

ZSFG JOINT CONFERENCE COMMITTEE MEETING

January 27, 2025

MEDICAL STAFF Report

Contents:

1. Chief of Staff Report
2. Chief of Staff Action List
 - a. Dermatology Rules & Regulations
 - b. Privileges Lists/Standardized Procedures
 - Department of Medicine Standardized Procedures
 - Department of Medicine/Pulmonary Medicine Standardized Procedures
 - RTC-CASARC Rape Treatment Center (RTC)/Trauma Recovery Center (TRC) and Child and Adolescent Support, Advocacy and Resource Center (CASARC) ZSFG Department of Psychiatry CPC NP/PA Standardized Procedure
 - CPC NP/PA Standardized Procedure
 - AFF Optometry Privilege Form
 - Sleep Medicine Privileges
3. Dermatology Biennial Service Report

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on January 27, 2025
January 2025 MEC Meetings

DERMATOLOGY CLINICAL SERVICE REPORTS: Erin Amerson, MD

The highlights of the Dermatology report are as follows:

- I. Scope of Clinical Service- Dermatology offers a full range of services, including clinics, inpatient consults, tele-dermatology, and specialty services like phototherapy and HIV dermatology.
 - a) Scope of Clinical Service-Adult Medical Dermatology- Wd 92, LHH, Pediatric Dermatology- 6M, Surgical Dermatology, Laser- Wd 92, B5, HIV Dermatology- Wd 86, Dermatopathology, Inpatient Consultation Service, Teledermatology e-consult service, Specialty Clinics (Rheum/Derm, Hidradenitis, Hair, Pigmentary disorders- Wd 92) and Phototherapy- Wd 92
 - b) Services Volume-The service is extremely busy, with a 20% increase in patient volumes since 2023, now managing over 5,400 patient visits annually. The Outpatient Adult Dermatology Clinic handles an average of 450 patients per month (5,400 annually), with 95% of visits conducted in-person and 5% via telephone or video. E-Consults average 550 per month (6,600 annually), reflecting a 20% increase from four years ago. Additionally, the service manages 35 surgeries, 45 pediatric dermatology visits, 25 hospital consults, 16 visits to Laguna Honda, 60 dermatopathology cases, and 110 phototherapy visits monthly.
 - c) Dermatology E-Consults have exceeded 5,000 annually since the implementation of Epic, with approximately 60% involving virtual co-management. This has led to a 25% increase in the total number of patients managed or co-managed by dermatology, significantly improving access to care, thereby enhancing efficiency. A cost analysis revealed savings of \$140 per new patient referral.
- II. Leadership and Faculty
 - a) The service is led by Division Chief and Medical Director Eric Amerson, MD, with Kieron Leslie, MD, serving as Assistant Chief Director of HIV Dermatology. Herbert Castillo-Valladares, MD, oversees the Inpatient Consult Service as its Director, while Aileen Chang, MD, leads as the Director of Research. Dan Klufas, MD, focuses on ensuring excellence as the Director of Dermatologic Surgery Quality and Safety. Sarah Coates, MD, serves as the Director of Pediatric Dermatology, and Carlo De La Sancha Verduzco, MD, specializes in Dermatopathology.
 - b) Faculty- The faculty members in the dermatology department specialize in various areas of expertise. In Adult Medical Dermatology, Robert Ricardo-Gonzalez, MD, PhD, and Marlys Fassett, MD, PhD, lead with their extensive knowledge. Joanna Tu, MD, focuses on Pediatric Dermatology, while Haley Naik, MD, specializes in Hidradenitis. Amit Pandaya, MD, is an expert in Pigmentary conditions, and Paradi Mirmirani, MD, brings her specialization in Hair-related dermatological issues.
 - c) Administrative Staff and Support Staff- The administrative staff includes Mounira Kenaani, UCSF Department Manager; Emily Leang, ZSFG Division Manager; Sheri Sanders, Administrative Assistant; and Yanel Hernandez, MS4, who serves as a Patient Navigator and QI Analyst. The support staff is led by Ward 92 Nurse Manager Charles Bellah, RN, and includes two part-time RNs, three Medical Assistant Externs (MEAs), one MEA dedicated to phototherapy, and three clerks.
- III. Training Program
 - a) The UCSF Dermatology Training Program for 2024-2025 is dedicated to training a diverse group of dermatology residents who value the unique clinical opportunities at ZSFG. The program emphasizes research on health equity, social determinants, infectious diseases, and other areas relevant to vulnerable populations. Faculty members are nationally recognized for their significant contributions to research and education. The program includes residents across three classes: 3rd Year Residents (Class of 2025), 2nd Year Residents (Class of 2026), and 1st Year Residents (Class of 2027). Training encompasses Medical Dermatology, Pediatric Dermatology, Surgical Dermatology, Dermatopathology, HIV Dermatology, Inpatient Consultations, Teledermatology, and a Social Determinants of Health Curriculum.
 - b) Other Trainees-The program also trains other learners, including 45 medical students annually, 90 residents from Family Medicine, Pediatrics, and Internal Medicine, as well as medical student fellows. Faculty are actively involved in university and national committee service, such as Kieron Leslie serving as CHR Vice Chair, Erin Amerson leading the Resident Education Committee, and Herbert Castillo-Valladares co-leading the Resident Selection Committee with Erin Amerson. Additional contributions include directing the MSC-South Homeless Clinic Dermatology (Aileen Chang) and participating in GloDerm and various American Academy of Dermatology task forces focusing on safety net hospitals, global health, LGBTQ+ health, HIV, and quality and safety.
 - c) Awards and Honors-The program has also garnered prestigious awards and honors, including the 2024 Watson Scholar award for Herbert Castillo-Valladares, the 2023 AAD Young Investigators Clinical Research Award for Aileen Chang, the 2023 Henry J. Kaiser Award for Excellence in Teaching for Sarah Coates, and the 2025 Academy of Medical Educators Excellence in Teaching award for Joanna Tu.
- IV. Performance Improvement and Patient Safety Initiatives-Quality Improvement (QI) projects include monitoring cardiometabolic risks and ensuring appropriate screening for TB and hepatitis B among immunosuppressed patients. Gender Affirming Care efforts underway to provide facial feminization procedures using donated fillers, reducing external costs
 - a) The Quality Improvement (QI) Projects focus on enhancing patient care and safety in dermatology. Key initiatives include EAR-MOPHS, which improves screening for obesity, hypertension, hyperlipidemia, and diabetes in patients with psoriasis and HS, and BLSi, which ensures high-quality biopsy site photographs to prevent wrong-site surgeries. Other projects aim to improve access to written educational and instructional materials for patients with limited English proficiency and ensure appropriate monitoring of patients on immunosuppressive medications for TB and HBV.
 - b) ZSFG Dermatology Patient Satisfaction Scores- ZSFG Dermatology Patient Satisfaction Scores reveal an average of 74% in the "Rate the Provider" category. A thematic analysis of negative comments (17%) areas for improvement, including appointment delays (6%), negative experiences with providers (4%), facilities (4%), and front desk staff (3%). Positive feedback (69%) frequently mentions providers being attentive, professional, and kind.
- V. Financial Report- Dermatology remains financially stable, with a strategic move of surgical procedures to spaces that allow billing for professional fees, increasing budget flexibility
- VI. Summary
 - a) Accomplishments- The dermatology department has achieved several significant accomplishments, including the July 2023 relocation of dermatologic surgery to 5R, which led to an increase in Profee billing, the expansion of gender-affirming services, the appointment of the

first NIH-funded ZSFG faculty member (Dr. Aileen Chang), and the establishment of a funded medical student fellowship to support QI, research, and patient care

- b) Strengths- The strengths of the department include engaged and mission-driven faculty excelling in teaching, clinical medicine, and research; stellar support staff; talented residents; a diverse patient population; a commitment to diversity, equity, and inclusion; collaborative relationships with other specialties; strong departmental and university representation; national leadership in global health, telemedicine, and HIV research; collaboration with the ZSFG Specialty Pharmacy; and a solid financial position.
- c) Challenges- However, challenges remain, such as increasing service demand with limited MD staffing, resident workload and consult service pressures, clinic space limitations on Ward 92, heavy reliance on restricted funding sources, data collection issues in PIPS, NIH over-the-cap challenges, drug formulary limitations, and uncertainties in city, state, and federal funding environments.
- d) Opportunities- Opportunities include leveraging the national focus on research areas like skin of color, homelessness, equity, telemedicine, and health services, transitioning operations to 4B and 5R, building a robust Quality and Safety Program, fostering data-driven research, incorporating social care into specialty care with patient navigators and a new Ward 92 social worker, and developing philanthropic funding to support research.
- e) Goals- Goals focus on expanding residency slots and creating a dedicated consult service resident position, establishing a permanent patient navigation role, and growing philanthropic funding. Short-term objectives include expanding residency and Mohs services, building QI/PIPS programs, increasing grant funding, and establishing a philanthropic fund for investigator-initiated research. Long-term goals aim to lead the field in clinical expertise and research involving vulnerable populations, maintain the program's model status for safety net dermatology, and secure an endowment to sustain research efforts.

VII. Dermatology Rules and Regulations – an approval is requested for the Dermatology’s Service’s Rules and Regulations

Dr. Erin Amerson’s work was praised by Dr. Mercer and other MEC members for its focus on interdisciplinary collaboration, clinician sustainability, and creative problem-solving to manage resources effectively. Approval requested for the Dermatology Service Rules and Regulations.

