD
Endocrinology

Edgar Pierluissi, MD (2024)
- Hospital Medicine

Margaret Wheeler, MD
- General Internal Medicine

Lisa Winston, MD
- Hospital Medicine & Infectious Disease

ACGME-based OPPE Metrics

Patient Care

- Death
- Medication & allergy review
- Access: panel size maintenance
- Screening:
  - Colorectal cancer
  - HIV
- Procedures:
  - Adverse events (biopsy, pacemaker, bronchoscopy, endoscopy)
  - Technique (cecal intubation and mean withdrawal time for colonoscopy)
  - Results (polyp detection rate for colonoscopy; adequacy of thyroid FNA)
- Disease management:
  - Hypertension control
  - Rheumatoid arthritis disease activity

Professionalism

- Conference attendance
- Timely completion of trainee's evaluation
- Adherence to clinical duty schedule

Practice-Based Learning & Improvement

- QI
- CURES check
- Annual ZSFG training modules
- Completion of pre-chemo checklist prior to treatment

Medical/Clinical Knowledge

- Board certification, CA License
- CME
- Teaching skills

Interpersonal & Communication Skills

- Unusual Occurrences
- Patient, staff, colleague, student complaints

System-Based Practice

- Timely note completion
- Timely E-consult response

Med Staff Committee Membership

Ambulatory Care Committee
- Elizabeth Murphy
- Shreya Patel
- Neda Ratanawongsa
- Anne Rosenthal
- Shobha Sadasivaiah
- Delphine Tuot

CIDP Committee
- Gabe Ortiz

By Laws Committee
- Jeff Critchfield
- Joanna Eveland
- Gabe Ortiz

Credentials Committee
- Kelly Han
- Gabe Ortiz

Primary Care Performance Improvement Committee
- Claire Horton (COS past)
- Vivek Jain
- Anne Rosenthal
- Dan Wlodarczyk

Risk Management Committee
- Jeff Critchfield (Co-Chair)
- Mary Gray (Co-Chair)

Utilization Management
- Gabe Ortiz

Medical Staff Wellbeing
- Jeff Critchfield
- Larissa Thomas

Nominating Committee
- Jeff Critchfield

Joint Conference Committee
- Jeff Critchfield
- Gabe Ortiz

Committee on Interdisciplinary Practice
- Kelly Han – Chair
- Vanessa Thompson
- Emily Wistar

Medical Executive Committee
- Jeff Critchfield

Performance Improvement & Patient Safety (PIPS) Committee
- Jeff Critchfield
- Gabe Ortiz
- Lisa Winston

Cancer Committee
- Paul Couey
- Niharika Dixit
- Terry Friedlander
- Mary Ellen Kelly

Ethics Committee
- Bob Brody

Critical Care Committee
- Elaine Dekker
- Antonio Gomez
- Carolyn Hendrickson
- Jaya Mallidi
- Gabe Ortiz
- Sithu Win
- Lucas Zier

Education and Training

Who and What We Teach

MEDICAL STUDENTS:

- 1/3 (n=52 students) of each SOM class annually are on medicine rotation
- **Model ZSFG**: Site-Based Continuity Clerkship Program
  - Students spend 8 months at SFGH, including the Medicine core clerkship
  - FCM, med, psych, OB/Gyn, peds, neurology surgery participate
  - 22-24 Students participate annually
- **Match 2025**: 32 UCSF students applying in medicine (25% match at UCSF)

EDUCATIONAL INNOVATIONS:

- Health and Society Pathway Health Equities Track
- Prison medicine, substance use, homeless medicine Curricula/electives
- Quality Improvement curriculum and projects
- Vertical Mentorship: residents/senior students mentor pre-clinical student projects & clinical experiences
- WEEKLY M&M Conferences
  - Many focused on patient safety in vulnerable populations
- CME course on Care of Vulnerable Populations

RESIDENTS:

3 Chief Residents: Pooja Lalchandani (Inpatient); Harry Cheung (Inpatient); Tamara Sanchez-Ortiz (Ambulatory)

- **31 Residents/month** on inpatient SF Wards, SF Cards, SF ICU, SF Med Consult (Includes Psychiatry, FCM, Anesthesia, and EM residents)
- 35 **Residents with highly rated continuity clinics** in RFPC (24 in ZSFG primary care residency (leadership in care of underserved) with 6 funded by HRSA Primary Care Grant Funds)
- 10 Clinical Fellows (8 subspecialties)
- 39 Post-doctoral scholars

UCSF/Zuckerberg San Francisco General Hospital Primary Care Internal Medicine Residency Program (SFPC)

Teaches the practice of comprehensive, high-quality medicine for historically marginalized and underserved people and populations and cultivates the next generation of leaders in primary care, education, advocacy, and scholarship.

- Joanie Addington-White, MD, Program Director
- Lisa Ochoa-Frongia, MD, Associate Program Director
- Eva Lo, Program Coordinator
- Jonathan Ballard, Administrative Officer

AAMC in 2025 projected a shortage of 20-40,000 primary care physicians by 2036

- SFPC graduates in past 5 years (n=39):
  - **82% working in primary care settings**
  - 10% in medicine subspecialties
  - 8% in hospital medicine
  - These percentages are similar to our historic averages
- Many SFPC graduates work in DGIM at ZSFG --->

UCSF Addiction Medicine Fellowship

Prepares physicians to be leaders in care of persons with unhealthy substance use in safety net communities Embedded in public sector health care delivery system

- 1st addiction medicine (ADM) fellowship in UC system, 2015
- Initial ACGME accreditation, 2018
- Over 20 ADM board-certified multidisciplinary faculty
- 8 cohorts (31 fellows) completed training program, all BE/BC
  - 94% practice in medically underserved communities
  - 74% provide primary care
  - 58% serve in the Bay Area
- **Synergistic with Addiction Care Team ACT**
- Primary funding source: City & County of San Francisco
- Second 5-year $4M HRSA expansion grant (2020-25, 2025-30) to address national shortage of ADM specialists in underserved and community-based settings
- Private donations

Communication is our procedure

2025-2026 UCSF Addiction Medicine Fellows

Program Director: Paula J. Lum, MD MP
Associate Program Director: Alex Logan, MI
Program Administrator: Alyssa Michaels, M
Learn more at: https://addictionmed.ucsf.ed

20 Members of the Haile T. Debas Academy of Medical Educators

Katherine Brooks
- Hospital Medicine
- **2024 Inductee**

Jennifer Mandal, MD
- Rheumatology
- **2024 Inductee**

Harini Sarathy, MD
- Nephrology
- **2025 Inductee**

David Chia, MD
- Hospital Medicine

Mary Margaretten, MD
- Rheumatology

Justin Sewell, MD
- Gastroenterology

Alicia Fernandez, MD
- General Internal Medicine

Meghan O'Brien, MD
- Hospital Medicine

Shelene Stine, MD
- Hospital Medicine
- **2024 Inductee**

Meghana Gadgil, MD
- Hospital Medicine
- **2024 Inductee**

Lisa Ochoa-Frongia, MD
- General Internal Medicine

Larissa Thomas, MD
- Hospital Medicine

Sarah Goglin, MD
- Rheumatology

Binh An Phan, MD
- Cardiology

Vanessa Thompson, MD
- General Internal Medicine

Beth Harleman, MD
- Hospital Medicine

Edgar Pierluissi, MD
- Hospital Medicine

Lisa Winston, MD
- HIV, ID, and Global Medicine

Kate Lupton, MD
- General Internal Medicine

Sumant Ranji, MD
- Hospital Medicine

Care.
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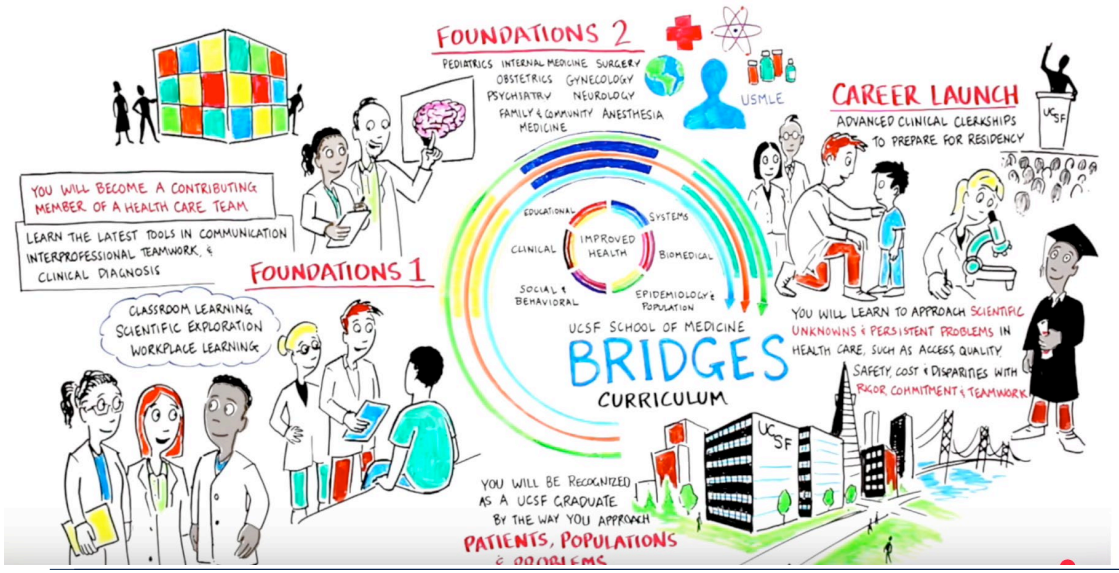
Bridges Curriculum Clinical Microsystem Clerkship

- **Bridges Coaches in ZSFG DOM (n=7)**
  - Rebeccah Brusca, MD, MPH
  - Bethlehem Churnet, MD
  - Veronica Manzo, MD, MS
  - Mimi Margaretten, MD, MAS
  - Meghan O'Brien, MD, MBE
  - Jamie Yao, MD
  - Meghana Gadgil, MD



- **5-6 students per coach**
- **MS-1s involved in quality improvement projects aligned with ZSFG True North metrics, related to flow, interprofessional teamwork, patient experience, patient education, safety.**

ZSFG DOM Bridges Coaches


Meghan O'Brien
Hospital Medicine


Mimi Margaretten,
MD Rheumatology


Jaime Yao
Hospital Medicine


Veronica Manzo
Hospital Medicine


Rebecca Brusca
Hospital Medicine


Bethleham Churnet
Hospital Medicine


Meghana Gadgil,
Hospital Medicine

Teaching Awards 2024-2025

2024 (n=6)

- **Alicia Fernandez** – 2024 Academic Senate Distinction in Mentoring Award
- **Mary Gray** – Patricia Cornett Subspecialty Faculty Teaching Award
- **Jaya Mallidi** – Floyd C. Rector Award for Excellence in Teaching
- **Monica Gandhi** – 2024 Lifetime Achievement in Mentoring Award
- **Carolyn Hendrickson** – Academy of Medical Educator Excellence in Teaching Award
- **Laurence Huang** – Academy of Medical Educator Excellence in Interprofessional Teaching Award

2025 (n=6)

- **Binh An Phan** – Bridges Curriculum Award for Excellence in Innovative Teaching Modalities
- **Shelene Stine** – Henry J. Kaiser Award for Excellence in Teaching
- **Laurence Huang** – UCSF Academic Senate Distinction in Mentoring Award
- **Jaya Mallidi** – UCSF Academic Senate Distinction in Teaching Award
- **Laurence Huang** – Distinction in Mentoring Award
- **Jaya Mallidi** – Distinction in Mentoring Award

ZSFG Medicine discovery for the betterment of our patients

Research: Crosscutting & Other Themes

Disparities & Health Equity
- Asthma
- Prostate cancer
- Diabetes & obesity
- Systemic Lupus Erythematosis
- Health technology
- Transitional care
- Tobacco
- Genetic counseling
- Undocumented immigrant health
- Women's Health

Interventions
- HIV, TB & Hepatitis Rx
- Malaria Rx
- Immunotherapy
- Hemodialysis and artificial kidney
- Bariatric surgery
- Acupuncture & pain control
- Cholesterol therapeutics

Social & Environ Exposures
- Homelessness
- Food insecurity & diet
- Tobacco, eCigarettes & 2nd hand smoke
- Cannabis
- Substance use/addiction
- Disease outbreaks & surveillance
- Ozone
- Climate Health and Equity

Health Care Delivery
- Quality of Care
- Transitional care
- Health communication
- Health IT
- Electronic referral

Disease Mechanisms
- Inflammation & immunity
- Fibrosis
- Cellular stress & cell death

Methods
- Omics & biomarkers
- Implementation science
- Informatics & data science
- Stem cell biology

Prevention
- Colorectal cancer screening
- Hepatitis B screening
- Diabetes
- Malaria transmission
- HIV transmission
- Kidney disease awareness
- HIV bone loss
- SARS CoV-2
- Vaccine Research (TB, HCV)

Research: Crosscutting & Other Themes

Areas Directly (or disproportionally) Affected by Trump Administration Priorities

Disparities & Health Equity
- Asthma
- Prostate cancer
- Diabetes & obesity
- Systemic Lupus Erythematosis
- Health technology
- Transitional care
- Tobacco
- Genetic counseling
- Undocumented immigrant health
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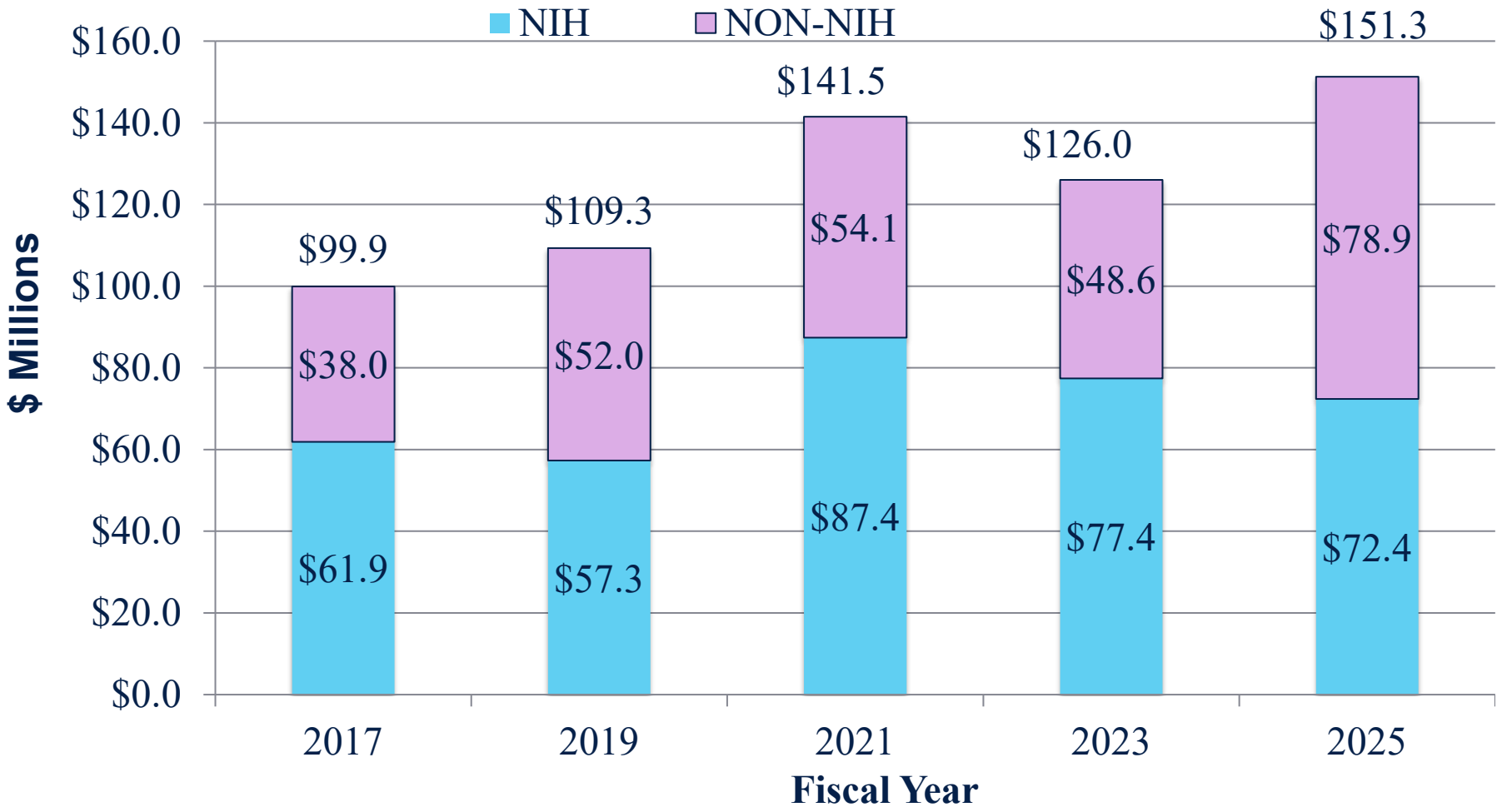
- HIV transmission
- Kidney disease awareness
- HIV bone loss
- SARS CoV-2
- Vaccine Research (TB, HCV)

ZSFG Medicine 2017-2025 Research Funding

($ Millions)



FY2025 Award Type
(New & Active)
66 R Grants
64 Other Grants
14 Cooperative Agreements
12 K Awards
9 K24 Awards
62 Contracts
3 Fellowships
119 Subcontracts

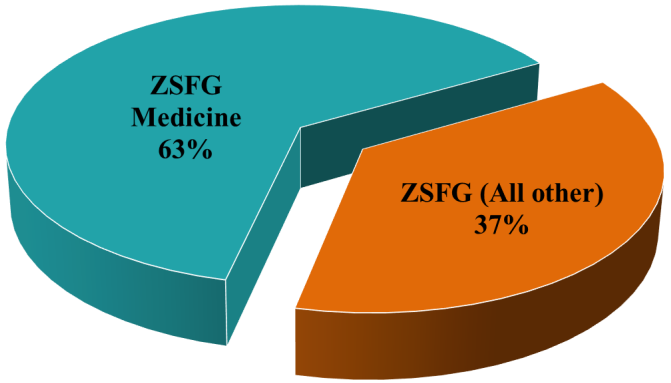
*Total $: direct and indirect costs (Note: These amounts do not include budget amounts awarded under Industry-sponsored Clinical Trials)

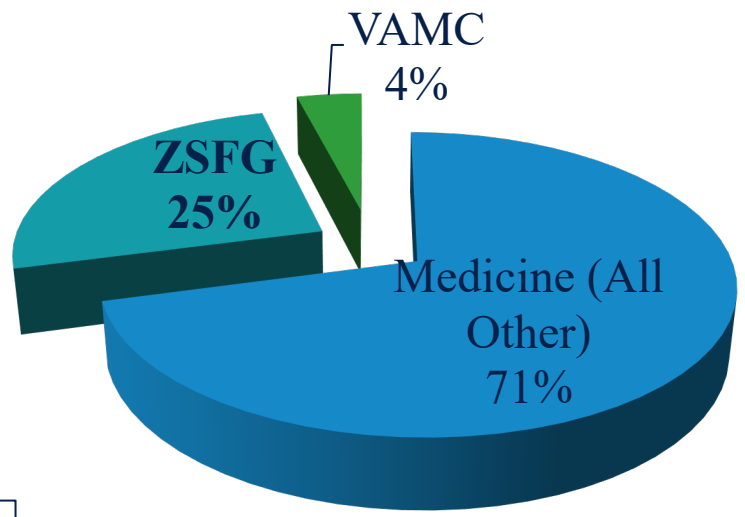
ZSFG Medicine as Percentage of ZSFG Campus and of Total DOM Research Funding and NIH Funding in 2025

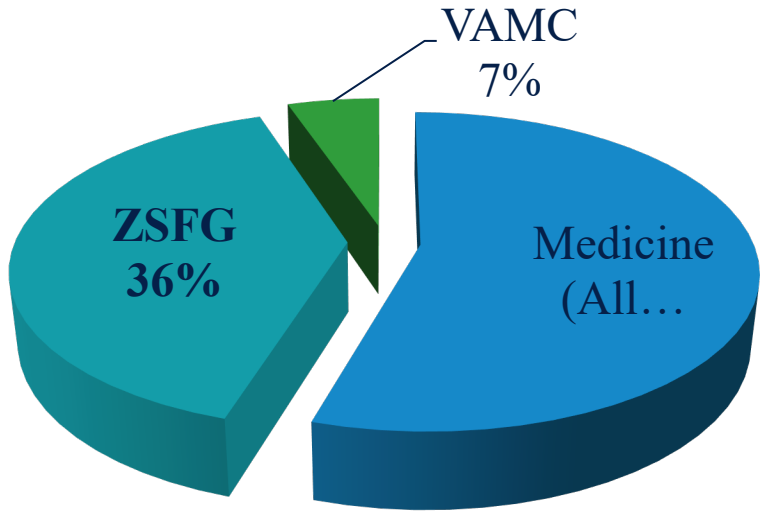
Total SOM ZSFG Campus=$227M
ZSFG Medicine = $144M (63%)
compared to 21% ($80M) of total SOM ZSFG Campus Clinical Enterprise ($369M)

Total DOM = $601,589,776
Medicine (All Other) = $426,234,853
ZSFG = $151,267,841
VAMC = $24,087,082

Total NIH DOM = $202,231,123
Medicine (All Other) = $115,985,121
ZSFG = $72,414,438
VAMC = $13,831,564







ZSFG DOM faculty are 18% of the ZSFG Campus Faculty

ZSFG DOM faculty are 21% of the entire UCSF DOM faculty

ZSFG Total Sponsored Research Dollars Awarded by Division and Fiscal Year

~ $10M or more

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
CARD	$12,394,917	$3,676,183	$3,848,285	$4,093,275	$5,947,384	$3,644,053	$6,628,460	$7,775,637	$6,762,000	$6,674,918
CLIN PHARM	$1,799,972	$1,841,897	$1,777,404	$2,795,418	$4,124,279	$1,293,000	$1,216,587	N/A	N/A	N/A
DES (Prev CVP)				$1,158,575	$1,131,811	$6,355,819	$5,001,059	$6,164,175	$5,038,043	$9,767,522
DGIM	$12,759,349	$7,169,121	$10,699,538	$9,124,523	$6,322,931	$9,342,668	$10,441,533	$12,580,854	$14,360,413	$13,989,349
ENDO	$138,027	$255,778	$212,727	$1,101,096	$882,405	$1,091,738	$923,193	$1,310,855	$1,037,485	$187,998
EXP MED	$13,971,939	$6,701,167	$7,961,566	$8,184,358	$11,611,352	$9,384,097	$15,568,258	$15,190,296	$14,523,201	$23,328,706
GI	$3,897,981	$4,332,028	$3,212,562	$4,471,263	$5,580,280	$3,550,136	$4,540,275	$4,349,917	$4,645,992	$5,635,973
HEM-ONC	$4,954,624	$5,945,043	$8,277,042	$9,292,250	$2,091,581	$3,863,359	$3,114,075	$2,615,270	$1,454,119	$1,997,126
HIV/ID/GM	$39,228,117	$51,322,324	$48,054,179	$53,353,913	$50,959,863	$67,507,997	$65,370,520	$53,040,254	$35,315,358	$72,366,153
HOSP	$212,245	$248,335	$359,767	$1,603,496	$2,647,988	$1,934,506	$2,328,639	$2,111,905	$1,229,119	$625,627
LBC	$5,288,784	$3,802,684	$6,177,349	$9,252,784	$6,371,280	$7,961,967	$2,503,338	N/A	N/A	N/A
NEPH	$2,440,335	$1,275,363	$2,107,072	$2,277,954	$1,036,117	$644,040	$520,697	$1,069,750	$919,628	$1,665,854
OEM	$2,178,234	$2,409,434	$1,740,464	$2,937,957	$1,728,297	$1,706,476	$2,109,726	$2,207,445	$3,432,293	$2,823,195
PULM	$7,718,954	$7,879,411	$10,526,778	$13,613,710	$17,708,005	$23,200,011	$18,041,430	$17,813,691	$14,006,672	$9,936,150
RHEUM	$1,265,602	$704,939	$1,182,307	$1,368,312	$1,089,527	$1,706,772	$1,568,013	$1,611,358	$975,395	$2,269,269
Grand Total	**$108,249,080**	**$97,563,707**	**$106,137,040**	**$124,628,884**	**$119,233,100**	**$143,186,639**	**$139,875,803**	**$127,841,407**	**$103,699,718**	**$151,267,840**

*These dollar amounts include total budget amounts awarded under industry-sponsored Clinical Trials

DES = Division of Health Equity and Society
OEM = Occupational Environmental Medicine

NOTES: Cardiology and Clinical Pharmacology Divisions merged in FY23
LBC at ZSFG merged with Pulmonary-Core in FY23

Research Centers: Breaking down disciplinary boundaries

- **Center for Infectious Diseases Molecular Imaging** Tim Henrich (DEM), Henry Van Brocklin (Radiology) ****New in 2024****
- **Action Research Center for Health Equity (ARC):** Margot Kushel
- **Curry TB Center**: Lisa Chen
- **Experimental and Population-based Pathogen Investigation Center** (EPPIcenter): Bryan Greenhouse, Isabel Rodriguez-Barraquer
- **Rice Liver Center:** Jackie Maher
- **Center of Excellence in Vascular Research**: Peter Ganz
- **UCSF Center for AIDS Research:** Monica Gandhi
- **UCSF Center for Tuberculosis**: Payam Nahid
- **PRISE Center:** Neeta Thakur, Margaret Handley

PIVOT - ESI Course

PIVOT (**P**rincipal **I**n**V**estigator **O**rganizational management **T**raining for Early-Stage Investigators [ESI]): interactive course of didactics and case studies on four topics:

- Research Ecosystem (interacting with UCSF Research Services and NIH partners)
- Organizational Management (leading and managing a team as PI)
- Human Resources (hiring staff and collaborating with HR)
- Finance (budget projecting, saving, and spending)

Direct result of feedback collected during 2021 meeting with junior faculty investigators on challenges faced during the NIH K to R transition. Provide foundational guidance for ESIs to successfully launch their independent research programs.

