Sacramento VA Medical Center
Inpatient Medicine Rotation Curriculum
UC Davis Internal Medicine Residency Program

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I. EDUCATIONAL PURPOSE

The Sacramento VAMC rotation is a four week inpatient experience comprised of caring for Medicine Ward, Intensive Care Unit, and Coronary Care Unit patients. The rotation allows residents and interns in internal medicine and family practice an opportunity to manage patients in a small community hospital setting, complementing the tertiary care experience at the University hospital and the large community hospital model at the Kaiser Hospital. Despite the small hospital setting, the VAMC is a referral center for the outlying VA clinics in Northern California and provides a full-range of subspecialty consultative services. This particular feature allows the residents to receive more focused training in caring for common as well as unusual medical problems directly from specialists and subspecialists.

II. PRINCIPAL TEACHING METHODS

A. Direct Supervised Patient Care:
Residents/interns will learn through direct patient care with attending supervision. Residents/interns will first evaluate the patient and then present the patient to the attending for discussion during teaching and management rounds. In addition, didactic case discussions with resident involvement and direct observation of the residents’ interaction with patients will occur during teaching rounds. Attending rounds in the ICU will take place with a Cardiologist for cardiac patients and with a Critical Care Specialist for medical ICU patients.

B. VA Academic Conferences:
- **NOON CONFERENCE**: 12:00-12:45pm everyday EXCEPT Thursdays.
  - **Mondays**: Board Review Questions
  - **Tuesdays**: Cardiology or Pulmonology Conference
  - **Wednesdays**: Subspecialty, Pathology, Radiology or Attending Conference
  - **Thursdays**: Interdisciplinary Rounds
  - **Fridays**: Case Conference
    - Check the 3rd floor conference room board for presenter schedule.
    - Presenter arrives 5 minutes early and writes complete case on the board.
    - Case presented in 10-15 minutes, 5 minutes for questions, then 5-10 minute teaching point.

- **Interdisciplinary Rounds**: REQUIRED. Every Thursday at 11:30am in the 3rd floor conference room AND every Tuesday at 12:45pm in the 4th floor conference room. A representative from each team (preferably the resident) meets with the nurse manager, PT/OT, social worker, discharge planner, and dietician to facilitate patient needs and disposition.
- **Medical Student Chief Rounds**: Fridays at 1:00pm in 4th floor Chief’s office.
- **Grand Rounds**: Thursdays 8:00-9:00am teleconferenced on the 4th floor. There will be a sign-in sheet.
- **Monday IM Academic Conference**: 1:30-4:30pm at UCDMC, PSSB auditorium.
- **Tuesday FP Academic Conference**: In the afternoon at UCDMC.
III. EDUCATIONAL CONTENT

A. Mix of Diseases, Patient Population:
Diseases seen in this patient population cover the breadth of internal medicine from common problems such as coronary artery disease, chronic obstructive pulmonary disease, and diabetes to less common disorders such as gastric cancer, nephrotic syndrome and posttraumatic stress disorder. Diseases frequently encountered in the Intensive Care Unit include unstable angina, congestive heart failure, cardiac arrhythmia, acute myocardial infarction, chronic obstructive pulmonary disease exacerbation, sepsis, diabetic ketoacidosis, acute renal failure, and pneumonia with respiratory compromise. Because of the wide geographic coverage, patients may present in the early stages of the disease or be referred when the disease is in its advanced stages. Patients range in age from young adults aged 20-30’s to geriatric patients aged 80-90’s. In addition to the traditional VA patients, Sacramento VAMC also provides medical care for TRICARE patients, comprised of retired military personnel and dependents of military personnel.

B. Learning Venue:
This rotation takes place at the Sacramento VA Medical Center at Mather Field, which is a 50-bed, state-of-the-art, inpatient facility offering a full range of comprehensive health care services including medical, surgical, primary and mental health care. The medical center, which is comprised of 28 Medical-Surgical beds, 12 Transitional Care Unit beds, 10 Intensive Care Unit beds, and a four room operating suite, also houses a cardiac catheterization lab, a gastrointestinal & endoscopy suite, an interventional radiology and angiography suite and 16,000 square-feet of research space. The medical center offers a wide range of outpatient and diagnostic services, including laboratory services, x-rays and mammography, MRI, CT, and PET scanning. Patients will be cared for by residents on the Medical-Surgical Ward, Intensive Care Unit, Coronary Care Unit, or Urgicenter.

C. Types of Encounters:
Residents will do inpatient admissions to the Medical-Surgical Wards, Transitional Care Unit, Medical Intensive Care Unit, and Coronary Care Unit. They will also perform medical consultations for the non-medicine hospital services.

D. Procedures:
Basic procedures include lumbar puncture, paracentesis, thoracentesis, arthrocentesis, central venous catheter placement, arterial line placement, and Swan-Ganz catheter placement.

IV. EDUCATIONAL GOALS AND OBJECTIVES
The Sacramento VAMC rotation will focus on patient evaluation and management in a diverse clinical setting with an interdisciplinary staff. The rotation experience will consist of two components: 1) in-patient, 2) basic procedures. Hospital skills will emphasize the ability to manage patients across multiple specialties, often with residents/interns functioning as the specialist with staff supervision. Emphasis will be upon skills required of a general internist or primary care physician in the changing scope of practice including community based home health care, dermatology, geriatrics, primary gynecology, mental health, neurology, rheumatology, nephrology, gastroenterology, cardiology, pulmonology, otolaryngology, ophthalmology, and inpatient-based procedures.

A. Patient Responsibility:
The residents will be responsible for the in-patient care of all patients admitted to their service, act as the primary physician for these patients, and ensure appropriate follow-up care once discharged, under the guidance and supervision of the attending physician. There are no non-teaching patients. Interns, with assistance from their residents and the Day Float resident, will be the primary physician for the patients and are responsible for pre-rounding on their patients each day, authoring the admitting History and Physical Examination, writing the daily progress notes, and performing any required procedures on their patients. Residents will supervise the interns in managing patients and performing procedures and be responsible for work rounds and teaching. The FP or IM residents will also be responsible for any medicine consults on their call shifts, supervised by their attending.
The attendings (MedSurg, MICU, CCU) are responsible for teaching rounds and management rounds. They will supervise the interns and residents in caring for the patients and guide the interns and residents in making appropriate and cost-effective decisions. Early in the year, the attendings may need to be more “hands-on,” when interns and residents are less experienced in their respective roles. As the academic year progresses, the interns/residents should assume more and more primary decision making as their skills, fund of knowledge, and clinical judgment advances.

B. Assessment of Competency and Rotation Specific Competencies:
The evaluation will be based on the resident’s skill in obtaining a thorough history, performing an accurate physical examination, formulating a reasonable differential diagnosis, developing reasonable plans for management, and performing invasive procedures. In addition, his/her fund of medical knowledge, chart documentation, overall clinical competence, professionalism, communication skills, interpersonal skills, humanistic qualities, ability to use the medical literature and prior experience to improve patient care, and ability to work within the VA system to optimize and improve patient care will be evaluated.

Interns and residents will rotate through the VA approximately 1 block per year. There are specific learning objectives that residents should meet at each level of training for each of the six core competencies. It is intended that these objectives will provide specific milestones to which the residents will strive to achieve. Many of the objectives listed below may overlap more than one of the core competencies and effort has been made to limit redundancy by listing most objectives under only one area of competency. When similar objectives appear under more than one competency, this was done intentionally to add emphasis to that objective. Residents are instructed that achievement of overall clinical competency is dependent upon successful performance in each of these interrelated core competencies. Notably, the objectives listed below are intended to be progressive. That is, achievement of competency at one training level is dependent upon achieving the objectives listed at that level as well as all of the objectives listed for prior levels of training.

1. Core Competency: Patient Care

Goal: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

PGY-1 Residents are expected to:

- Demonstrate respect, compassion and empathy for patients and their families.
- Be able to obtain a complete and accurate patient history using interviews of patients and families/friends, thorough review of the medical records, and review of outside records when applicable.
- Be able to perform a general physical exam and to tailor the exam according to clinical situation. This should include appropriate exam components depending upon on the presentation, such as performing a neurologic, mental status, rectal, and pelvic exams on appropriate patients.
- Correctly delineate normal from abnormal findings, and understand the relevance of abnormal findings.
- Integrate information obtained from the history and physical exam to develop a pertinent and prioritized problem list and an initial differential diagnosis with supervision.
- Select initial diagnostic studies and therapeutic interventions based on the initial differential diagnosis.
- Integrate the results of diagnostic studies to refine the differential diagnosis.
- Select additional diagnostic studies and therapeutic interventions based on the refined differential diagnosis, with some supervision.
- Incorporate patient preferences into the care plan.
- Counsel patients/families about their medical conditions including the diagnostic and treatment plan.
- Show sound clinical judgment and ask questions or for help when clinical uncertainty exists.
- Work toward completing the requirements for technical and cognitive proficiency for invasive procedures, especially those required by the ABIM. Perform invasive procedures under supervision until those requirements are met.
- Recognize the role of healthcare providers from other disciplines and services, and work in cooperation with those providers to provide comprehensive, patient-centered care.