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

Clinical Service Rules and Regulations:

- Dermatology Rules and Regulations (summary of changes)
- Dermatology Rules and Regulations (with tracked changes)
- Dermatology Rules and Regulations (clean version)

Credentials Committee

Delineation of Privileges List/Standardized Procedures:

- Department of Medicine Standardized Procedures
- Department of Medicine/Pulmonary Medicine Standardized Procedures
- RTC-CASARC Rape Treatment Center (RTC)/Trauma Recovery Center (TRC) and Child and Adolescent Support, Advocacy and Resource Center (CASARC) ZSFG Department of Psychiatry CPC NP/PA Standardized Procedure
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- AFF Optometry Privilege Form
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Medical Executive Committee (MEC)
Summary of Changes

Document Name:	<i>ZSFG Clinical Service Rules and Regulations</i>
Clinical Service :	Summary of changes to Dermatology R&R Report- 2025
Date of last approval:	1/24/2023
Summary of R&R updates:	Minor changes were made to the updated report. This includes the following:
Update #1:	Addition of botulinum toxin and injectable fillers/soft tissue augmentation to the core privileges (competence in this skill is part of board certification for all dermatologists)
Update #2:	Changes to the PIPS metrics and measurements evaluated by the service
Update #3:	The committee that evaluates resident performance has changes names (from the "Resident Evaluation Committee" to "Clinical Competence Committee")
Update #4:	Minor stylistic changes throughout, including to the scope of service section
Update #5:	Faculty meetings are held quarterly, not monthly

**DERMATOLOGY CLINICAL SERVICE
RULES AND REGULATIONS**

2025

**DERMATOLOGY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS**

I.	DERMATOLOGY CLINICAL SERVICE ORGANIZATION	3
A.	SCOPE OF SERVICE	3
B.	MEMBERSHIP REQUIREMENTS.....	3
C.	ORGANIZATION OF DERMATOLOGY CLINICAL SERVICE	3
II.	CREDENTIALING	3
A.	NEW APPOINTMENTS	4
B.	REAPPOINTMENTS	4
C.	AFFILIATED PROFESSIONALS	4
D.	STAFF CATEGORIES.....	4
III.	DELINEATION OF PRIVILEGES	5
A.	DEVELOPMENT OF PRIVILEGE CRITERIA	5
B.	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM	5
C.	CLINICAL PRIVILEGES	5
D.	TEMPORARY PRIVILEGES	5
IV.	PROCTORING AND MONITORING.....	5
A.	MONITORING (PROCTORING) REQUIREMENTS	5
B.	ADDITIONAL PRIVILEGES	6
C.	REMOVAL OF PRIVILEGES	6
V.	EDUCATION	6
VI.	DERMATOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION	6
VII.	DERMATOLOGY CLINICAL SERVICE CONSULTATION CRITERIA.....	6
VIII.	DISCIPLINARY ACTION.....	6
IX.	PERFORMANCE IMPROVEMENT AND PATIENT SAFETY	7
A.	CLINICAL INDICATORS.....	7
B.	THRESHOLDS	7
C.	DATA COLLECTION	7
D.	EVALUATE CARE.....	8
E.	TAKE ACTION TO SOLVE PROBLEMS.....	8
F.	ASSESSMENT OF ACTION & DOCUMENTATION OF IMPROVEMENT.....	8
G.	COMMUNICATE RELEVANT INFORMATION TO THE PERFORMANCE IMPROVEMENT AND PATIENT SAFETY DEPARTMENT.....	8
H.	DERMATOLOGY CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES	8
X.	MEETING REQUIREMENTS.....	9
XI.	ADOPTION AND ADMENDMENT.....	9

**DERMATOLOGY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS (Continued)**

APPENDIX A – DERMATOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM 10

APPENDIX B – DERMATOLOGY CLINICAL HOUSESTAFF MANUAL 13

APPENDIX C - DERMATOLOGY CHIEF OF CLINICAL SERVICE JOB DESCRIPTION..... 14

I. DERMATOLOGY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The ZSFG Dermatology Clinical Service serves children and adults ~~a pediatric and adult population~~, with dermatologic disease, ~~providing acute or chronic episodic dermatologic disease. The Dermatology Clinical Services provides~~ diagnostic evaluation including skin biopsies, therapeutic regimens, ranging from pharmaceutical to phototherapy to ambulatory surgery, and patient education. The service treats a range of acute and chronic neoplastic, infectious, and inflammatory skin conditions. ~~primary diagnoses relate to skin cancer, acute conditions such as infectious diseases of the skin and allergic contact dermatitis, and chronic conditions such as acne, psoriasis and atopic and nummular dermatitis.~~ Care is provided by attending physicians and resident physicians in dermatology.

Important aspects of care for the Dermatology Clinical Services are:

1. Diagnosis and treatment of acute and chronic skin diseases
2. Phototherapy and photochemotherapy
3. Definitive procedural treatment of benign and malignant skin lesions
4. Telemedicine co-management of simple dermatologic conditions
5. Hospital consultation for inpatients with skin diseases

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF DERMATOLOGY CLINICAL SERVICE

The Chief of Dermatology Clinical Services at ZSFG has overall responsibility for assuring quality of care through ongoing monitoring and evaluation of activities. This responsibility, however, is shared with the department representative of Performance Improvement and Patient Safety (PIPS) Committee. The PIPS Committee department representative prepares the minutes of the Departmental PIPS Plan, and also communicates directly with residents and staff regarding Performance Improvement and Patient Safety activities. This representative is appointed annually by the Chief of Dermatology.

II. CREDENTIALING

The ZSFG Dermatology Clinical Services is a small department with a high degree of interaction and consultation. Difficult cases and routine consults are often seen by several attending physicians. Thus, the skills of the various physicians are well known among the staff. The attendings are also able to evaluate the skills of one each another through cross-coverage of clinics and through patients who return to other clinic days and attendings, ~~although to promote attending continuity is not the rule~~. The staff physicians are evaluated yearly by the Chief of

*Zuckerberg San Francisco General Hospital & Trauma Center
1001 Potrero Ave
San Francisco, CA 94110*

Dermatology for clinical competence, educational competence, personal qualities, and administrative skills.

Where patient care falls below standard levels, the Chief will be responsible for counseling

involved faculty and for taking whatever action is necessary to assure that appropriate corrections are made.

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

The Dermatology Clinical Service practitioners are evaluated by the following factors. Dermatology attendings in the clinic act as attendings or consultants. Several attendings may be present in the same clinic on a given day, so linking attendings to the patients on whom they consult is difficult. The attending performance is evaluated by several factors. The dermatology residents evaluate the attendings. Additionally, full-time attendings at ZSFG work closely with the courtesy attendings ~~regularly~~ and discuss and evaluate cases seen in the clinic. These two sources are used to evaluate the performance of courtesy attendings. Courtesy attendings in general dermatology are not credentialed to perform or supervise any dermatologic procedures other than simple skin biopsy and cryotherapy.

2. Staff Status Change

The process for Staff Status Change for members of the Dermatology Services is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

3. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Dermatology Services is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals of ZSFG through the Dermatology Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

D. STAFF CATEGORIES

The Dermatology Clinical Service staff fall into the same staff categories which are described in the ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Dermatology Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

Minimum Formal Training: Successful completion of an approved four-year [one (1) transitional year PGY-1 year, and three (3) years in dermatology] residency program in Dermatology

Certification: Board Certification (and recertification when required) In Dermatology from the American Board of Dermatology or is an active candidate as defined by the American Board of Dermatology.

Previous Experience: Demonstration that the applicant has provided care to at least twenty-five (25) patients as an attending physician (or senior resident) during the past 12 months.

Core Privileges: The ability to work up, consult and provide nonsurgical therapy to patients with illnesses and injuries of the integumentary system, including performance of the following procedures: skin biopsy, simple excision, and repair.

Surgical special privileges which require separate threshold criteria include nail surgery, ~~scalp surgery~~, laser surgery, ~~filler therapy~~ and sclerotherapy. (Note: the following procedures are not currently being performed at ZSFG in Dermatology: Mohs Surgery, ~~and~~ Liposuction).

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Dermatology Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Dermatology Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Dermatology Clinical Service. (Appendix A).

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Monitoring (proctoring) requirements for the Dermatology Clinical Service shall be the Responsibility of the Chief of the Service. Proctoring is performed by the full-time

Attendings at ZSFG. Performance by the attendings is regularly discussed at the Dermatology ~~Faculty~~Staff meetings. If deemed necessary, charts from the clinic are reviewed to determine adequate performance.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Dermatology Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Dermatology Clinical Service shall be in accordance with ZSFG Bylaws, and the Rules and Regulations.

V. EDUCATION

All Dermatology Clinical Service attendings must complete a minimum of 50 hours Category I CME every two years. Dermatology members are encouraged to attend CME offering at UCSF.

VI. DERMATOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Housestaff evaluations are performed at six-month intervals by the full-time Attendings at ZSFG. Any substandard performances are brought before the UCSF Dermatology “Clinical CompetenceResidential Education Committee” (CCC) and the appropriate action decided by this committee. The ~~CCC Residential Education Committee~~ includes one attending from ZSFG (the Division Chief). (See Dermatology Housestaff Manual – Appendix B).

VII. DERMATOLOGY CLINICAL SERVICE CONSULTATION CRITERIA

Consultations in Dermatology are made by e-Referral in Epic. E-Referrals must have an attached photo unless an exception is granted by the dermatology team. Images and consultations are reviewed by ~~dermatology attendings or the dermatology~~ residents; (supervised by an attending), most weekdays and at least once per week. The dermatology team will decide whether a dermatology clinic appointment is necessary, or whether a trial of virtual co-management with the referring provider is appropriate. If urgent consultation is required, the referring provider may contact the clinic, the dermatology resident, or the Service Chief or Administrative Assistant by phone or pager to make such arrangements.

Inpatient consultations are ~~all~~ arranged by phone or page contact. Inpatient consultations are seen within 24 hours. In some instances, ~~due to the public health emergency~~, it may be appropriate for inpatient consults to be managed virtually. We will provide in-person consultation whenever possible.

All consultations, both inpatient and outpatient, are staffed by an attending dermatologist. All consultations, inpatient, outpatient, and virtual, are documented in Epic.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital Medical Staff Bylaws, and the Rules and Regulations will govern all disciplinary action involving members of the ZSFG Dermatology Clinical Service.

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

To define the ZSFG Dermatology Clinical Service method of monitoring and evaluating patient care is carried out through the implementation of the following Performance Improvement and Patient Safety Plan.

The important aspects of care of the Dermatology Clinical Services have been identified below and these important aspects are monitored continuously. The monitoring data are compared to pre-established thresholds for evaluation to determine the quality and appropriateness of care and identify opportunities to improve patient care.