The 5th cohort begins in April 2026.

Meet the Team

Leonard Telesca
ZSFG Central Admin

Pat Wirattigowit
UCSF Health Central Admin

Jennifer Chen
UCSF Health
Gastroenterology

Gabe Chamie
ZSFG HIV, ID, & Global Medicine

Cardiology

Chemical Research in Toxicology

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pubs.acs.org/crt

Article

Nicotine Dosimetry in Evaluating Electronic Cigarettes Compared to Cigarette Smoking: Implications for Tobacco Regulatory Science

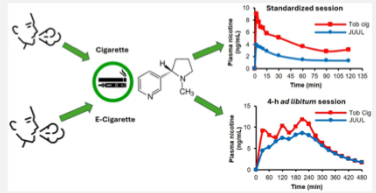
Neal L. Benowitz,* Hao-Yuan Yang, Peyton Jacob, III, and Gideon St Helen

Cite This: *Chem. Res. Toxicol.* 2025, 38, 686−694

Read Online

ACCESS | Metrics & More | Article Recommendations

ABSTRACT: The delivery and systemic absorption of nicotine are important for assessing the potential safety and efficacy of novel inhaled nicotine delivery devices. We describe an experimental approach for examining systemic nicotine intake, looking at individual variability, comparing JUUL electronic cigarettes and cigarette smoking, and comparing standardized puffing and ad libitum use. Fourteen cigarette smokers who were infrequent e-cigarette users vaped JUUL or smoked cigarettes, both in a standardized session (ten 3.5 s puffs over 5 min) and in a 4 h ad libitum use session. Plasma nicotine concentrations were measured, and using sex and body weight-based population nicotine clearance predictions, systemic nicotine dose was estimated in each session.



The pharmacokinetically (PK)-estimated nicotine dose in the standardized session averaged 0.55 mg (range 0.16−0.82) for JUUL and 1.15 mg (range 0.35−4.56) for cigarette smoking. The PK-estimated dose with ad libitum use averaged 4.1 mg (range 0.4−9.5) for JUUL and 5.0 mg (range 1.5−15) for smoking (average 3.4 cigarettes). Within individual correlations, comparing PK-estimated dose for JUUL use with standardized vs ad libitum session was weak ($r = 0.45$, NS) but was much stronger for cigarette smoking ($r = 0.82$, $p < 0.001$). Data from ad libitum use predicted that consumption of the liquid contained in a JUUL pod would correspond to smoking 15 cigarettes, which is similar to that observed in real world studies. We conclude that standardized vaping sessions do not predict usual nicotine self-administration behavior with ad libitum use. With ad libitum use, nicotine intake is much more similar to vaping and smoking and provides a much better predictor of product delivery in the real world. This approach is recommended for screening of novel inhaled nicotine devices and to aid FDA regulatory decision making.

Endocrine and Nephrology

Facilitators of and Barriers to Medicaid Investment in Electronic Consultation Services

Julie E. Kim, MD; Libby Sagara, BA; Alison M. DeDent, MD, MAS; and Delphine S. Tuot, MDCM, MAS

ABSTRACT

OBJECTIVE: Electronic consultation, or e-consult, programs have enhanced access to specialty care for primary care providers and their patients, reducing unnecessary in-person visits and maintaining cost-effectiveness. In California, there is great variability in access to e-consult programs for low-income patients who rely on Medicaid managed care plans (MCPs) for covered benefits. This study aimed to understand MCP facilitators of and barriers to e-consult investment in California.

STUDY DESIGN: Interviews conducted with California Medicaid MCPs' leaders to learn about the facilitators of and barriers to investment in e-consult programs.

METHODS: Interviews were analyzed using content analysis with multistage coding. The Exploration, Preparation, Implementation, and Sustainment framework was used to organize facilitator and barrier themes into 4 contexts: outer context (landscape of health care delivery in California),

Although Medicaid expansion in the US has increased potential access to routine primary care, it has also led to new challenges and health care disparities, chief among them access to high-quality specialty care.[1] Reasons for this include low reimbursement rates for treating patients with Medicaid and limited availability of specialists. To address the supply-demand mismatch, electronic consultation (e-consult) systems have been developed.[2] E-consults allow referring primary care providers (PCPs) to obtain specialty expertise without the patient communicating directly with the specialist, whether through an in-person or a telehealth (phone or video) appointment. In an e-consult, a PCP sends an asynchronous message to a specialist who responds with recommendations. The PCP can share these recommendations with the patient at a future appointment or through other modes of communication, such as a phone call or electronic messaging via a patient portal. E-consult has demonstrated benefits consistent with the Quadruple Aim[3]: improving equitable patient access to

Experimental Medicine

SCIENCE TRANSLATIONAL MEDICINE | RESEARCH ARTICLE

CORONAVIRUS

Tissue-based T cell activation and viral RNA persist for up to 2 years after SARS-CoV-2 infection

Michael J. Peluso[1]*†, Dylan Ryder[1,2]†, Robert R. Flavell[3]†, Yingbing Wang[3], Jelena Levi[4], Brian H. LaFranchi[2], Tyler-Marie Deveau[2], Amanda M. Buck[2], Sadie E. Munter[1,2], Kofi A. Asare[1,2], Maya Aslam[3], Walter Koch[3], Gyula Szabo[5], Rebecca Hoh[1], Monika Deswal[1], Antonio E. Rodriguez[1], Melissa Buitrago[1], Viva Tai[1], Uttam Shrestha[3], Scott Lu[6], Sarah A. Goldberg[6], Thomas Dalhuisen[6], Joshua J. Vasquez[2], Matthew S. Durstenfeld[7], Priscilla Y. Hsue[7], J. Daniel Kelly[6], Nitasha Kumar[2], Jeffrey N. Martin[6], Aruna Gambhir[4], Ma Somsouk[8], Youngho Seo[3], Steven G. Deeks[1], Zoltan G. Laszik[5], Henry F. VanBrocklin[3]*†, Timothy J. Henrich[2]*†

The mechanisms of postacute medical conditions and unexplained symptoms after SARS-CoV-2 infection [Long Covid (LC)] are incompletely understood. There is growing evidence that viral persistence, immune dysregulation, and T cell dysfunction may play major roles. We performed whole-body positron emission tomography imaging in a well-characterized cohort of 24 participants at time points ranging from 27 to 910 days after acute SARS-CoV-2 infection using the radiopharmaceutical agent [^{18}F]F-AraG, a selective tracer that allows for anatomical quantitation of activated T lymphocytes. Tracer uptake in the postacute COVID-19 group, which included those with and without continuing symptoms, was higher compared with prepandemic controls in many regions, including the brain stem, spinal cord, bone marrow, nasopharyngeal and hilar lymphoid tissue, cardiopulmonary tissues, and gut wall. T cell activation in the spinal cord and gut wall was associated with the presence of LC symptoms. In addition, tracer uptake in lung tissue was higher in those with persistent pulmonary symptoms specifically. Increased T cell activation in these tissues was also observed in many individuals without LC. Given the high [^{18}F]F-AraG uptake detected in the gut, we obtained colorectal tissue for in situ hybridization of SARS-CoV-2 RNA and immunohistochemical studies in a subset of five participants with LC symptoms. We identified intracellular SARS-CoV-2 single-stranded spike protein–encoding RNA in rectosigmoid lamina propria tissue in all five participants and double-stranded spike protein–encoding RNA in three participants up to 676 days after initial COVID-19, suggesting that tissue viral persistence could be associated with long-term immunologic perturbations.

Gastroenterology

Contents lists available at ScienceDirect

Contemporary Clinical Trials

journal homepage: www.elsevier.com/locate/conclintrial

Multilevel intervention for follow-up of abnormal FIT in the safety-net: IMProving Adherence to Colonoscopy through Teams and Technology (IMPACTT)

Katarina Wang [a,b], Jeanette Wong [c,d], Leslie Avilez [c,d], Kristan Olazo [c,d], Samuel Olanrewaju [e], Charles E. McCulloch [b], Rena Pasick [e], Shreya Patel [f], Ma Somsouk [d,e,f,1], Urmimala Sarkar [c,d,e,*,1]

[a] *School of Medicine and Dentistry, University of Rochester, Rochester, New York, USA*
[b] *Department of Epidemiology and Biostatistics, University of California San Francisco, San Francisco, California, USA*
[c] *Division of General Internal Medicine, Department of Medicine, University of California San Francisco, San Francisco, California, USA*
[d] *Action Research Center for Health Equity, Zuckerberg San Francisco General Hospital, University of California San Francisco, San Francisco, California, USA*
[e] *School of Medicine, University of California San Francisco, San Francisco, California, USA*
[f] *Division of Gastroenterology, University of California San Francisco, San Francisco, California, USA*

ARTICLE INFO

Keywords:
Colorectal cancer screening
Safety-net health systems
Cancer health disparities
Digital health

ABSTRACT

Background: Fecal immunochemical testing (FIT) is a widely used first step for colorectal cancer (CRC) screening. Abnormal FIT results require a colonoscopy for screening completion and CRC diagnosis, but the rate of timely colonoscopy is low, especially among patients in safety-net settings. Multi-level factors at the clinic- and patient-levels influence colonoscopy completion after an abnormal FIT. Our study aims to implement a multi-level approach consisting of a clinic- and patient-level intervention to improve the completion of diagnostic colonoscopy after an abnormal FIT.

Methods: We will test a multilevel intervention with one safety-net system across 12 primary care clinics – a clinic-level intervention using a stepped wedge design and a patient-level intervention with patient-level randomization. At the clinic level, we will implement a "best practices bundle" to improve workflow for primary care providers and staff using a stepped-wedge design. At the patient level, we will randomize 2000 patients to receive text messages and call reminders or usual care.

Results: For the main analysis, we will use a mixed effects logistic model to assess the impact of the clinic intervention on the primary outcome (completion of colonoscopy within 180 days after abnormal FIT). Secondary outcomes include median days to colonoscopy completion, rate of referral to colonoscopy at 42 days, rate of scheduled colonoscopy at 56 days, and bowel preparation quality at colonoscopy.

Discussion: This study will assess the extent to which a multi-level intervention can improve timely colonoscopy completion in a diverse patient population cared for in a safety-net setting.

Trial registration: NCT, NCT06191185. Registered 20 December 2023. https://clinicaltrials.gov/study/NC

General Internal Medicine

NEJM Evidence

ORIGINAL ARTICLE

Pregnancy after Tubal Sterilization in the United States, 2002 to 2015

Authors: Eleanor Bimla Schwarz, M.D., Amy Yunyu Chiang, Ph.D., Carrie A. Lewis, M.P.H., Aileen M. Gariepy, M.D., and Matthew F. Reeves, M.D. Author Info & Affiliations

Published August 27, 2024 | NEJM Evid 2024;3(9) | DOI: 10.1056/EVIDoa2400023 | VOL. 3 NO. 9

Health Equity and Society

JAMA | Original Investigation

Illicit Substance Use and Treatment Access Among Adults Experiencing Homelessness

Ryan D. Assaf, PhD, MPH; Meghan D. Morris, PhD, MPH; Elana R. Straus, BA; Priest Martinez, AS; Morgan M. Philbin, PhD, MHS; Margot Kushel, MD

IMPORTANCE The lack of representative research on homelessness risks mischaracterizing and misrepresenting the prevalence of illicit substance use.

OBJECTIVE To estimate the population prevalence and patterns of illicit substance use, treatment, nonfatal overdose, and naloxone possession among people experiencing homelessness in 1 US state.

DESIGN, SETTING, AND PARTICIPANTS This representative survey study of adults experiencing homelessness from October 2021 to November 2022 in 8 California counties used multistaged probability-based sampling and respondent-driven sampling. Eligible individuals were 18 years or older and met the federal definition of homelessness.

MAIN OUTCOMES AND MEASURES The primary outcome measures included lifetime and past-6-month illicit substance use and substance type (methamphetamine, nonprescription opioids, or cocaine). Lifetime and current substance use treatment, unmet treatment need, types of treatments received, nonfatal overdose (lifetime and current episode of homelessness), and current possession of naloxone were measured. Population prevalence estimates with 95% Wald CIs were calculated using survey replicate weights.

RESULTS Of 3865 individuals approached, 3042 (79%) participated and an additional 158 participants were recruited through respondent-driven sampling. Among 3200 participants, the mean age was 46.1 (95% CI, 45.3-46.9) years, 67.3% (95% CI, 65.2%-69.3%) were cisgender male, and there were similar proportions of Black and African American, Hispanic and Latine, and White participants. Overall, an estimated 65.3% (95% CI, 62.2%-68.4%) of participants used illicit drugs regularly (≥3 times per week) in their lifetime; 41.6% (95% CI, 39.4%-43.8%) began using regularly before their first episode of homelessness and 23.2% (95% CI, 20.5%-25.9%) began using regularly after. In the past 6 months, an estimated 37.1%

Hematology-Oncology

Original Reports | Sarcoma

Phase I Trial to Evaluate the Safety of Intralesional Nivolumab Therapy for Limited Cutaneous Kaposi Sarcoma

Chia-ching J. Wang, MD[1]; Alexander Bang, MD[2]; Sona Chowdhury, PhD[1]; Kieron S. Leslie, MBBS, FRCP[1]; Ursula E. Lang, MD, PhD[1]; Michiko Shimoda, PhD[1]; Timothy J. Henrich, MD[1]; Rebecca Hoh, MS[1]; Steve G. Deeks, MD[1]; Chao Wang, PhD[1]; Amelia N. Deitchman, PharmD, PhD[1]; Paul Couey, BA[1]; and Toby Maurer, MD[3]

DOI https://doi.org/10.1200/OA-24-00098

ABSTRACT

PURPOSE Intralesional vinblastine can induce regression of Kaposi sarcoma (KS), but it is often painful. We conducted a phase I trial to evaluate the safety and tolerability of intralesional injections of nivolumab to treat cutaneous KS.

PATIENTS AND METHODS We enrolled participants with limited cutaneous KS and injected 1 mL (10 mg) of nivolumab into target KS lesions once every 2 weeks for four doses, with op-

ACCOMPANYING CONTENT

- Appendix
- Data Sharing Statement
- Protocol

HIV, ID and Global Medicine

JAMA

HIV Viral Suppression With Use of Long-Acting Antiretroviral Therapy in People With and Without Initial Viremia

Long-acting (LA) cabotegravir/rilpivirine was approved in the US for people with HIV with virologic suppression with use of oral antiretroviral therapy (ART) in 2021. Soon thereafter, the Ward 86 HIV clinic in San Francisco started using LA-ART among individuals with adherence challenges to oral ART, including those with HIV viremia.[1] Although this population was not studied in initial clinical trials, individuals with adherence challenges could benefit from monthly or bimonthly clinic-administered LA-ART to mitigate stigma and difficulty with daily pills.[1-3] This study compares 48-week viral load outcomes after starting LA-ART among people with HIV with or without viremia.

Supplemental content

Methods | Using electronic medical record data verified by clinician review, we evaluated viral suppression up to 48 weeks able program (Special Program of Long-Acting Antiretrovirals to Stop HIV [SPLASH]). We ir rting LA-ART with viremia (HIV RNA l it of detection of the assay used) or without viremia from January 2021 through September 2024. The study was approved by the University of California, San Francisco, institutional review board, with informed consent not required because data were collected as part of quality improvement efforts. Individuals with any cabotegravir- or rilpivirine-associated variations were excluded (eAppendix in Supplement 1).[1] Individuals with viremia had to commit to attending in-person visits monthly, with injections spaced to bimonthly after 3 months if an undetectable viral load (<30 copies/mL) was attained. A pharmacist reviewed each referral for ART history and resistance after referral by a clinician, and a pharmacy technician provided counseling. Patients received a reminder call/text for appointments but could drop in for injections if presenting within the target date ±1 week.[1,4] Characteristics of individuals with vs without initial viremia were compared using χ^2 tests. For those starting LA-ART with initial viremia, the time to viral

Matthew A. Spinelli, MD, MAS; Megan J. Heise, PhD; Nathanial Gistand, BS; Chesa Cox, MPH; Janet Grochowski, PharmD; Jon Oskarsson, RN; David V. Glidden, PhD; Monica Gandhi, MD, MPH

Hospital Medicine

Katherine C. Brooks, MD[1]; Katie E. Raffel, MD[2,3]; David Chia, MD[1]Abhishek Karwa, DO[1]; Colin C. Hubbard, PhD[4]; Andrew D. Auerbach, MD[4]; Sumant R. Ranji, MD[1]

Stigmatizing Language, Patient Demographics, and Errors in the Diagnostic Process

Stigmatizing language (SL) is widespread throughout medical documentation.[1] It is more likely to be found in the records of Black patients,[2,3] patients with public insurance,[2] and patients with certain comorbidities.[3] We investigated associations between SL, errors in the diagnostic process, and demographics for hospitalized patients.

JAMA Internal Medicine

Methods | This multicenter, retrospective cohort study was conducted as part of the Utility of Predictive Systems for Diagnostic Errors (UPSIDE) study.[4] Using a structured adjudication tool, UPSIDE assessed the presence of diagnostic errors and diagnostic process errors

Supplemental content

tratively at study sites. bed elsewhere.[6] This study of California San Francisco ned consent was waived bec

As a secondary aim, e of SL throughout physician, nursing, and ancillary staff notes. Stigmatizing language was defined as containing one of the following features: questioning of patient credibility, racial or social class stereotyping, expressions of disapproval toward patients, and descriptions of difficult patients.[1]

Univariate analysis between SL, diagnostic errors, and demographics was performed using χ^2 testing with Rao-Scott second-order correction, taking into account the sampling design of the UPSIDE study.[6] We used generalized estimating equations to fit logistic regression models with clustering by

ORIGINAL RESEARCH

Annals of Internal Medicine

Availability of Cardioprotective Medications for Type 2 Diabetes in the Medicaid Program

Anil N. Makam, MD, MAS; Logan Bailey, MD; Nigel Anderson, BA; Kathy Bellitti, MPH; Sasha Skinner, MPH; and Oanh Kieu Nguyen, MD, MAS

Background: Sodium–glucose cotransporter-2 inhibitors (SGLT2is) and glucagon-like peptide-1 receptor agonists (GLP-1 RAs) are the only type 2 diabetes medications that reduce cardiovascular disease and death, yet their availability in Medicaid is unclear.

Objective: To assess the unrestricted availability of SGLT2is and GLP-1 RAs, using dipeptidyl peptidase-4 inhibitors (DPP4is) as a benchmark.

Design: National cross-sectional study using publicly available data.

of MCO enrollees with availability varied markedly among states (SGLT2i range, 24% to 100%; GLP-1 RA range, 0% to 99%; DPP4i range, 41% to 100%). Primarily because of more MCO restrictions, 1.7 million enrollees (lower to upper bound, 1.33 million to 2.17 million enrollees; 25%) had restricted SGLT2i availability, 2.72 million (lower to upper bound, 2.12 million to 3.45 million; 40%) had restricted GLP-1 RA availability, and 1.5 million (lower to upper bound, 1.17 million to 1.90 million; 22%) had restricted DPP4i availability. Availability increased from 2020 to 2024, especially in FFS,

Pulmonary

AMERICAN THORACIC SOCIETY DOCUMENTS

Climate Change and Respiratory Health: Opportunities to Contribute to Environmental Justice

An Official American Thoracic Society Workshop Report

Daniel P. Croft*, Alison Lee*, Tara M. Nordgren*, Chandra L. Jackson, Hasan Bayram, John R. Balmes, Nicholas Nassikas, Gary Ewart, Mary B. Rice, Tarik Benmarhnia, Juan C. Celedón, Stephanie M. Holm, Gaige H. Kerr, Susan Anenberg, Pablo Méndez-Lázaro, Preshona Ambri, Gillian C. Goobie, Meghan E. Rebuli, Sacoby Wilson, Isabella Annesi-Maesano, Kalpana Balakrishnan, Kevin Cromar, Ilona Jaspers, Jack R. Harkema, Vikas Kapil, Peggy Lai, Jennifer Maccarone, Alexandra Noël, Laura M. Paulin, Kent E. Pinkerton, Arianne Teherani, Eddie Ahn, George Thurston, and Neeta Thakur‡; on behalf of the American Thoracic Society Assembly on Environmental, Occupational and Population Health and the American Thoracic Society Committee on Environmental Health Policy

Rheumatology

JAMA Dermatology | Original Investigation

Neighborhood Socioeconomic Status and New Hidradenitis Suppurativa Diagnoses in a Single Health System

Aileen Y. Chang, MD; Maria Elena Sanchez-Anguiano, BS; Krittin Supapannachart, MD; Erin H. Amerson, MD; Haley B. Naik, MD; Stephen Shiboski, PhD; Mindy C. Derouen, PhD, MPH; Jinoos Yazdany, MD, MPH

IMPORTANCE Hidradenitis suppurativa (HS) is a chronic inflammatory skin condition. Risk factors for developing HS (eg smoking and obesity) are influenced by social drivers of health at the neighborhood level. However, the association of neighborhood-level socioeconomic status (nSES) and HS has not been adequately assessed.

OBJECTIVE To evaluate the association of nSES with new HS diagnoses among dermatology patients within a single health system.

DESIGN, SETTING, AND PARTICIPANTS This was a cross-sectional study of patients of the dermatology clinics at the University of California San Francisco health system between August 1, 2019, and May 31, 2024, who were also residents of the San Francisco Bay Area at index visit. Data analyses were performed from June 1, 2024, to February 11, 2025.

EXPOSURE Census tract-level index measure of nSES that incorporated income, poverty, housing cost, rental cost, education, occupation, and employment. Quintiles of nSES were assigned based on nSES distribution in the San Francisco Bay Area counties.

MAIN OUTCOMES AND MEASURES A new HS diagnosis during the study period, identified by the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* code, and confirmed by medical record review. Logistic regression models were constructed and fit by generalized estimating equations accounting for clustering by census tract with nSES quintile as the primary exposure (reference used was quintile 5, the highest nSES quintile); new HS diagnosis as the binary outcome; and age, sex, and race and ethnicity as confounders. In secondary analyses, smoking status, obesity, and health insurance type were assessed as possible mediators.