PGY-2 Residents are also expected to:
• Ensure that the intern obtains an adequate history and to fill in blanks where necessary.
• Ensure that interns have complete problem lists, adequate differential diagnoses, and treatment plans.
• Demonstrate the ability to elicit subtle findings from the history and physical exam, or to augment the physical exam with additional maneuvers as needed to support or refute a diagnostic hypothesis.
• Integrate all information from history, physical exam and diagnostic studies to develop a diagnostic and therapeutic plan with minimal supervision.
• Begin to incorporate consideration of risks, benefits, and costs into patient management plans.
• Effectively communicate the management plan to patients/families and modify that plan based on their values and preferences.
• Begin to utilize information technology to retrieve and apply current medical evidence (e.g. guidelines, original literature) to refine the patient management plan.
• Initiate and coordinate the involvement of healthcare providers from other disciplines and services to provide comprehensive, patient-centered care.

PGY-3 Residents are also expected to:
• Integrate all information from history, physical exam and diagnostic studies to develop a diagnostic and therapeutic plan at the level of a general internist without need for supervision.
• Consistently incorporate consideration of risks, benefits, and costs into patient management plans.
• Consistently utilize information technology to retrieve and apply current medical evidence (e.g. guidelines, original literature) to patient management.
• Complete the requirements for proficiency in invasive procedures, especially those required by the ABIM.
• Function competently as an internal medicine consultant to other services.

2. Core Competency: Medical Knowledge

Goal: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

PGY-1 Residents are expected to:
• Have a basic understanding of the mechanism of diseases commonly encountered in internal medicine (such as acute coronary syndrome, pneumonia, urinary tract infection, abdominal pain, chest pain, edema, shortness of breath, and alcohol withdrawal).
• Display an attitude of inquisitiveness and a desire to continuously expand their knowledge base.
• Utilize reference materials (e.g. textbooks, Up-To-Date®, pocket references) to correct deficits in knowledge related to the diagnosis and treatment of the patients for which they are providing care.
• Attend 70% of the teaching conferences.
• Take and pass the USMLE Step 3 examination.

PGY-2 Residents are also expected to:
• Have more in-depth understanding of diseases commonly encountered in internal medicine, as demonstrated by the ability to develop an appropriate initial diagnostic and treatment approach to these conditions, with minimal supervision.
• Utilize current medical evidence (e.g. guidelines, original literature) to correct deficits in knowledge related to the diagnosis and treatment of the patients for which they providing care.
• Teach the team on common medical conditions.
• Develop a plan of independent study to expand their knowledge of internal medicine and its subspecialties.

PGY-3 Residents are also expected to:
• Have an understanding of diseases encountered in an internal medicine practice that is appropriate for a general internist, as demonstrated by the ability to develop a comprehensive diagnostic and treatment approach to these conditions without supervision.
• Have a basic understanding of unusual or complex diseases commonly encountered in the subspecialties of internal medicine.
3. Core Competency: Practice-Based Learning and Improvement

**Goals:** Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.

**PGY-1 Residents are expected to:**
- Be able to supervise and teach 3rd year medical students. Seek and accept feedback from students and use that feedback to improve their teaching and supervisory skills.
- Seek and accept feedback from attendings, fellows and supervising residents, and utilize that feedback to improve their clinical performance.
- Set short-term learning goals. Evaluate and critiques their own performance relative to those goals at the beginning and end of the rotation.
- Learn from errors and use errors to improve patient care on both a personal and system-wide level.
- Be able to formulate clinically relevant questions related to the diagnosis and treatment of their patients’ medical conditions.
- Be familiar with common medical databases and common search engines (e.g. OVID, PubMed, etc.) and to use these information sources effectively to support patient care decisions and to educate self, patients and other physicians.

**PGY-2 Residents are also expected to:**
- Be able to supervise and teach 4th year medical students and interns. Seek and accept feedback from students and interns, and use that feedback to improve their teaching and supervisory skills.
- Seek and accept feedback from attendings and fellows, and utilize that feedback to improve their clinical performance. Be able to critique own performance.
- Set longer-range learning goals for their training. Develop learning plans to help achieve those goals and a method of evaluation to determine their success in meeting them.
- Know basic methods for searching the medical literature and be able to find original medical literature related to the diagnosis and treatment of their patients’ conditions, and then to incorporate that knowledge into the treatment plan.
- Be able to critically appraise literature related to diagnosis and treatment, and appropriately apply the results of that literature to their clinical practice.

**PGY-3 Residents are also expected to:**
- Be able to run effective teaching conferences, including Noon Conference.
- Learn basic principles and methodology of Clinical Quality Improvement (CQI).
- Be able to discuss the principles of executive management skills and develop a personal improvement plan.

4. Core Competency: Interpersonal and Communication Skills

**Goals:** Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.

**PGY-1 Residents are expected to:**
- Provide verbal presentations that are thorough, yet succinct and pertinent, and that reflect understanding of the patients’ condition and/or support a differential diagnosis.
- Maintain comprehensive, timely and legible medical records in the EMR.
- Provide electronic and verbal sign-out of patients that is efficient, pertinent, and explicit.
- Be open and receptive to questions and recommendations from members of the nursing and ancillary staff.
- Develop a good working relationship and rapport and communicates clearly with other physicians, health professionals and patients.
- Be proactive about contacting discharge planning and social workers for discharge care planning.
- Develop a therapeutic relationship with patients and their families, regardless of their background.
• Be able to explain a patient’s condition and plan of care to the patient and family in terms that are understandable and appropriate.
• Be able to discuss the risks and benefits of procedures or interventions with patients and families, and obtain informed consent.
• Be able to discuss resuscitation status with patients and families, answer their questions regarding this issue, and elicit the patient’s wishes in regard to cardiopulmonary resuscitation.
• Communicate expectations to 3rd year students and provide them with feedback.

PGY-2 Residents are also expected to:
• When appropriate, provide written senior admission notes that succinctly summarize the patient’s condition, reason for admission and management plan.
• Ensure that discharge summaries succinctly summarize and convey the pertinent details of the patient’s hospitalization and post-hospitalization follow-up needs.
• Effectively communicate verbally with consulting physicians. Be able to succinctly summarize the patient’s condition and the explicit reason(s) why consultation is being requested.
• Effectively communicate and coordinate the plan of care with nursing staff and members of ancillary healthcare services.
• Engage patients and their families in shared decision-making, especially in situations whether there is clinical uncertainty and/or ambiguity.
• Lead family/team meetings, with some support from the attending physician, including discussions of end-of-life care.
• Be able to resolve conflicts with patients/families, staff, or within the team, with some involvement of the attending physician.
• Communicate expectations to 4th year students and interns and provide them with feedback.

PGY-3 Residents are also expected to:
• Effectively communicate with physicians as a consultant, and be able to provide succinct, explicit recommendations both verbally and in writing.
• Lead family/team meetings, with minimal or no support from the attending physician, including discussions of end-of-life care.
• Be able to resolve conflicts with patients/families, staff, or within the team, with minimal or no involvement of the attending physician.

5. Core Competency: Systems Based Practice

Goal: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

PGY-1 Residents are expected to:
• Work within the VA system to ensure continuity of care between inpatient and outpatient arenas.
• Work proactively with Nurse Practitioners assigned to the health care team.
• Complete all charting/documentation/dictations in a timely manner (H&Ps at the time of admission and discharge summaries within 48 hours).
• Learn the role of other members of the healthcare team, including case managers, social workers, physical/occupational/speech/respiratory therapists, nutritionists, clinical pharmacists, and others.
• Recognize when their patients may benefit from the involvement of other healthcare providers, and invoke their assistance when appropriate.
• Learn what evidence-based guidelines and standardized order sets are available in our institution. Know how to find these resources, and utilize them when appropriate for patient care.
PGY-2 Residents are also expected to:
- Effectively coordinate the involvement of healthcare providers from other disciplines and physicians from other specialties to provide comprehensive, patient-centered care.
- Learn to anticipate patients’ discharge needs (e.g. transportation and medication assistance; need for placement, home health care, and durable medical equipment; etc.), and begin discharge planning early in their hospitalization, with some prompting by the attending physician.
- Participate effectively in Interdisciplinary rounds, and to take a leadership/advocacy role for patients when necessary.
- Work within the VA system in quality improvement initiatives.
- Supervise and direct the Nurse Practitioners assigned to the health care team.
- Appropriately triage patient admission and transfer issues, and to manage patient flow.

PGY-3 Residents are also expected to:
- Consistently anticipate patients’ discharge needs and begin discharge planning early in the hospitalization, with minimal or no prompting by the attending physician.
- Describe the basic systems of payment for health care, and the principal types of payers for health care.
- Demonstrate understanding of commonly used coding systems and describe the relationship between supporting documentation, accurate coding and reimbursement.
- Demonstrate understanding of basic principles of healthcare management systems.

6. Core Competency: Professionalism

Goal: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

PGY-1, PGY-2, and PGY-3 Residents are expected to:
- Treat all patients, regardless of background, with respect, compassion and empathy.
- Treat everyone else – nursing staff, ancillary healthcare providers, program personnel, students, residents from our own and other programs, attending physicians in all specialties, others – with respect and courtesy, and in a way that reflects positively on them as individuals and the medical profession as a whole.
- Respect patients’ autonomy and their right to make informed decisions about their own health care.
- Commit to advocating for their patients’ needs in the healthcare system, and be willing to place the patients’ needs above their own.
- Commit to providing the highest quality, most effective and most efficient care that their experience and level of training permit.
- Understand and safeguard patient confidentiality and protected health information.
- Be honest in all aspects of their professional life, including documentation of patient information, disclosure of medical errors, and acknowledgement of mistakes and of deficiencies in medical knowledge and skills.
- Be committed to self-directed learning, self-evaluation, and self-improvement.
- Comply with the policies and expectations of the residency program, and complete administrative tasks (e.g. evaluation forms) on time.
- Adhere to principles of confidentiality, scientific and academic integrity and informed consent.
- Be willing to assist their colleagues and the program with patient care and service coverage when needed.
V. ANCILLARY EDUCATION MATERIALS

Basic textbooks of medicine such as Harrison’s or Cecil’s should be used as the reference text, supplemented by Up-to-Date for quicker access to medical information that is immediately useful and by literature searches for the most current data.