The following Performance Improvement and Patient Safety issues are discussed during the Dermatology Clinical Services department's ~~quarterly~~ monthly meeting, which is attended by all full-time faculty members. Issues are also discussed with the Chief and relevant Medical Director ad hoc as they arise.

1. Mor**bi**idity/mortality report
2. Complications
3. Review of ongoing monitors
4. Report on indicator evaluation studies conducted by the QM program staff
5. General discussion of new or old issues pertaining to quality of care

A. CLINICAL INDICATORS

1. Timely treatment of biopsy-proven melanoma - outcome indicator
2. Teledermatology- virtual co-management- process indicator
3. Timely detection and referral of cardiometabolic and infectious co-morbidities in patients with psoriasis and hidradenitis~~Acess to written educational materials for patients with LEP~~ process and equity indicator
4. High-quality biopsy site photographs to prevent wrong-site surgery- process indicator

B. THRESHOLDS

- | | | |
|----|--|---------------------------|
| 1. | Treatment of melanoma | 100% |
| 2. | Teledermatology virtual co-management | 60% |
| 3. | <u>Co-morbidity detection and management</u> ~~Acess to written educational materials~~ | <u>90</u> ~~25~~ % |
| 4. | High-quality biopsy site photographs | 90% |

C. DATA COLLECTION

1. A department member appointed by the Chief of Dermatology will review the pathology book and note all biopsies positive for melanoma. The biopsy log records, departmental shadow charts, and the actual practitioners who performed the biopsy will be used to determine which patients have not received definitive treatment of skin cancers within 12-16 weeks. All such patients will be contacted by phone or notified by certified letter. A critical alert indicator will be placed in the Lifetime Clinic Record for individuals for whom there is no forwarding address or contact number.
2. The Performance Improvement and Patient Safety program director and dermatology faculty and staff, using medical records will collect and organize data as directed by the Department's representative to the PIPS committee.

D. EVALUATE CARE

Data will be monitored by the Department's PIPS representative and the entire Dermatology Clinical Service department at regular meetings, compared with predetermined objective measurable indicators and thresholds for evaluation.

E. TAKE ACTION TO SOLVE PROBLEMS

When problems are identified by the ~~Chief~~ of the Dermatology Clinical Services and/or PIPS representative, the department will meet to correct or improve the situation. Actions to be taken will be communicated to all physicians at this meeting and in Performance Improvement and Patient Safety Committee minutes.

F. ASSESSMENT OF ACTION & DOCUMENTATION OF IMPROVEMENT

After allowing enough time to occur, a follow-up assessment is conducted as part of ongoing monitoring of indicators. If further action is required, it will be made until situation has met pre-established criteria. If the thresholds are met, further follow-up studies are performed to document sustained improvement. Threshold will also be altered as appropriate to reflect expected improvement over prior thresholds.

G. COMMUNICATE RELEVANT INFORMATION TO THE PERFORMANCE IMPROVEMENT AND PATIENT SAFETY DEPARTMENT

The Performance Improvement and Patient Safety Plan, and monthly minutes are reviewed by the Performance Improvement and Patient Safety Program staff.

H. DERMATOLOGY CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Monitoring requirements for the Dermatology Clinical Service shall be the responsibility of the Chief of the Service. Proctoring is performed by the full-time Attendings at ZSFG. Performance by the attendings is regularly discussed at the Dermatology Staff meetings. If deemed necessary, charts from the clinic are reviewed to determine adequate performance.

Housestaff evaluations are performed at six-month intervals by the full-time Attendings at ZSFG. Any substandard performances are brought before the Dermatology "~~Clinical Competence Committee~~~~Residential Education Committee~~" and the appropriate action decided by this committee. The ~~Clinical Competence~~~~Residential Education~~ Committee includes ~~the ZSFG Chief of Dermatology, two attendings from ZSFG—the Director of the Residency Program and the Department Chair.~~

The Dermatology Clinical Service has no Affiliated Professionals or ZSFG employees whom Dermatology is responsible to evaluate.

X. MEETING REQUIREMENTS

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

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

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

XI. ADOPTION AND ADMENDMENT

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

APPENDIX A – DERMATOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM

Privileges for Zuckerberg San Francisco General Hospital

Clinical Privileges

Provider:

Approved: -

Privilege	Status	Approved
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Derm DERMATOLOGY 2017 (05/09 MEC)

FOR ALL PRIVILEGES

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

10.10 CORE PRIVILEGES: GENERAL DERMATOLOGY

Patient management, including history and physical exam, diagnostic and therapeutic treatments, procedures and interventions, requiring a structure and function of the skin and related systems diagnosis, medical therapy and surgical management (including administration of topical, local and regional anesthesia) of abnormalities affecting the skin and related systems. Specific examples include: skin and nail biopsy, cryosurgery, incision & drainage abscess, botulinum toxin injection, chemical peels, dermal filler injection/soft tissue augmentation, ~~collagen or other dermal filler injection/soft tissue augmentation~~, destruction of benign and malignant tumors, electrosurgery, excision of benign and malignant lesions with simple, intermediate, and complex repair techniques, including flaps and grafts, intralesional injections, patch tests, phototherapy, topical and systemic pharmacotherapy, sclerotherapy, in adults and children.

10.20 SPECIAL PRIVILEGES

10.21 DERMATOPATHOLOGY

Diagnosis of skin conditions based on interpretation/reading of skin biopsy specimens.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology and additional certification in Dermatopathology Specialty Boards.

PROCTORING: 5 reviewed cancer cases

REAPPOINTMENT: 25 cases

10.22 DERMATOSURGERY

To include dermabrasion and chemical peel, sclerotherapy of superficial veins, liposuction with local anesthesia and repair of cutaneous defects to include skin grafts and local flaps.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Dermatology and additional certification in dermatologic surgery or micrographic surgery.

PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.

REAPPOINTMENT: 25 operative procedures.

10.23 MICROGRAPHIC SURGERY

Surgical procedure that maps the skin in such a way that the sectioning can be performed allowing for complete examination of surgical margins.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Dermatology and additional certification in dermatologic surgery or micrographic surgery.

PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures

REAPPOINTMENT: 25 operative procedures.

10.24 PROCEDURAL SEDATION

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year for the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

10.25 LASER SURGERY

Removal of congenital and acquired lesions (tattoos, hemangiomas, pigmented lesions) using Carbon Dioxide Laser, Argon Laser, Dye Laser, Copper Vapor Laser, and Solid-Crystal Lasers.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology. Appropriate training, complete the laser safety module prepared by the ~~ZSFGSFGH~~ Laser Safety Committee and baseline eye examination within the previous 1 year.

PROCTORING: 2 observed procedures

REAPPOINTMENT: 2 cases in the previous two years

10.26 PUNCH BIOPSY NORMAL SKIN

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Internal Medicine or an internal medicine subspecialty and completed punch biopsy training of normal skin under the chief of dermatology or a designated dermatology attending at ~~ZSFGSFGH~~ with the approval of the chief of dermatology.

PROCTORING: Direct observation of 2 successful skin punch biopsies in 2 years by an ~~ZSFGSFGH~~ dermatology faculty member.

REAPPOINTMENT: Direct observation of 2 successful skin punch biopsies in 2 years by an ~~ZSFGSFGH~~ dermatology faculty member.

10.27 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

APPENDIX B – DERMATOLOGY CLINICAL HOUSESTAFF MANUAL

Current version of the housestaff manual may be found on the UCSF Dermatology Department Collaborative Learning Environment link at: <https://courses.ucsf.edu/course/view.php?id=3708> under Residency Handbook → ZSFG Guidelines and Clinical Conference Schedule.

APPENDIX C - Dermatology Chief of Clinical Service Job Description

Chief of Dermatology Clinical Service

Position Summary:

The Chief of Dermatology Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also insures that the

Service's functions are integrated with those of other clinical departments and with the Hospital as a whole.

Reporting Relationships:

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

Position Qualifications:

The Chief of Dermatology Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Dermatology Clinical Service include the following:

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

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

In collaboration with the Executive Administrator and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.

**DERMATOLOGY CLINICAL SERVICE
RULES AND REGULATIONS**

2025

**DERMATOLOGY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS**

I.	DERMATOLOGY CLINICAL SERVICE ORGANIZATION	3
A.	SCOPE OF SERVICE	3
B.	MEMBERSHIP REQUIREMENTS.....	3
C.	ORGANIZATION OF DERMATOLOGY CLINICAL SERVICE	3
II.	CREDENTIALING	3
A.	NEW APPOINTMENTS	4
B.	REAPPOINTMENTS	4
C.	AFFILIATED PROFESSIONALS	4
D.	STAFF CATEGORIES.....	4
III.	DELINEATION OF PRIVILEGES	5
A.	DEVELOPMENT OF PRIVILEGE CRITERIA	5
B.	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM	5
C.	CLINICAL PRIVILEGES	5
D.	TEMPORARY PRIVILEGES	5
IV.	PROCTORING AND MONITORING.....	5
A.	MONITORING (PROCTORING) REQUIREMENTS	5
B.	ADDITIONAL PRIVILEGES.....	6
C.	REMOVAL OF PRIVILEGES	6
V.	EDUCATION	6
VI.	DERMATOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION	6
VII.	DERMATOLOGY CLINICAL SERVICE CONSULTATION CRITERIA.....	6
VIII.	DISCIPLINARY ACTION.....	6
IX.	PERFORMANCE IMPROVEMENT AND PATIENT SAFETY	7
A.	CLINICAL INDICATORS.....	7
B.	THRESHOLDS	7
C.	DATA COLLECTION	7
D.	EVALUATE CARE.....	8
E.	TAKE ACTION TO SOLVE PROBLEMS.....	8
F.	ASSESSMENT OF ACTION & DOCUMENTATION OF IMPROVEMENT.....	8
G.	COMMUNICATE RELEVANT INFORMATION TO THE PERFORMANCE IMPROVEMENT AND PATIENT SAFETY DEPARTMENT.....	8
H.	DERMATOLOGY CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES	8
X.	MEETING REQUIREMENTS.....	9
XI.	ADOPTION AND ADMENDMENT.....	9

**DERMATOLOGY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS (Continued)**

APPENDIX A – DERMATOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM 10

APPENDIX B – DERMATOLOGY CLINICAL HOUSESTAFF MANUAL 13

APPENDIX C - DERMATOLOGY CHIEF OF CLINICAL SERVICE JOB DESCRIPTION..... 14

I. DERMATOLOGY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The ZSFG Dermatology Clinical Service serves children and adults with dermatologic disease, providing diagnostic evaluation including skin biopsies, therapeutic regimens, ranging from pharmaceutical to phototherapy to ambulatory surgery, and patient education. The service treats a range of acute and chronic neoplastic, infectious, and inflammatory skin conditions. Care is provided by attending physicians and resident physicians in dermatology.