RESULTS The analyses included a total of 65 766 patients (mean [SD] age, 50.4 [18.3] years;

Occupational & Environmental Med

CellPress OPEN ACCESS

Cell Leading Edge

Review

Mechanisms of long COVID and the path toward therapeutics

Michael J. Peluso[1,*] and Steven G. Deeks[1,*]
[1]Division of HIV, Infectious Diseases, and Global Medicine, University of California, San Francisco, San Francisco, CA, USA
*Correspondence: michael.peluso@ucsf.edu (M.J.P.), steven.deeks@ucsf.edu (S.G.D.)
https://doi.org/10.1016/j.cell.2024.07.054

SUMMARY

Long COVID, a type of post-acute sequelae of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (PASC) defined by medically unexplained symptoms following infection with SARS-CoV-2, is a newly recognized infection-associated chronic condition that causes disability in some people. Substantial progress has been made in defining its epidemiology, biology, and pathophysiology. However, there is no cure for the tens of millions of people believed to be experiencing long COVID, and industry engagement in developing therapeutics has been limited. Here, we review the current state of knowledge regarding the biology and pathophysiology of long COVID, focusing on how the proposed mechanisms explain the physiology of the syndrome and how they provide a rationale for the implementation of a broad experimental medicine and clinical trials agenda. Progress toward preventing and curing long COVID and other infection-associated

Contents lists available at ScienceDirect

Water Research

journal homepage: www.elsevier.com/locate/watres

Mixed contaminant exposure in tapwater and the potential implications for human-health in disadvantaged communities in California

Kelly L. Smalling[a,*], Kristin M. Romanok[a], Paul M. Bradley[b], Michelle L. Hladik[c], James L. Gray[d], Leslie K. Kanagy[d], R. Blaine McCleskey[e], Diana A. Stavreva[f], Annika K. Alexander-Ozinskas[g], Jesus Alonso[h], Wendy Avila[i], Sara E. Breitmeyer[j], Roberto Bustillo[i], Stephanie E. Gordon[k], Gordon L. Hager[f], Rena R. Jones[f], Dana W. Kolpin[l], Seth Newton[m], Peggy Reynolds[n], John Sloop[o,1], Andria Ventura[h], Julie Von Behren[n], Mary H. Ward[f], Gina M. Solomon[n]

National Honor Societies

American Society of Clinical Investigation (n=13)

- Kamran Atabai
- Neal Benowitz*
- Steven Deeks
- Peter Ganz
- Diane Havlir
- **Tim Henrich (2024)**
- Peter Hunt
- Babak Javid
- Margot Kushel
- Mike McCune*
- Neil Powe
- Morris Schambelan*
- Jinoos Yazdany

Association of American Physicians (n=13)

- Donald Abrams*
- Neal Benowitz*
- Chip Chambers*
- Steven Deeks
- Joel Ernst
- Diane Havlir
- John Imboden*
- Mike McCune*
- David Pearce*
- Neil Powe
- Phil Rosenthal
- Morris Schambelan*
- Dean Schillinger

National Academy of Medicine (n=6)

- Andrew Bindman*
- **Alicia Fernandez (2024)**
- Eric Goosby*
- Diane Havlir
- Catherine Lucey
- Neil Powe

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***Emerita/us faculty**

Other Awards and Honors

2024 (n=21)

- **Diane Havlir** – UCSF Chancellor Award for Public Service
- **Wagahta Semere** – UCSF Multiethnic Health Equity Research Center Emerging Health Equity Scholar Award
- **Neil Powe** – TIME Magazine's 100 Most Influential People in Health
- **Antonio Gomez** –UCSF at ZSFG Exceptional Physician Award
- **Margot Kushel** – Exceptional Service to the School of Medicine
- **Jonathan Davis** – Longitudinal Subspecialty Clinic Preceptor
- **Scott Steiger** – Residency Advising and Development Advisor of Year
- **Kate Lupton** – Residency Advising & Development Advisor of year
- **Neil Powe** – American Academy of Arts & Sciences
- **Elise Riley** – Jeanne Kreek Award for Research in Underserved Populations, College on Problems of Drug Dependence
- **Isabel Rodriguez-Barraquer** – Teri Liegler Young Scientist Award
- **Leslie Suen** –New Investigation /Educator Award
- **Sheiphali Gandhi** – Irene Perstein Award
- **Ward 86** – Cleve Jones Leadership Award (SF AIDS Foundation)
- **Binh An Phan** –Maxine Papadakis Award
- **Alicia Fernandez** – UCSF Chancellor Award - Dr. MLK Jr. Leadership
- **Susan Ehrlich** – 2024 San Franciscan of the Year
- **Alicia Fernandez** – 2024 Chancellor Award
- ***Ari Johnson** – Kristof Holiday Impact Prize
- **Lucas Zier** – CAPH Quality Leaders Award in Health Equity

2025 (n=10)

- **Elise Riley** – Mary Jeanne Kreek Underserved Populations Award
- ***Charles Chiu** – Luminary Award of Infectious Disease
- **Mike Reid** – UCSF Chancellor Award for Public Service
- **Angela Suen** – UCSF SOM Watson Scholar Award
- **Matt Durstenfeld** – Early Career Research Excellence Award
- **Jaya Mallidi** – UCSF's Distinction in Teaching Award
- **Maria Ruiz** – Julius R. Krevans Award
- **Mike Reid** – UCSF Chancellor Award for Public Service
- **Jonathan Davis** – ZSFG's Exceptional Physician Award
- **Alicia Fernandez** – National Academy of Medicine (NAM)

Summary

Strengths

- Exemplary faculty, staff and trainees who provide exemplary care
- Devotion to mission of care for historically marginalized and underserved
- Synergy between discovery and conditions/diseases we manage in clinical care with emphasis on social determinants of health (and health equity?)
- Impact in innovation, education, dissemination and community

Summary

ZSFG Medicine Major Challenges

- **Service volume increases without commensurate increase in Affiliation Agreement funding**
  - **Inpatient census** (surges without a permanent structural fix of predictable funding at time of budget and faculty work planning)
  - **Outpatient clinic visits** in primary and specialty care
- **Limited space** for ambulatory primary and specialty care clinical operations
- **Many innovative ideas** for serving our patients, but **limited funding** to advance them
- **Current political climate** in the U.S.
- **Generating accurate clinical and operational data** in a timely fashion for feedback on performance and decision making
- **High cost of Bay Area** housing (recruitment & retention)
- **Faculty and staff weariness** from work and impact on well-being

Summary

Overall Goals & Actions (1)

- **Continue to align goals with SFHN**
  - ✓ Work collaboratively and foster partnerships with other services
  - ✓ Accelerate learning healthcare system harnessing full capability of data
  - ✓ Innovate and improve quality, safety, patient-centeredness, integration and efficiency of care to meet or exceed clinical performance standards
- **Improve communication, collaboration, alignment & trust**
- **Recruit, develop, manage and retain talent (faculty, trainees and staff) in face of challenges and austere times**

2026

Summary

Overall Goals & Actions (2)

- **Improve well-being of trainees, faculty, managers & staff**
  - ✓ Recognize people/unit contributions: reward & support PRIDE values
  - ✓ Monitor and address workload and experience
  - ✓ Provide opportunities for development of diverse talents
- **Maintain resilience & economic stability**
  - ✓ Strategic and equitable stewardship of resources
  - ✓ Advance philanthropy

2026

Thank You!

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Appendix: Selected ZSFG DOM QI projects

Novel clinical care delivery: Low-barrier HIV care models improve viral suppression rates for all patients

Ward 86 patients have high rates of viral suppression [HIV RNA <200 c/mL]:

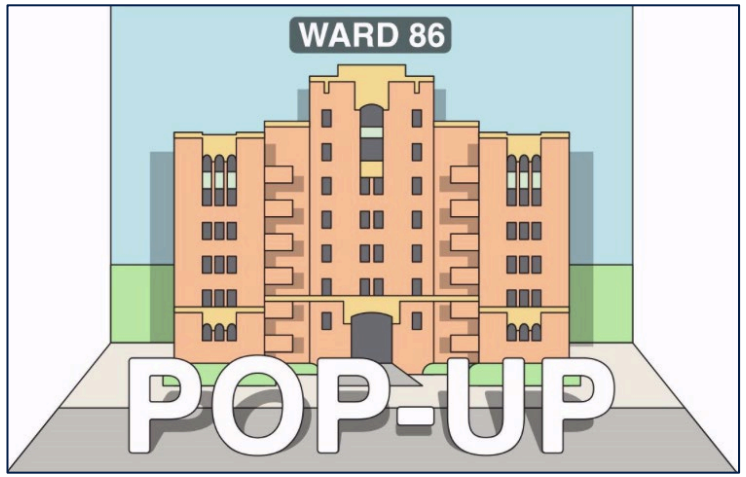
- **FY 23: 89.5%**
- **FY 24: 90.5%**
- **FY 25: 91.3%**

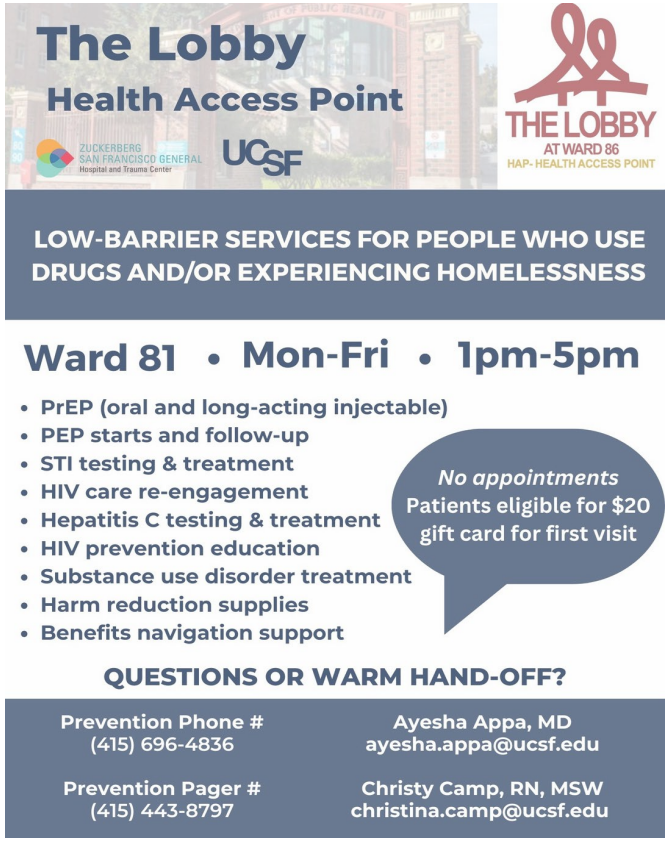
Compared to viral suppression
San Francisco: 74% (2023)
U.S.: 66%

Low barrier care access models: POP-UP & Health Access Point

- Drop-in comprehensive HIV care
- Addiction, mental health, social services
- Case and panel management
- Mobile outreach

Health Access Point
Status Neutral/PWUD



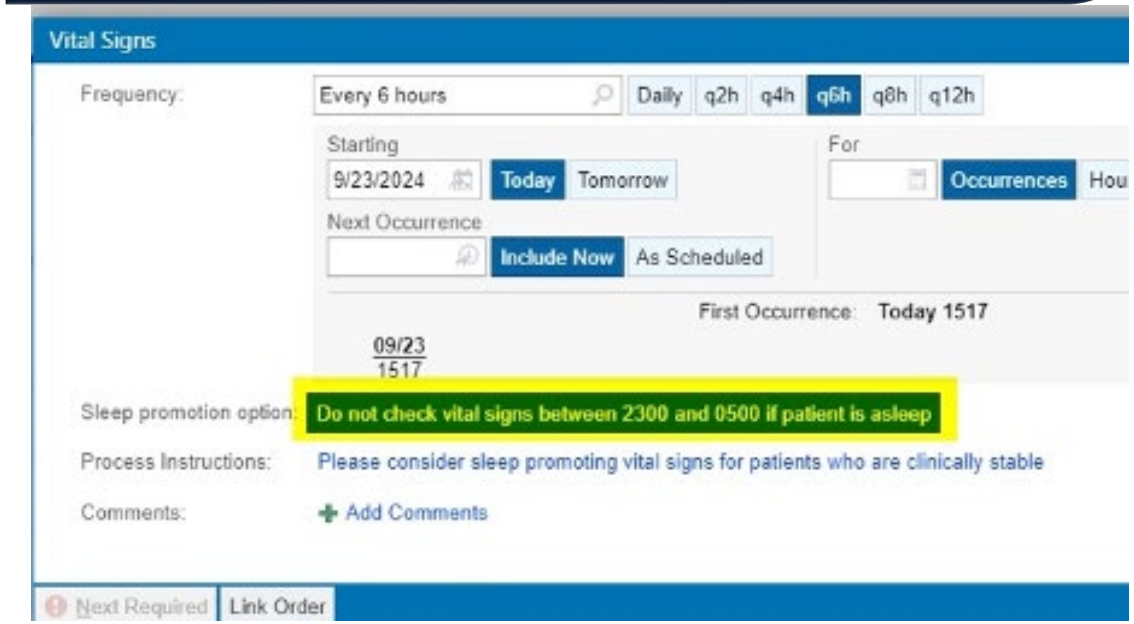


Leverage EHR: Decrease Fragmented Sleep with Sleep Promoting Vitals

Improving Sleep Quality for Patients in the Acute Care for Elders Unit at Zuckerberg San Francisco General Hospital

A Bridges curriculum medical student project in collaboration with UCSF IM resident Arvind Suresh

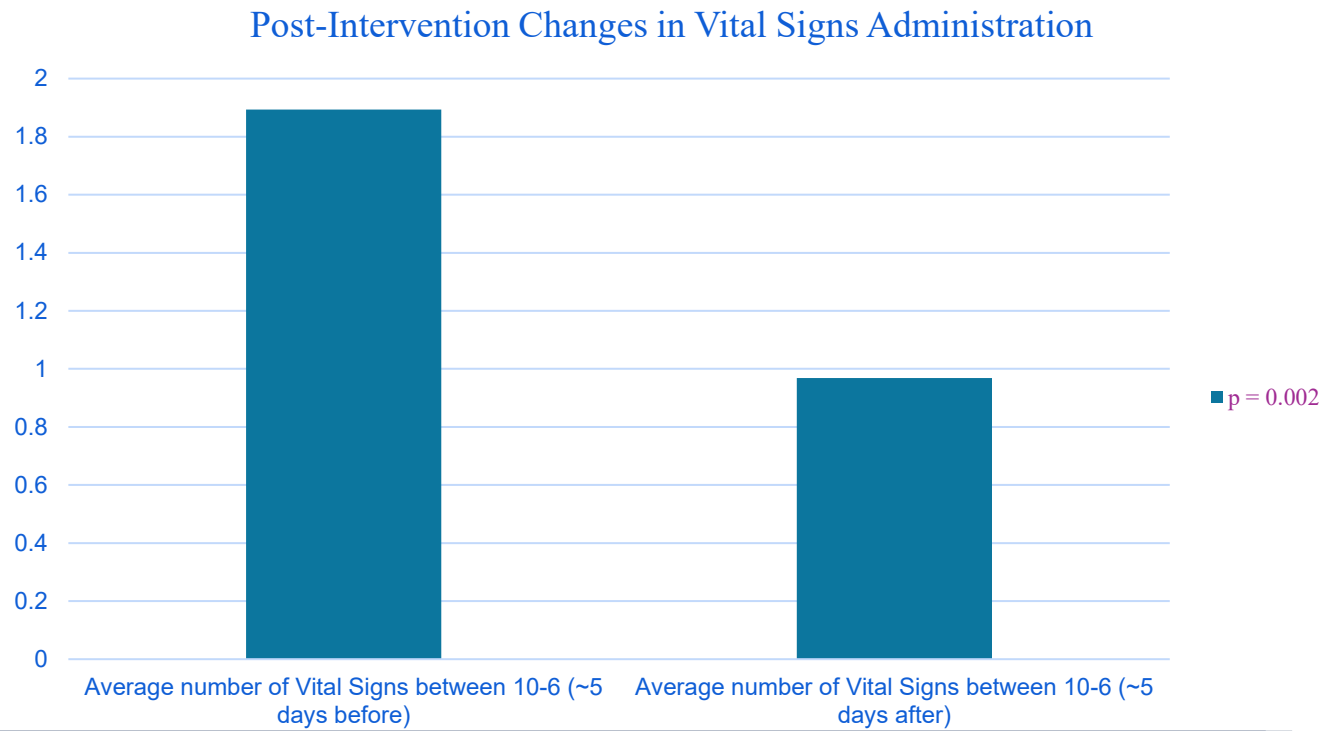
UCSF Medical Students: Amartya Dave, Maithily Diaz, Maria Gonzalez, Chris Pineda, Alythia Vo, Ryan Wilson
Faculty Mentor: Jamie Yao MD



Sleep Kits for ACE unit patients:

· Includes eye masks, ear plugs, white noise machines and headphones, journals/pens, chamomile tea bags, do not disturb door signs

· All patients on H76 are eligible to receive a sleep kit. Stop by Annelie Nilsson's office if you think your patient may benefit from one



Equity focus: Culturally concordant group classes improve knowledge & efficacy about steatotic liver disease

I think when there is a social aspect, it could be helpful because at least other people keep you accountable… the social networks help continue to bring you in.

The Mediterranean is not where our people come from … You're asking people to eat differently… with just that title… it's hard for people to connect with it

TABLE 1 …nd facilitators for lifestyle modification recommendations acro… …(societal, comm… …and Asian communities

		…mon themes	
		…spaces …ssistance services	
Comm…		…lcohol in social settings Misinformation	Cul…
	Facilitators	Traditional foods	
Interpersonal	Barriers	Social influences	Childcare constraints
	Facilitators	Family motivation Central role of family	
Individual	Barriers	Sugars and carbohydrates Unhealthy cooking methods Time constraints from work Limited nutrition knowledge Limited SLD knowledge	
	Facilitators	Healthy cultural habits	

PMID: 40489763

Identifying Barriers and Facilitators for Colonoscopy Completion among African American/Black Individuals with a Positive Fecal Immunochemical Test (FIT)

Fiona Ng, MD, MPH,[1] Marisol Solis, MD,[1] Griffin Plattner, MD,[1] Ghezal Saffi, BS, MS,[1] Anne E. Rosenthal, MD,[1,2]
[1] University of California San Francisco Department of Medicine; [2] Division of General Internal Medicine at Zuckerberg San Francisco General

Research Objectives

1) Identify barriers and facilitators for colonoscopy completion among Black and African American patients
2) Understand patient preferences for:
   - Receiving Fecal Immunochemical Test (FIT) results and counseling
   - Format and content of education material
   - Resources for facilitating colonoscopy completion

Study Design

⁎ Population Studied

1) Black or African American (B/AA) patients of an academic, safety-net hospital based primary care practice
   - Disproportionate impact of colorectal cancer (CRC) and lower rates of colonoscopy completion
2) Surveyed B/AA patients who completed a FIT between December 19, 2022-December 19, 2024. Sampled from:
   - Positive FIT (N = 12)
   - Matched group of negative FIT (N = 25).
3) 11 participants completed the survey: 6 (+) FIT, 5 (-) FIT

Participants Who Completed…

1) ⁎ Survey Design and Implementation

2) Developed a 9-question survey guided by the Consolidated Framework for Implementation Research (CFIR)
3) Four physicians conducted phone surveys between December 2024 – February 2025
4) Three attempts were made to reach each participant
5) Those we reached and needed a colonoscopy were referred to the gastroenterology clinic
6) $50 gift cards mailed to all patients who completed the survey

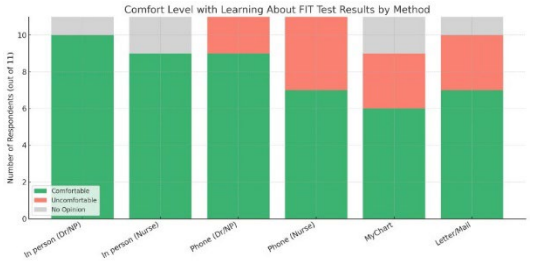
Principal Findings

⁎ Preferred Method to Learn about FIT Result

MOST COMFORTABLE
In-person notification
- Primary care provider (NP or MD): 10/11 (91%)
- Clinic nurse: 9/11 (82%)

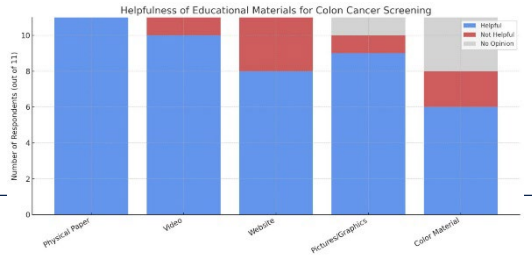
LESS COMFORTABLE
Phone notification
- Doctor or NP: 9/11 (82%)
- Nurse: 7/11 (64%)

LEAST COMFORTABLE
Electronic or mail delivery
- MyChart: 6/11 (55%)
- Mail: 7/11 (64%)



⁎ Perceived helpfulness of educational material by modality

- ALL participants found physical paper to be helpful
- More individuals found video (10/11, 91%) to be helpful compared to website-based material (8/11, 73%).

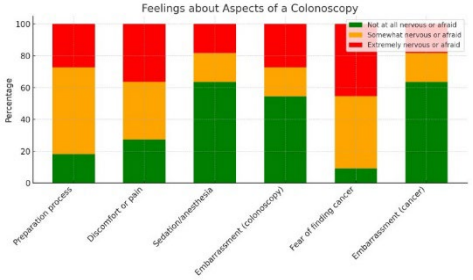


⁎ Feeling Nervous/Afraid about Aspects of a Colonoscopy

82% The colonoscopy preparation process

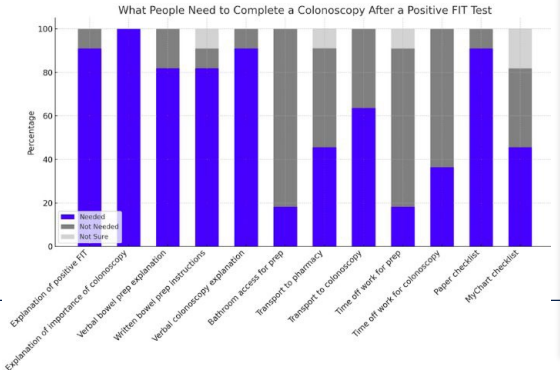
82% Being diagnosed with colon cancer

73% Experiencing discomfort/pain during colonoscopy



⁎ Facilitators for Completing a Colonoscopy

- Most participants found it necessary that a provider explained:
  - The meaning of a positive FIT (10/11, 91%)
  - The importance of a colonoscopy (11/11, 100%)
  - Logistics of a colonoscopy procedure (10/11, 91%)



Need to output at 200%

Conclusion

- Our survey of B/AA patients who underwent FIT screening for CRC showed a strong preference for their PCP (physician or nurse practitioner) to deliver abnormal FIT results in-person
- Disclosure of FIT results should be accompanied by explaining the implications of a positive FIT test
- Participants felt that a written checklist of colonoscopy logistics would be helpful
- Attention should be given to anxiety and fear regarding bowel preparation, procedural pain, and a potential diagnosis of CRC.

Implications for Practice

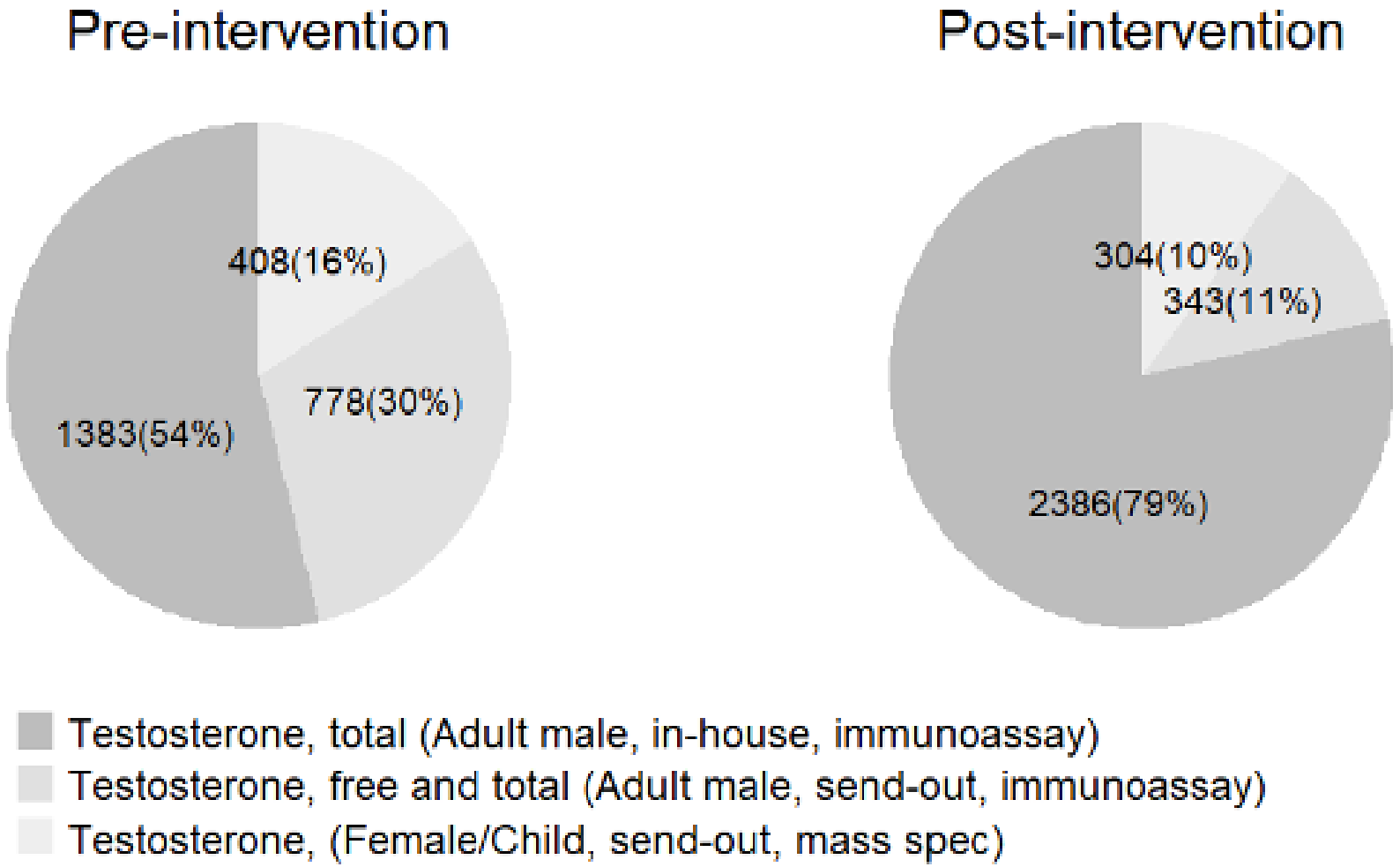
- A standardized checklist and patient-informed educational materials would help ensure appropriate patient counseling and identify individual (health literacy, logistical, and psychological) barriers to obtaining a colonoscopy
- These should be considered as part of the initial disclosure workflow after a positive FIT
- Web-based materials do not replace the need for high quality hard-copy and video resources
- Proactive appointment scheduling after a positive FIT is recommended to improve colonoscopy completion rates

ACTIONS: Finalize abnormal FIT workflow
- Assigned a dedicated FIT navigator to manage follow-up for positive FIT results.
- Improve the rate of completed colonoscopy after (+) FIT.
- Assist patients who need additional support to complete colonoscopy.