A. Hospital Library:
The hospital library is on the first floor, which is available 24 hours a day. Basic internal medicine textbooks and commonly used internal medicine journals are available in the library. On-line literature searches and journals, as well as Up-to-Date are available through the Education website on the Intranet system: http://vww.northern-california.med.va.gov/edu/library/. See the librarian for details. The librarian will also obtain for you any journal articles that are not available in the library or on-line through inter-library loans.

B. Internet Access:
The internet can be accessed from any computer terminal in the hospital so that relevant literature searches can be done. There are various Clinical Practice Guidelines developed by the VA for treating common disorders such as congestive heart failure, chronic obstructive pulmonary disease, chronic renal failure, and spinal cord injury, which are available on the Intranet.

C. Resident Computer Room and Library:
The Resident Computer Room contains a minimum of 10 computer workstations for patient care and for electronic literature searches. Also housed in that room are General Medicine textbooks and frequently utilized sub-specialty reference guides.

VI. METHODS OF EVALUATION

A. Resident Evaluation:
Residents/interns will be evaluated based on their performance within the 6 core competencies in the Intensive Care Unit and the in-patient Med- Surg Ward by their ICU, CCU and General Medicine attendings and fellows. Residents will be provided continuous feedback on performance throughout the rotation. Evaluators are also to provide a verbal evaluation and feedback session at the close of the rotation. The methods used to perform these evaluations will include direct observation on teaching and management rounds, active participation during discussions on teaching rounds and morning report, chart audit and review, and input from peers and support personnel. A global evaluation will be filled out by fellows and faculty in the E-Value system. The VA Program Director will be responsible for coordinating the evaluation process and for ensuring that the process is completed.

B. Rotation Evaluation:
The residents will evaluate the rotation and each attending at the end of the rotation, using E-value. Specific feedback will be sought concerning the teaching value of each component of the rotation. Exit interviews will also be conducted at the end of each block by the Chief Resident to obtain general suggestions on improving the rotation.

VII. SUPERVISION

Supervision within and outside of attending rounds is always available. In the Intensive Care Unit, a Critical Care and Cardiology fellow and attending are on-call 24 hours a day and are available for any questions and issues that may arise outside of attending rounds. The Medicine Ward attending is available for any questions and issues that arise outside of attending rounds. The Urgent Care Physician is also available in house in the event back-up is needed and provides additional coverage for hospitalized patients. In addition, the Medicine Chief Resident assigned to the VA hospital is always available by pager.
VIII. STRUCTURE

A. Team Structure and Schedule

1. Teams:
5 residents and 5 interns are assigned to the VA Medical Center. There will be 3 Internal Medicine (IM) residents, 3 Internal Medicine interns, 2 Family Practice (FP) residents, and 2 Family Practice interns. The residents and interns rotate on a weekly basis between a closed ICU and the Floor Teams. Generally, FP residents will supervise FP interns and IM residents will supervise IM interns. On occasion, an IM resident will supervise FP interns, but FP residents will not supervise IM interns. Typical structure is as follows:

- Floor Team 1 (7a-7p): Resident, Intern A, Intern B
- Floor Team 2 (7a-7p): Resident, Intern A, Intern B
- ICU / Cardiology Team (7a-7p): Resident, Intern A, Cardiology/MATI FP Intern (outside rotator)
- Day Float Resident (7a-7p)
- Night Float Resident (7p-7a)

The FP residents will not be in the ICU during this rotation, but may request dedicated ICU time. The Day Float and Night Float resident will be either an IM resident or a FP resident. There will be an ICU attending, a CCU attending, and two Floor attendings that will supervise the academic teams.

2. Schedule:
Each week, some residents and interns will rotate. Due to the odd numbers of residents and interns, some people may do more or less of a certain team than others. When on a floor or ICU team, interns will be assigned the designation of Intern A or Intern B. Admissions orders need to reflect the team numbers and the appropriate intern.

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<th>Intern A</th>
<th>Intern B</th>
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3. Floor Schedule:

- **Team Cap**: 9 patients per intern or 18 patients per team. Overflow patients over 18 patients are temporarily managed by the NPs.
- **Days Off**: Interns pick non-good day (can be weekend day), Resident has good day (Saturday or Sunday)
- **Nurse Practitioners**: There will be one NP assigned to each floor team. They will assist with day to day patient care. Each NP will work 4 days/week, 10 hrs/day (typically 6:30a-5:00p). Their responsibilities include discharges, writing orders, cross-covering patients, admissions, and assisting with procedures.

- **Floor Team Structure: Monday-Friday**
  - **Admission Cap**: Each intern picks up 2 patients per day or 4 patients for the team (combination of Overnight, Dayfloat, New Admissions, and Medicine Consults, but cap does not include bouncebacks or ICU transfers). Teams must take 4 patients per day regardless of who is there or who is off, unless the team is at the team cap. If the interns or the teams cap, then overflow admissions temporarily go to the 2 NPs, for a maximum of 4 new admissions, as long as the NPs are available to take admissions. If the NPs are not available to do admissions (e.g., they have left for the day, are busy doing other clinical work, getting training, etc.), then these additional admissions are to be done by the ER, cross-covered by Dayfloat/Nightfloat and handed off to the interns the next a.m. for jeopardy. See admission cap overflow for further details.
  - **Overnight Patients**: If available, the NPs will pick up overnight patients at 7a, round on them and present them on rounds. These patients will be distributed to the interns at noon and counts to the admission caps. Interns may elect to take the patients at 7a. Either the NP or the intern will do the daily progress note.
  - **Typical Time Schedule**:
    - 7a – 8a: Accept signout, accept overnight admissions, preround
    - 8a – 8:15a: Discharge rounds with discharge planner
    - 8:15a – 9a: Work rounds with resident
    - 9a – 11a: Attending rounds, didactics
    - 11a – 12p: Do orders, call consults, arrange discharges
    - 12p – 5:30p: New admissions
    - 5:30p – 7p: Finish work
    - 7p: Sign out to Nightfloat (under NO CIRCUMSTANCES are teams to stay late)

- **Floor Team Structure: Saturday-Sunday**
  - No Dayfloat on weekends. NPs typically not available on the weekends.
  - Floor Team 1 takes all admissions on the odd weekend day and has a good day on the other weekend day.
  - Floor Team 2 takes all admissions on the even weekend day and has a good day on the other weekend day.
  - Teams cap at 8 new admissions (combination of Overnight and New admissions, but cap does not include bouncebacks or ICU transfers), with any additional admissions done by the ER and cross-covered by the team to be handed off to Nightfloat and distributed in the a.m. to the other team.
  - When their work is done, good day team can sign-out to the admitting team.

- **Typical Time Schedule**:
  - 7a – 8a: Accept signout, accept overnight admissions, preround
  - 8a – 9a: Work rounds with resident
  - 9a – 11a: Attending rounds, didactics
  - 11a – 12p: Do orders, call consults, arrange discharges
  - 7a – 7p: New admissions
  - 7p: Sign out to Nightfloat (under NO CIRCUMSTANCES are teams to stay late)

- **Admission Cap Overflow**: When a team has had 4 admissions (or 8 total admissions for both teams), the NP can then accept 2 overflow patients for that team (4 total overflow patients for both teams). With supervision from the Team Resident and the Dayfloat Resident, the NP will admit these patients. These overflow patients are to be co-managed by the NP and the Team Resident, or if that Resident is not available, then the Dayfloat Resident will assist the NP in managing these patients. These patients are held by the NP until a lighter admission day, when the NP and the Residents will then distribute the patients to the interns on that team. This distribution counts to that day’s cap.
• **NP-Managed Patients**: Although not required, the NP may carry 1-3 patients of their own that is staffed directly with the Attending. The 2 NPs have overlapping shifts that cover Monday through Friday. When one NP is off during the weekday, either the other NP or one of the interns will cross-cover those patients. The NPs will sign out to the interns for coverage over the weekend. On the weekend, Team 1 NP patients will be covered by Team 1 interns and Team 2 NP patients will be covered by Team 2 interns.

• **Team Cap Overflow**: When a floor team reaches 18 patients (totaed from the 2 interns and the 1 NP), then the Dayfloat and ICU/Cardiology Residents must meet to distribute some of the cardiology patients on the floor team to the ICU/Cardiology team, as long as that team has room to accept these patients.

• **Protected Educational Time**: Floor interns will be given one afternoon per week to either attend academic conference or use as educational time. This is in addition to the VA noon academic conferences. Internal Medicine Floor interns will be assigned Monday afternoons and Family Practice Floor interns are assigned either Tuesday or Wednesday afternoons. These interns are expected to leave after the VA noon academic conference. The team that is missing the interns will then utilize both NPs and the Dayfloat to assist with admissions and day to day patient care for the rest of that day. Dayfloat is expected to be present during attending rounds with the team that will be missing the interns in the afternoon.