Important aspects of care for the Dermatology Clinical Services are:

1. Diagnosis and treatment of acute and chronic skin diseases
2. Phototherapy and photochemotherapy
3. Definitive procedural treatment of benign and malignant skin lesions
4. Telemedicine co-management of simple dermatologic conditions
5. Hospital consultation for inpatients with skin diseases

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF DERMATOLOGY CLINICAL SERVICE

The Chief of Dermatology Clinical Services at ZSFG has overall responsibility for assuring quality of care through ongoing monitoring and evaluation of activities. This responsibility, however, is shared with the department representative of Performance Improvement and Patient Safety (PIPS) Committee. The PIPS Committee department representative prepares the minutes of the Departmental PIPS Plan, and also communicates directly with residents and staff regarding Performance Improvement and Patient Safety activities. This representative is appointed annually by the Chief of Dermatology.

II. CREDENTIALING

The ZSFG Dermatology Clinical Services is a small department with a high degree of interaction and consultation. Difficult cases and routine consults are often seen by several attending physicians. Thus, the skills of the various physicians are well known among the staff. The attendings are also able to evaluate one another through cross-coverage of clinics and through patients who return to other clinic days and attendings. The staff physicians are evaluated yearly by the Chief of Dermatology for clinical competence, educational competence, personal qualities, and administrative skills.

Where patient care falls below standard levels, the Chief will be responsible for counseling

involved faculty and for taking whatever action is necessary to assure that appropriate corrections are made.

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

The Dermatology Clinical Service practitioners are evaluated by the following factors. Dermatology attendings in the clinic act as attendings or consultants. Several attendings may be present in the same clinic on a given day, so linking attendings to the patients on whom they consult is difficult. The attending performance is evaluated by several factors. The dermatology residents evaluate the attendings. Additionally, full-time attendings at ZSFG work closely with the courtesy attendings and discuss and evaluate cases seen in the clinic. These two sources are used to evaluate the performance of courtesy attendings. Courtesy attendings in general dermatology are not credentialed to perform or supervise any dermatologic procedures other than simple skin biopsy and cryotherapy.

2. Staff Status Change

The process for Staff Status Change for members of the Dermatology Services is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

3. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Dermatology Services is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals of ZSFG through the Dermatology Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

D. STAFF CATEGORIES

The Dermatology Clinical Service staff fall into the same staff categories which are described in the ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Dermatology Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

Minimum Formal Training: Successful completion of an approved four-year [one (1) transitional year PGY-1 year, and three (3) years in dermatology] residency program in Dermatology

Certification: Board Certification (and recertification when required) In Dermatology from the American Board of Dermatology or is an active candidate as defined by the American Board of Dermatology.

Previous Experience: Demonstration that the applicant has provided care to at least twenty-five (25) patients as an attending physician (or senior resident) during the past 12 months.

Core Privileges: The ability to work up, consult and provide nonsurgical therapy to patients with illnesses and injuries of the integumentary system, including performance of the following procedures: skin biopsy, simple excision, and repair.

Surgical special privileges which require separate threshold criteria include nail surgery, laser surgery, and sclerotherapy. (Note: the following procedures are not currently being performed at ZSFG in Dermatology: Mohs Surgery and Liposuction).

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Dermatology Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Dermatology Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Dermatology Clinical Service. (Appendix A).

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Monitoring (proctoring) requirements for the Dermatology Clinical Service shall be the Responsibility of the Chief of the Service. Proctoring is performed by the full-time

Attendings at ZSFG. Performance by the attendings is regularly discussed at the Dermatology Faculty meetings. If deemed necessary, charts from the clinic are reviewed to determine adequate performance.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Dermatology Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Dermatology Clinical Service shall be in accordance with ZSFG Bylaws, and the Rules and Regulations.

V. EDUCATION

All Dermatology Clinical Service attendings must complete a minimum of 50 hours Category I CME every two years. Dermatology members are encouraged to attend CME offering at UCSF.

VI. DERMATOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Housestaff evaluations are performed at six-month intervals by the full-time Attendings at ZSFG. Any substandard performances are brought before the UCSF Dermatology “Clinical Competence Committee” (CCC) and the appropriate action decided by this committee. The CCC includes one attending from ZSFG (the Division Chief). (See Dermatology Housestaff Manual – Appendix B).

VII. DERMATOLOGY CLINICAL SERVICE CONSULTATION CRITERIA

Consultations in Dermatology are made by e-Referral in Epic. E-Referrals must have an attached photo unless an exception is granted by the dermatology team. Images and consultations are reviewed by dermatology attendings or residents (supervised by an attending), most weekdays and at least once per week. The dermatology team will decide whether a dermatology clinic appointment is necessary, or whether a trial of virtual co-management with the referring provider is appropriate. If urgent consultation is required, the referring provider may contact the clinic, the dermatology resident, or the Service Chief or Administrative Assistant by phone or pager to make such arrangements.

Inpatient consultations are arranged by phone or page contact. Inpatient consultations are seen within 24 hours. In some instances, it may be appropriate for inpatient consults to be managed virtually. We will provide in-person consultation whenever possible.

All consultations, both inpatient and outpatient, are staffed by an attending dermatologist. All consultations, inpatient, outpatient, and virtual, are documented in Epic.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital Medical Staff Bylaws, and the Rules and Regulations will govern all disciplinary action involving members of the ZSFG Dermatology Clinical Service.

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

To define the ZSFG Dermatology Clinical Service method of monitoring and evaluating patient care is carried out through the implementation of the following Performance Improvement and Patient Safety Plan.

The important aspects of care of the Dermatology Clinical Services have been identified below and these important aspects are monitored continuously. The monitoring data are compared to pre-established thresholds for evaluation to determine the quality and appropriateness of care and identify opportunities to improve patient care.

The following Performance Improvement and Patient Safety issues are discussed during the Dermatology Clinical Services department's quarterly meeting, which is attended by all full-time faculty members. Issues are also discussed with the Chief and relevant Medical Director ad hoc as they arise.

1. Morbidity/mortality report
2. Complications
3. Review of ongoing monitors
4. Report on indicator evaluation studies conducted by the QM program staff
5. General discussion of new or old issues pertaining to quality of care

A. CLINICAL INDICATORS

1. Timely treatment of biopsy-proven melanoma - outcome indicator
2. Teledermatology- virtual co-management- process indicator
3. Timely detection and referral of cardiometabolic and infectious co-morbidities in patients with psoriasis and hidradenitis- process and equity indicator
4. High-quality biopsy site photographs to prevent wrong-site surgery- process indicator

B. THRESHOLDS

- | | |
|--|------|
| 1. Treatment of melanoma | 100% |
| 2. Teledermatology virtual co-management | 60% |
| 3. Co-morbidity detection and management | 90% |
| 4. High-quality biopsy site photographs | 90% |

C. DATA COLLECTION

1. A department member appointed by the Chief of Dermatology will review the pathology book and note all biopsies positive for melanoma. The biopsy log records, departmental shadow charts, and the actual practitioners who performed the biopsy will be used to determine which patients have not received definitive treatment of skin cancers within 12-16 weeks. All such patients will be contacted by phone or notified by certified letter. A critical alert indicator will be placed in the Lifetime Clinic Record for individuals for whom there is no forwarding address or contact number.
2. The Performance Improvement and Patient Safety program director and dermatology faculty and staff, using medical records will collect and organize data as directed by the Department's representative to the PIPS committee.

D. EVALUATE CARE

Data will be monitored by the Department's PIPS representative and the entire Dermatology Clinical Service department at regular meetings, compared with predetermined objective measurable indicators and thresholds for evaluation.

E. TAKE ACTION TO SOLVE PROBLEMS

When problems are identified by the Chief of the Dermatology Clinical Services and/or PIPS representative, the department will meet to correct or improve the situation. Actions to be taken will be communicated to all physicians at this meeting and in Performance Improvement and Patient Safety Committee minutes.

F. ASSESSMENT OF ACTION & DOCUMENTATION OF IMPROVEMENT

After allowing enough time to occur, a follow-up assessment is conducted as part of ongoing monitoring of indicators. If further action is required, it will be made until situation has met pre-established criteria. If the thresholds are met, further follow-up studies are performed to document sustained improvement. Threshold will also be altered as appropriate to reflect expected improvement over prior thresholds.

G. COMMUNICATE RELEVANT INFORMATION TO THE PERFORMANCE IMPROVEMENT AND PATIENT SAFETY DEPARTMENT

The Performance Improvement and Patient Safety Plan, and monthly minutes are reviewed by the Performance Improvement and Patient Safety Program staff.

H. DERMATOLOGY CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Monitoring requirements for the Dermatology Clinical Service shall be the responsibility of the Chief of the Service. Proctoring is performed by the full-time Attendings at ZSFG. Performance by the attendings is regularly discussed at the Dermatology Staff meetings. If deemed necessary, charts from the clinic are reviewed to determine adequate performance.

Housestaff evaluations are performed at six-month intervals by the full-time Attendings at ZSFG. Any substandard performances are brought before the Dermatology "Clinical Competence Committee" and the appropriate action decided by this committee. The Clinical Competence Committee includes the ZSFG Chief of Dermatology.

The Dermatology Clinical Service has no Affiliated Professionals or ZSFG employees whom Dermatology is responsible to evaluate.