Cross-Departmental: Correct Testosterone Assay Ordering Saves Money

QI Intervention: Epic change

- Modify name of testosterone order
- Update preference lists to prioritize in-house test



Distribution of testosterone test requisitions for the two 18-month time periods. Pre-intervention total tests = 2569 (July 2020 to December 2021) and post-intervention total tests = 3033 (January 2022 to June 2023)

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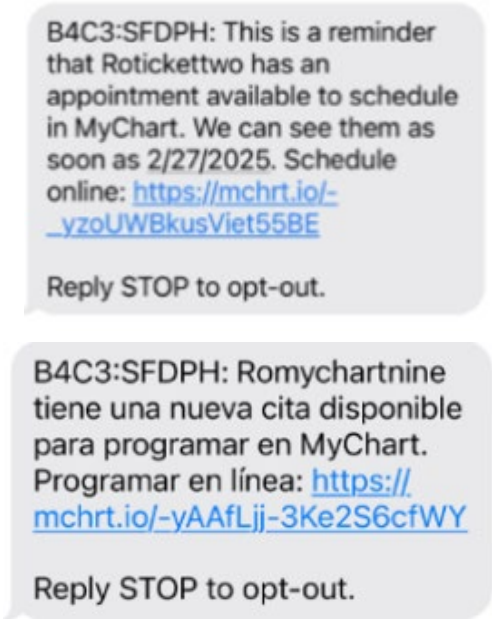
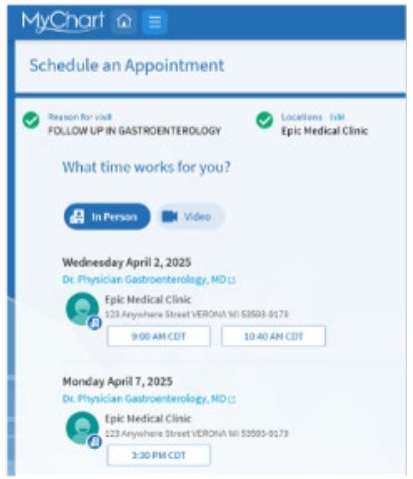
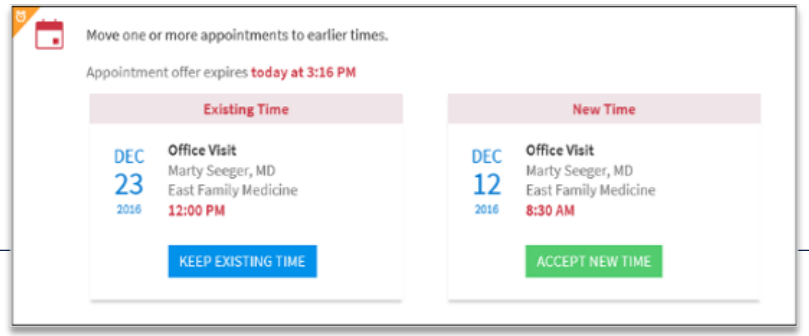
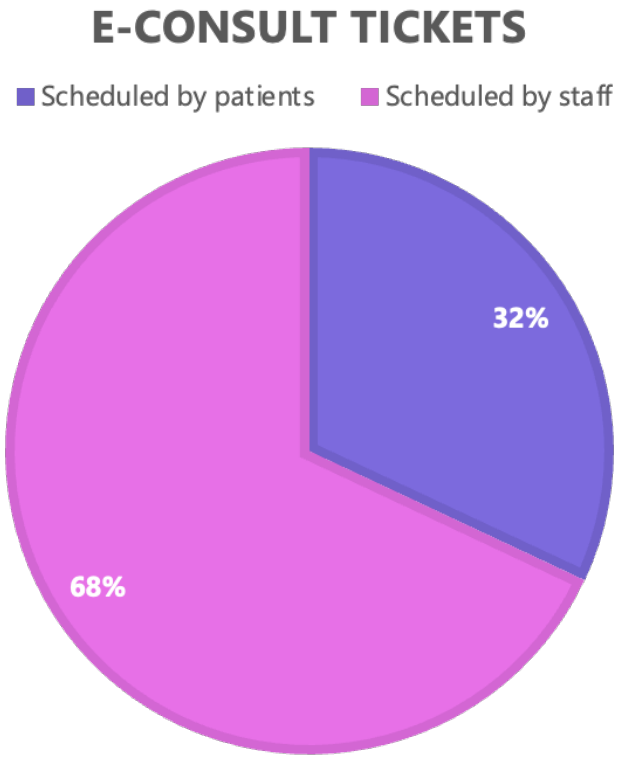
Innovation/Access in Care: Self-Scheduling and Template Optimization

- **Template optimization and patient-facing tools to improve access including self-scheduling, wait list features, reserving urgent slots**









Pilot clinics (GI/Liver + 5M): September 2025

Equity | Safety | Quality | Care Experience | Workforce Care & Development | Financial Stewardship

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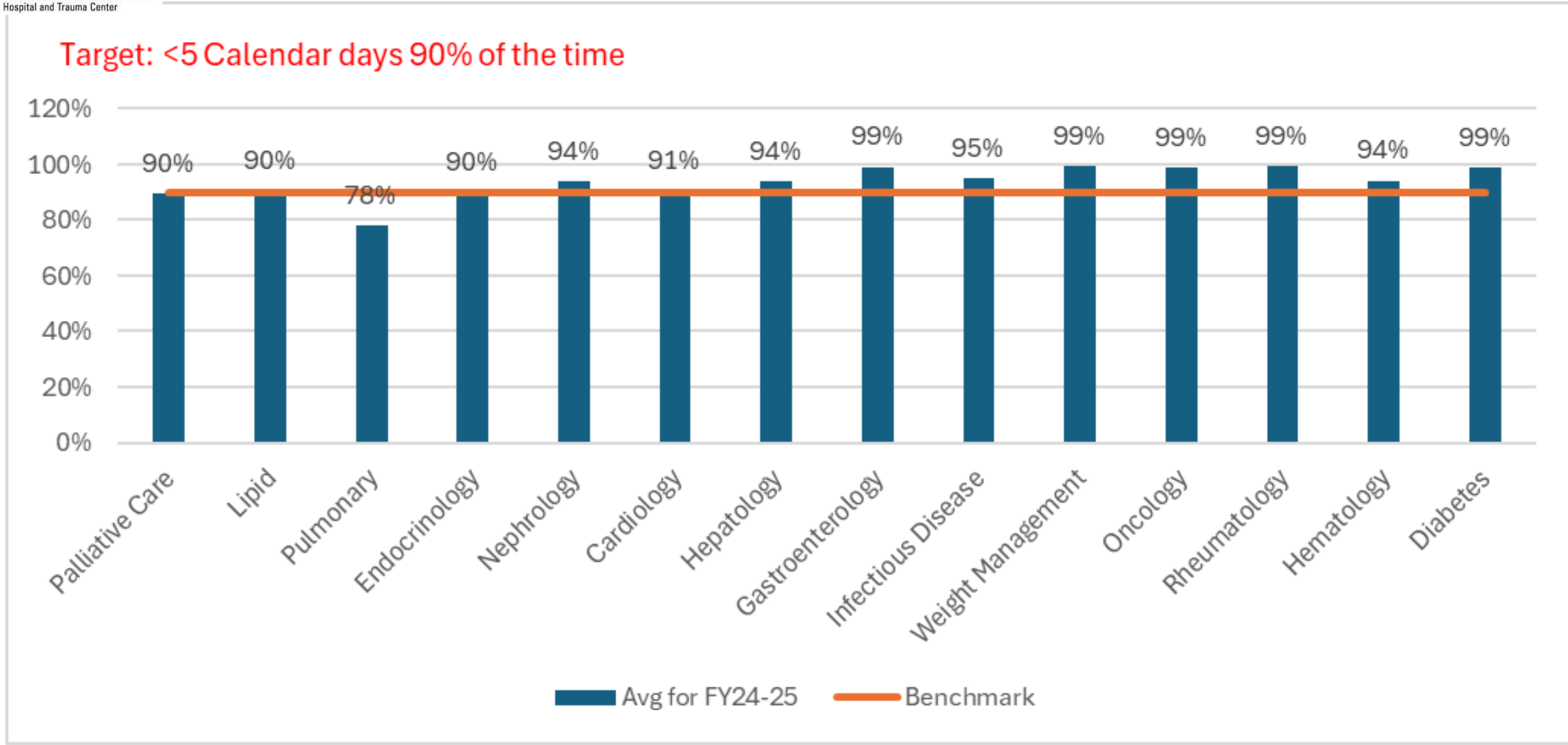
Quality of Care: eConsult response is consistently timely



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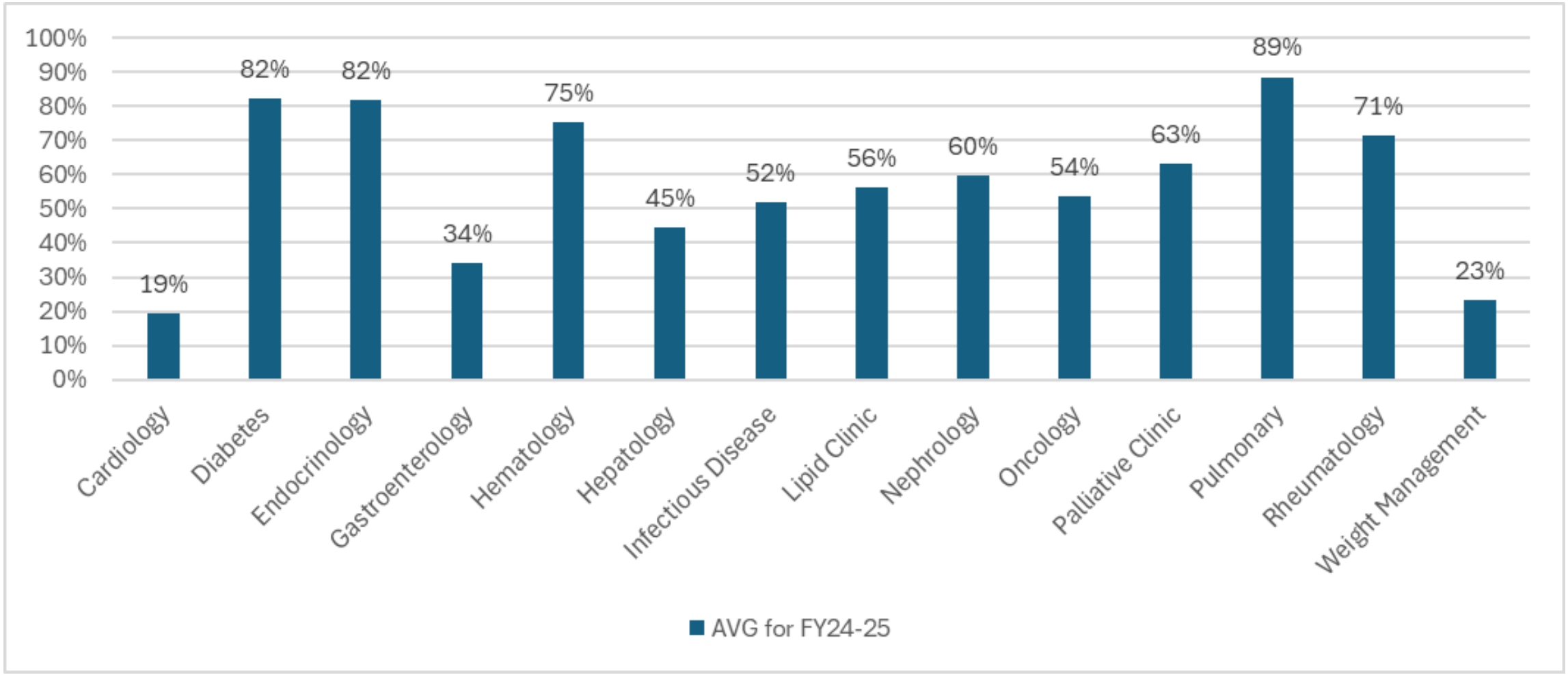
Quality of Care: Virtual Co-Management for eConsult Saves Clinic Visits and Increases Access



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DOM Collaboration on Performance Improvement with Other Departments

Radiology

- Pulmonary: Lung cancer screening navigator: appropriate ordering of low-dose chest CT
- Hepatology: Liver cancer screening: increasing rates of liver cancer screening

Surgery

- Oncology: Improving gastric cancer to better align with NCCN guidelines

Laboratory Medicine

- Endocrinology: Direct providers to order the correct (and often cheaper) testosterone test

Pathology and Surgery

- Endocrinology: Reinstated thyroid pathology review to reduce unnecessary testing and guide surgical decisions

Performance Improvement Examples by Division

Inpatient

Cardiology

- Reducing heart failure admissions by optimizing outpatient heart failure management

Hospital Medicine

- Reducing overnight vital signs for stable patients

Medical Intensive Care Unit

- Adoption of ceftriaxone administration for patients with TBI
- Standard work for daily sedation interruption and spontaneous breathing trials

Ambulatory

Gastroenterology:

- Primary care support for colon ca screening: sharing GI-designed pt education & bowel prep orders

General Internal Medicine/RFPC:

- Hypertension: Close disparity in BP control for Black patients
- Colon cancer screening: Improve rates of completed colon cancer screening

Ambulatory (con't)

Hepatology:

- Created and culturally adapted steatotic liver disease classes to improve patient understanding of metabolic-associated or alcohol-related liver disease

HIV / Ward 86

- Increase rates of viral suppression among people living with HIV
- Provide low-barrier care options (POP-UP clinic, health access point in ward 81)

Pulmonary:

- Improved guidance on appropriate lung cancer screening orders

Nephrology

- Increasing use of SGLT2-inhibitors and equity in prescribing rates between Black and White patients
- Increasing microalbumin testing as part of CKD screening
- Increasing adoption of home dialysis (PD)

Rheumatology

- Increasing depression screening among patients not already screened in primary care

City and County of San Francisco

Department of Public Health

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

Daniel Lurie
Mayor

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	*ZSFG Clinical Service Rules and Regulations*
Clinical Service :	*Medicine*
Date of last approval:	*December 2023*
Summary of R&R updates:	
Update #1:	• Captured the expanded role of the Vice Chief of Clinical Medicine Services to include, "providing additional oversight and management of clinical operations at ZSFG. Responsibilities will also include oversight of teaching activities for residents, fellows, and allied health professionals." • Added roles for Outpatient Residency Site Director and Associate Program Director for ZSFG Primary Care Medicine Residency Program. • Added ICD-10, HCPCS, CMS, and AMA guidelines to the Attendance and Admission Policies section. • Discharge of patient was updated to reflect all admitted patients.
Update #2:	• In Appendix A, removed reference to "ZSFG Do Not Use Abbreviations" and "The DOM encourages the development and implementation of computerized ordering to ensure medication use and patient safety" as these lines are no longer relevant since we have EPIC. • In Appendix A, under Program Reporting Structure, removed "Inpatient Acute Medicine Nurse Practitioners" and changed "monthly" to "regularly" under the Hospitalists' Group • In Appendix A, updated one instance of the "Community Health Network" to the "San Francisco Health Network" • Under Inpatient Operational Performance Improvement Plan, Unusual Occurrences have been updated to the new SAFE reporting system.
Update #3:	• In Appendix B, the first sentence under Housestaff training in procedures was removed, "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." • In Appendix B, under patient care for the critical care resident, "step-down units" was removed from the competency demonstration. • In Appendix B, added "resident report" throughout the various sections and removed "telemetry", where appropriate. • In Appendix B, under various Medical Knowledge sections, removed "from stimulant ingestions" and added a new bullet for "Cardiac complications of substance use." • In Appendix B, Educational Goals added a section for the Medicine/Cardiology Night float Resident (R2/R3) – Section H. • In Appendix B, under team structure, added "Neurology or Anesthesia" interns to the critical care team; replaced "Sub-intern" with "acting intern" throughout, removed the MS4 from the Cardiology Ward team, adjusted the Night float Resident from 1 to 2, and added

	"with back-up admitting from the Medicine/Cardiology Night Float Resident" to the Cardiology Night Resident. • In Appendix B, Under Team Structure and Responsibilities, edits to Section H include: (1) Remove of previous section 3.d.ii "Sub-interns will be responsible for no more than give admissions per twenty four hours and no more than eight admissions per forty eight hours; (2) reduced maximum new patients from seven to six; (3) removed previous section 6 which read "Assumes primary responsibility for supervising sub-interns (MS4s) and will write an admission note for all patients admitted by sub-interns; and (4) on-call period decreased from 24 hours to 14 hours, and sign-out/educational activities reduced from four hours to two hours. • In Appendix B, Under Team Structure and Responsibilities, edits to section J include: (1) editing bullet point 3 by removing "take sign out from the Swing Resident and cross cover on those new admission in addition to following up on any pending studies as directed by the Swing Resident" and replacing it with "be responsible for triaging admissions to the inpatient medical service"; and (2) removing previous bullet point 4, "Will take sign out from the on call team directly and cross cover these patients in addition to following up on any pending studies as directed by the on call team." • In Appendix B, Under Team Structure and Responsibilities, added Section K "Medicine|Cardiology Night Float Resident (R2/R3)." • In Appendix B, Under Team Structure and Responsibilities, edited Section L "Night Float Intern" by: (1) changing arrive time to 8PM and departure time to "by 10AM"; (2) edited bullet point 4 from "patients" to "non-Long Call medicine patients"; and (3) Added bullet point 7. • In Appendix B, Under Team Structure and Responsibilities, edited Section O "Swing Resident" by adding bullet point 7.
Update #4:	• In Appendix C, renamed "Medicine 110 Third Year Students, to "MS 3 Medicine Core Clerkship Summary" • In Appendix C, under Expectations and Responsibilities, section 5, clinical and educational work hours for all changed to 72 hours. • In Appendix C, renamed "MS4 Sub-Internship (Acting Intern) Summary, to "MS4 Acting Internship Summary" • In Appendix C, under Responsibilities and Assessments, section 8, clinical and academic work hours for all changed to 72 hours.
Update #5:	• The document was reformatted to ensure consistency throughout the document with respect to font, size, alignment, etc. • Minor grammatical and punctuation edits were made throughout the document. These changes did not alter the meaning or intent of the document. Any material changes were previously mentioned above.

MEDICINE SERVICE
RULES AND REGULATIONS

~~2023~~2025-~~2025~~2027

MEDICINE SERVICE RULES AND REGULATIONS

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I. ORGANIZATION OF THE DEPARTMENT

MISSION AND VISION
The Mission of the Medicine Service of Zuckerberg San Francisco General Hospital and Trauma Center is: To advance health by developing and supporting clinical innovators in patient-centered care, scientific discovery, medical education and public policy.

VISION
Patient care: Provide the highest quality clinical service that is patient-centered and culturally compassionate.
Research: Be the leading engine of scientific discovery to advance health and attract the world's best investigators ~~For~~, for the problems we encounter.
Education: Be recognized as innovators in education, attracting and developing the next generation of leaders in medicine.
Public Policy: Be the most trusted and influential leaders in shaping public policy to advance health~~.~~.

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 the 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

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 care, 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 services in the outpatient clinic and hospital wards for patients with malignancies.

HIV, ID, and Global Medicine

The Division of HIV, ID, 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), Addiction Medicine, Palliative and Supportive Care, Medicine Consult, 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.

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 Zuckerberg San Francisco General Hospital and Trauma Center 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 ZSFG 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 ZSFG 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.

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 Zuckerberg San Francisco General Hospital and Trauma Center. All fully licensed physicians and other licensed health care providers who are members of the Medicine Service at ZSFG are bound by the Bylaws, Rules and Regulations, and accompanying manuals of Zuckerberg San Francisco General Hospital and Trauma Center 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 Zuckerberg San Francisco General Hospital and Trauma Center.

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 ZSFG in accordance with the ZSFG Medical Staff Bylaws, appoints the Chief of the Medicine Service at ZSFG. The Chief of the Medical Service is subject to the Medical Staff process for reappointment to the ZSFG Medical Staff every two years.

The Chief of the Medical Service at ZSFG reports to the Chief Executive Officer of ZSFG 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 ZSFG 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 Z 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~~ Clinical Medical Services – responsible for supervising the inpatient clinical programs at ZSFG, providing additional oversight and management of clinical operations at ZSFG. Responsibilities will also include oversight of teaching activities for residents, fellows, and allied health professionals.~~.~~

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

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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. Inpatient Residency Site Director - responsible for the supervision and guidance of the house staff during ~~Residency training~~residency training on the Medicine Clinical Service at ZSFG.

b. Outpatient Residency Site Director - responsible for the supervision and guidance of the house staff during ambulatory residency training on the Medicine Clinical Service at ZSFG.

~~b.~~c. Associate Program Director (APD) for Residency Program – responsible for the oversight of programmatic development and curriculum innovation. There are 5 APDs across the ZSFG, 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~~Inpatient Affairs is a member of the Department of Medicine at ZSFG.

d. Program Director for ZSFG Primary Care Medicine Residency Program - responsible for the supervision and guidance of the house staff during Primary Care residency training ~~Residency training~~ on the Medicine Clinical Service at ZSFG.

~~c.~~e. Associate Program Director for ZSFG Primary Care Medicine Residency Program - responsible for the supervision and guidance of the house staff during Primary Care residency training on the Medicine Clinical Service at ZSFG.

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 ZSFG 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

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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 ZSFG.

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 Zuckerberg San Francisco General Hospital and Trauma Center, regardless of financial, social, or medical status. All health care providers are bound to follow the ZSFG 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~~ 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 (CPG) 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 and certified professional coders to assign appropriate CPT, ICD-10, and HCPCS codes based on the documentation provided in the clinical ~~record~~charts and CMS and AMA guidelines.

For the purposes of payment, Evaluation and Management services billed by the attending physician require the attending to have either performed the service or be physically present during the key or critical portions of the service when performed by a resident, fellow, or medical student. The attending provides such documentation in the attestation portion of the billing template and links to the resident/fellow note by indicating review of the note and discussion of the findings.

F. INFECTION CONTROL

Each member of the ZSFG 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 ZSFG 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 the 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.

H. CONFIDENTIALITY

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

I. PROCEDURAL SEDATION

All members of the Medicine Service will abide by the "Sedation Guideline: Sedation Administration" of Zuckerberg 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 ZSFG 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 ZSFG Policy No. 1.8.

K. RESUSCITATION OF PATIENTS (DNAR) POLICY

It is the policy of Zuckerberg 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 admitted patients ~~hospitalized for longer than 48 hours~~ require a discharge summary, which must be completed by a provider within 24 hours of discharge.

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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.

O. NATIONAL PATIENT SAFETY GOALS

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

II. CREDENTIALING

A. INITIAL APPOINTMENTS

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

C. STAFF CATEGORIES

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

DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Medicine Service privileges are developed in accordance with ZSFG 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 ZSFG 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.