• **Early Sign-out**: On weekdays when both floor teams cap early and both teams finish early, one team will stay until 7pm to sign-out to Night Float and the other team can sign-out to the team that is staying. Team 1 will be the cross-covering team for odd days, and Team 2 will be the cross-covering team for even days.

4. **ICU / Cardiology Schedule**:

• **Team Cap**: 12 patients (ICU patients and critically-ill cardiology patients)

• **Days Off**: Interns choose Saturday or Sunday, Resident picks a week day (typically Thursday or Friday)

• **Admission Cap**: 5 patients
  - Admission cap includes overnight patients, does not include transfers from floors
  - ICU boarders and stable telemetry patients can go to floor teams with appropriate consults

• **Transfers**: At the discretion of the fellow or attending, the ICU / Cardiology team may transfer 1 patient to each floor team that is admitting per day as long as that team’s census is 14 patients or less (census counted at 7pm the evening before). Thus, the maximum transfers are 2 per weekday, and 1 per weekend day. Transfers must occur by 7:30am and transfer orders and transfer summary must be completed before a floor team accepts a patient. The Floor Team will staff the patient with the Floor Attending the day of transfer. Intern bouncebacks can transfer at any time and do not count to transfer cap. There are no NP bouncebacks.

• **Patient Responsibility**: When there are two interns in the ICU during the week, each will be responsible for covering the other intern when he/she is off, is in clinic, or is at an academic conference. This includes writing notes and performing day to day patient care activities. If both interns are not available, then the resident is responsible for all patients on the service. If there is only one intern in the ICU during the week, then that intern and resident are responsible for all patients and should cross-cover each other when the other is not available. Use Dayfloat as an extra pair of hands, not as the primary caretaker.

• **Typical Time Schedule: Monday-Friday**

  7a – 8a: Accept signout, accept overnight admissions, preround on most pts
  8a – 9a: ICU Attending rounds and didactics
  9a – 9:15a: Discharge rounds with discharge planner
  9:15a – 10a: Continue pre-rounding on remaining cardiology patients
  10a – 11a: Cardiology Attending rounds and didactics
  11a: Get ICU / Cardiology Admission pager from Dayfloat on weekdays
  11a – 5:30p: New admissions, max of 5 new patients (includes overnight admits)
  5:30p – 7p: Finish work
  7p: Sign out to Nightfloat (under *NO CIRCUMSTANCES* are teams to stay late)

• **Typical Time Schedule: Saturday-Sunday**

  7a – 8a: Accept signout, accept overnight admissions, preround on most pts
  8a – 9a: ICU Attending rounds and didactics
  9a – 10a: Continue pre-rounding on remaining cardiology patients
  10a – 11a: Cardiology Attending rounds and didactics
  7a – 7p: New admissions, max of 5 new patients (includes overnight admits)
  7p: Sign out to Nightfloat (under *NO CIRCUMSTANCES* are teams to stay late)
• **Team Cap Overflow**: When the ICU team reaches 12 patients, then the Dayfloat and ICU/Cardiology Residents must meet to distribute some of the cardiology patients on the ICU/Cardiology team to either of the Floor Teams, as long as those teams have room to accept these patients.

• **Protected Educational Time**: If there are two ICU interns during the week, then each will be given a half day of protected educational time. This is in addition to the VA noon academic conferences. The Internal Medicine intern will be assigned Monday afternoons and the Family Practice intern will be assigned Wednesday afternoons. The Family Practice intern per FP Department policies will have clinic on Tuesday afternoons. These interns are expected to cross-cover each other when the other is not there. If there is only one ICU intern during the week, then there is no protected educational time.

5. **Dayfloat Schedule (Monday-Friday, no Dayfloat on Weekends):**

- **Responsibilities:**
  - Check for any overnight admissions with admissions office and floor clerks every day
  - Print out all of the IMSIGNOUT sheets to keep tabs on patient census
  - Do ICU/Cardiology admissions 7am – 11am and do Floor admissions 7am – 12pm
  - Act as first call screening hospitalist from 12pm – 5:30pm for Floor Teams, distributing these patients to the Floor Teams for admission; please screen the patients first before distribution
  - If teams are busy between 12pm – 5:30pm, please help the teams by doing H&P’s, orders, procedures, and discharges. If a team asks to help them, please help them.
  - Do Floor and ICU/Cardiology admissions from 5:30pm – 7pm
  - Help manage the NPs and their patients, help NPs with admissions, and help cross-cover NPs when they leave early in evening
  - Manage patient transfers from NPs to interns and from Floor Teams to Cardiology if caps are reached and patient volume is high
  - Cross-cover for residents at clinic or have a day off; interns still responsible for patients, but Dayfloat acts as extra help with admissions and patient care questions. Please be available for all intern or medical student questions.
  - If the ICU resident is off, the Dayfloat should carry the ICU admissions pager
  - Help to get all the teams out **ON TIME**: there should be **NO DOWN TIME** for the Dayfloat
  - Dayfloat **SHOULD NOT LEAVE** until the teams have all left

- **Typical Time Schedule: Monday-Friday**
  - 7a: Meet with all teams and help Night Float distribute overnight admissions
  - 7a – 11a: Does admissions for floor and ICU/Cardiology teams
  - 8a – 11a: To help the team that will have the interns missing in the afternoon for protected educational time, please round with the team during attending rounds.
  - 11a: Give ICU admissions pager to ICU resident, sign out ICU patients to ICU team
  - 11a – 12p: Continue admissions for Floor Teams
  - 12p: Distribute Floor Admissions to Floor Teams; Keep Floor Admissions pager
  - 12p – 5:30p: Cross-covers residents when at clinic or have a day off
  - 5:30p – 7p: Does admissions for floor and ICU/Cardiology teams
  - 7p: Notifies all teams of admissions from 5:30p – 7p, so they can pick up in a.m.
  - Assigns the admits to a specific floor team
  - These admissions count toward current day’s admission cap and not the next day’s cap
  - It is the job of the Dayfloat to stabilize and start admissions from 5:30-7p, and to complete them if time permits
  - Any remaining admissions not completed by Dayfloat is to be completed by Nightfloat
6. Nightfloat Schedule (*Monday-Friday, Weekends covered by ambulatory/consult resident pool*)

- **Responsibilities:** DO NOT LET ANY TEAM STAY LONGER THAN 7:30PM!!
  - Accept ALL sign out from all teams, cross-cover all academic patients, AND finish ALL work (except daily progress notes) not completed by the Day Teams during the day
  - Will do no admissions overnight EXCEPT those accepted by a Day Team and arriving in evening
  - **DO ALL ADMISSIONS** not completed by the teams or by Dayfloat
  - Check with ER frequently to see if they admitted any patients, to get signout on those patients, learn about the patients and distribute those patients to the Day Teams in the morning

- **Typical Time Schedule:**
  - 7p – 7:30p: - Accept signout from all teams, gets both admission pagers
  - 7:30p – 8p: - Go to ER to get sign out from attending on patients that need cross-cover
  - 7p – 7a: - Cross-cover all medical patients signed out by the academic teams
    - ER to do admissions overnight, but Night Float to cross-cover those patients
    - At midnight and 5-7 am, check with ER to see if they admitted any patients
    - Must do midnight rounds on all floors to check on patients
  - 7a: - Signout old patients to teams
    - Give both admission pagers to Day Float or to the teams admitting that day
    - Distribute new patients to the appropriate and proper teams

**B. Duty Hours:**
Maximum hours on a weekly basis:
- Floor Team interns: 5.5 days of work (66 hours), 1 day off, 0.5 days protected educational time.
- Floor Team residents: 6 days of work (72 hours), 1 day off.
- ICU/CCU interns: 5.5 days of work (66 hours), 1 day off, 0.5 days of protected educational time.
- ICU/CCU residents: 6 days of work (72 hours), 1 day off.
- Dayfloat residents: 5 days of work (60 hours), 2 days off.
- Nightfloat residents: 5 days of work (60 hours), 2 days off.

Days off and protected educational time (does not include noon conference) per 4 week block:
- Interns: 4 days off, 4 half-days of protected educational time
- Residents: 5 or 6 days off

**C. Pagers:**
Floor admission pager: 762-4136
ICU / Cardiology admission pager: 326-0937
Night Float will carry both pagers over night
Code pagers to be carried by ICU / Cardiology team

**D. Clinic Days/Protected Educational Time:**
These are pre-assigned, although the protected time can change if the need dictates. Please check amion and with the FP dept for cancellations and conflicts.