X. MEETING REQUIREMENTS

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

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

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

XI. ADOPTION AND ADMENDMENT

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

APPENDIX A – DERMATOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM

Privileges for Zuckerberg San Francisco General Hospital

Clinical Privileges

Provider:

Approved: -

Privilege	Status	Approved
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Derm DERMATOLOGY 2017 **(05/09 MEC)**

FOR ALL PRIVILEGES

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

10.10 CORE PRIVILEGES: GENERAL DERMATOLOGY

Patient management, including history and physical exam, diagnostic and therapeutic treatments, procedures and interventions, requiring a structure and function of the skin and related systems diagnosis, medical therapy and surgical management (including administration of topical, local and regional anesthesia) of abnormalities affecting the skin and related systems. Specific examples include: skin and nail biopsy, cryosurgery, incision & drainage abscess, botulinum toxin injection, chemical peels, dermal filler injection/soft tissue augmentation, destruction of benign and malignant tumors, electrosurgery, excision of benign and malignant lesions with simple, intermediate, and complex repair techniques, including flaps and grafts, intralesional injections, patch tests, phototherapy, topical and systemic pharmacotherapy, sclerotherapy, in adults and children.

10.20 SPECIAL PRIVILEGES

10.21 DERMATOPATHOLOGY

Diagnosis of skin conditions based on interpretation/reading of skin biopsy specimens.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology and additional certification in Dermatopathology Specialty Boards.

PROCTORING: 5 reviewed cancer cases

REAPPOINTMENT: 25 cases

10.22 DERMATOSURGERY

To include dermabrasion and chemical peel, sclerotherapy of superficial veins, liposuction with local anesthesia and repair of cutaneous defects to include skin grafts and local flaps.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Dermatology and additional certification in dermatologic surgery or micrographic surgery.

PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.

REAPPOINTMENT: 25 operative procedures.

10.23 MICROGRAPHIC SURGERY

Surgical procedure that maps the skin in such a way that the sectioning can be performed allowing for complete examination of surgical margins.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Dermatology and additional certification in dermatologic surgery or micrographic surgery.

PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures

REAPPOINTMENT: 25 operative procedures.

10.24 PROCEDURAL SEDATION

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:

- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year for the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association.

10.25 LASER SURGERY

Removal of congenital and acquired lesions (tattoos, hemangiomas, pigmented lesions) using Carbon Dioxide Laser, Argon Laser, Dye Laser, Copper Vapor Laser, and Solid-Crystal Lasers.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology. Appropriate training, complete the laser safety module prepared by the ZSFG Laser Safety Committee and baseline eye examination within the previous 1 year.

PROCTORING: 2 observed procedures

REAPPOINTMENT: 2 cases in the previous two years

10.26 PUNCH BIOPSY NORMAL SKIN

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Internal Medicine or an internal medicine subspecialty and completed punch biopsy training of normal skin under the chief of dermatology or a designated dermatology attending at ZSFG with the approval of the chief of dermatology.

PROCTORING: Direct observation of 2 successful skin punch biopsies in 2 years by a ZSFG dermatology faculty member.

REAPPOINTMENT: Direct observation of 2 successful skin punch biopsies in 2 years by a ZSFG dermatology faculty member.

10.27 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

APPENDIX B – DERMATOLOGY CLINICAL HOUSESTAFF MANUAL

Current version of the housestaff manual may be found on the UCSF Dermatology Department Collaborative Learning Environment link at: <https://courses.ucsf.edu/course/view.php?id=3708> under Residency Handbook → ZSFG Guidelines and Clinical Conference Schedule.

APPENDIX C - Dermatology Chief of Clinical Service Job Description

Chief of Dermatology Clinical Service

Position Summary:

The Chief of Dermatology Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also insures that the

Service's functions are integrated with those of other clinical departments and with the Hospital as a whole.

Reporting Relationships:

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

Position Qualifications:

The Chief of Dermatology Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Dermatology Clinical Service include the following:

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

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

In collaboration with the Executive Administrator and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of Service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.



ZSFG Dermatology Service Report 2025

Erin Amerson, MD
Dermatology Chief
January 13, 2025



Clinical Service

Scope of Clinical Service

- Adult Medical Dermatology- Wd 92, LHH
- Pediatric Dermatology- 6M
- Surgical Dermatology, Laser- Wd 92, B5
- HIV Dermatology- Wd 86
- Dermatopathology
- Inpatient Consultation Service
- Teledermatology e-consult service
- Specialty Clinics- Rheum/Derm, Hidradenitis, Hair, Pigmentary disorders- Wd 92
- Phototherapy- Wd 92



Service Volume

- Outpatient Adult Dermatology Clinic:
Avg 450 pts/month (5400 annually- 20% increase since last report in 2023)- 95% in-person, 5% telephone/video
- E-Consults: Avg 550/month (6600/annually)
→20% increase from 4 years ago
- Surgeries: 35/month
- Pediatric Derm: 45/month
- Hospital Consults: 25/month
- Laguna Honda: 16/month
- Dermatopathology: 60 cases/month
- Phototherapy: 110 visits/month

ZSFG Dermatology Leadership



Erin Amerson, MD
Division Chief, Medical Director



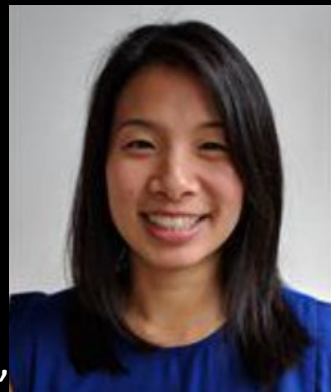
Carlo De la Sancha
Verduzco, MD
Dermatopathology



Sarah Coates, MD
Director, Pediatric
Dermatology



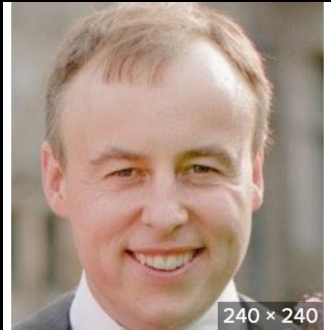
Dan Klufas, MD
Director, Derm Surgery,
Quality/Safety



Aileen Chang, MD
Director of Research



Herbert Castillo-Valladares,
MD
Director, Inpatient Consult
Service



Kieron Leslie, MD
Assistant Chief
Director,
HIV Dermatology

ZSFG Dermatology Faculty

Adult Medical Dermatology

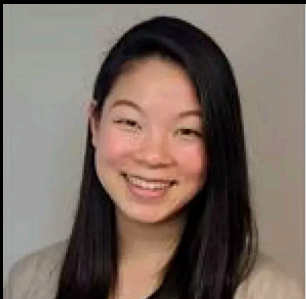


Roberto Ricardo-Gonzalez,
MD, PhD



Marlys Fassett, MD, PhD

Pediatric Dermatology



Joanna Tu, MD

Hidradenitis



Haley Naik, MD

Pigmentary



Amit Pandya, MD

Hair



Paradi Mirmirani, MD

Administrative Staff

- Mounira Kenaani, UCSF Department Manager
- Emily Leang, ZSFG Division Manager
- Sheri Sanders, Administrative Assistant
- Yanel Hernandez, MS4, Patient Navigator, QI Analyst

Support Staff

- Wd 92 Nurse Manager- Charles Bellah, RN
- 2 part time RNs
- 3 MEAs
- 1 MEA for phototherapy
- 3 clerks



Dermatology E-Consults- the Numbers

- Over 5,000 e-consults annually since Epic implementation
- ~60% Virtual Co-Management
- 25% increase in total patients managed or co-managed by dermatology since teledermatology implementation (increase in access)
- Same number of providers (increased efficiency)
- Cost analysis: Savings of \$140 per new patient referral

Zakaria et al Impact of Teledermatology on accessibility and efficiency of dermatology care in an urban safety net hospital: a pre-post analysis Journal American Academy of Dermatology 2019

Zakaria et al Cost Minimization Analysis of a Teledermatology Triage System in a Managed Care Setting JAMA Dermatol 2021

Training Program

Trainees

UCSF DERMATOLOGY RESIDENTS AND FELLOWS 2024-2025

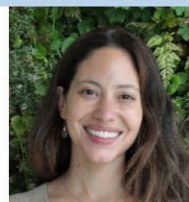
3RD YEAR RESIDENTS - CLASS OF 2025



Laura Baker, MD



Flora Bradley, MD



Elsy Compres, MD
Chief Resident



Briana Garcia, MD
Chief Resident



Virginia 'Gina' Alvarado
Jones, MD, MS



James 'Jimmy' Meixiong,
MD, PhD



Vidhatha 'Vid' Reddy, MD
Chief Resident



Eduardo Torre, MD,
PhD

2ND YEAR RESIDENTS - CLASS OF 2026



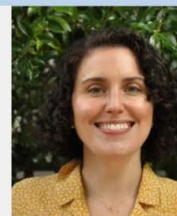
Francine Castillo, MD



Tess Engel, MD



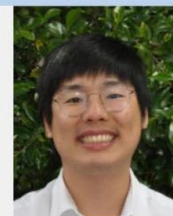
Taylor Jamerson, MD



Michelle 'Shelly' Mintz, MD,
PhD



Garrett Patrick, MD,
PhD



Krittin 'Jay'
Supannachart, MD



Adam Zakaria, MD

1ST YEAR RESIDENTS - CLASS OF 2027



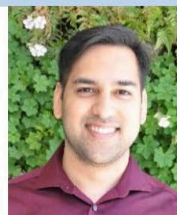
Annika Belzer, MD, MHS



Mitchell Braun, MD



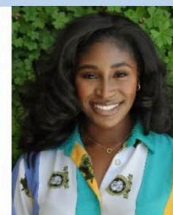
Parinaz Fozouni, MD, PhD



Shamik Mascharak, MD,
PhD



Deega Omar, MD, MPH



Nicole Syder, MD



Jazzmin Williams, MD

Training program elements

- Medical Dermatology
- Pediatric Dermatology
- Surgical Dermatology
- Dermatopathology
- HIV Dermatology
- Inpatient consultations
- Teledermatology
- Social Determinants of Health Curriculum

Other Trainees

- Medical Students (45/yr)
- Family Medicine, Pediatrics and Internal Medicine residents (90/yr)
- Medical student fellows

Dermatology Department, University and National Committee Service

- **CHR Vice Chair- Kieron Leslie**
- **Resident Education Committee- Erin Amerson**
- **Resident Selection Committee- Erin Amerson, Herbert Castillo-Valladares**
- **MSC-South Homeless Clinic Dermatology Director-Aileen Chang**
- **GloDerm- Erin Amerson, Aileen Chang, Sarah Coates**
- **American Academy of Dermatology- Safety Net Hospital resource group, global health dermatology, LGBTQ+ health, HIV and sexually transmitted diseases, Quality and Safety –courses, committees, task forces**

Awards and Honors

- Herbert Castillo-Valladares- 2024 Watson Scholar
- Aileen Chang- 2023 AAD Young Investigators Clinical Research Award
- Sarah Coates- 2023 Henry J. Kaiser Award for Excellence in Teaching
- Joanna Tu- 2025 Academy of Medical Educators Excellence in Teaching

PIPS Initiatives

QI PROJECT GOALS AND PROGRESS



1. EAR-MOPHS – Improve screening for obesity, hypertension, hyperlipidemia, and diabetes in dermatology patients with psoriasis and HS.