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING

A. PROCTORING REQUIREMENTS

Proctoring requirements for the Medicine Service shall be in accordance with ZSFG 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 Zuckerberg 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

Requests for additional and/or new privileges for the Medicine Service shall be in accordance with the ZSFG 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 ZSFG 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 ZSFG 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 Zuckerberg San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations and accompanying manuals will govern all disciplinary action involving members of the ZSFG 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 ZSFG 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 prior to the beginning of the attending rotation. 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 at the close of the rotation. 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 house staff on the first day of the rotation

B. Clinical:

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

XI. EDUCATION – HOUSE STAFF TRAINING COMPETENCIES & SUPERVISION

The Medicine Service complies with the ZSFG 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, ZSFG assures adequate house staff 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)*

XII. MEDICAL STUDENT TRAINING PROGRAM AND SUPERVISION

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

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

Twenty-four-hour inpatient care is delivered by Medicine in Building 25.

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.

Ward 92 specialty clinics include: 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 procedure. Care delivery services include cancer chemotherapy, antibiotic and antifungal infusion, blood and blood product transfusion, and invasive post-procedure observation.

The **GI Diagnostic unit** includes GI invasive procedures and Gastroenterology and Liver clinics. Ambulatory bronchoscopy by the Pulmonary Division is also done here.

The **Pulmonary Function Lab** provides comprehensive Pulmonary Function Testing.

The **Cardiology Lab** provides Echocardiography, treadmill testing, cardiac ambulatory monitoring, 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.

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

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.

Commented [U8]: This will all change, of course, in Building 25. Do you want to update it now?

Commented [HE9]: multiple of these clinics have moved out of 1M. Cardiology and Bridge for sure. Would check Pulmonary and Diabetes as well. For simplicity, you could just list all the clinics and say the care is delivered in 1M and Bldg 80/90.

Commented [LT10R9]: NEIL - I looked online, and care is highly fragmented. Should we list where all of these take place, or just remove that piece completely given the timeline that we have?

Commented [HE11]: should these be listed in the first section above? or at least come right after it, since they also describe clinical services delivered to adults? Also, did Heme/Onc move their clinical operations from W86 to 4C as well, or just infusion?

Commented [LT12R11]: NEIL - Let me know where you want this

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, Resident Physicians, and Medical Students.

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

D. CARE PROVIDER CREDENTIALING AND EDUCATION

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 ZSFG Medical Staff Bylaws.2. 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 ZSFG 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 ZSFG 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:

- 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 LEAN -PDSA: 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; Study 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 measurements 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 ~~ZSFG 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.

Commented [HE13]: consider removing this since EPIC addresses it in orders and I don't think we get feedback on whether providers are using do not use abbreviations in notes

Commented [HE14]: no longer relevant since we have EPIC

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 outcomes. 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 ZSFG Cancer Committee reviews the performance improvement activities of the UCSF/ZSFG 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/ZSFG Cardiovascular Service when Department of Medicine patients requiring this service are referred for treatment during the Cath Conference discussion.

Patient Experience
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 the hospital patient feedback processes.

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 ZSFG 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 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 quality improvement (QI) activities takes place through an established committee structure:

Department of Medicine Inpatient QI Committee
The QI 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 regularly ~~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 Quality and Performance Committee meeting with a complete, programmatic review and PIPS Plan review every year. The program is assessed ~~in regard to~~on:

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 Zuckerberg San Francisco General Hospital. This plan includes monitoring the multidisciplinary care of patients in all the inpatient areas of the Department of Medicine at Zuckerberg San Francisco General Hospital.

A. CONCURRENT REVIEW

1. Best practice treatments and complications will be discussed at Residents' Report on 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 ZSFG Hospital Policy.
4. As part of the individual attending performance evaluation, access to information gathered through the Resident and Student computerized evaluation system, Med Hub is available to the Chief of Medicine and the Division Chiefs.

5. The Dept. of Medicine and the Quality Management Dept. of ZSFG 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

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C. EVALUATED ASPECTS OF CARE

Review of Clinical Pertinence:

PLAN: Each record 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.

Approved and respectfully submitted by:

_____ _____

Neil R. Powe, MD, MPH, MBA Date
Chief, Medical Services, Zuckerberg San Francisco General Hospital
Constance B. Wofsy Distinguished Professor and
Vice-Chair of Medicine, University of California San Francisco

APPENDIX B - Housestaff Educational Goals and Responsibilities

The Medical Service at Zuckerberg San Francisco General Hospital consists of five medical ward teams, ~~four~~ one cardiology team~~s~~, and one critical care team providing comprehensive inpatient care to acutely ill medicine patients.

The **Swing Resident** assists medicine wards teams with work and procedures, cross-covers wards teams after they sign out, and admits patients after the on-call team has capped and before the Night admitting team arrives.

The **Medicine Night float Intern and Resident** assist in providing care for patients on the Medicine Service and ~~do~~ perform overnight admissions~~, respectively~~.

The **Cardiology Night Resident** and **ICU Night Resident** provide care to patients on the Cardiology and ICU services, respectively, and admit patients to their respective services overnight.

A **Medicine Consult Resident** provides consultative care to patients admitted to surgical or other non-medical services within the hospital. This is an optional elective rotation for 2nd and 3rd year residents.

Medicine residents and interns also care for patients on elective rotations at Zuckerberg San Francisco General Hospital.

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~~All 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, or by an attending physician.

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 ZSFG 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.
    - 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 ZSFG 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~~their 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 ZSFG 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 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, 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 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 Richard H. Fine People's Clinic, Ward 86, Community Health Network clinics, and other clinics.
    - Timely documentation of medications and discharge summary information in EPIC system.

D. General Medicine Ward Intern (R1)

By the end of the ZSFG 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 medical conferences which include: attending rounds, interns report, 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.

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/R3)

By the end of their ZSFG 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~~or~~,~~ 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):
    - ~~o~~ Management of acute coronary syndromes due to coronary artery disease ~~from stimulant ingestion~~
    - Valvular heart disease
    - Congestive heart failure
    - Cardiac complications of substance use
- 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.
- Advocate for appropriate allocation of limited health care resources.
- Participate in organized teaching conferences for this rotation as well as required conferences for the ZSFG medicine department such as resident report, 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 ZSFG 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):
    - ~~o~~ 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 medical conferences which include: attending rounds, interns report, 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

- 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 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/Cardiology Night float Resident (R2/R3)

At the completion of this rotation, the Medicine/Cardiology 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 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.

~~H~~I. 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 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~~J. Medicine Consult Resident (R2/R3)

At the completion of this elective 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~~K. Medicine Swing Resident (R2/R3)
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.

~~K~~L. Cardiology Night Resident (R2/R3)
At the completion of this rotation, the Cardiology Night Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient cardiac problems.
2. Demonstrate organizational skills necessary for the care of cardiology 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. Triage cardiology admissions to the appropriate level of care (CCU, ~~telemetry~~floor~~, etc~~).

~~L~~M. ICU Night Resident (R2/R3)
At the completion of this rotation, the ICU Night Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse critical care problems.
2. Demonstrate organizational skills necessary for the care of critically ill patients.
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. Triage critically care admissions to the appropriate level of care.

A. TEAM STRUCTURE AND RESPONSIBILITIES

B. 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, Neurology, or Anesthesia). ~~R1 or 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 an acting ~~sub~~ intern (MS4). A social worker and care coordinator RN are 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 and care coordinator RN are assigned to help care for patients on the FIS.

The Cardiology Ward team consists of one cardiology attending, three 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 and care coordinator RN are assigned to the team to aid in identifying and meeting discharge needs.

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

~~A~~Two Night float Resident and one hospitalist attending admit patients to the medicine service in the overnight hours (9 PM to 6AM).

A Cardiology Night resident provides coverage of the Cardiology service and admits patients to the Cardiology service in the overnight hours (9PM to 6AM)with back-up admitting from the Medicine/Cardiology Night Float Resident.

An ICU Night resident provides coverage of the ICU service and admits patients to the ICU service in the overnight hours (9PM to 6AM).

The Medicine Consult team consists of one attending +/- one resident (optional resident elective).

B. Critical Care Attending Physician:

1. Holds appropriate clinical privileges at ZSFG 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 (DNAR 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 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 that the medical ICU team is consulted on.
    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 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 ZSFG 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 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 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 be expected to attend as many teaching conferences as allowed by patient care responsibilities. Expected attendance at the following conferences:
    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 for readmissions or during admissions surges. The medicine teams will admit all medical ward 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 FIS and the Swing resident. If the admission threshold is exceed, backup admitting guidelines will be employed.
        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 providing feedback on the performance of the interns, MS4, and MS3s.9.
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 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
    e) Residents' 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/their 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 ZSFG 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 the wards. The attending should conduct daily management rounds, which include the following:
    a) Interaction at regular intervals with CCU 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 (DNAR orders).

H. Cardiology Ward Resident (R2/R3):

Under the guidance of the attending Cardiology physicians and the Cardiology fellows, the R2esident directs the comprehensive inpatient care of acutely ill medicine and cardiology patients on the wards and 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 be expected to attend as many teaching conferences as allowed by patient care responsibilities. Expected attendance at the following conferences:
   a) Weekly Morbidity and Mortality conference.
   b) Weekly Grand Rounds.
   c) Residents' Report.
3. Directs the admission and initial evaluation of patients to the cardiology service:
   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 ~~seven~~ six new patients.

iv) Total admissions per admitting resident will not exceed seven per 24-hour call day; a backup admitting system will be activated for admissions in excess of this threshold.
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~~ Residents 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~~6. Responsible for providing feedback on the performance of the intern, MS4 and MS3s.
~~8~~7. Responsible for providing written evaluation of the attending physician, intern, MS4 and MS3s.
~~10~~8. Residents will not work in excess of an average of eighty hours per week during any inpatient ward months.
~~11.~~ 9. Residents will have at least one day off in every seven averaged over the month. Residents will have a break of at least eight hours between shifts.
~~8.~~ 10. The on call period will consist of 1~~2~~4 hours of patient care and new admissions, plus up to ~~four~~ two hours for sign out and educational activities.
~~9.~~ 11. ~~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.

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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 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 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 sign all medical student orders once reviewed 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. Medicine 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.~~be responsible for triaging admissions to the inpatient medical service.
~~4. Will take sign out from the on-call team directly and cross-cover these patients in addition to following up on any pending studies as directed by the on-call team.~~
~~5~~4. The Night float Resident will admit general medicine patients to the wards between the hours of 9PM-6AM.
~~6~~5. 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.
~~7.~~6. The FIS hospitalist attending is responsible for assisting the night float Resident 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 FIS hospitalist attending, the Night float Resident will employ the backup admitting system (Admission Surge Guidelines).
~~6~~7. The Night float Resident will personally sign out patients to the ward teams and FIS between 8AM-10AM.

K. ~~K. Night float Intern (R1):~~Medicine | Cardiology 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 receive signout from the Swing and cross-cover on Swing Resident new admissions in addition to following up on any pending studies as directed by the Swing Resident.
4. Will receive signout from the Medicine call team and cross-cover these patients overnight
5. The Medicine | Cardiology Night float Resident will admit general medicine and cardiology patients to the wards between the hours of 9PM-6AM.
6. The Medicine|Cardiology Night float Resident will sign out patients to the ward teams, cardiology teams, and FIS between 8AM-10AM

L. Night floar 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~~by 10AM; 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 patients on the wards.
4. Will receive written sign-out on all ~~patients~~non-Long Call medicine 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/their care and will personally evaluate patients for whom there are any concerns.
7. Will admit 1-2 general medicine patients to the wards with supervision by Medicine Night float resident.

~~7~~8. 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 and notify the supervising resident.

~~8~~9. 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~~M. Medicine Consult Attending:

1. Holds appropriate clinical privileges at ZSFG.
2. Supervises and assumes ultimate responsibility for General Medicine consultations on inpatients and Orthopedic Surgery co-management.
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~~N. Medicine Consult Resident (R2/R3):

1. Will see all medicine consult patients, 7:30 AM to 5:30 PM Monday-Friday.
2. Will discuss each case with the medicine consult attending.
3. Will write appropriate orders with agreement of primary team.
4. Will give written sign-out to the FIS Swing cross-cover provider.
5. Will initiate transfers to the Medicine Service when appropriate**.**

O. Swing Resident (R2):

1. Will arrive at the hospital at 12:00 PM and leave by 12:00 AM.
2. Will assumes primary cross cover responsibilities until ~~8~~9:00 PM for the non-Long C~~e~~all 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/their 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 and notify the supervising attending.
6. Will alternate admissions with the Swing Hospitalist between 6-~~9~~ 8 PM or when the on-call team has capped.
7. Will sign out non-Long Call cross-cover patients to Night float intern at 8 PM.

~~7~~8. Will sign out admitted patients to the Medicine|Cardiology Night float Resident at 9 PM.

APPENDIX C – MEDICAL STUDENT TRAINING PROGRAM
SAN FRANCISCO GENERAL HOSPITAL

~~Medicine 110 Third Year Students~~MS 3 Medicine Core Clerkship Summary

Objectives

Major objectives

- Perform a complete admission history and physical examination
- Select and interpret appropriate diagnostic tests
- Develop an assessment/differential diagnosis, based on H & P, lab data
- Write up each admission and daily progress notes
- Give a complete new admission oral presentation
- Follow the patient daily throughout the hospital stay
    - Perform focused daily H and P, interpret relevant tests
    - Present the patient in SOAP format on daily rounds, with updated problem list
    - Write a daily note
    - Participate in the coordination of care including discharge planning
    - Communicate with patients and families about the hospital experience and their perspective on their care

Priority patients (Core Experiences, Procedures that will be logged in MedHub):

- Acute non-surgical GI/liver symptoms (nausea/vomiting, abdominal pain, diarrhea, GI bleed, abnormal LFTs)
- Chest pain
- Chronic coronary artery disease and/or metabolic syndrome (hypertension, diabetes, hyperlipidemia)
- Common arrhythmia (e.g., atrial fibrillation)
- Dyspnea (COPD exacerbation, CHF, PE, asthma, etc.)
- Electrolyte abnormalities and/or acute or chronic renal failure
- Fever
- Geriatric patient
- I was observed doing a relevant history and cardiopulmonary physical exam for a cardiac or pulmonary complaint.
- Life–threatening or terminal illness
- Meet with the site director or longitudinal medicine preceptor for midpoint feedback

Knowledge objectives

The following are topic areas covered on the final examination:

Laboratory data interpretation: Complete blood count and peripheral blood smear, Arterial blood gas (oxygenation, ventilation, and acid-base status), pleural fluid, peritoneal fluid, pulmonary function tests, EKG, chest X-ray

Clinical Symptoms, signs, and disease:

- Gastrointestinal: Upper & lower GI bleeding, acute and chronic pancreatitis, cirrhosis

- Cardiac: Chest pain, coronary artery disease/ischemic heart disease, congestive heart failure, valvular heart disease, atrial fibrillation
- Endocrine: DM, hyper- and hypothyroidism, adrenal insufficiency/excess
- Hematology/Oncology: Anemia and transfusions, platelet disorders, lymphadenopathy, lung cancer (not chemotherapy regimens)
- Infectious Disease: Pneumonia, UTI, sepsis and bacteremia, endocarditis, HIV/AIDS, TB
- Pulmonary: Dyspnea, asthma, COPD, DVT and PE
- Renal/ Electrolytes: Hyper- and hyponatremia, hyper- and hypokalemia, hyper- and hypocalcemia, acute and chronic renal failure, acid-base disorders, management of intravenous fluids
- Other: Altered mental status (atypical presentation of common illnesses in the elderly), end-of-life decision-making, managing physical symptoms at the end of life, teaching patients and families about illness, treatment, and prognosis

Expectations and Responsibilities

1. Call expectations
   - Admit 1 patient per long or short call; and depending on their census and patient complexity, may be able to admit another patient on other days of the cycle (e.g., pick up a holdover or short call patient). Average census is anywhere from 1-3 (ideal patient census ~2).
   - The time a student leaves on call days will vary depending on the clinical workflow and team; they may write notes and read about patients at home.
   - Review admission H&P note with resident or intern.
   - Practice oral presentation on and be expected to present either on-call day or post-call day.
   - Should have a note in the patient chart immediately following attending rounds on the post-call day.
   - Follow admitted patients daily, including presenting and writing notes.

2. Student education
   - Core afternoon student lectures: Attendance is required; students are excused from patient activities during this time.
   - Conference:
     - Resident and intern report: Students are highly encouraged to attend.
     - Noon conferences and grand rounds report.
   - BBOTs:
     - Twice a week, students are required to be observed by the attending or resident (not intern) while interviewing and examining a patient (15 min observation, 5 min feedback). These should be filled out online and should cover skills in history taking, the physical exam, communication in general, presenting, and note writing.
   - Serious Illness Communication Workshop: Students will participate in a program to learn about how to talk to their patients about code status and end-of-life ~~your patients about code status and end-of-life~~ decision-making.
   - Consideration of Social Risk in Diagnosis Assignment: Students will practice evaluating the impact of social context on the diagnostic process through a clinical case. Students will present their patient at a student case presentation and complete a post-activity survey.

3. Days off
   - 1 day off per week (4 per month) assigned by the resident; weekend days are preferred but will depend upon resident and intern schedules. This should not be on FCM clinic day or FS day.
   - 1 full day to attend Family Community Medicine or FS didactics day.

- Complete Absence Request Form for an absence for one or more required clinical dates due to planned or emergent absences. ~~https://ucsf.co1.qualtrics.com/jfe/form/SV_8dfouJ4OU19XZWd)~~
- Students who are away on a post-call day should try to admit an early patient on call so that they can work up their patient and potentially present their patient.

4. Feedback

- Students should meet with each attending and senior resident at the start and end of their time together to discuss expectations and feedback. If they work together for more than 2 weeks, there should also be a mid-point feedback meeting.
- Interns can give regular feedback to students during routine patient care.

5.Work Hour Policy:

- Work hours are defined as all clinical and academic activities related to the rotation. This is defined as patient care (including patient-related administrative duties such as patient notes) and scheduled activities (such as conferences). It does NOT include time spent studying for exams, reading, preparing for oral presentations, or commute time.
- Clinical and educational work hours must be limited to no more than ~~80~~ 72 hours/week~~; medical students should be scheduled for no more than 72 hrs/week.~~
-

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Student Evaluation

- ~~After~~ After the first week of the rotation, residents, and attendings who work with a student for at least 7 days will be asked to evaluate the student on MedHub. ~~and in turn will be evaluated by the student.~~ Note that in some cases because of days off, students might be evaluated by a team member who ends up working with them <7 days. This 7-day calendar ~~day rule is applied~~rule applies across all clerkship sites.
- Cardiology attendings do not fill out MedHub evaluations because of the structure of the service (more direct interactions with residents/interns than attendings; sharing of attendings between teams).
- Grading committee reviews composite evaluations together. If questions exist~~s~~ about passing, the grading committee confers on the final grade and next steps if necessary.
- The site director compiles the final evaluation based on team evaluations and exam scores.
- To pass the course, you must also pass the shelf exam. A passing grade is two standard deviations below the national mean.

Maximizing Clerkship Experience

- Participate actively: look up questions that arise on rounds and share what they read with their team.
- Think of the patients as their patients.
- Ask their team to involve them in their patient's workup.
- Sit down with the resident and attending early on to set goals and expectations.
- Remind the team about the conference schedule and other responsibilities.
- Be active in patient care; know their patient's conditions better than anyone else on the team.

MS4 ~~Sub-Internship (Acting Intern)~~Acting Internship Summary

Goals:

- Assume primary responsibility for patient, including new emphasis on communication, coordination of care, and information management.
- Be the main person updating patients and families, contacting consultants and outpatient providers, and coordinating with interdisciplinary team members.
- 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~~ for multiple patients
- Students will be supervised in these tasks, especially early on, but the goal is for them to develop independence.

Objectives:

Patient Care

- Acquire accurate and relevant histories from patients in an efficiently customized, prioritized, and hypothesis-driven fashion
- Perform accurate physical examinations that are appropriately targeted to the patient's complaints and medical conditions. Identify pertinent abnormalities
- Recognize situations ~~which~~ that need urgent or emergent medical care, including ~~life threatening~~life-threatening conditions
- Recognize when to seek additional guidance
- Request and provide consultative care
- Recognize tasks that ~~are needed~~need to be completed to advance patient care
- Make appropriate priorities in tasks that ~~are needed~~need to be done to advance patient care
- Execute tasks needed to advance patient care

Medical Knowledge

- Understand the relevant pathophysiology and basic science for common medical conditions
- Select, order, and interpret appropriate diagnostic tests, paying attention to how the results will affect management.

Interprofessional and Interpersonal Communication

- Deliver appropriate, succinct, hypothesis-driven oral presentations
- Provide legible, accurate, complete and timely written communication that is congruent with medical standards
- Request consultative services in an effective manner
- Actively seek to understand patient differences and views and reflect this in respectful communication and shared decision-making with the patient and the healthcare team
- Communicate compassionately, and in language appropriate for each person, with patients and their families about their illness experience, clinical situation, and goals.
- Provide patients and their families with anticipatory guidance for diagnosis, prognosis, and treatment.
- Communicate appropriately with each patient depending on their needs ~~including the using interpreters, low literacy language and resources~~, including the use of interpreters, low literacy language and resources, and culturally sensitive approaches.
- Effectively communicate plan of care to all members of the health care team.
- This includes planning and communicating effectively with other providers to facilitate safe transitions of care for patients within the hospital (i.e., morning hand-offs for patients admitted by another team; evening sign-outs) and on discharge.
- Communicate respectfully and clearly with consultants, primary care providers, and allied health professionals to advance patient care and provide safe and continuous care.

~~Systems Based~~Systems-Based Care

- Work effectively as a member within the interprofessional team to ensure safe patient care

- Appreciate the variety of health care provider roles, including, but not limited to, consultants, therapists, nurses, home care workers, pharmacists, and social workers
- Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, subacute, acute, rehabilitation, and skilled nursing

~~Practice Based~~Practice-Based Care

- Actively seek to expand knowledge, through supplemental reading and consultation of the literature, soliciting and responding to feedback, and self-reflection

Professionalism

- Recognize when it is necessary to advocate for individual patient needs
- Respond promptly and appropriately to clinical responsibilities, including but not limited to calls and pages
- Ensure prompt completion of clinical, administrative, and curricular tasks
- Carry out timely interactions with colleagues, patients, and their designated caregivers
- Recognize and address personal, psychological, and physical limitations that may affect professional performance
- Recognize the scope of abilities and ask for supervision and assistance appropriately

Patient Advocacy

- Recognize the social determinants of health that may be contributing to health, illness, and the effectiveness of care for an individual patient.
- Construct patient-centered diagnostic, treatment, and discharge plans based upon recognition of influential social determinants of health for individual patients. Promote variations in plans and mobilize and provide resources to execute patient-centered care.
- Minimal Competency expected at the end of the rotation
- The Acting Intern will be able to admit 2 patients on a call day and manage them semi-independently, while maintaining responsibility for the patients they have previously admitted.

Responsibilities and Assessments:

1. Call expectations:
   - Work up to admit 2 patients on call, at the discretion of the supervising resident who understands the overall team/other intern census and complexity of patients
   - By the end of rotation, must be able to semi-independently admit 2 patients
   - Daily census may range on average from 2-5 patients, depending on the call cycle
   - Go home on-call and post-call at the same time as the team; ~~sign out~~sign out as interns do

2. Orders:
   - Acting interns can pend orders in EPIC

3. Documentation/Discharges:
   - Be responsible for writing discharge summaries and ~~review~~ reviewing with the resident

4. Days off:
   - 1 day off per week for a total of 4 days during a 28-day rotation; specific days are decided with your resident because the resident needs to consider days off/clinic days for other team members

5. Absences:

a. Students should notify their teams (attending/resident), site director, and course coordinator ~~(Amy Zhen)~~ of any planned or emergency absences.
b. Turn in SOM absence request at this link: https://ucsf.co1.qualtrics.com/jfe/form/SV_b8EFcYYTn9bEGiN

6. Expectations
   - Sit down with the resident and the attending to set up goals/expectations
   - Check in with the resident and attending at the beginning, midway, and at the end

7. Assessments and feedback
   - This is a purely clinical rotation without a final exam. Students are evaluated by resident/s and attending~~/~~s only. It is graded Honors/Pass/Fail.
   - Residents and attendings who have been assigned for 7 days or more on the calendar will be assigned an evaluation. Usually, this entails fewer than 7 days actually working together because of days off (e.g., the number of actual work days together is shorter, e.g., 4-5)
   - Fill out the midpoint attending feedback card and turn it in to Amy Zhen.
   - Fill out one BBOT on the ability to identify and execute tasks. Verbally request one task-oriented BBOT from either a resident or attending during the rotation. Then summarize their feedback under "Other" using the BBOT QR code.