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### Week 2:
#### Family Practice
- ICU: FP MATI 1 CLINIC
- FPI 2 PM CLINIC
- FPI 1: PROTECTED TIME

#### Internal Medicine
- ALL INTERNAL MEDICINE RESIDENTS, REVIEW AMION FOR YOUR ASSIGNED CLINIC DAYS
- ALL INTERNAL MEDICINE INTERNS, REVIEW AMION FOR YOUR ASSIGNED CLINIC DAYS
- IM INTERNS: GO TO ACAD CONF

### Week 3:
#### Family Practice
- ICU: FP MATI 2 CLINIC
- FPI 2 PM CLINIC
- FPI 1: PROTECTED TIME

#### Internal Medicine
- ALL INTERNAL MEDICINE RESIDENTS, REVIEW AMION FOR YOUR ASSIGNED CLINIC DAYS
- ALL INTERNAL MEDICINE INTERNS, REVIEW AMION FOR YOUR ASSIGNED CLINIC DAYS
- IM INTERNS: GO TO ACAD CONF

### Week 4:
#### Family Practice
- ICU: FP MATI 2 CLINIC
- FPI 2 PM CLINIC
- FPI 1: PROTECTED TIME

#### Intern Switch
- FP MATI 2 & FPI 2: PROTECTED TIME

#### Internal Medicine
- ALL INTERNAL MEDICINE RESIDENTS, REVIEW AMION FOR YOUR ASSIGNED CLINIC DAYS
- ALL INTERNAL MEDICINE INTERNS, REVIEW AMION FOR YOUR ASSIGNED CLINIC DAYS
- IM INTERNS: GO TO ACAD CONF

### E. Specific Duties and Information

**MEDICAL RECORDS DOCUMENTATION:**

Residents will be responsible for timely, accurate, legible, and thorough medical record documentation upon admission, on a daily basis, and at discharge for all of their patients. Residents may type or dictate their admitting history and physical examination (STAT) and discharge summaries. Residents must sign all verbal orders within 24 hours. A list will be generated weekly for incomplete medical records and sent to the medical education offices for Family and Community Medicine and Internal Medicine. When notified of incomplete medical records, residents are to contact the medical records office at Sacramento VA to arrange a visit to complete these records as soon as possible. Alternatively, interns/residents can connect to the VA Computerized Patient Record System (CPRS) on the UC Davis campus via the “VA NCHCS” icon in HS Apps and from any computer by going to the website [https://www.enet.visn21.med.va.gov](https://www.enet.visn21.med.va.gov). When you arrive at the page for remote linking, you will be asked to log-on just as you would onto a VA computer. Then, double click on the icon for CPRS on the next page and enter your Username and Verify Code for CPRS as when physically present at the VA. Each intern/resident is responsible for signing his/her documents after leaving the VA rotation and will not be allowed to graduate from the program until all medical records have been cleared.
ADMISSIONS:
Admissions may come from:

1. **ER:** NPs, PAs and MDs will call you for admissions. If admission orders are not written within one hour from notification of admission, the ER physicians are allowed to write holding orders for transfer up to the floor in order to facilitate flow in the ER; or you may ask the ER physicians to write holding orders if you know you can’t get down there right away.

2. **Clinics:** PCPs and Subspecialty MDs will call you for direct admissions. These patients may be directly admitted to the floor, but if you are unsure how to triage severity of illness, send the patient to the ER and have the ER take vital signs and call you when the patient arrives.

3. **Transfers:** You may get calls from outside hospitals, surrounding VA clinics, or the CREC.

4. **General Medicine Consults:** These patients are to be staffed with the floor attending and you must write a full consult note. A consult counts as an admission. Please refer any cardiology or pulmonary consults directly to the cardiology or pulmonary fellow or attending even if overnight.

If you are unsure of how to triage or transfer a patient, please see Appendix B. There are phone numbers listed, a worksheet to help determine inpatient criteria and a summary on which patients would be appropriate for a TCU setting. Further questions are to be directed to the attending and if not available, then utilize the Chief Resident.

All admissions **must** first have a bed assigned to them; this is the responsibility of the outside person (ER MD, clinic MD, CREC MD, etc.) who calls you to admit the patient. If they have not secured a bed prior to calling you with the admission, please refer them to **BED CONTROL FIRST!** (Bed control on-call pager: 916-275-3073. Bed Control office: 1-6939.) Bed-control is available 24 hrs/day, 7 days/wk, so if there is no answer, try again.

TRANSFER PROTOCOL:

- See Appendix B for further help and guidance.
- For VA patients from outside hospitals, admits from surrounding VA clinics, or the CREC.
- **Physician-to-physician communication** to accept a patient should occur after Bed Control has determined bed availability. **IT IS NOT YOUR JOB TO DETERMINE BED AVAILABILITY. IT IS THE TRANSFERRING PHYSICIAN’S RESPONSIBILITY.** Bear in mind that the transferring physician is legally responsible for anything that happens en route. Nevertheless, do not be afraid to ask (in a cordial and professional manner) for more details about the patient’s history, laboratory, and vital signs. You may request that the transferring physician fax you documents before you accept the patient.

1. Transferring physician calls bed control to determine bed availability. Bed control contacts the resident to find out the current number of admissions and then calls the ER to determine the number of pending medicine admissions. (ER admissions take precedence OVER outside transfers.)
2. If a bed is available, but the teams have capped, the transfer will go to the ER attending to admit.
3. Bed control is responsible for communicating who the accepting physician will be (Resident vs. ER attending) to the transferring physician. Only then can the transferring physician contact the appropriate physician for the required doctor-to-doctor communication regarding the patient.
4. If you agree to accept the transfer, please communicate this back to bed control so they will continue to hold the bed.

- If you are uncomfortable with ANY transfer, ask your attending or fellow to speak to the outside attending. **All blocked admissions and diversions are tracked** and you will be called on it if it was an inappropriate diversion.
- **Certain services are not available at the Sacramento VA,** for example, neurosurgery, radiation oncology, peritoneal dialysis, after hours MRI and ultrasound, interventional cardiac catheterization, and open-heart surgery.
- All transfers accepted to MSU must first go through the ER to determine stability prior to floor transfer (vital signs, etc). This does not mean a “full work-up”. Transfer patients accepted to the ICU can be directly transferred to their assigned bed.
- If you accept a transfer and it has not arrived, sign out the patient to the Nightfloat Resident who will then admit the patient for you. You will pick the patient up in the morning. This patient will count to the current day’s cap and not the next day’s cap. If you wish, you may also negotiate with the ER to take your transfer if you wish to admit an ER patient instead.
ADMISSIONS TO CCU AND ICU:
- Notify pulmonary/critical care fellow of all ICU admissions.
- Notify cardiology fellow of all CCU admits until 5 PM (unless otherwise instructed by the fellow). Call cardiology attending or UCDMC CCU fellow after 5 PM, depending on the call schedule.

PATIENT FLOW AND DISCHARGES:
- **Patient Flow and Timing of Discharges:**
  - It is your responsibility to identify patients on pre-rounds who can be transferred to a lower level of care or be discharged. These patients should be discussed as a priority on attending rounds. Some patients may be able to go from the ICU or CCU to the MSU without having to spend time in the telemetry unit.
  - It is our goal to initiate transfers and discharges as early as possible.
  - Please try to determine possible discharges the evening before; have a plan (i.e. follow-up, discharge med list) ready. Utilize the NP to help you with discharges. To facilitate discharges, make sure orders are written by 10:00 a.m. so that the nurses, pharmacists and social workers have time to meet with the patient.
  - If you need them, the pharmacists will round with the teams in the morning to help with medication reconciliation before discharge.

- **ER Discharges:** Before you discharge a patient from the ER, you must present the patient to your attending and if your attending is agreeable, then you can discharge the patient from the ER. You must still write a note, have your attending co-sign that note, and your attending will still need to write his/her own note.

- **Ancillary Services:**
  - If any patient has special needs upon discharge, please mention these during interdisciplinary rounds.
  - Recruit the help of the Discharge Planner and Social Worker quickly to help coordinate services.
  - Home oxygen therapy, CPAP/BiPAP requires certain forms and will take at least 24 hours to complete.
  - Physical therapy deals with ambulation and devices to aid in ambulation.
  - Occupational therapy deals with Activities of Daily Living and seating devices.
  - Home health care, SNF’s and the CREC require specific information, so inquire early.

- **Pharmacy:** Please write discharge medications the day before anticipated discharge, especially when discharging patients on a weekend or holiday, so that pharmacy will have ample time to fill the prescriptions and so that patients are more likely to be discharged in the morning (this is especially important in those for whom we have to provide transportation back home). Discharge medications should be entered in the computer, but controlled substances would need to be written on a VA prescription pad.

- **SNF or CREC:** For discharges to a skilled nursing facility or CREC, dictate or write the discharge summary STAT so that it is available at the time of discharge/transfer. The CREC can and will refuse patients without a transfer summary.

- **Home Based Primary Care:** The VA has a home care service called Home Based Primary Care (HBPC). They are a small department but they see veterans with VA-only insurance. Patients with Medicare or another HMO should not be referred to HBPC, unless they are frail elderly patients who will need an intensive in-home interdisciplinary team geriatric evaluation, and palliative care/hospice patients. The HBPC will consult on palliative care patients before discharge to make sure that all medications and supplies are ordered before the patient goes home. Contact the HBPC office at 561-7520, or call the Site Manager Janelle Culjis at 240-4611 or the Physician Cynthia Alli at 240-4613. Do not send a computer consult to HBPC without consulting with the in-patient social worker or HBPC staff member to make sure that there is an opening on the HBPC service for the patient and that the patient is appropriate for HBPC.

CODE BLUES:
- The ICU team runs the code.
- If during the day, a cardiology attending or ER attending should be present (they are on the code team, plus a cardiology or pulmonary fellow, and RT). After 5 PM, it’s the ER MD.
- ICU resident carries the CODE PAGER. In the morning, that pager is recharged while the ICU resident takes the other pager (which was charged overnight). There are 2, one on a body, the other being charged.