2. BLSi – Take high-quality biopsy site photographs to prevent wrong-site surgery in dermatology.



3. Patient Education – Improve access to written educational and instructional materials for patients with limited english proficiency.



4. Monitoring: Appropriately monitor patients on immunosuppressive medications for TB and HBV.

EAR-MOPHS- evaluating and attenuating risk of metabolic outcomes in psoriasis and hidradenitis suppurativa

II. TARGET STATEMENT

Primary Target: For patients with psoriasis and/or HS who attend their dermatology appointment and qualify, our 2023 goals are to:

- 1) Increase PCP participation/offer 90% of them a PCP referral
- 2) Appropriately screen 90% of them for diabetes and hyperlipidemia (HL)
- 3) Offer 70% of them a smoking cessation program referral
- 4) Offer 50% of them a diabetes prevention program referral

Secondary Target:

- A1c and lipid labs are completed by 50% of patients who were eligible.

Metric/Target Details:

- PCP Referral Eligibility: no PCP visit within the last 3 years and/or no assigned PCP in chart.
- Appropriate screening of HgbA1c: 1x/year if A1C is above 5.7, or 1x/3 years if normal A1C (<5.7).
- Appropriate screening of lipids: 1x/3 years if abnormal results (cholesterol >200, HDL < 40, LDL > 100), or 1x/5 years if normal.
- Smoking Cessation Program eligibility: current smoker and interested in smoking cessation. Available in English only.
- Diabetes prevention program eligibility: A1C > 5.7, BMI > 25 (BMI >23 if Asian), and no prior diagnosis of diabetes. Available in English, Spanish, and Cantonese only.

Cardiometabolic Screening and Eligibility Results for Patients with Psoriasis and/or Hidradenitis Suppurativa Based on Race and Ethnicity

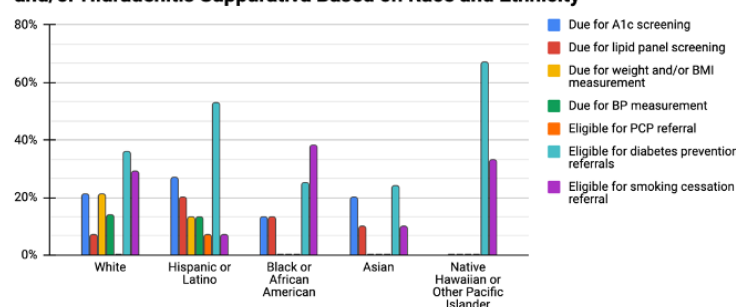


Figure 1: Patient Navigator Care Coordination Model for Cardiometabolic Risk Factor Screening in Patients with Psoriasis and Hidradenitis suppurativa

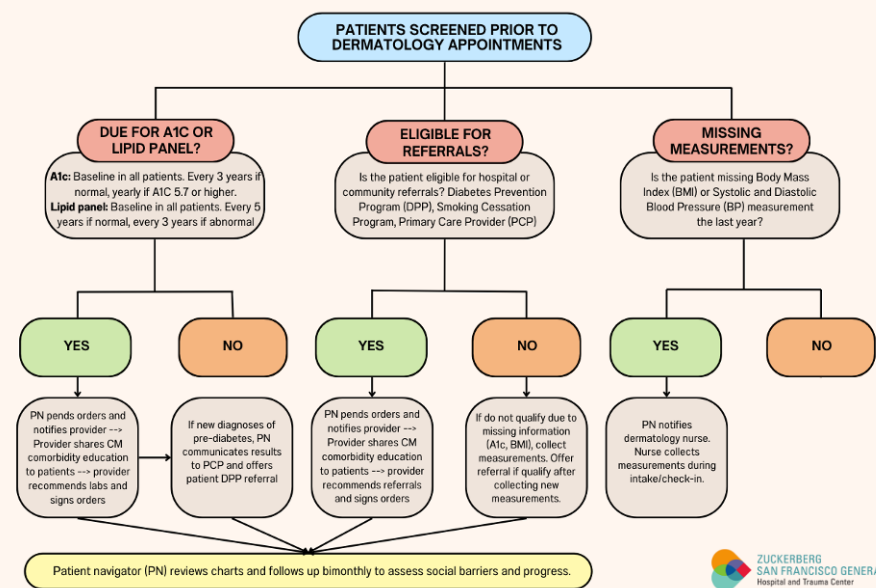
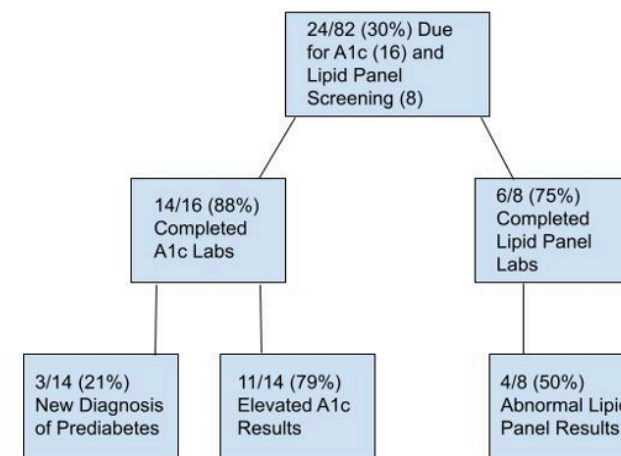
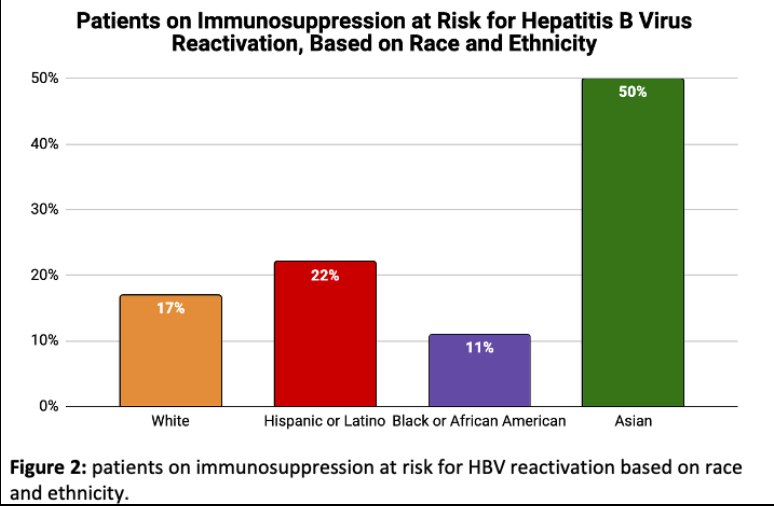
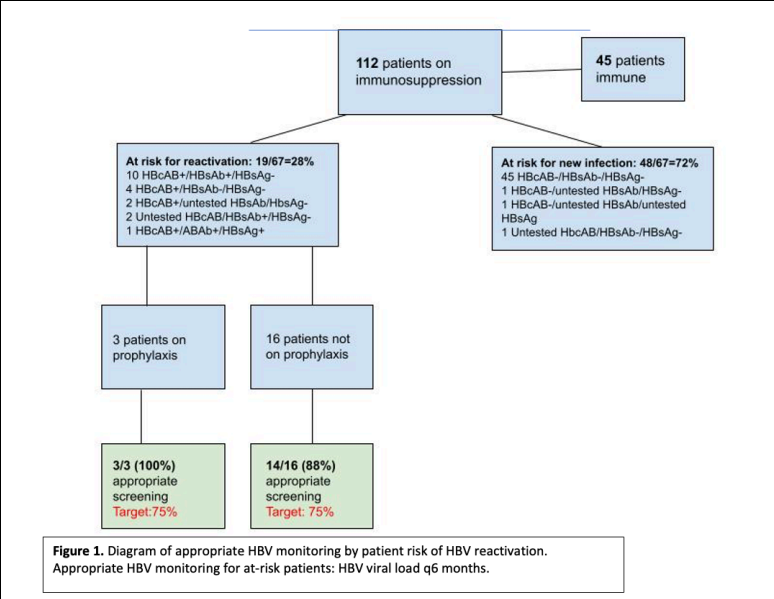


Figure 2 below: Lab results (A1c and lipid panel) for patients who attended their dermatology appointments and qualified (n=24), during monitoring period (September 16, 2023 – January 31st, 2024):