8. Work Hour Policy
   - Work hours are defined as all clinical and academic activities related to the rotation. This is defined as patient care (including patient-related administrative duties such as patient notes) and scheduled activities (such as conferences). It does NOT include time spent studying for exams, reading, preparing for oral presentations, or commute time.
   - Clinical and ~~educational~~ academic work hours must be limited to no more than ~~80hrs~~72 hours/week.~~; medical students should be scheduled for no more than 72 hours/week.~~

MEDICINE SERVICE
RULES AND REGULATIONS

2025-2027

MEDICINE SERVICE RULES AND REGULATIONS

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I. ORGANIZATION OF THE DEPARTMENT

A. MISSION

The Mission of the Medicine Service of Zuckerberg San Francisco General Hospital and Trauma Center is: To advance health by developing and supporting clinical innovators in patient-centered care, scientific discovery, medical education, and public policy.

VISION

Patient care: Provide the highest quality clinical service that is patient-centered and culturally compassionate.
Research: Be the leading engine of scientific discovery to advance health and attract the world's best investigators for the problems we encounter.
Education: Be recognized as innovators in education, attracting and developing the next generation of leaders in medicine.
Public Policy: Be the most trusted and influential leaders in shaping public policy to advance health.

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 the best interest of our workforce
- Lifelong learning, mentoring, and advocacy
- High ethical standards
- Caring, compassion, and commitment to social justice and responsibility

B. 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

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 care, 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 services in the outpatient clinic and hospital wards for patients with malignancies.

HIV, ID, and Global Medicine

The Division of HIV, ID, 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), Addiction Medicine, Palliative and

Supportive Care , Medicine Consult, 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.

Rheumatology

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

C. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General Hospital and Trauma Center 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 ZSFG 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 ZSFG 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.

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.

D. MEDICAL SERVICE LEADERSHIP

The Medical Service is organized under the Bylaws, Rules and Regulations of Zuckerberg San Francisco General Hospital and Trauma Center. All fully licensed physicians and other licensed health care providers who are members of the Medicine Service at ZSFG are bound by the Bylaws, Rules and Regulations, and accompanying manuals of Zuckerberg San Francisco General Hospital and Trauma Center 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 Zuckerberg San Francisco General Hospital and Trauma Center.

- **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 ZSFG in accordance with the ZSFG Medical Staff Bylaws, appoints the Chief of the Medicine Service at ZSFG. The Chief of the Medical Service is subject to the Medical Staff process for reappointment to the ZSFG Medical Staff every two years.

  The Chief of the Medical Service at ZSFG reports to the Chief Executive Officer of ZSFG 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 ZSFG 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 Z and Department of Medicine at UCSF.

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

- **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 Clinical Medical Services – responsible for supervising the inpatient clinical programs at ZSFG, providing additional oversight and management of clinical operations at ZSFG. Responsibilities will also include oversight of teaching activities for residents, fellows, and allied health professionals.

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

- **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. Inpatient Residency Site Director: Responsible for the supervision and guidance of the house staff during residency training on the Medicine Clinical Service at ZSFG.
  b. Outpatient Residency Site Director: Responsible for the supervision and guidance of the house staff during ambulatory residency training on the Medicine Clinical Service at ZSFG.
  c. Associate Program Director (APD) for Residency Program: Responsible for the oversight of programmatic development and curriculum innovation. There are 5 APDs across the ZSFG, 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 Inpatient Affairs is a member of the Department of Medicine at ZSFG.
  d. Program Director for ZSFG Primary Care Medicine Residency Program: Responsible for the supervision and guidance of the house staff during Primary Care residency training on the Medicine Clinical Service at ZSFG.
  e. Associate Program Director for ZSFG Primary Care Medicine Residency Program: Responsible for the supervision and guidance of the house staff during Primary Care residency training on the Medicine Clinical Service at ZSFG.

- **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 ZSFG 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 ZSFG.
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 Zuckerberg San Francisco General Hospital and Trauma Center, regardless of financial, social, or medical status. All health care providers are bound to follow the ZSFG 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 (CPG) 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 and certified professional coders to assign appropriate CPT, ICD-10, and HCPCS codes based on the documentation provided in the clinical charts and CMS and AMA guidelines.

For the purposes of payment, Evaluation and Management services billed by the attending physician require the attending to have either performed the service or be physically present during the key or critical portions of the service when performed by a resident, fellow, or medical student. The attending provides such documentation in the attestation portion of the billing template and links to the resident/fellow note by indicating review of the note and discussion of the findings.

F. INFECTION CONTROL

Each member of the ZSFG 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 ZSFG 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 the 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.

H. CONFIDENTIALITY

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

I. PROCEDURAL SEDATION

All members of the Medicine Service will abide by the "Sedation Guideline: Sedation Administration" of Zuckerberg 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 ZSFG 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 ZSFG Policy No. 1.8.

K. RESUSCITATION OF PATIENTS (DNAR) POLICY

It is the policy of Zuckerberg 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 admitted patients 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.

O. NATIONAL PATIENT SAFETY GOALS

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

II. CREDENTIALING

A. INITIAL APPOINTMENTS

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

C. STAFF CATEGORIES

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Medicine Service privileges are developed in accordance with ZSFG 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 ZSFG 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.

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING

A. PROCTORING REQUIREMENTS

Proctoring requirements for the Medicine Service shall be in accordance with ZSFG 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 Zuckerberg 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

Requests for additional and/or new privileges for the Medicine Service shall be in accordance with the ZSFG 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 ZSFG 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 ZSFG 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 Zuckerberg San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations and accompanying manuals will govern all disciplinary action involving members of the ZSFG 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 ZSFG 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 prior to the beginning of the attending rotation. 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 at the close of the rotation. 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 house staff on the first day of the rotation

B. Clinical

1. Clinical care provided by the attending and the house staff is documented in the electronic clinical documentation system, and charges for inpatient physician services are submitted for professional fee billing.

2. Primary Care Providers are contacted by the admitting clinicians when their patients are admitted to the Medicine Service.

XI. EDUCATION – HOUSE STAFF TRAINING COMPETENCIES & SUPERVISION

The Medicine Service complies with the ZSFG 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, ZSFG assures adequate house staff 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).

XII. MEDICAL STUDENT TRAINING PROGRAM AND SUPERVISION

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

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

Twenty-four-hour inpatient care is delivered by Medicine in Building 25.

B. DELIVERY OF OUTPATIENT CARE

Adult Medical Center (1M and Bldg. 80/90)

The Center offers a variety of clinical services to adults at two hospital-based clinic sites.

Clinics include primary care (Richard H. Fine People's Clinic), the specialty services of Cardiology, Anti-coagulation, Pulmonary, Diabetes, Bridge Clinic, 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 procedure. Care delivery services include cancer chemotherapy, antibiotic and antifungal infusion, blood and blood product transfusion, and invasive post-procedure observation.

The **GI Diagnostic Unit** includes GI invasive procedures and Gastroenterology and Liver clinics. Ambulatory bronchoscopy by the Pulmonary Division is also done here.

The **Pulmonary Function Lab** provides comprehensive Pulmonary Function Testing.

The **Cardiology Lab** provides Echocardiography, treadmill testing, cardiac ambulatory monitoring, cardiac catheterization, pacemaker placement and emergency angioplasty.

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 physi9cians are responsible for oversight and coordination of the Medical Team
2. Medical trainees include fellows, resident physicians, and medical students
3. Affiliated staff include nurse practitioners, physician assistants, and clinical pharmacists

D. CARE PROVIDER CREDENTIALING AND EDUCATION

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 ZSFG Medical Staff Bylaws.2. 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 ZSFG 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 ZSFG 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:

   - 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 AND 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 LEAN-PDSA: 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; Study 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 measurements 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 Medical Record policies. Persistent non-compliance is referred to the Division Chief and the Chief of Medical Service. 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 outcomes. 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 ZSFG Cancer Committee reviews the performance improvement activities of the UCSF/ZSFG 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/ZSFG Cardiovascular Service when Department of Medicine patients requiring this service are referred for treatment during the Cath Conference discussion.

Patient Experience
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 the hospital patient feedback processes.

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 ZSFG 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 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 quality improvement (QI) activities takes place through an established committee structure:

<u>Department of Medicine Inpatient QI Committee</u>

The QI Committee receives periodic summary reports on the status of performance improvement activities that have been undertaken in 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.)

<u>Hospitalists' Group</u>

Faculty hospitalists in the Department of Medicine meet regularly to improve the quality of inpatient care and patient satisfaction. Hospitalists also serve on the Quality Improvement committee.

<u>Nursing Quality Assessment</u>

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 San Francisco 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 Quality and Performance Committee meeting with a complete, programmatic review and PIPS Plan review every year. The program is assessed on:

a. Effectiveness in resolving problems as they relate to PI monitors.
b. Effectiveness in detecting and monitoring individual and generalized patient care problems and systems issues.
c. 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.

INPATIENT OPERATIONAL PERFORMANCE IMPROVEMENT PLAN

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

A. CONCURRENT REVIEW

1. Best practice treatments and complications will be discussed at Residents' Report on as well as with participating members of the Faculty and Housestaff, held by the Vice-Chief of Inpatient Medicine or designee. Medical trainees include fellows, resident physicians, and medical students
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 are logged into the ZSFG SAFE report system and reviewed by the Medicine Director of the PI Committee. Management of incidents is in compliance with ZSFG Hospital Policy.
4. As part of the individual attending performance evaluation, access to information gathered through the Resident and Student computerized evaluation system, Med Hub is available to the Chief of Medicine and the Division Chiefs.
5. The Dept. of Medicine and the Quality Management Dept. of ZSFG 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 Medicaid/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 record 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.

Approved and respectfully submitted by:

_____ _____

Neil R. Powe, MD, MPH, MBA Date
Chief, Medical Services, Zuckerberg San Francisco General Hospital
Constance B. Wofsy Distinguished Professor and
Vice-Chair of Medicine, University of California San Francisco

APPENDIX B – HOUSESTAFF EDUCATIONAL GOALS AND RESPONSIBILITIES

The Medical Service at Zuckerberg San Francisco General Hospital consists of five medical ward teams, one cardiology team, and one critical care team providing comprehensive inpatient care to acutely ill medicine patients.

The **Swing Resident** assists medicine wards teams with work and procedures, cross-covers wards teams after they sign out, and admits patients after the on-call team has capped and before the Night admitting team arrives.

The **Medicine Night float Intern and Resident** assist in providing care for patients on the Medicine Service and perform overnight admissions.

The **Cardiology Night Resident** and **ICU Night Resident** provide care to patients on the Cardiology and ICU services, respectively, and admit patients to their respective services overnight.

A **Medicine Consult Resident** provides consultative care to patients admitted to surgical or other non-medical services within the hospital. This is an optional elective rotation for 2nd and 3rd year residents.

Medicine residents and interns also care for patients on elective rotations at Zuckerberg San Francisco General Hospital.

Housestaff training in procedures:
All interns 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, such as lumbar puncture, paracentesis, and thoracentesis, are supervised by the senior ward resident on the team, who has demonstrated competency by performing a requisite number of procedures or by an attending physician.

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 ZSFG 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 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.
    - 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 the 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 the incorporation of cost-awareness principles into complex clinical scenarios.

B. CRITICAL CARE INTERN (R1)

By the end of the ZSFG 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 the 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 the site director for concerns.
- Recognize the scope of their abilities and ask for supervision and assistance appropriately.
- Recognize that disparities exist in health care among populations and that they may impact the 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 ZSFG 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 based on their degree of illness.

Medical Knowledge

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

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 Bridge clinic, 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 medical conferences, which include: attending rounds, resident report, M&M, and Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and the site director for concerns.

System-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 Richard H. Fine People's Clinic, Ward 86, Community Health Network clinics, and other clinics.
    - Timely documentation of medications and discharge summary information in EPIC.

D. GENERAL MEDICINE WARD INTERN (R1)

By the end of the ZSFG 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 the 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 medical conferences, which include: attending rounds, interns' report, resident report, M&M, and Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and the 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 the 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/R3)

By the end of the ZSFG medicine rotation, the R2/R3 resident will be able to:

Patient Care

- Evaluate and treat patients with cardiac diseases found in underserved populations, including but not limited to:
    - Acute coronary syndrome
    - Congestive heart failure
    - Endocarditis
    - Cardiac complications of substance use
- Triage these patients to the appropriate level of care: floor, or CCU.
- Demonstrate and teach how to elicit important physical findings for junior members 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 Valvular heart disease
    - Congestive heart failure
    - Cardiac complications of substance use
- 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.
- Advocate for appropriate allocation of limited health care resources.
- Participate in organized teaching conferences for this rotation as well as required conferences for the ZSFG medicine department, such as resident report, M&M, and Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and the 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 ZSFG cardiology rotation, the R1 resident will be able to:

Patient Care

- Under the 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 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 the 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 medical conferences, which include: attending rounds, interns' report, resident report, M&M, and Grand Rounds
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and the site director for concerns.

Systems-Based Practice

- Recognize awareness of common socioeconomic barriers that impact health care, and work with the 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:

Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical problems.

- Demonstrate organizational skills necessary for the care of medicine inpatients.
- Efficiently and effectively document findings and clinical decisions in the medical record.
- Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
- Utilize consult services and diagnostic studies appropriately.
- Supervise the Medicine Night float Intern in the 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/CARDIOLOGY NIGHT FLOAT RESIDENT (R2/R3)

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

- Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical and cardiac problems.
- Demonstrate organizational skills necessary for the care of medicine inpatients.
- Efficiently and effectively document findings and clinical decisions in the medical record.
- Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
- Utilize consult services and diagnostic studies appropriately.
- 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.

I. MEDICINE NIGHT FLOAT INTERN (R1)

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

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

- Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
- Utilize consult services and diagnostic studies appropriately.
- 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.

J. MEDICINE CONSULT RESIDENT (R2/R3)

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

- Formulate a differential diagnosis and outline a plan for evaluating and managing diverse medical problems occurring on non-medical services.
- Evaluate patients preoperatively and provide an assessment of their surgical risk.
- 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.
- Demonstrate knowledge of post-operative medical complications and their management.
- Function as an effective consultant to non-medical services.

K. MEDICINE SWING RESIDENT (R2/R3)

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

- Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical and cardiac problems.
- Demonstrate organizational skills necessary for the care of medicine inpatients.
- Efficiently and effectively document findings and clinical decisions in the medical record.
- Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
- Utilize consult services and diagnostic studies appropriately.
- 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.

L. CARDIOLOGY NIGHT RESIDENT (R2/R3)

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

- Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient cardiac problems.

- Demonstrate organizational skills necessary for the care of cardiology inpatients.
- Efficiently and effectively document findings and clinical decisions in the medical record.
- Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
- Utilize consult services and diagnostic studies appropriately.
- Triage cardiology admissions to the appropriate level of care (CCU, floor).

M. ICU NIGHT RESIDENT (R2/R3)

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

- Formulate a differential diagnosis and outline a plan for evaluating and managing diverse critical care problems.
- Demonstrate organizational skills necessary for the care of critically ill patients.
- Efficiently and effectively document findings and clinical decisions in the medical record.
- Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
- Utilize consult services and diagnostic studies appropriately.
- Triage critically care admissions to the appropriate level of care.

II. TEAM STRUCTURE AND RESPONSIBILITIES

A. TEAM STRUCTURE

The Critical Care team consists of one critical care attending, four residents, and four interns (two to three Internal Medicine, one Family Medicine, Neurology, or Anesthesia).

The five General Medicine Ward teams consist of one medicine attending, one resident, two interns, one to two third-year medical students (MS3), and an acting intern (MS4). A social worker and care coordinator RN are 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 and care coordinator RN are assigned to help care for patients on the FIS.

The Cardiology Ward team consists of one cardiology attending, three cardiology fellows, four teams consisting of one resident and one intern each, one to two third-year medical students (MS3), a social worker, and a care coordinator RN are assigned to the team to aid in identifying and meeting discharge needs.

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

Two Night float Residents and one hospitalist attending admit patients to the medicine service in the overnight hours (9PM to 6AM).

A Cardiology Night resident provides coverage of the Cardiology service and admits patients to the Cardiology service in the overnight hours (9PM to 6AM) with back-up admitting from the Medicine/Cardiology Night Float Resident.

An ICU Night resident provides coverage of the ICU service and admits patients to the ICU service in the overnight hours (9PM to 6AM).

The Medicine Consult team consists of one attending +/- one resident (optional resident elective).

B. CRITICAL CARE ATTENDING PHYSICIAN

1. Holds appropriate clinical privileges at ZSFG 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 (DNAR 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 ATTENDING PHYSICIAN

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. 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 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 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 patients admitted to the CCU that the medical ICU team is consulted on.
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 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. CRITICAL CARE ATTENDING PHYSICIAN

1. Holds appropriate clinical privileges at ZSFG 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 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 completion 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 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 be expected to attend as many teaching conferences as allowed by patient care responsibilities. Expected attendance at the following conferences:
    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 for readmissions or during admissions surges. The medicine teams will admit all medical ward 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 FIS and the Swing resident. If the admission threshold is exceeded, backup admitting guidelines will be employed.
    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 providing feedback on the performance of the interns, MS4, and MS3s.9.
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 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
e. Residents' 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 their 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 ZSFG 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 the wards. The attending should conduct daily management rounds, which include the following:
   a. Interaction at regular intervals with CCU 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 (DNAR orders).

H. CARDIOLOGY WARD RESIDENT (R2/R3)

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

1. Responsible for coordinating the day-to-day function of the team and directly supervising interns.
2. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents will be expected to attend as many teaching conferences as allowed by patient care responsibilities. Expected attendance at the following conferences:
   a. Weekly Morbidity and Mortality conference.
   b. Weekly Grand Rounds.
   c. Residents' Report.
3. Directs the admission and initial evaluation of patients to the cardiology service:
   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. Resident physicians will be responsible for admitting patients and writing detailed admission notes in excess of five admissions per intern per twenty-four-hour period up to a maximum of six new patients.
    iii. Total admissions per admitting resident will not exceed seven per 24-hour call day; a backup admitting system will be activated for admissions in excess of this threshold.
    iv. Resident physicians will be responsible for ensuring that individual intern and sub-intern patient loads do not compromise patient care and educational goals.

4. Residents 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. Responsible for providing feedback on the performance of the intern, MS4s, and MS3s.
7. Responsible for providing written evaluation of the attending physician, intern, MS4s, and MS3s.
8. Residents will not work in excess of an average of eighty hours per week during any inpatient ward months.
9. Residents will have at least one day off in every seven, averaged over the month. Residents will have a break of at least eight hours between shifts.10. The on-call period will consist of 14 hours of patient care and new admissions, plus up to two hours for sign out and educational activities.11. 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 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 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 sign all medical student orders once reviewed 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. MEDICINE 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 be responsible for triaging admissions to the inpatient medical service.
4. The Night float Resident will admit general medicine patients to the wards between the hours of 9PM-6AM.
5. 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.
6. The FIS hospitalist attending is responsible for assisting the night float Resident 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 FIS hospitalist attending, the Night float Resident will employ the backup admitting system (Admission Surge Guidelines).
7. The Night float Resident will personally sign out patients to the ward teams and FIS between 8AM-10AM.

K. MEDICINE|CARDIOLOGY 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 receive sign-out from the Swing and cross-cover on Swing Resident new admissions in addition to following up on any pending studies as directed by the Swing Resident.

4. Will receive signout from the Medicine call team and cross-cover these patients overnight
5. The Medicine | Cardiology Night float Resident will admit general medicine and cardiology patients to the wards between the hours of 9PM-6AM.
6. The Medicine|Cardiology Night float Resident will sign out patients to the ward teams, cardiology teams, and FIS between 8AM-10AM.

L. NIGHT FLOAT INTERN (R1)

1. Will arrive at the hospital 8PM and leave by 10AM; 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 patients on the wards.
4. Will receive written sign-out on all non-Long Call medicine 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/their care and will personally evaluate patients for whom there are any concerns.
7. Will admit 1-2 general medicine patients to the wards with supervision by Medicine Night float resident.
8. 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 and notify the supervising resident.
9. 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.

M. MEDICINE CONSULT ATTENDING

1. Holds appropriate clinical privileges at ZSFG.
2. Supervises and assumes ultimate responsibility for General Medicine consultations on inpatients and Orthopedic Surgery co-management.
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.

N. MEDICINE CONSULT RESIDENT (R2/R3)

1. Will see all medicine consult patients, 7:30 AM to 5:30 PM, Monday-Friday.
2. Will discuss each case with the medicine consult attending.
3. Will write appropriate orders with agreement of primary team.
4. Will give written sign-out to the FIS Swing cross-cover provider.
5. Will initiate transfers to the Medicine Service when appropriate.

O. SWING RESIDENT (R2)

1. Will arrive at the hospital at 12:00 PM and leave by 12:00 AM.

2. Will assumes primary cross-cover responsibilities until 8:00 PM for the non-Long 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/their 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 and notify the supervising attending.
6. Will alternate admissions with the Swing Hospitalist between 6-8 PM or when the on-call team has capped.
7. Will sign out non-Long Call cross-cover patients to Night float intern at 8 PM.
8. Will sign out admitted patients to the Medicine|Cardiology Night float Resident at 9 PM.

APPENDIX C – MEDICAL STUDENT TRAINING PROGRAM
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL

I. MS3 MEDICINE CORE CLERKSHIP

A. OBJECTIVES

1. Major objectives
   - Perform a complete admission history and physical examination
   - Select and interpret appropriate diagnostic tests
   - Develop an assessment/differential diagnosis, based on H & P, lab data
   - Write up each admission and daily progress notes
   - Give a complete new admission oral presentation
   - Follow the patient daily throughout the hospital stay
     - Perform focused daily H and P, interpret relevant tests
     - Present the patient in SOAP format on daily rounds, with updated problem list
     - Write a daily note
     - Participate in the coordination of care including discharge planning
     - Communicate with patients and families about the hospital experience and their perspective on their care

2. Priority patients (Core Experiences, Procedures that will be logged in MedHub)
   - Acute non-surgical GI/liver symptoms (nausea/vomiting, abdominal pain, diarrhea, GI bleed, abnormal LFTs)
   - Chest pain
   - Chronic coronary artery disease and/or metabolic syndrome (hypertension, diabetes, hyperlipidemia)
   - Common arrhythmia (e.g., atrial fibrillation)
   - Dyspnea (COPD exacerbation, CHF, PE, asthma, etc.)
   - Electrolyte abnormalities and/or acute or chronic renal failure
   - Fever
   - Geriatric patient
   - I was observed doing a relevant history and cardiopulmonary physical exam for a cardiac or pulmonary complaint.
   - Life-threatening or terminal illness
   - Meet with the site director or longitudinal medicine preceptor for midpoint feedback

3. Knowledge objectives
   The following are topic areas covered on the final examination:

   Laboratory data interpretation: Complete blood count and peripheral blood smear, Arterial blood gas (oxygenation, ventilation, and acid-base status), pleural fluid, peritoneal fluid, pulmonary function tests, EKG, chest X-ray

   Clinical Symptoms, signs, and disease:

   - Gastrointestinal: Upper & lower GI bleeding, acute and chronic pancreatitis, cirrhosis

- Cardiac: Chest pain, coronary artery disease/ischemic heart disease, congestive heart failure, valvular heart disease, atrial fibrillation
- Endocrine: DM, hyper- and hypothyroidism, adrenal insufficiency/excess
- Hematology/Oncology: Anemia and transfusions, platelet disorders, lymphadenopathy, lung cancer (not chemotherapy regimens)
- Infectious Disease: Pneumonia, UTI, sepsis and bacteremia, endocarditis, HIV/AIDS, TB
- Pulmonary: Dyspnea, asthma, COPD, DVT and PE
- Renal/ Electrolytes: Hyper- and hyponatremia, hyper- and hypokalemia, hyper- and hypocalcemia, acute and chronic renal failure, acid-base disorders, management of intravenous fluids
- Other: Altered mental status (atypical presentation of common illnesses in the elderly), end-of-life decision-making, managing physical symptoms at the end of life, teaching patients and families about illness, treatment, and prognosis

B. EXPECTATIONS AND RESPONSIBILITIES

1. Call expectations
   - Admit 1 patient per long or short call; and depending on their census and patient complexity, may be able to admit another patient on other days of the cycle (e.g., pick up a holdover or short call patient). Average census is anywhere from 1-3 (ideal patient census ~2).
   - The time a student leaves on call days will vary depending on the clinical workflow and team; they may write notes and read about patients at home.
   - Review admission H&P note with resident or intern.
   - Practice oral presentation on and be expected to present either on-call day or post-call day.
   - Should have a note in the patient chart immediately following attending rounds on the post-call day.
   - Follow admitted patients daily, including presenting and writing notes.

2. Student education
   - Core afternoon student lectures: Attendance is required; students are excused from patient activities during this time.
   - Conference
     - Resident and intern report: Students are highly encouraged to attend.
     - Noon conferences and grand rounds report.

   - BBOTs
     - Twice a week, students are required to be observed by the attending or resident (not intern) while interviewing and examining a patient (15 min observation, 5 min feedback). These should be filled out online and should cover skills in history taking, the physical exam, communication in general, presenting, and note writing.