AUTOPSIES:
We are having a national crisis; up to 24-27% of our diagnoses are incorrect. Please request autopsy WITH ALL DEATHS!!! Vets do not have to pay for autopsies. Autopsy results return to your e-inbox as a View Alert.
CONSULTS:

• The Call schedule is available online. Go to VA Intranet icon on the desktop, then click call schedules for medicine, surgery, and sub-specialty consults.

• **All Consults should be called/paged AND also be entered into the computer.**

• Nephrology Consults: Call nephrology on ALL DIALYSIS PATIENTS when they are admitted!! (Even if they don’t need urgent dialysis, so nephrology can plan their dialysis schedule accordingly). There are no PD capabilities here at the VA, so patients should not be admitted if they need peritoneal dialysis.

• GI Consults: GI pagers may not work in the GI lab, so go downstairs and find the fellow directly or call the GI lab: 366-5339.

• IVC Filters: Requires a consult to Dr. Eugene S. Lee, of vascular surgery, NOT to IR.

• STAT Radiology: Requires an order plus a call down to radiology so that they know about the patient.

• Social Work: Please specify type of service or rehab and any IV meds with length and duration. Consults take 24-48 hrs to complete. Substance abuse and detox consults go to Mental Health.

ORDERS, LABS & NOTES:

• Please put the **CORRECT** attending’s name on the orders and ALL notes (very important, so that the right attending gets the H&P, progress notes, D/C summary to co-sign).

• H&Ps dictated STAT may not return within one day. Dictations are only done M-F, 8-5 pm. If you dictate the H&P, please write a brief note in computer for cross-cover purposes. D/C summary should be dictated as per JCAHO, that is, no abbreviations are allowed. Always record job numbers in a progress note! By the way, dictations done on the weekends will not show up until the weekday.

• There are 2 scheduled lab draws per day: 6am and 2:30pm. For routine morning labs, order as “**Lab Collect**”. For labs to be drawn by the nurses, order as “**Ward Collect**”. Labs ordered in the TCU and ICU should always be “**Ward Collect**”. Group labs together so that your patient is not continually being stuck. If a lab is not “life and death or urgent”, then “**Lab Collect**” is usually sufficient.

• If a patient is transferred from the floor to the ICU and your initial orders were designated for the floor, then these orders will NOT be carried out since the ICU nurses do NOT have access to these orders, and vice versa. The lab orders must be rewritten.

  HINT: Always check your orders after transferring patients from ICU to the floor—some orders may not be carried over!!

• **DNR Orders:** These orders must be signed by your attending within 24 hours, otherwise it is INVALID. Please write DNR progress notes separately from the H&P, i.e. there is a separate form for this.

• **ACS Note/Order set:** If you are admitting a “Rule out ACS” patient, please use the ACS Note with the accompanying order set. Do not start the orders until you have the clerk change the patient to “Admit” status, otherwise your orders will be erased.

• **Transfer Note:** Please use the note titled “Transfer note” when transferring patients between levels of care (i.e. MSU → TCU → ICU, or if there is a change of attending). Also make sure you and the attendings (accepting and receiving) all document that this transfer of care was discussed.

• **Discharge note & Discharge summary:** This is required for all patients. Discharge note are the discharge instructions to the patient so please write in plain language. Discharge summary is the summary of the hospitalization and is a REQUIRED part of the chart. You have 48 hours to complete the discharge summary.

• **Instructions for Admission Referrals to the CREC Subacute Care Program:**

  In CPRS: Enter a GEC referral note

  Please note:

  1) referral to “x” (includes adult day health care, HBPC, CREC, SNF)
  2) identify additional signers: unit RN/RN manager, Social Worker
  3) goals of care
  4) estimated duration of service

PICC LINES:

Eventually, the NP’s will be trained in PICC line placement. Until then, PICC lines are placed by an RN who has other responsibilities, so plan ahead if you need a PICC, since it may not be done the same day. If the PICC RN is not available, and you need an urgent PICC, talk to SW and the charge RN to arrange for an outside agency to place the PICC. The VA has a contract with River City Pharmacy to place PICC lines.
PROCEDURES/INFORMED CONSENTS:
• Informed consent is needed for emergent or any bedside procedures, and must be signed by at least one provider and one witness. These are now done on the computer through CPRS.  
  Go to “Tools” in CPRS on one of the mobile computers with a signature pad.  
  Click on iMed Consent.  
  Choose the type of procedure and follow the prompts.  
  You, the patient/representative, and a witness must all sign the consent.  
• Informed consent is needed for blood transfusions as well.  
• Per JCAHO rules you must take and document a “time out” in your procedure note.  
  (i.e. Document that “Time out: The (procedure) is being done on (Patient Name and ID #) on (Site/side).”

RADIOLOGY:
• An x-ray tech is in the hospital until midnight on weekdays.  
• On weekends, the x-ray tech is available until 5 PM, then on-call from home after 5 PM.  
• No ultrasound/MRI is available after hours, CT is available 24/7.  
• STAT radiology: please call radiology & let them know you are sending a STAT order or they might be missed.  
• After-hours/weekend Radiology: Read by David Grant/Travis radiology. Call them prior to ordering the study to make sure you are ordering the correct study and to alert them that you will need a reading: (707) 423-7300 or (707) 434-5989. Most CT scans are read overnight and on the weekends, so please wait for the preliminary read to enter the memos section of stentor before calling for a read. If overnight or on the weekends, a read for a non-CT scan is urgently needed and it cannot wait until the morning, the radiology residents have been instructed to help to insure patient safety.  
• IR needs an order (e.g., fluoroscopy guided needle placement) and a call for a consult to the IR attending.  
• If IR at the Sac VA is not available because the attendings are on leave, patients can be temporarily transferred to David Grant for their procedures and then transferred back.

INCIDENT REPORTS:
• Please document all incident reports with a chief resident, MD staff, nursing staff, PT/OT, or Social work. This is a VITAL part of making personnel and system improvements.  
• Be consistent, detailed, and thorough in your documentation. Include patient name and MRN. List specific details of the event or events, if possible.  
• Incident Reports are now done through CPRS, under the Tools menu. Or contact the Chief Resident or Pat Penn, Quality Coordinator at the VA (office 843-7156, pager 854-1032).  
• You may also use “e-value.net” and enter a concern card.

VACCINATIONS:
Please evaluate patients to see if they are candidates for influenza and/or pneumococcal vaccinations at discharge. Do not administer in patients who are allergic to any component of the vaccines (e.g., influenza vaccines have egg components in it), or who are acutely ill or decompensating.

MISCELLANEOUS:
• Food: Canteen no longer provides trays. Instead, you get weekly food vouchers that are good at the canteen.  
• Call rooms: On third floor with lockers and a computer. Door code: 253.  
• Telephones: Please do NOT page to a 4 digit number starting with “6”, this is for in-house calls ONLY. The resident workroom number is 843-7266 and this CAN be reached from the outside. Calling 843-7xxx or 366-5xxx is acceptable for outside calls. For in-house calls, this can be dialed as 1-7xxx or 1-5xxx.  
• Long-distance phone calls: Must use your calling PIN to make long distance calls. To get forgotten PIN numbers, call Lori Hammet at 350-2005 (in-house) or 925-372-2005 (outside the hospital). In a pinch, call the operator and ask them to connect you.  
• Physician Workroom: Door code: 415. PLEASE help keep this room clean, since housekeeping does not clean the room other than emptying the trash and occasional vacuuming.  
• HIPAA/Patient confidentiality: Please do not leave patient information scattered out on the desks, etc. in the physician workroom, or discard it in regular trash cans. Please use the documents-for-shredding box.
COMPUTERS & DOCUMENTATION:
The majority of the laboratory data, radiology reports, procedure reports, and prior discharge summaries are available via the CPRS computer database. Additional clinic notes and EKGs are available via Deliverex (a web-based program that allows access to individual paper medical records that have been scanned into the system). Individual computer codes for each resident will be available the first day of the rotation, and a computer in-service will be provided. The hospital formulary is available in the Vista/CHCS computer system if you enter “^drug” after any prompt.