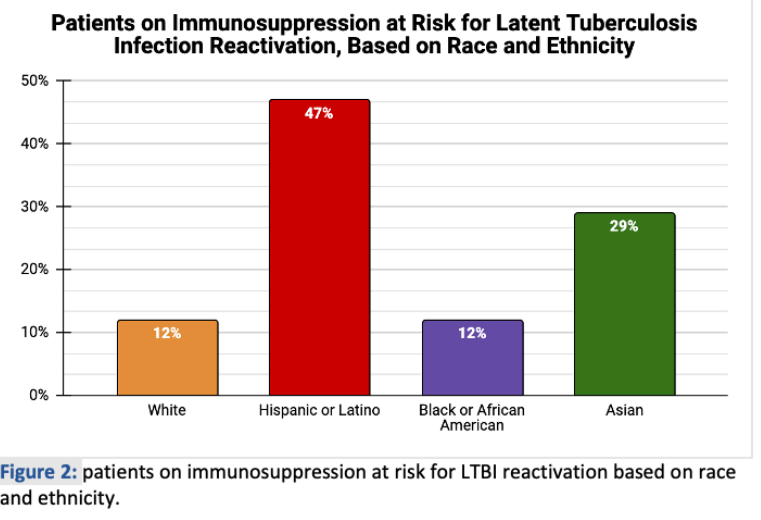
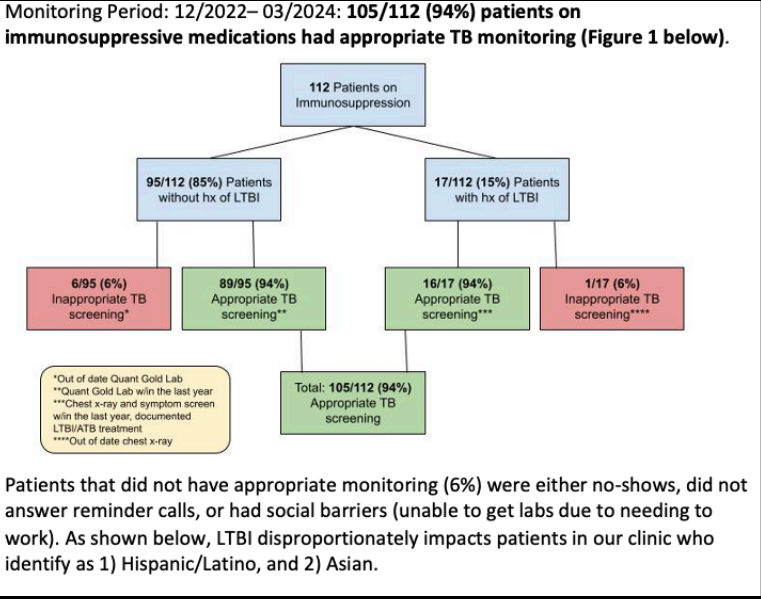


HBV and TB monitoring for patients on Immunosuppressive medications

HBV



TB



ZSFG Dermatology Patient Satisfaction Scores

- Average 74% on 'Rate the Provider' Scores
- Thematic analysis of negative comments (17%):
 - Appointment delays (6%)
 - Negative experience with provider (4%)
 - Facilities (4%)
 - Front desk staff (3%)
- Thematic analysis of positive comments (69%):
 - Attentive
 - Professional
 - Kind

Research Program

Scope of Research Program

HIV and Infectious Diseases

Global Health, Migrant Health

Health Equity/Disparities

Social Determinants of Health

Healthcare Services, Policy, Informatics

Workforce Diversity

Vulnerable Populations (Homelessness, Migrants and Refugees, PWID)

Medical dermatology- diseases linked with SDOH

Autoinflammation

Clinical Trials

A blue spotlight beam shines down from the top left, creating a circular pool of light on a dark, textured stage floor. The beam is bright at the top and fades as it descends.

Research Spotlight 2023-24

- Diversity and Equity in Dermatology Workforce
- HIV/STIs/Kaposi sarcoma/MPox
- Comorbidities of psoriasis and HS across diverse populations
- Migrant health and forensic dermatology
- Social determinants of health, homelessness

Original Investigation

October 25, 2023

Patient Perspectives on Social Risk Screening and Documentation in a Dermatology Clinic

Kamina Wilkerson, BS¹; Emilia De Marchis, MD, MAS²; Nora Rudd, BS¹; [Jazzmin C. Williams, MD¹](#); Matt Pantell, MD, MS³; Sara L. Ackerman, MPH, PhD⁴; Erin H. Amerson, MD^{5,6}; Aileen Y. Chang, MD^{5,6}

[» Author Affiliations](#) | [Article Information](#)

JAMA Dermatol. 2023;159(12):1346-1358. doi:10.1001/jamadermatol.2023.3887

Special Communication

February 9, 2023

Mpox—A Rapidly Evolving Disease

Edward W. Cowen, MD, MHSc¹; Eric R. Tkaczyk, MD, PhD^{2,3}; Scott A. Norton, MD, MPH, MSc⁴; Kieron S. Leslie, MBBS, DTM&H⁵

[» Author Affiliations](#) | [Article Information](#)

JAMA Dermatol. 2023;159(4):424-431. doi:10.1001/jamadermatol.2023.0041

Multi-Institutional Clinical Forensic Dermatology Training for Dermatology Residents

JAMA Dermatology Published online January 2, 2025

Maha Kazmi, BS
Mehar Maju, MPH
Rubi Danielle Montejano, MD
Ivan Rodriguez, BS
Coleen Kivlahan, MD
Herbert B. Castillo Valladares, MD

JAMA | Review

Scabies, Bedbug, and Body Lice Infestations
A Review

Cristina Thomas, MD; Herbert Castillo Valladares, MD; Timothy G. Berger, MD; Aileen Y. Chang, MD

JAMA. 2024;332(14):1189-1199. doi:[10.1001/jama.2024.13896](#)

Publications

 JAMA Dermatology

A retrospective cross-sectional analysis of gender and racial/ethnic diversity trends in dermatology chairs

Jazzmin C. Williams, MD,^a Herbert Castillo Valladares, MD,^b Michael A. Waul, MD,^b Erin Matthes, MD,^b Amit G. Pandya, MD,^{c,d} and Erin H. Amerson, MD^{b,e}

J AM ACAD DERMATOL
VOLUME 91, NUMBER 3

Skin cancer risk across racial/ethnic groups among solid organ transplant recipients in the United States, 2000-2022

Feyisayo Ojute, MD,^a Adam Zakaria, MD,^b Shannon Zullo, MD,^b Daniel Klufas, MD,^{b,c} and Erin Amerson, MD^{b,c}

J AM ACAD DERMATOL
■ 2024

Screening for cardiometabolic risk factors in patients with psoriasis and hidradenitis suppurativa: A pilot study in a safety net population

Maria Elena Sanchez-Anguiano, BS,^{a,b} Daniel Klufas, MD,^{b,c} and Erin Amerson, MD^{b,c}

J AM ACAD DERMATOL
DECEMBER 2024

Genital cancer risk among solid organ transplant recipients in the United States, 2000 to 2022: A cohort study

Feyisayo Ojute, MD,^a Adam Zakaria, MD, MAS,^b Shannon Zullo, MD,^b Daniel Klufas, MD,^{b,c} and Erin Huiras Amerson, MD^{b,c}

J AM ACAD DERMATOL
VOLUME 91, NUMBER 3

Association between psoriasis and cardiometabolic comorbidities in a racially and ethnically diverse low-income primary care population

Nora Rudd¹,^a Nathaly Gonzalez,² Michael A. Kohn,³ Herbert Castillo Valladares,^{4,5} Aileen Y. Chang^{4,5},^a Sarah Kim⁶ and Erin H. Amerson^{4,5}

Clin Exp Dermatol 2024; **49**:155–159
<https://doi.org/10.1093/ced/llad359>

Hidradenitis suppurativa is associated with cardiometabolic comorbidities in a racially and ethnically diverse safety net population: A cross-sectional analysis

Mariano Alba, MS,^a Nora Rudd, BS,^b Adam Zakaria, MD, MAS,^{c,d} Aileen Y. Chang, MD,^{c,d} and Erin H. Amerson, MD^{c,d}

JAAD INT
FEBRUARY 2025

Skin cancer risk in people living with HIV: a call for action

Jacob P Reinhart, Kieron S Leslie

Lancet HIV 2024; 11: e60–62

Published Online
October 18, 2023

Increased risk of skin cancer in solid organ transplant recipients living with HIV

Mitchell Hanson, BS,^a Adam Zakaria, MD, MAS,¹ J AM ACAD DERMATOL
VOLUME 92, NUMBER 1
Kieron S. Leslie, MBBS^b

Improving migrant health in the USA: opportunities for dermatologists to participate in care delivery, asylum medicine and community partnership

Br J Dermatol 2023; 188: 131–133

Penelope Kim-Lim^a,¹ Herbert Castillo Valladares,²
Alexia Knapp,^{3,4} Coleen Kivlahan⁵
and Aileen Y. Chang^a^{2,3,6}

HIV and mpox: Evaluation of clinical course and outcomes from an international dermatologic registry

A dermatologic assessment of 101 mpox (monkeypox) cases from 13 countries during the 2022 outbreak: Skin lesion morphology, clinical course, and scarring



Sonya Prasad, MSc,^{a,b} Cristina Galvan Casas, MD,^{c,d} Alexis G. Strahan, MSN,^{a,c} L. Claire Fuller, MD,^{e,g}
Klint Peebles, MD,^h Andrea Carugno, MD,^{i,j} Kieron S. Leslie, FRCP, DTM&H,^k Joanna L. Harp, MD,^l
Teodora Pumnea, MD,^m Devon E. McMahon, MD,ⁿ Misha Rosenbach, MD,^{n,o} Janet E. Lubov, BSN,^{a,p}
Geoffrey Chen, BA,^q Lindy P. Fox, MD,^k Allen McMillen, MS,^r Henry W. Lim, MD,^s Alexander J. Stratigos, MD,^t
Terrence A. Cronin, MD,^u Mark D. Kaufmann, MD,^v George J. Hruza, MD, MBA,^w Lars E. French, MD,^{mi,x} and
Esther E. Freeman, MD, PhD^{a,q}

J AM ACAD DERMATOL
VOLUME 88, NUMBER 5

Clinical and Epidemiologic Research

Biologic Therapies in HIV/AIDS Patients with Inflammatory Diseases: A Systematic Review of the Literature

Alexander S. Bang, BS^{1,2,3}, Marwa Hakimi, MD⁴, Peggy Tahir, MLIS⁵, Tina Bhutani, MD⁴, and Kieron S. Leslie, MBBS⁴