   - Serious Illness Communication Workshop: Students will participate in a program to learn about how to talk to their patients about code status and end-of-life decision-making.
   - Consideration of Social Risk in Diagnosis Assignment: Students will practice evaluating the impact of social context on the diagnostic process through a clinical case. Students will present their patient at a student case presentation and complete a post-activity survey.

3. Days off
    - 1 day off per week (4 per month) assigned by the resident; weekend days are preferred but will depend upon resident and intern schedules. This should not be on FCM clinic day or FS day.
    - 1 full day to attend Family Community Medicine or FS didactics day.
    - Complete Absence Request Form for an absence for one or more required clinical dates due to planned or emergent absences.
    - Students who are away on a post-call day should try to admit an early patient on call so that they can work up their patient and potentially present their patient.

4. Feedback
    - Students should meet with each attending and senior resident at the start and end of their time together to discuss expectations and feedback. If they work together for more than 2 weeks, there should also be a mid-point feedback meeting.
    - Interns can give regular feedback to students during routine patient care.

5. Work Hour Policy
    - Work hours are defined as all clinical and academic activities related to the rotation. This is defined as patient care (including patient-related administrative duties such as patient notes) and scheduled activities (such as conferences). It does NOT include time spent studying for exams, reading, preparing for oral presentations, or commute time.
    - Clinical and educational work hours must be limited to no more than 72 hours/week

C. STUDENT EVALUATIONS

- After the first week of the rotation, residents, and attendings who work with a student for at least 7 days will be asked to evaluate the student on MedHub. Note that in some cases because of days off, students might be evaluated by a team member who ends up working with them <7 days. This 7-day calendar rule applies across all clerkship sites.
- Cardiology attendings do not fill out MedHub evaluations because of the structure of the service (more direct interactions with residents/interns than attendings; sharing of attendings between teams).
- Grading committee reviews composite evaluations together. If questions exist about passing, the grading committee confers on the final grade and next steps if necessary.
- The site director compiles the final evaluation based on team evaluations and exam scores.
- To pass the course, you must also pass the shelf exam. A passing grade is two standard deviations below the national mean.

D. MAXIMIZING CLERKSHIP EXPERIENCE

- Participate actively: look up questions that arise on rounds and share what they read with their team.
- Think of the patients as their patients.
- Ask their team to involve them in their patient's workup.
- Sit down with the resident and attending early on to set goals and expectations.
- Remind the team about the conference schedule and other responsibilities.
- Be active in patient care; know their patient's conditions better than anyone else on the team.

II. MS4 Acting Internship Summary

A. GOALS

- Assume primary responsibility for patient, including new emphasis on communication, coordination of care, and information management.
- Be the main person updating patients and families, contacting consultants and outpatient providers, and coordinating with interdisciplinary team members.
- 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 for multiple patients
- Students will be supervised in these tasks, especially early on, but the goal is for them to develop independence.

B. OBJECTIVES

1. Patient Care
   - Acquire accurate and relevant histories from patients in an efficiently customized, prioritized, and hypothesis-driven fashion
   - Perform accurate physical examinations that are appropriately targeted to the patient's complaints and medical conditions. Identify pertinent abnormalities
   - Recognize situations that need urgent or emergent medical care, including life-threatening conditions
   - Recognize when to seek additional guidance
   - Request and provide consultative care
   - Recognize tasks that need to be completed to advance patient care
   - Make appropriate priorities in tasks that need to be done to advance patient care
   - Execute tasks needed to advance patient care

2. Medical Knowledge
   - Understand the relevant pathophysiology and basic science for common medical conditions
   - Select, order, and interpret appropriate diagnostic tests, paying attention to how the results will affect management.

3. Interprofessional and Interpersonal Communication
   - Deliver appropriate, succinct, hypothesis-driven oral presentations
   - Provide legible, accurate, complete, and timely written communication that is congruent with medical standards
   - Request consultative services in an effective manner
   - Actively seek to understand patient differences and views and reflect this in respectful communication and shared decision-making with the patient and the healthcare team
   - Communicate compassionately, and in language appropriate for each person, with patients and their families about their illness experience, clinical situation, and goals.
   - Provide patients and their families with anticipatory guidance for diagnosis, prognosis, and treatment.
   - Communicate appropriately with each patient depending on their needs, including the use of interpreters, low literacy language and resources, and culturally sensitive approaches.
   - Effectively communicate plan of care to all members of the health care team.

- This includes planning and communicating effectively with other providers to facilitate safe transitions of care for patients within the hospital (i.e., morning hand-offs for patients admitted by another team; evening sign-outs) and on discharge.
- Communicate respectfully and clearly with consultants, primary care providers, and allied health professionals to advance patient care and provide safe and continuous care.

4. Systems-Based Care
   - Work effectively as a member within the interprofessional team to ensure safe patient care
   - Appreciate the variety of health care provider roles, including, but not limited to, consultants, therapists, nurses, home care workers, pharmacists, and social workers
   - Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, subacute, acute, rehabilitation, and skilled nursing

5. Practice-Based Care
   - Actively seek to expand knowledge, through supplemental reading and consultation of the literature, soliciting and responding to feedback, and self-reflection

6. Professionalism
   - Recognize when it is necessary to advocate for individual patient needs
   - Respond promptly and appropriately to clinical responsibilities, including but not limited to calls and pages
   - Ensure prompt completion of clinical, administrative, and curricular tasks
   - Carry out timely interactions with colleagues, patients, and their designated caregivers
   - Recognize and address personal, psychological, and physical limitations that may affect professional performance
   - Recognize the scope of abilities and ask for supervision and assistance appropriately

7. Patient Advocacy
   - Recognize the social determinants of health that may be contributing to health, illness, and the effectiveness of care for an individual patient.
   - Construct patient-centered diagnostic, treatment, and discharge plans based upon recognition of influential social determinants of health for individual patients. Promote variations in plans and mobilize and provide resources to execute patient-centered care.
   - Minimal Competency expected at the end of the rotation
   - The Acting Intern will be able to admit 2 patients on a call day and manage them semi-independently, while maintaining responsibility for the patients they have previously admitted.

C. RESPONSIBILITIES AND ASSESSMENTS

1. Call expectations
   - Work up to admit 2 patients on call, at the discretion of the supervising resident who understands the overall team/other intern census and complexity of patients
   - By the end of rotation, must be able to semi-independently admit 2 patients
   - Daily census may range on average from 2-5 patients, depending on the call cycle
   - Go home on-call and post-call at the same time as the team; sign out as interns do

2. Orders
   - Acting interns can pend orders in EPIC

3. Documentation/Discharges
    - Be responsible for writing discharge summaries and reviewing with the resident

4. Days off
    - 1 day off per week for a total of 4 days during a 28-day rotation; specific days are decided with your resident because the resident needs to consider days off/clinic days for other team members

5. Absences
    - Students should notify their teams (attending/resident), site director, and course coordinator of any planned or emergency absences.
    - Turn in SOM absence request at this link: https://ucsf.co1.qualtrics.com/jfe/form/SV_b8EFcYYTn9bEGiN

6. Expectations
    - Sit down with the resident and the attending to set up goals/expectations
    - Check in with the resident and attending at the beginning, midway, and at the end

7. Assessments and feedback
    - This is a purely clinical rotation without a final exam. Students are evaluated by resident/s and attendings only. It is graded Honors/Pass/Fail.
    - Residents and attendings who have been assigned for 7 days or more on the calendar will be assigned an evaluation. Usually, this entails fewer than 7 days actually working together because of days off (e.g., the number of actual work days together is shorter, e.g., 4-5)
    - Fill out the midpoint attending feedback card and turn it in to Amy Zhen.
    - Fill out one BBOT on the ability to identify and execute tasks. Verbally request one task-oriented BBOT from either a resident or attending during the rotation. Then summarize their feedback under "Other" using the BBOT QR code.

8. Work Hour Policy
    - Work hours are defined as all clinical and academic activities related to the rotation. This is defined as patient care (including patient-related administrative duties such as patient notes) and scheduled activities (such as conferences). It does NOT include time spent studying for exams, reading, preparing for oral presentations, or commute time.
    - Clinical and academic work hours must be limited to no more than 72 hours/week.

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

1. *Summarize the content changes that were made to the SP/protocols or Privileges using the table in Section I*
2. *Complete Section II: Follow instructions outlined in table*
3. *Email the revised SP with track changes and this completed form to the Michelle Mai, ZSFG Medical Staff Analyst (michelle.mai@sfdph.org), the CIDP Coordinator (erika.kiefer@sfdph.org), Nursing Manager (jennifer.berke@sfdph.org), and CIDP Co-Chairs (vagn.petersen@sfdph.org) (vanessa.aspericueta@sfdph.org).*

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:	
Standardized Procedure Title:	Primary care registered nurse standardized procedures and protocols
Department:	Primary care
Dept Chief:	Joseph Pace
SP Author(s):	Philippa Doyle, Anusha McNamara, Elaine Khoong, Elizabeth Gonzalez
Update #1:	Check BP goal from <140/90 to <130/80 throughout the document to be in line with current guidelines
Update #2:	Add how to document self monitored BP in the chart
Update #3:	Adjust recommendation for checking standing BP based on new evidence and updated CDC guidelines
Update #4:	Adjusted age from 65 to 70 for elderly patients.
Update #5:	Combined Appendices A-C in Primary Document

*Include additional rows to table, if needed

Section II: Standardized Revisions
Update the SP as instructed below. See also CA BRN Standardized Procedure Guidelines

Preamble	The Preamble is the portion of the SP that precedes the Protocols, the first pages of the SP, outlined I-VII, includes sections "Policy Statement, Functions to be Performed," etc. • The Preamble was updated in 2023 to include changes in legislation, regulations, and practice. (CIDP, 10/2023)
Equity	Ensure language within the SP is inclusive. Examples include but are not limited to: • Do not use race/ethnicity descriptors unless necessary • Do not use sex assigned at birth unless necessary • Use "their" rather than "him/her" (CIDP, 8/2022)
ZSFG	Change "San Francisco General Hospital" to "Zuckerberg San Francisco General Hospital" and SFGH to ZSFG (CIDP, 10/2016)
Qualified Provider	Specify any experience, training, and/or education requirements for performance of standardized procedure functions. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions. Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.
Record Keeping	Specify the scope of supervision required for performance of standardized procedure functions, for example, immediate supervision by a physician. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition. State the limitations on settings, if any, in which standardized procedure functions may be performed. Specify patient record keeping requirements. Provide for a method of periodic review of the standardized procedures, with signatures and dates of approval of Authors, Nursing Director, and Department Chief of Services/Medical Director.

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Primary Care Registered Nurse

Standardized Procedures and Protocols

San Francisco Health Network

Primary Care Registered Nurse
Standardized Procedures and Protocols Manual

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Distribution List:

Copy 1:	Primary Care Nurse Manager Offices
Copy 2:	CIDP committee
Electronic copy 3:	Primary Care Director of Nursing
Master copy:	Medical Staff Office

~~S~~San Francisco Health Network
Primary Care

Standardized Procedures:
Primary Care Registered Nurse

Introduction

The following protocols are the policies and guidelines for the care provided to patients at San Francisco Health Network (SFHN) Primary Care (PC) by the Registered Nurse (RN). Since it is impossible to anticipate every clinical situation or presenting chief complaint that may arise, it is expected that Provider of the Day (POD) consultation may be warranted. The RN will consult the POD by using their nursing clinical judgment. In general, the RN shall function within the scope of practice as specified in the State of California Nurse Practice Act. Every patient presenting to Primary Care has ongoing evaluation by a provider (MD/NP/PA) regardless of the initiation of a standardized procedure by the RN. All Standard Procedures are intended for adult patients >18 years, unless otherwise indicated. When the Standardized Procedure is initiated and any diagnostic test is ordered (blood tests, radiologic exams as listed in the procedure), the Primary Care Provider will be listed as the ordering provider.

The Standardized Procedures were developed with assistance from the following:

~~1.~~ Implementation of Standardized Procedures. Position Statement of the California Nurse Association

~~2.~~ Standardized ~~Proced~~Proc~~e~~edure

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Primary Care

Standardized Procedures:
Primary Care Registered Nurse

The following Primary Care Nurses have reviewed the standardized procedure and have demonstrated competency as Registered Nurses working in SFHN Primary Care Clinics. They are authorized to practice in any SFHN Primary Care clinic under the Standardized Procedures and Protocols contained in this manual:

~~RN Name~~

RN Name

Joseph Pace MD
Medical Director, SFHN ~~Primaty~~Primary Care

Date

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Philippa Doyle, RN Date
Nurse Director, SFHN Primary Care

Updated: ~~9/6/20~~March 2025

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San Francisco Health Network
Committee on Interdisciplinary Practice

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STANDARDIZED PROCEDURE Registered Nurse Management of Chronic Disease in Primary Care

Title: Registered Nurse in Primary Care

I. Purpose of Policy

A. To expedite patient care by initiating evidence-based interventions by Registered Nurses (RNs) based on patient controlled of chronic disease. These medical staff approved procedures and protocols are intended to be a guide for RNs to initiate basic medication adjustments in Primary Care.

II. Policy Statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Registered Nurses, Physicians, Administrators and other Affiliated Staff and conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. To outline and define responsibility in performing interventions requiring a physician order in accordance with the California Board of Registered Nursing and the Nursing Practice Act, a copy of the signed procedures will be kept in an operational manual in each primary care clinic, and on file in the credentialing liaison Medical Staff Office.

Commented [JB2]: Are we still doing the hard copy process, or are we movign to electronic? We could change the language to: "...a copy of the signed procedures will be available either as hard copies or electronically in each primary care clinic and on file in the credentialing liaison Medical Staff Office."

III. Functions to be performed

The Registered Nurse, as outlined in the Nurse Practice Act, Business and Professions Code Section 2725, is authorized to implement appropriate standardized procedures or changes in treatment regimen after observing signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determining that these exhibit abnormal characteristics. The RN provides interdependent functions that overlap the practice of medicine. These overlapping functions require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the RN to seek PCP or designee consultation.

IV~~II~~. Circumstances Under Which RN May Perform Function

A. Setting
The Registered Nurse may perform the following standardized procedure functions in any SFHN Primary Care clinic consistent with their experience and training.

B. Scope of Supervision Required

1. The RN is responsible and accountable to the Primary Care Nurse Manager and PCP or provider designee.

2. Overlapping functions are to be performed in areas, which allow for a consulting Provider of the Day (POD) to be available to the RN, by phone or in person, including but not limited to the clinical area.

3. Provider consultation is to be obtained as specified in the protocols and under the following circumstances:

a) Assessment of acute and episodic illness and injuries
b) General evaluation of health status
c) Emergency conditions requiring prompt medical intervention
d) Upon request of nurse or provider
e) Any patient requiring likely hospitalization

4. Every patient who presents to primary care has ongoing evaluation by a provider, regardless of the initiation of a Standardized Procedure by the RN.

~~III.~~V. Requirements for the Registered Nurse

A. Experience and Education

a. Possess an unrestricted California license as a Registered Nurse.
b. Current Basic Life Support certification from an approved American Heart Association provider.
c. Experience using protocol with provider mentor on at least 6 patient cases.

B. Special Training

a. Work experience: ~~Nurse~~ RN with at least 6 months experience in primary care clinic
b. Successful completion of the protocol specific didactic and posttest
c. Successful completion of Primary Care RN orientation program

C. Evaluation of the Registered Nurse competence in performance of standardized procedures

a. Initial: At the conclusion of the standardized procedure training the Nurse Manager and Medical Director or designated provider will assess the RN's ability to perform the standardized procedure by:
   i. Verifying s~~S~~uccessful completion of RN orientation program
   ii. Review of a minimum of 5 patient cases for completeness of documentation by the Nurse Manager or preceptor

b. Annual: Nurse Manager, Medical Director or designated provider will evaluate the RN's competence through an annual performance appraisal and skills competency review along with feedback from colleagues, PCP, direct observation, and no fewer than 3 chart reviews.

c. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, Medical Director, or designated provider at appropriate intervals until acceptable skill level is achieved.

VI. ~~V.~~ Development and Approval of Standardized Procedure

A. Method of Development
Standardized procedures are developed collaboratively by the registered nurses, nurse managers, physicians, and administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

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Commented [JB3]: Didn't we switch to 3 for NPs? Are we good with 6 for this SP? (I don't have a recommendation, just checking in about it)

Commented [JB4]: Is this in any primary care clinic, or in one in the SFHN?

Commented [JB5]: Above it says the person needs to be mentored on six cases, and here the review is 5 cases. Do these numbers match current practice and make sense?

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B. Approval
The CIDP, Credentials, Medical Executive, Nursing Executive, and Joint Conference Committees must approve all standardized procedures prior to the implementation.

C. Review Schedule
The standardized procedures will be reviewed every three years by the registered nurses, nurse manager, nurse director and medical director and as practice changes.

D. Revisions
All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet

Protocol #1
Assessment and Management of Hypertension

DESCRIPTION:

1. **Function:** This protocol describes the functions, which may be performed by Registered Nurses (RNs) in managing uncomplicated hypertension in adults ages 18 and older.
2. **Definitions and criteria**
   - Hypertension: Patients who have been diagnosed by a provider with hypertension defined by systolic/diastolic blood pressure levels ≥1340/890 mmHg
   - Provider: A physician, physician assistant, nurse practitioner, or clinical pharmacist
3. **Blood Pressure Treatment Goal**
   - Generally: <1340/890 mmHg
   - Home blood pressure goal: <1305/805 mmHg
   - As defined by referring PCP
   - Consult with PCP on goal for patients ≥ 7065 years old

Commented [EK6]: @Doyle, Philippa (DPH) Reports the default goal is changing to <130/80 (3/5/25)

CIRCUMSTANCES UNDER WHICH RN MAY PERFORM FUNCTION:

1. **Target Population May Include:**
   - Adults aged 18 and older with known hypertension
   - At the request of the PCP regardless of if exclusion criteria below is met
   - Exclusion Criteria:
     - Age <45 with blood pressure >160/100 mmHg will need PCP assessment prior to nurse management to evaluate for secondary hypertension; *please check in with PCP prior to management*
     - History of myocardial infarction, chronic kidney disease with GFR <45, heart failure with reduced ejection fraction, atrial fibrillation or other arrhythmias, pregnancy or breastfeeding
     - Women of childbearing potential who are reasonably able to get pregnant
     - Hypertension that is treated off of this standardized procedure (uncontrolled hypertension with 3 or more maximized medications of drug classes included in this algorithm: thiazide diuretics, ACE inhibitors or ARBs, and dihydropyridine calcium channel blockers). Patients may be taking other anti-hypertensive medications other than those listed which will not be titrated.
     - Abnormal lab findings of sodium (Na <136 or >145), potassium (K <3.5 or >5.1), or serum creatinine (SCr >1.3) values within the past 6 months (RN can repeat labs if last labs were >6 months ago prior to follow up with PCP or pharmacist)
     - Active stimulant use and not ready to discontinue will need PCP consultation prior to nurse management
     - Unstable hyperthyroidism

FUNCTIONS TO BE PERFORMED

1. **Patient Education:**
   - Lifestyle modifications
     - Physical activity: (30 minutes, ≥4 times per week)
     - Weight management (goal BMI <25 kg/m^2)
     - Reducing dietary sodium (1.8-2.4 gram sodium daily)
     - Limiting alcohol consumption (≤1 drink for women, or ≤2 drinks for men per day)
     - Low-fat, high fruit, vegetable, and whole grain diet (DASH diet)
     - Smoking cessation
     - Advise patients to avoid drugs that can induce/aggravate hypertension- decongestants (Sudafed), OTC diet pills, sometimes NSAIDS or non-cardioprotective doses of Aspirin

(i.e. taken for pain – doses of >325 mg).

- Self-monitoring blood pressure and documentation with the use of preferred home blood pressure monitor:
  - Instruct patient to take 2 BP readings (1-2 minutes apart) upon waking and another 2 BP readings at bedtime, for five to seven days during the second week following medication adjustment
  - Educate on proper technique (refer to toolkit)
  - Calibrate machine (have patient bring machine to clinic and compare reading on home machine to in-clinic machine)
  - Home blood pressure goal <1305/805 mmHg
  - Document self-monitoring BP in patient reported vitals
- Women of child-bearing age: Reminder that ACE inhibitors and ARBs (e.g. Benazepril and Losartan) are contraindicated in pregnancy. Women with unexpected pregnancy on ACE inhibitors or ARBs are to discontinue ~~it~~ACE inhibitor and ARB and notify their provider.
- Importance and techniques for medication adherence and pharmacy navigation (e.g. mediset, phone alarm, auto refills)

2. **Procedure:**
   - Provider responsibilities prior to nurse management
     - Diagnose hypertension and identify BP goal
     - Request RN disease management visit for recheck of BP and medication titration according to protocol.
   - RN subjective assessment
     - Home BP machine validation, BP checking technique
     - Side effects from medications (see Appendix A)
     - Symptoms of end organ damage with elevated blood pressure (160-179 systolic and/or 100-109 diastolic): headache, chest pain, blurry vision
     - Symptoms of hypotension: dizziness, lightheadedness, fatigue
     - Adherence with medications and lifestyle modification
     - Allergies or intolerances to blood pressure medications previously taken
     - Pregnancy risk (use of contraception, sexual activity, etc.)
   - RN objective assessment
     - In-clinic BP, repeated with accurate positioning if elevated
     - Self-monitored blood pressure trends: Average systolic BP readings to obtain a mean systolic measure. Average diastolic BP readings to obtain a mean diastolic measure.
     - Standing BP (remain supine for 5 minutes, then have patient stand and check at 2 time points – 1-2 minutes after standing and 3-5 minutes ~~after standing~~in the standing position~~then recheck BP 2-5 minutes later~~) should be measured in all elderly patients (≥7065 years old), any age with sitting systolic BP <110, or patients who complain of hypotension side effects (orthostatic dizziness, syncope, fatigue, weakness). If there is a 20 mmHg systolic drop or 10 mmHg diastolic drop, patient is having orthostatic hypotension. Consider fall risks and a higher blood pressure goal; consult provider and adjust medications accordingly.
     - Serum potassium, sodium, and creatinine results done 2-4 weeks after initiation or dose titration of ACE inhibitors, ARBs, or thiazide diuretic (see Appendix A)
   - Assessment/Plan
     - Blood pressure 1340-159 systolic and/or 8900-99 diastolic
       - Follow medication titration steps that include initiating and titrating ACE inhibitor/ARB, thiazide diuretic, and dihydropyridine calcium channel blocker (see Appendix B) if
         - Patient is adherent to medication regimen
         - Labs are within normal limits
         - Self-monitored blood pressure average is within 10 mmHg of in-clinic

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blood pressure reading
        - Monitoring: See Appendix A
    - Blood pressure 160-179 systolic and/or 100-109 diastolic with no symptoms of end organ damage
        - Notify Primary Care Provider or Provider of the Day
        - Follow medication titration steps as explained above
    - Symptomatic hypotension (dizziness) or asymptomatic with systolic blood pressure <90 mmHg
        - Consult with provider.
    - Refer to provider for evaluation, and do not release the patient:
        - Blood pressure 160-179 systolic and/or 100-109 diastolic with symptoms of end organ damage
        - Blood pressure ≥ 180 systolic and/or 110 diastolic
        - Symptomatic hypotension, asymptomatic with systolic BP <100, or orthostatic hypotension
    - Note differences between home BP readings and in clinic BP readings
        - If home machine is reading >10 mmHg incorrectly from in-clinic machine, patient will need to call manufacturer for new machine
        - If home machine is reading accurately, and home BP is >130/80 mmHg, treat home BP (masked hypertension)
        - If home machine is reading accurately, and home BP is <130/80 mmHg but in clinic BP is elevated, treat home BP (white coat hypertension)
    - Review allergy list, screen for potential contraindications or precautions
    - Identify barriers to medication adherence
    - Intolerance to medication
        - Consult provider of the day to determine if intolerance is due to a side effect, allergic reaction (rash, shortness of breath, swelling of the face), or other cause
        - If discontinuing medication due to intolerance, document in medical record allergy list and progress note based on provider determination of cause
    - Pregnancy
        - Discontinue ACE inhibitor or ARB and notify PCP. Refer to OB GYN for management.
    - Any abnormal labs (Na <136 or >145, K <3.5 or >5.1, or SCr >1.3)
        - Consult with pharmacist or provider
- Patient follow up
    - After every medication initiation or titration:
        - Recheck BP every 2 weeks
        - Draw and review labs as indicated in Appendix A
        - Titrate medications per protocol (see Appendix B)
    - If home BP machine is reading accurately, follow up can take place via telehealth
    - Once patient has reached BP goal, patient will no longer require follow up through this protocol and will be returned back to their Primary Care Provider for continued follow up as needed.
        - Patient to continue to check home blood pressure
        - Refill current blood pressure medications for 1 year supply (90 days with 3 refills)
    - If the patient achieves maximum dosage of medications used in this protocol, and still does not achieve goals of BP less than 130/80, the patient will be returned back to their Primary Care Provider for continued follow up within 4 weeks.