- **Lourdes Cintron** is the CPRS computer orientation person. Contact her or the helpdesk with any issues.
- VISTA imaging display (in the “Tools” section of CPRS) will allow access to old ECGs online. Learn about this during your computer orientation.
- Please sign ALL notes in a timely fashion and prior to leaving the rotation, otherwise medical records will force you to come back to the hospital and sign (unless you have Citrix at home and can log-on to the VA remotely).
- Medical students may not dictate or write H&Ps or D/C Summaries, but all other notes can be done. The resident or attending (i.e. anyone with a medical license) must co-sign these notes and are still responsible for their own notes.
- **To access CPRS remotely:** [https://www.enet.visn21.med.va.gov/Citrix/MetaFrame/auth/login.aspx](https://www.enet.visn21.med.va.gov/Citrix/MetaFrame/auth/login.aspx)
- **Phone Directory:** Go to VA intranet page ➔ Phone Directory

SETTING UP COMPUTER PASSWORDS:
To set-up computer access code (to log-on to a VA computer or to log-into the VA Citrix remotely):
- All codes start as “vhamac” …. then first 5 letters of last name and first initial
- For password- first time type: Pa$$word or whatever they assign you
- Will prompt for a new password (at least 8 characters with at least 1 upper case, number, & symbol)

To set-up CPRS password and verify codes:
- Go to VISTA: you must set up in VISTA first before CPRS
- Type in access code (first 2 letters of last name, then first 2 of first name, then first 4 SS#)
- Hit return (maybe several times)
- Will prompt you to make-up verify code (Follow directions carefully)
- Verify code is at least 8 characters with at least 1 upper case, number, & symbol)
- Should prompt you to make signature code (Usually have to use caps and can be anything, like your name)

STAFF & ADMINISTRATION:
Chief Resident: Quy Tran (762-9242)
Lynette Tanner: 843-7096
Anthony Albanese: Program Director
David Siegel: Chief of Medicine
Nurse Practitioners: Curtis Jones (916) 326-7966
Mark Ahmed (916) 326-7438
Lourdes Cintron: computer orientation & CPRS help, office 366-5313, cell 826-3789,
Bed-control: pager: 275-3073, office: 1-6939
Pat Penn: processes INCIDENT REPORTS, office 843-7156, pager 854-1032
Nursing Supervisors:
  - Francisco Hurtado (Urgicenter)
  - Sandra Washington (MSU): 16329
  - Nina Edralin (ICU)
  - Mary-Ann Ramos Ripley (TCU)
Social Worker/Discharge Planning:
  - Inpatient: Darina Hul: 843-7226 -OR- Gloria Salter: 843-9413
  - Homeless veterans: Reed Walker-Haight: 843-9090
Urgicenter: 366-5406
Resident Physician Room: 843-7266
Computer Help desk: 350-2101 (direct line from hospital—don’t need to dial 9 first),
  1-800-416-5223 (available 24/7) or 925-372-2101
APPENDIX A

ER and RN Flyers
MSU and stable TCU admissions for a Floor Team
FLOOR ADMISSION PAGER IS 762-4136

7am – 7pm: Call 762-4136 for up to 8 admissions

**MONDAY-FRIDAY ONLY**: If the teams cap and if the NPs are available, each one can take up to 2 additional admissions (max 4 total for the two NPs)

7pm – 7am: ER does all admissions, but page 762-4136 to cross-cover those patients that move from the ER to the floor

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ICU, CCU, and sick cardiology TCU admissions for the ICU Team
ICU / CARDIOLOGY ADMISSION PAGER IS 326-0937

7am – 7pm: Call 326-0937 for up to 5 admissions

7pm – 7am: ER does all admissions, but page 326-0937 to cross-cover those patients that move from the ER to the ICU / CCU

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For admissions that the ER does, the ER is not to call the residents to cross-cover until the patient has left the ER and is physically on the floor or in the ICU.

If the day teams and the NPs are capped, the ER does further admissions and signs out those patients to either Dayfloat or Nightfloat for distribution to the teams.
DO NOT CALL OR PAGE BETWEEN 9 – 11 A.M. UNLESS IT IS URGENT OR LIFE THREATENING. THE TEAMS ARE IN ATTENDING ROUNDS AND ARE MAKING PATIENT CARE DECISIONS.

FLOOR TEAMS

- How to find the admitting MD for MSU and TCU Admissions (7 days/week):
  Page 762-4136

- How to find the cross-cover for currently admitted patients:
  Step 1: Check the orders for team assignment of the patient. It will be:
  - Team 1, with Intern A or Intern B, or
  - Team 2, with Intern A or Intern B

  Step 2: This is the schedule for both floor teams (7 days/week):
  - 7am – 7pm: Page Intern A or Intern B, if unavailable, call Resident
  - 7pm – 7am: Page 762-4136

ICU / CARDIOLOGY TEAM

- How to find the admitting MD for ICU and Cardiology admissions (7 days/week):
  7am – 7pm: Page 326-0937
  7pm – 7am: Call Urgi-center or Page 326-0937

- How to find the cross-cover for currently admitted patients (7 days/week):
  7am – 7pm: Page ICU Intern, if unavailable, call ICU Resident
  7pm – 7am: Page 326-0937
APPENDIX B

Phone Numbers for Transfers

Admission Screening Guide

TCU Guidelines

CREC Guidelines
PHONE NUMBERS FOR INPATIENT/OUTPATIENT TRANSFERS TO VAMCs

FRESNO
- UTILIZATION REVIEW QUALITY MANAGEMENT
  - JACK ALLEN  559 225-6100 X5186
  - JUDY BISHOP  559 225-6100 X5234
- EMERGENCY  559 225-6100 X422
- TELEPHONE CARE  559 225-6933 (AFTER 4 PM)

FALCONALTO
- TRANSFER COORDINATORS
  - SAM DELLICRUZ  650 498-2191
  - JOANNE RENAN  650 498-2191
  - MARK METAL  650 498-2191
  - ACO  650 493-5900 X65865 (AFTER 5PM)

RENO
- TRANSFER COORDINATOR
  - CHARLES NURSE  775 321-1494
  - AS FOR charge nurse AFTER 4PM

SAN FRANCISCO
- ADMISSSION
  - 415 750-2452
- TRANSFER COORDINATOR
  - 415 221-4410 ext 4310
  - Hours: 0800—1630

PHONE NUMBERS FOR INPATIENT & OUTPATIENT TRANSFERS TO CONTRACT HOSPITALS

UCMC
- CHIEF OF STAFF (COS)  707 420-7746 PAGER

UC DAVIS MEDICAL CENTER
- TRANSFER CENTER (CALL FIRST)  916 734-8200
- PHYSICIAN REFERRAL CENTER  800 482-3284 800 348-0499 FAX
INPATIENT/OUTPATIENT TRANSFERS TO NON-VA FACILITIES

KAISER PERMANENTE
**MUST HAVE KAISER BENEFITS**
- EMERGENCY ROOM PHYSICIAN REFERRAL
- TRANSFER COORDINATOR 1 800 447-3777

MERCY GENERAL HOSPITAL
- TRIAGE NURSE (NON-FRI) 7AM-7PM 916 453-4433 OR
  PAGE 916 523-9599
- HOUSE SUPERVISOR (AFTER HOURS & WEEKENDS)
  PAGE 916 523-9599

MERCY HOSPITAL OF FOLSOM
- MANAGER OF THE DAY 9AM-5PM 916 982-7470 (ER)
- HOUSE SUPERVISOR 5PM-8AM 916 982-7470 (ER)

MERCY SAN JUAN HOSPITAL
**MUST HAVE AN ACCEPTING PHYSICIAN BEFORE CONTACTING**
- PATIENT REGISTRATION & ADMISSSIONS
  CLOSER (MON-FRI) 7AM-3PM; SAT 7AM-430PM 916 537-5076
  - AFTFR HOURS AND SUNDAY
    PAGE 916 537-5076

METHODIST HOSPITAL OF SACRAMENTO
**MUST HAVE ACCEPTING PHYSICIAN**
- ADMISSIONS 916 423-6193

SUTTER GENERAL HOSPITAL
**MUST HAVE ACCEPTING PHYSICIAN**
- BED CONTROL 916 733-3900

SUTTER MEMORIAL HOSPITAL
**MUST HAVE ACCEPTING PHYSICIAN**
- BED CONTROL 916 733-3900

SUTTER PSYCHIATRY
**NO CONTRACT WITH VA.WILL ACCEPT VETS WITH PRIVATE HEALTH INSURANCE ONLY**
- ADMISSIONS 916 388-3711 OR 800 891-3711

SUTTER ROSEVILLE HOSPITAL
**MUST HAVE ACCEPTING PHYSICIAN**
- NURSING SUPERVISOR/DISCHARGE PLANNER 916 781-1000

Residents
Transfer/Admission Binder located on each Unit

Transfer (Hospital to Hospital) to/from SVAMC: Business Hours (800 – 1930)
- Transfer Coordinator: 916 342-7625 (800 – 1930)
- Admissions Page (916) 558-4334 (1000 – 1930)
- Off Hours: (M-F 1930 – 800, Weekends & Holidays)
  - Call MAS (916) 366-3400

Admission to SVAMC:
- Business Hours: Monday – Friday 800 – 1930
  - Contact Admissions Page (916) 558-4334
  - Off Hours: (M-F 1930 – 800, Weekends & Holidays)
  - Call MAS (916) 366-3400

- Patient Information Needed – Appendix E
- ICU/ICU patients are admitted directly to the unit
- MSU – Patients are triaged to Urgent Care (UC) and then admitted to the MSU (if stable).
  - Unstable patients will be stabilized prior to admission.
- SVAMC O/C may be admitted directly to the MSU.
  - If the patient is deemed unstable, they will be admitted directly to the MSU.
  - Direct patients to go to the Admissions Office to complete paperwork.
  - McCallen patients must stop at the Admissions Office.

Admission Criteria:
- ICU: requires continuous as well as invasive monitoring, needs nursing interventions q 1-2 hours
- TCU: needs nursing interventions q 2-4 hours, hemodynamically unstable, may or may not need continuous cardiac monitoring
- MSU: needs nursing interventions q 4-8 hours, IV medications requiring hospitalization for initial therapy as per SVAMC hospital policy
- Chest X-rays and monitoring, procedures requiring intubation and hospitalization
- OBS: Diagnosis, treatment, stabilization & Discharge reasonably expected within 24 hours

Transfers to another facility:
- Critical patients (IV drip, ventilators, intubations): Use critical care transport
- Call Nurse Supervisor or MAS: Order of hospital consideration depending on patient stability
  - VAMC: (714) 486-3000
  - DAV (Travis Air Force Base): (707) 637-2430
  - UC Davis (all locations except VA): (916) 279-4200
  - Community (Kaiser, Mercy, Sutter) Requires MD to MD contract

Transferring Resident is responsible for completion of the following:
- Transfers from yellow: see Binder & complete
- High risk items
- Transfer summary
**VA Northern California Health Care System**

**Marina, California**

**Attachment A**

**Policy Statement PS 11-21**

**September 10, 2001**

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### PRE-ADMISSION SCREENING FOR APPROPRIATE LEVEL OF CARE

**I. Provider completing screen:**
- Date:
- Requested Admission Date:
- Procedure:
- Critical Meta V 5 (see page 2 of Meta)

**II. SEVERITY OF ILLNESS**

- Acute onset pain unassociated with evacuation
- Increased respiration
- Uncontrolled hypertension
- Uncontrolled bleeding (specify location, blood loss)
- Urinary or fecal incontinence
- Extremity edema
- Diarrhea
- Dehydration
- Fever
- No change in mental status
- New abnormal findings
- New abnormal laboratory findings
- New abnormal EKG changes
- New abnormal physical examination
- New evidence of acute illness
- New abnormal vital signs
- Abnormal vital signs
- New evidence of acute illness
- New abnormal physical examination
- New abnormal laboratory findings
- New abnormal EKG changes
- Known compliance issues
- Renal dysfunction
- Renal failure
- Liver failure
- Diabetes
- Heart failure
- CHF
- COPD
- Pneumonia
- Other
- Seizure disorder
- Psychosis
- Schizophrenia
- Depression
- Other
- Allergies to medication
- Known drug allergies
- Recent surgery
- Recent infection
- Other
- Previous hospitalization
- Recent hospitalization
- Other
- Other
- Other

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### REFERRING PROVIDER COMPLETE—VA

**A. RATIONALE FOR ADMISSION PER REFERRING PROVIDER:**

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**Provider Signature**
TRANSPORTABLE CARE UNIT
Admission Policy

1. Purpose: To establish guidelines for transfer or admission to the Transportable Care Unit (TCU) in accordance with the scope of care for the mission of this unit.

2. Scope of Care: The unit consists of four beds, with cardiac telemetry monitoring available to all beds, for the care of medical, surgical, and cardiac patients requiring an intermediate level of care between intensive care and the medical-surgical unit.

3. Policy: A physician's order is necessary for admission or transfer into the TCU. Any patient is admitted to the unit. Written orders are required to accompany any patients admitted to the unit, or admitting physician must accompany the patient. Physician Order Form must be filled out and accompany the patient.

4. Admissions: The physician will assess the need for care in the TCU. If there is a question or concern regarding the admission, the admitting physician will consult with the Chief of TCU, Dr. Adams, or his designee.

   a. The admitting physician will communicate with the charge nurse regarding bed availability prior to the admission.

   b. Written orders must accompany the patient on admission.

   c. Admission criteria may include, but are not limited to the following:

      (1) Patients who need cardiac monitoring for any reason.

      (2) Stable, non-ICU patients who need frequent (q1-2h) neurovascular, hemodynamic or airway monitoring and management.

      (3) Patients who are hemodynamically unstable who need monitoring more frequently than every 4 hours for an extended period. Examples include:

          a. Patients with severe infections that could result in instability.

          b. Patients who have had an invasive procedure with or without conscious sedation that may not meet postprocedure discharge criteria with a transient episode of hypertension.

5. Special Circumstances

   a. Intravenous Infusions

      Although the TCU is not capable of providing the hemodynamically unstable patient, or patients with significant dysrhythmias, there are instances when stable patients may benefit from the following continuous intravenous medications and the patient does not require Intensive Care Unit (ICU) level care:

      (1) Lidocaine no greater than (2 mg/min)

      (2) Propanolol (2 mg/min)

      (3) Dobutamine (>10 mcg/kg/min)
We can accommodate the following patients on a case-by-case basis with the following guidelines:

1. No patient will be admitted to the TCU who has just been, or is to be, started on Dobutamine, Prostacyclin or Lidozone drip. These medications will be permitted after being on an established stable dose for 24 hours.

2. The patient must be on a stable dose of the infusion without complication over a 24 hour period.

3. Drug dosage, concentration and volume of infusion must be written (e.g. mcg/kg/min) in the physician's orders.

4. Continuous infusions can be titrated down or off, but not increased.

Admission of stable patients who have continuous IV infusion such as Heparin, renal dose Dopamine (<5.5 mcg/kg/min) Aminophylline, Lasix and Ranitidine who are on telemetry and do not require ICU care are acceptable. Medications may be titrated to effect as ordered by the physician.

6. Diagnosis/Conditions not Permitted in TCU:

   a. High risk R/O MI: Patients who experience one or more of the following signs and symptoms:

      (1) Protracted recurrent chest pain.

      (2) Syncope associated with chest pain.

      (3) Hypertension >180 Hypotension <90.

      (4) Significant left ventricular failure severe CHF.

      (5) A "positive EKG" defined as new pathologic Q-wave.

      (6) Significant (1mm) ST segment elevation or depression.

      (7) T-wave inversion.

      (8) Left BBB.

      (9) Observed high degree heart block, 2nd degree or 3rd degree.

      (10) Frequent multifocal PVC's/complexes.

      (11) Ventricular tachycardia or ventricular fibrillation for > 4 hours (heart rate > 120).

   b. Patients with life-threatening dysrhythmias, or patient with poorly controlled ventricular response.
CENTER FOR REHABILITATION AND EXTENDED CARE

1. PURPOSE
To define the VA Northern California Health Care System (VANCHCS) Center for Rehabilitation and Extended Care (CREC) program.

2. MISSION
The mission of the Center for Rehabilitation and Extended Care Program (CREC) is:

a. Compassionate interdisciplinary healthcare management and rehabilitation;
b. Administrative process to enhance patient access to the delivery of health care;
c. Research and development of optimum performance and outcomes of health delivery and;
d. Education of patient, family, and staff to promote health and improve quality of life.

3. POLICY
The CREC will provide patient care and services to enhance quality care and promote interdisciplinary relationships.

4. SCOPE
a. The Northern California Health Care System (VANCHCS) CREC is a 125-bed skilled nursing care facility providing rehabilitation, transitional long term care, palliative care, and respite care to eligible veterans throughout Northern California. Additionally, efficient and effective care may be provided for these ambulatory care patients who have had a surgical or diagnostic procedure or treatment and require observation for 23 hours or less.
b. The CREC offers five (5) patient programs. Each patient program has an assigned Physician Manager and Nurse Manager who are responsible for the development and implementation of the plan of care based upon patient and family assessments and identified needs. The programs are:

   (1) Extended Care (Long Term Care) Program;
   (a) Long Term Care is provided in a skilled unit specializing in rehabilitation and restorative care for an average period of 6 months length of stay (LOS).

   (2) Respite Care;
   (a) Respite care is provided as a short stay program for patients who live at home with a caregiver. This program is structured to provide the primary caregiver health education and a period of relief for up to 45 intermittent days per year.

   (3) Transitional Care (Sub-Acute) Program:
   (a) Transitional Care: This is a time limited program (up to 90 days), for patients who require less than an acute hospital setting, but need skilled nursing care in an interim setting before discharge home.

   (4) Palliative Care:

   (5) Neurodegenerative Care:

   c. Provides care, treatment, and rehabilitation of patients with cognitive deficits due to neurologic dysfunction for 6 to 90 days.

   d. Services available in the CREC:

   (1) Ambulatory/Observation (23-hour stay)
   (2) Medical Care
   (3) Nursing Care
   (4) Rehabilitation medicine, occupational, physical and recreational therapy
   (5) Audiology and Speech Pathology
   (6) Social Work Service
   (7) Nutritional Service
   (8) Pharmacy Service
   (9) Dental Care

   e. Services available in the CREC:

   (1) Radiology
   (2) Ultrasound
   (3) Cardiology
   (4) Respiratory Therapy

   f. Services available in the CREC:

   (1) Endoscopic biopsy
   (2) Chemoembolization
   (3) Percutaneous biopsy

   g. Services available in the CREC:

   (1) Hemodialysis
   (2) Nephrostomy
   (3) Peritoneal dialysis

   h. Services available in the CREC:

   (1) Transplantation
   (2) Chemotherapy
   (3) Radiation therapy

5. RESPONSIBILITIES

a. The CREC Director is responsible for all programs and activities within the CREC system.

b. The Director of the CREC is the approving authority for recommendations which impact the CREC policies, procedures, programs, and operations. The Director of the CREC also functions as a representative of the VANCHCS governing body. The Director receives reports and recommendations concerning the performance improvement activities of the CREC on a regular basis. The CREC Director reports to the Chief of Staff.
b. Criteria for Admission: Each program has specific admission, discharge, and continued stay criteria as indicated in Attachments A-E.

7. REVISION

8. REFERENCES
IACACEP Comprehensive Accreditation Manual for Long-Term Care Manual, current edition
IACACEP Comprehensive Accreditation Manual for Sub-Acute Care, current edition

9. BIENIAL REVIEW, RESCISSION OR REISSUE DATE
Nursing Service (CREC 11) will review this policy for rescission or reissue within two years of the date of issue.

Brian J. O'Neill, M.D.
Acting Director

Attachments

Distribution: C