Documentation: Epic Smart Phrase (see Appendix C)

Appendix A: Medication Details

Drug	Dosing	Contraindications (do not initiate)	Precautions (review with provider or pharmacist before initiating)	Adverse effects needing dose adjustment or counseling	Adverse effects needing discontinuation	Monitoring parameters	Notes
Hydrochlorothiazide – HCTZ (thiazide diuretic) Chlorthalidone (more potent)	25 mg (start 12.5 mg for age >60) 12.5 mg – 25 mg	• History of allergic reaction with prior thiazide diuretic use	• Hypercalcemia or hyperparathyroism • Gout • Cardiac arrhythmias • Already taking a diuretic (e.g. furosemide) • Hyponatremia, hypokalemia, hypomagnesemia • GFR <30 – thiazides are not effective	Dizziness, excessive urination, skin photosensitivity Serum creatinine elevation 30-50%	Allergic reaction Hypokalemia (K^+ <3.5), Hyponatremia (Na <135) Serum creatinine elevation >50% Gout attack	Recheck BP in 2-4 weeks after initiation or dose increase Check BMP (basic metabolic panel) 2 weeks after initiation or dose increase	Suggest dosing in the morning to avoid excessive urination overnight (unless a patient prefers this); maximize last if patient experiencing urinary side effects (if patient is ok with this)
Losartan (Angiotensin Receptor Blocker – ARB, ends in "-SARTAN")	25 mg (equivalent to benazepril 10 mg) – 100 mg (equivalent to benazepril 40 mg)	• Pregnancy • Bilateral renal artery stenosis • History of angioedema or allergic reaction with prior ACE inhibitor or ARB use • Already taking an ACE inhibitor	• Potassium ≥ 5.1 mEq/L, check with PCP prior to starting • Women of childbearing age, counsel pt to contact clinic immediately if she becomes or plans on becoming pregnant due to teratogenic effects in later trimesters	Dizziness, hypotension Serum creatinine elevation 30-50%	Allergic reaction Angioedema Hyperkalemia (K^+ > 5.1) Serum creatinine elevation >50%	Recheck BP in 2-4 weeks after initiation or dose increase Check BMP (basic metabolic panel) 2-4 weeks after initiation or dose increase	Preferred in patients who have diabetes or CKD; maximize this dose first for these patients.

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Drug	Dosing	Contraindications (do not initiate)	Precautions (review with provider or pharmacist before initiating)	Adverse effects needing dose adjustment or counseling	Adverse effects needing discontinuation	Monitoring parameters	Notes
~~Drug~~	~~Dosing~~	~~Contraindications (do not initiate)~~	~~Precautions (review with provider or pharmacist before initiating)~~	~~Adverse effects needing dose adjustment or counseling~~	~~Adverse effects needing discontinuation~~	~~Monitoring parameters~~	~~Notes~~
Benazepril or Lisinopril (more potent) (Angiotensin - converting enzyme inhibitor – ACE inhibitor)	10 mg – 40 mg	• Pregnancy • Bilateral renal artery stenosis • History of angioedema or allergic reaction with prior ACE inhibitor or ARB use • Already taking an ARB (angiotensin receptor blocker suffix "-sartan")	Potassium ≥ 5.1 mEq/L, check with PCP prior to starting Women of childbearing age, counsel pt to contact clinic immediately if she becomes or plans on becoming pregnant due to teratogenic effects	Dry nonproductive cough (change to ARB), dizziness, hypotension Serum creatinine elevation 30-50%	Allergic reaction Angioedema Hyperkalemia (K^+ > 5.1) Serum creatinine elevation >50%	Recheck BP in 2-4 weeks after initiation or dose increase Check BMP (basic metabolic panel) 2-4 weeks after initiation or dose increase	Preferred in patients who have diabetes with proteinuria or CKD; maximize this dose first for these patients. If patient experiences cough, discontinue ACE inhibitor and start ARB.
Amlodipine (calcium-channel blocker, ends in "-DIPINE")	5 mg – 10 mg (start 2.5 mg for age >60)	History of allergic reaction with prior calcium-channel blocker use Use in combination with simvastatin >20 mg	Severe CHF Severe aortic stenosis Lower extremity edema (may worsen)	Peripheral edema (dose dependent), dizziness, headache, flushing, constipation	Allergic reaction	Recheck BP in 2-4 weeks after initiation or dose increase	Peripheral edema is not clinically significant, and not necessary to discontinue Do not need lab monitoring

*If a patient is taking any of the following medications, refer to pharmacist: Lithium, potassium, carbamazepine

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Appendix B: Medication Treatment Algorithm

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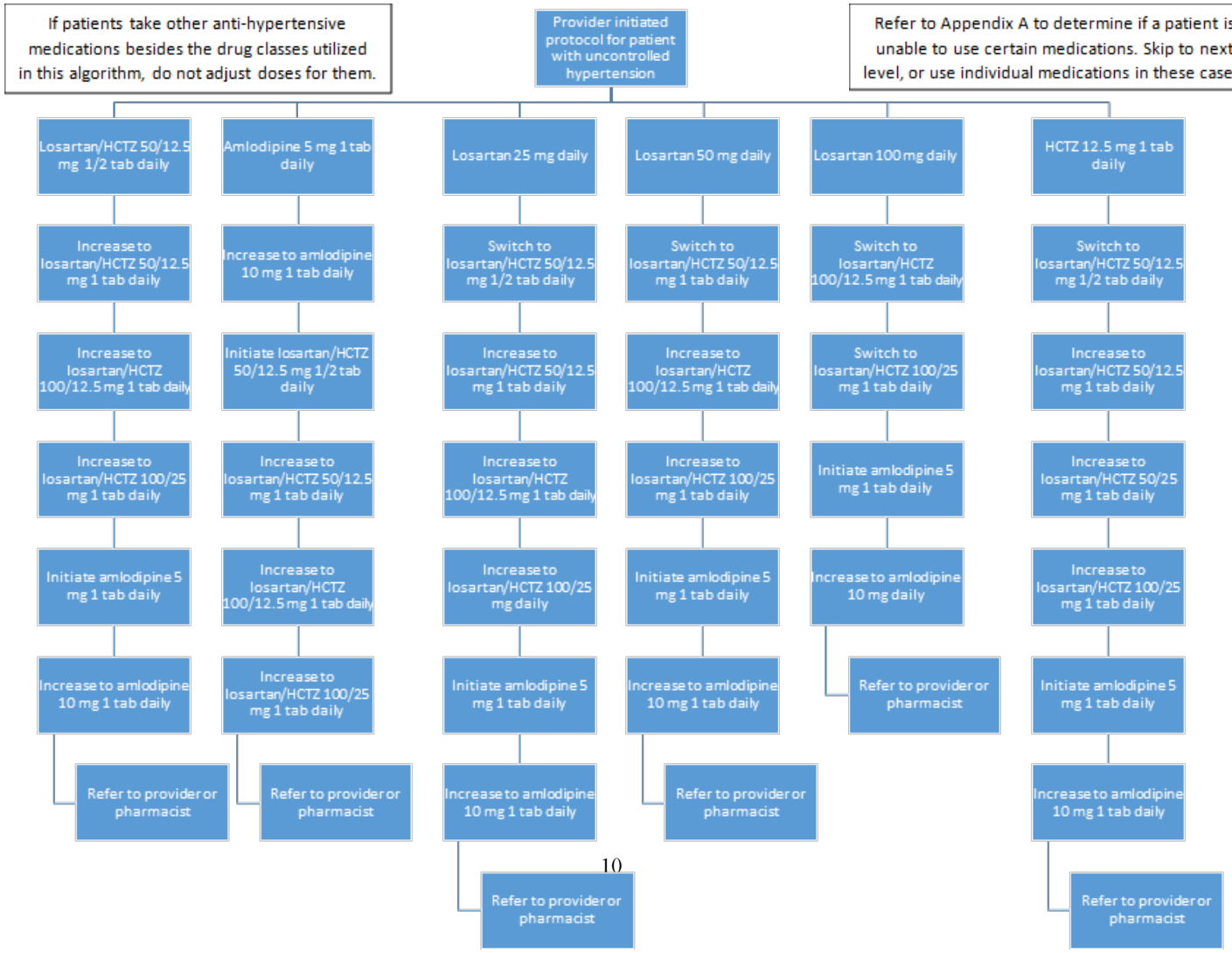

Appendix B: Medication Treatment Algorithm

Equivalent Doses

ARBs and ACE inhibitors

Always go by PCP recommendations in notes first before using this algorithm.

If a patient has CKD, history of MI, or CHF, make sure ARB is maximized.

Losartan 25 mg	Valsartan 80 mg	Benazepril 10 mg	Lisinopril 10 mg
Losartan 50 mg	Valsartan 160 mg	Benazepril 20 mg	Lisinopril 20 mg
Losartan 100 mg	Valsartan 320 mg	Benazepril 40 mg	Lisinopril 40 mg

Calcium channel blockers

Amlodipine 5 mg	Felodipine 5 mg
Amlodipine 10 mg	Felodipine 10 mg

Thiazide diuretics

HCTZ 12.5 mg	--
HCTZ 25 mg	Chlorthalidone 12.5 mg
HCTZ 50 mg	Chlorthalidone 25 mg

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Appendix C: RN Hypertension Visit Smart Phrase

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SUBJECTIVE

.interpassist
.name is a .language-speaking .age .genderidentity here for a blood pressure follow-up visit.

Self-measured blood pressure
Has home BP monitor? {Yes/no}
Checks BP at home? {Yes/no}
Recent home measured values/dates are: ***

Medication adherence and side effects
.name reports missing *** doses of blood pressure medications in the past 7 days, and generally reports {excellent/good/poor} adherence
The patient is currently experiencing these side effects: {dizziness, cough, leg swelling, urinary frequency, none, ***}

The patient was taking these anti-hypertensive medications before the visit: ***

Other relevant medications/substances being used: {stimulants; NSAIDs; none; ***}

Diet and exercise
The patient {does/does not} have a heart healthy diet and {is/is not} meeting exercise goals.

OBJECTIVE

Vitals
.resufast {labcrea; potassium; sodium; albcrea; last 3}

ASSESSMENT & PLAN

.name is a .language-speaking .age .genderidentity here for a blood pressure follow-up visit.

.probdiag

Please use .dphhtnrn dotphrase in your problem-based charting

Goal blood pressure is {<140/90 (default); PCP designated a different goal: ***
Clinic BP {is/is not} at goal
Home BP {is/is not} at goal
Electrolytes {are/are not} normal
Creatinine {are/are not} normal

Medication plan (medication name and dose)
Continue: ***
Change in dose: ***
Stop: ***

The current DPH hypertension algorithm can be found here.

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

1. *Summarize the content changes that were made to the SP/protocols or Privileges using the table in Section I*
2. *Complete Section II: Follow instructions outlined in table*
3. *Email the revised SP with track changes and this completed form to the Michelle Mai, ZSFG Medical Staff Analyst (michelle.mai@sfdph.org), the CIDP Coordinator (erika.kiefer@sfdph.org), Nursing Manager (Jennifer.Berke@sfdph.org), and CIDP Co-Chairs (vagn.petersen@sfdph.org) (Vanessa.Aspericueta@sfdph.org).*

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP: 8/6/25	
Person completing this form: Erika Kiefer	
Standardized Procedure Title:	CIDP Preamble
Department:	
Dept Chief:	
SP Author(s):	Erika Kiefer
Update #1:	▪ listed additional oversight bodies
Update #2:	▪ Italicized standard wording
Update #3:	▪ changed language about storing SPs electronically
Update #4:	▪ Looked for any MD/NP/PA to change to "Physician/NP/PA"
Update #5:	▪ (Updated Mayor and Chief of Staff *on this form* & also updated the instructions in the table below in the row entitled "ZSFG")

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below.

Preamble	• The Preamble is the portion of the SP that precedes the Protocols, the first pages of the SP, outlined I-VII, includes sections "Policy Statement, Functions to be Performed," etc. • The Preamble was updated in 2023 to include changes in legislation, regulations, and practice. (CIDP, 10/2023)
Equity	Ensure language within the SP is inclusive. Examples include but are not limited to: • Do not use race/ethnicity descriptors unless necessary • Do not use sex assigned at birth unless necessary • Use "their" rather than "him/her" (CIDP, 8/2022)
ZSFG	Change "San Francisco General Hospital" to "Zuckerberg San Francisco General Hospital" and SFGH to ZSFG (CIDP, 10/2016) · "Community Health Network" change to "**San Francisco Health Network**" · "CHN" change to "**SFHN**"
Qualified Provider	Insert the following after every use of words "qualified provider:" who has completed proctoring and subsequently maintained their eligibility for performing the procedure. *Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure*. (Credentials Committee, 11/2023)
Prerequisites	Onsite training no longer to be listed as a prerequisite. Instead, the training to be completed once procedure is approved for the provider and then before the provider initiates proctoring. Update protocols to reflect this change (Credentials Committee, 11/2023)

Zuckerberg San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: ___

Commented [DJ(1]: DIRECTIONS: Insert title of the SP

I. Policy Statement

A. *It is the policy of ~~the San Francisco Health Network and~~ Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose m~~M~~embership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, ~~Psychologists,~~ and Administrators, and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.*

Commented [MJ2]: I thought at one point we clarified that Clinical Psychologists do not have Standardized Procedures. Should they be listed here?

Commented [KE3R2]: Yes, I think that's correct. Thanks for catching that. I thought I'd taken it out already.

B. *All standardized procedures are to be kept electronically and on file in the Medical Staff Office; Department Chief, and ZSFG, Director of Nursing Office. ~~All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the _____ Department Office and on file in the Medical Staff Office.~~*

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Program	Practice Location

II. Functions to be Performed

The following standardized procedures are formulated as process protocols to explain the overlapping functions performed by the NP/PA in their practice. Each practice area will vary in the functions that will be performed, such as primary care in a clinical setting or inpatient care on a unit-based hospital setting.

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing

and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every ten years (6 year recertification cycle prior to 2014, 10 year recertification cycle starting in 2014 and thereafter). Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight, utilization of standardized procedures and the Physician Assistant Practice Agreement (PAPA).

The NP/PA conducts physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care, performs invasive procedures and furnishes medications/issues drug orders as established by state law.

~~Each practice area will vary in the functions that will be performed, such as a clinical, ambulatory and specialty clinic care setting, or inpatient care in a unit-based hospital setting. The NP/PA conducts physical exams, diagnoses, and treats illness, orders and interpret tests, counsels on preventative health care, assists in surgery, performs invasive procedures, and furnish medications/issue drug orders as established by state law.~~

~~A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. NPs provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the NP to seek physician consultation.~~

~~Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the~~

~~Accreditation Review Commission on education for the Physician Assistant (ARC PA). While functioning as a member of the Community Health Network, PAs perform health care related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (documents supervising agreement between supervising physician and PA).~~

III. Circumstances Under Which NP/PA May Perform Function

A. *Setting*

1. *Location of practice is* **any staffed medical unit on the ZSFG campus**~~the outpatient _____Clinic and Inpatient units at ____~~

.

2. *Role in the outpatient and inpatient setting may include performing physical exams, diagnosing, and treating illnesses, ordering, and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications.*

B. *Supervision*

1. *Overall Accountability: The NP/PA is responsible and accountable to the* ____
2. *A consulting physician, which may include attendings and fellows, will be available to the NP/PA by phone, in person, or by other electronic means always.*
3. *Physician consultation is to be obtained as specified in the protocols and under the following circumstances:*
   a. *Acute decompensation of patient situation.*
   b. *Problem that is not resolved after reasonable trial of therapies.*
   c. *Unexplained historical, physical, or laboratory findings.*
   d. *Upon request of patient, NP, PA, or physician.*
   e. *Initiation or change of medication other than those in the formulary(ies).*
   f. *Problem requiring hospital admission or potential hospital admission.*

IV. Scope of Practice

Protocol #1

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

1. *Active California NP/PA license.*
2. *Successful completion of a master's level or higher program, which conforms to the Board of Registered Nurses (BRN)/Accreditation*

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Review Commission on Education for the Physician Assistant (ARC)-PA standards.

3. *Maintenance of Board Certification from:*
   a. *American Nurses Credentialing Center (ANCC); or*
   b. *American Academy of Nurse Practitioners (AANP); or*
   c. *National Commission on the Certification of Physician Assistants (NCCPA) certification; or*
   d. *American Association of Critical Care Nurses; or*
   e. *Pediatric Nursing Certification Board; or*
   f. *National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties; or*
   g. *Addictions Nursing Certification Board.*
4. *Maintenance of certification of American Heart Association Basic Life Support for Health Care Providers (BLS-HCP)*
5. *Possession of a National Provider Identifier or must have submitted an application.*
6. *Copies of licensure and certificates must be kept electronically and on file in the Medical Staff Office.*
7. *Furnishing Number and DEA number if applicable.*
8. *Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center Physician Assistant Practice Agreement (PAPA). Copies of PAPA must be kept at each practice site for each PA.*

~~1. Active California Registered Nurse/ Physician Assistant license.~~
~~2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC) PA standards.~~
~~3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.~~
~~4. Maintenance of certification of Basic Life Support (BLS) by an approved American Heart Association provider.~~
~~5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.~~
~~6. Copies of licensure and certificates must be on file in the Medical Staff Office.~~
~~7. Furnishing Number within 12 months of hire for NPs.~~
~~8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Practice Agreement. Copies of Practice Agreement must be kept at each practice site for each PA.~~

B. Specialty Training
   1. Specialty requirements
      a. NP specialty certification as an ANP, FNP, ACNP

Commented [TM7]: List of NP certifying bodies is a little more extensive and also includes:
*American Association of Critical Care Nurses (Numerous APRN certifications)
*Pediatric Nursing Certification Board (numerous)
*National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (2 certifications)
and the *Addictions Nursing Certification Board (ANCB, Just one certification for APRNs))

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Commented [DJ(8]: DIRECTIONS: List other NP specialty certifications, if applicable in "b"

Commented [DJ(9]: DIRECTIONS: List any other specialty requirements in V.B.1.b

b. ____

C. *Evaluation*

1. *Evaluation of NP/PA Competence in performance of standardized procedures.*

Initial: at the conclusion of the standardized procedure training, the Medical Director and supervising clinical provider(s) will assess the NP/PA's ability to practice clinically.

a. Clinical Practice

i. *Length of proctoring period will be up to three (3) months. The term may be shortened or lengthened at the discretion of the supervising clinical provider; however, the proctoring period shall not exceed the six (6) months CCSF probationary period. ~~At the end of the proctoring term, the NP/PA will be generally supervised by Chief of ____, _____ Service Attending, or designated clinical provider.~~*

ii. *The evaluator will be the Chief of ____ or designated clinical provider.*

iii. *The method of evaluation in clinical practice will be those needed to demonstrate clinical competence*

~~a. All cases are presented to the evaluator~~
~~b. Medical Record review is conducted for out-patient discharge medication~~
~~c. Medical Record review may be conducted retrospectively by the clinical supervisor.~~
~~d. Proctoring will include a minimum evaluation of five (5) chart reviews and direct observations, with at least one case representing each core protocol, discharge of inpatients, and furnishing medications/drug orders, if applicable.~~
~~e. Procedural skills are incorporated into the competency assessment orientation~~

2. Ongoing Professional Performance Evaluation (OPPE): Affiliated staff will be monitored for compliance to department specific indicators and reports will be sent to the Medical Staff Office.

~~2.~~ *Follow-up: areas requiring increased proficiency as determined by the*
~~3.~~ *initial or reappointment evaluation will be re-evaluated by the Medical*
~~4.~~ *Director and/or designated clinical supervisor at appropriate*

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intervals
~~5.~~3. until ~~acceptable~~an acceptable skill level is achieved.

4. Biennial Reappointment: Medical Director and/or designated clinical provider must evaluate the NP/PA's clinical competence. The number of procedures and chart reviews will be done as noted in the specific procedure protocols.
~~Biennial Reappointment: Medical Director and/or designated clinical provider must evaluate the NP/PA's clinical competence. The number of procedures and chart reviews will be done as noted in the specific procedure protocols.~~

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VI. Development and Approval of Standardized Procedure

A. *Method of Development*
Standardized procedures are developed collaboratively by the NPs/PAs, Physicians, and Administrators, and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

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B. *Approval*
The CIDP, Credentials, Medical Executive Committee, and Joint Conference Committee must approve all standardized procedures prior to their~~its~~ implementation.

C. *Review Schedule*
The standardized procedure will be reviewed every three years by the NP/PA and the Medical Director, and as practice changes.

D. Revisions
The CIDP, Credentials, Medical Executive Committee, and Joint Conference Committee must approve all revisions to standardized procedures prior to implementation.

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DIRECTIONS: Include protocols after this section of the document. Use page breaks between each protocol.

MS.08.01.03: Summary of Changes

Current	Revision
51.00 CORE PRIVILEGES PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty.	PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine.
51.11 LUMBAR PUNCTURE PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty.	PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine.
51.12 THORACENTESIS PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty.	PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine.
51.13 PARACENTESIS PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty.	PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine.
51.14 CENTRAL VENOUS LINE PLACEMENT PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty.	PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine.

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Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Medicine Hospital Medicine 2018

Provider Name:

Privilege	Status	Approved

MedHosp HOSPITAL MEDICINE 2018
(0808 MEC)

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

51.00 CORE PRIVILEGES ___
Admit, work-up and provide treatment or consultative services to adult patients in the ambulatory and inpatient settings.

PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

51.10 SPECIAL PRIVILEGES ___
PLEASE NOTE: Privileges are required for those faculty who will personally perform the following procedures:

51.11 LUMBAR PUNCTURE ___

PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine

PROCTORING: Review of 2 cases. One of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases. One of which may be performed on a simulated model.

51.12 THORACENTESIS ___

PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine

PROCTORING: Review of 2 cases. One of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases. One of which may be performed on a simulated model.

51.13 PARACENTESIS ___

PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine

PROCTORING: Review of 2 cases. One of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases. One of which may be performed on a simulated model.

51.14 CENTRAL VENOUS LINE PLACEMENT ___

Deleted: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, or an Internal Medicine Subspecialty, or Family Community Medicine..

Deleted: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, or Family Community Medicine.

Deleted: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, or Family Community Medicine.

Deleted: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, or Family Community Medicine.

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Medicine Hospital Medicine 2018

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Board-certified or board-eligible by the American Board of Internal Medicine (in Internal Medicine or an ABIM-recognized subspecialty) or by the American Board of Family Medicine.

PROCTORING: Review of 2 cases. One of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases. One of which may be performed on a simulated model.

51.15 PALLIATIVE MEDICINE ___

Provide palliative medicine consultative services to adult patients in the ambulatory and inpatient settings.

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, or an Internal Medicine Subspecialty or Anesthesiology, Family Medicine, Physical Medicine and Rehabilitation, Psychiatry and Neurology, Surgery, Pediatrics, Emergency Medicine, Radiology, or Obstetrics and Gynecology; or Board Certified in Hospice and Palliative Medicine.

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases

51.16 WAIVED TESTING

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

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

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

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

Fecal Occult Blood Testing (Hemoccult®) ___

Vaginal Ph Testing (Ph Paper) ___

Urine Chemistrip® Testing ___

Urine Pregnancy Test (Sp® Brand Rapid Test) ___

51.17 ACUPUNCTURE ___

Perform acupuncture, acupressure and moxibustion on adult patients in the ambulatory and inpatient settings.

PREREQUISITES: Successful completion by a licensed physician of at least 200-hours instruction and didactic training course given by a UC or other nationally recognized program.

PROCTORING: Direct observation and chart review on 5 different patients by a medical staff member who maintains Acupuncture Privileges within the CHN/ZSFG system. Direct observation and chart review may be on the same patient or on different patients.

REAPPOINTMENT: Review of 5 cases by a medical staff member who maintains Acupuncture Privileges within the CHN/ZSFG system.

Deleted: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, or Family Community Medicine.

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Medicine Hospital Medicine 2018

Provider Name:

Privilege	Status	Approved

51.30 ADDICTION MEDICINE ___

Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and board admissible, certified or re-certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, American Board of Family Medicine, American Board of Pediatrics, American Board of Psychiatry and Neurology, or American Board of Emergency Medicine. Approval of the Director of the Addiction Medicine Service required for all applicants.

PROCTORING: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

REAPPOINTMENT: Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

_____ _____

Addiction Medicine Director/Designee Date

90.00 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH

Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants.

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

APPROVED BY

_____ _____

Division Chief Date

_____ _____

Service Chief Date