AIDS Patient Care and STDs
Volume 37, Number 5, 2023

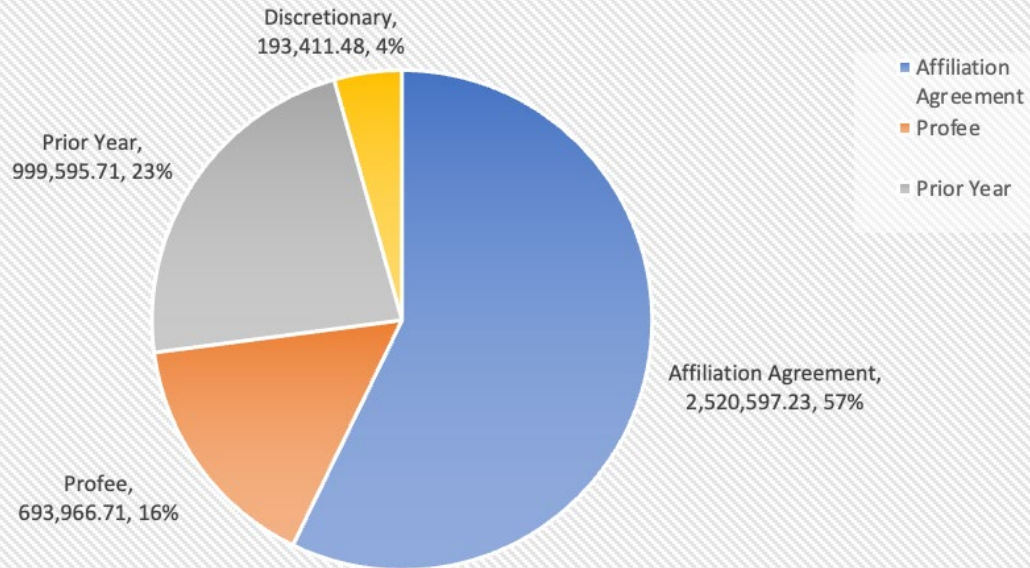
The skin of people experiencing homelessness: more (known) is less (neglected)

Olivier Chosidow^a^{1,2,3} and Aileen Y. Chang^a^{4,5}

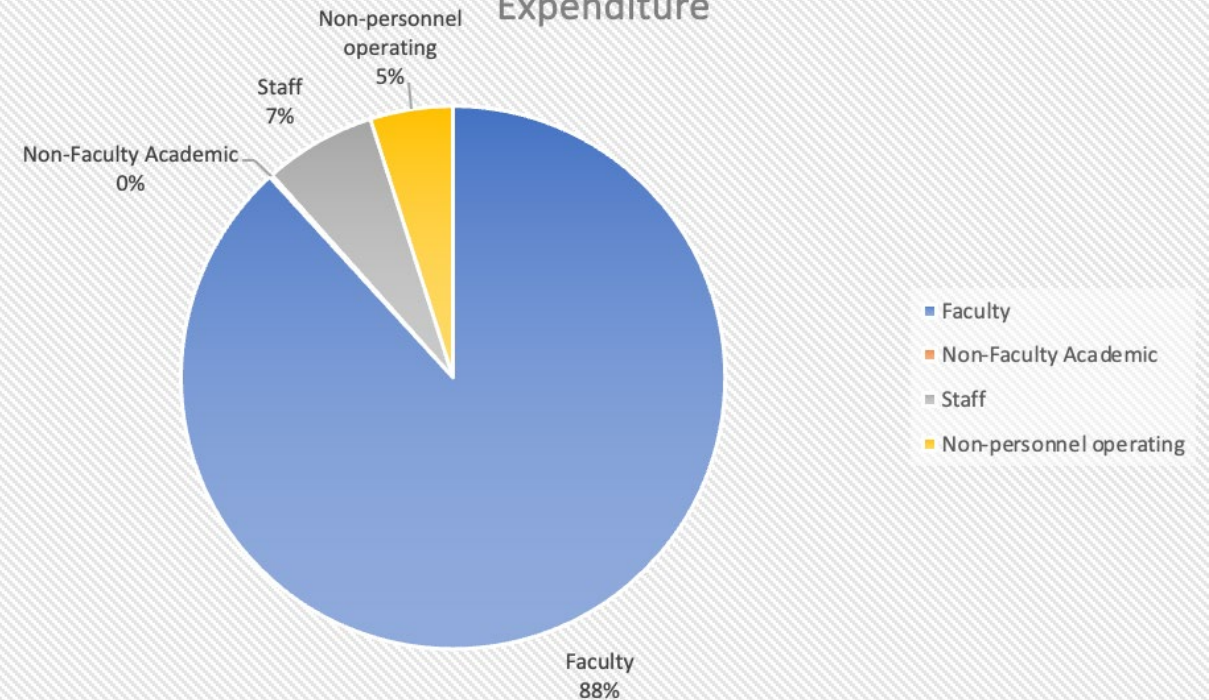
British Journal of Dermatology, Volume 188, Issue 6, June 2023, Pages 694–695

Finance Report

FY2023-2024 Dermatology ZSFG
Revenue



FY2023-2024 Dermatology ZSFG
Expenditure



Summary

- Accomplishments, Strengths, Challenges, Opportunities
- Goals – short and long term

Accomplishments

- July 2023 Derm surgery move to 5R- increase in Prof fee billing
- Expansion of gender affirming services
- First NIH-funded ZSFG faculty member (Dr. Aileen Chang)
- Funded Medical student fellowship to support QI, research, and patient care

Strengths

- Engaged, mission-driven faculty who excel at teaching, clinical medicine, and research
- Stellar support staff, W92 nurse manager
- Talented residents, highly rated teaching site
- Diverse patient population
- Commitment to diversity, equity and inclusion
- Collaborative relationships with other specialties
- Strong departmental and university representation
- National leadership in global health, SDH, telemedicine, and HIV research
- Collaboration with ZSFG Specialty Pharmacy
- Solid financial position

Challenges

- Increasing service volume, meeting demands with current MD staffing
- Work compression, declining trainee evals, no dedicated resident for consult service
- Clinic space on Ward 92
- Heavy reliance on Affiliation Agreement instead of Profees (restricted funding)
- PIPS - data collection
- NIH over-the-cap
- Drug formulary limitations
- City/State/Federal Funding environment

Opportunities

- National focus on research areas where we excel and have access to patients- skin of color, homelessness, equity, telemedicine, health services
- Move to 4B, 5R
- Building our Quality and Safety Program
- Opportunities for data-driven research
- Incorporating social care into specialty care- patient navigator, new ward 92 social worker
- Develop philanthropic funding for research mission

Goals

Short Term

- Residency expansion to meet clinical and educational needs
- Mohs expansion at ZSFG
- Build QI/PIPS Program
- Increase grant funding, build philanthropic fund for investigator-initiated research

Long Term

- Lead field in clinical expertise and research involving vulnerable populations
- Continue to be the model program for dermatology in the safety net
- Secure endowment for research program

Thank you





San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice
STANDARDIZED PROCEDURE – NURSE PRACTITIONER /
PHYSICIAN ASSISTANT

2017

PREAMBLE

Title: Department of Medicine

I. Policy Statement

- A. It is the policy of 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, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.
- B. 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 5K1 Pulmonary Office, 1M Clinic room 1M 13, Cardiology 5G1, Cardiac Catheterization Lab, Unit 5B Nurse Lounge, GI Fellows Conference Room, Hematology/Oncology Administration Office, GI Conference Room 3D22, Occupational Health Clinic, HERO Medical record system and on file in the Medical Staff Office.

II. Functions To Be Performed

Each practice area will vary in the functions that will be performed, such as primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting and in performance of procedures.

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 six years. 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 and with the utilization of standardized procedures and Delegation of Services Agreement (documents supervising agreement between supervising physician and PA).

The NP/PA conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel patients on preventative health care, perform invasive procedures and furnish medications/issue drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

1. Location of practice is: Inpatient Units, GCRC, Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Infusion Center, 3 D Gastroenterology Clinic, Occupational Health Service, Positive Health Clinic, Hematology/Oncology Clinic, 1M and 5F Cardiology Clinics, Ward 17 Renal Dialysis, Pulmonary Outpatient Diagnostic Service (PODS), the Bronchoscopy Suite in Endoscopy Center, and the Emergency Department.
- 2). Role may include primary care, urgent care, furnishing medications, performing procedures and coordinating admissions and discharges. Role may also include admissions, transfers and discharges. Role may also include clinical research studies.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to: site Medical Director, Chief of Service, designated physician and other supervisors as applicable.
2. A consulting physician, who may include attendings, chief residents and fellows, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
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, affiliated staff, or physician.
 - e. Initiation or change of medication other than those in the formulary (ies).
 - f. Problem requiring hospital admission or potential hospital admission.
 - g. Acute, severe respiratory distress.
 - h. An adverse response to respiratory treatment, or a lack of therapeutic response.
 - i. Problem requiring invasive or surgical procedure.
 - j. Need for transfusion.
 - k. Review of electrocardiograms, if no prior interpretation or change from previous recording.
 - l. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.
 - m. Upon oncology providers seeing a newly diagnosed oncology patient in outpatient clinic.
 - n. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
 - o. Conditions severe enough to warrant partial or total disability work status prescription.
 - p. Any problem requiring transfer of care to the Emergency Department.
4. For Cardiology, GI, and Pulmonary Medicine providers only: NP/PA management of medical emergencies, including cardio-pulmonary arrest, shock and life-threatening bleeding shall include initial evaluation and stabilization of the patient through the utilization of Advanced Cardiac Life Support (ACLS), alerting the supervising physician and activation of the Code Blue Team by dialing X61122.

IV. Scope of Practice

- Protocol #1: Core: Acute/Urgent Care
- Protocol #2: Core: Primary Care
- Protocol #3: Discharge of Inpatient
- Protocol #4: Furnishing Medications/Drug Orders
- Protocol #5: Routine Occupational Health Screening
- Protocol #6: Evaluation and treatment of Occupational Illness/Injury and Exposure to Physical Chemical and Biological Hazards
- Protocol #7: eReferral Review
- Protocol #8: Procedure: Abdominal Paracentesis

Protocol #9: Procedure: Arthrocentesis and Intraarticular Injections
 Protocol #10: Procedure: Bone Marrow Aspiration and Biopsy
 Protocol #11: Procedure: Colonoscopy
 Protocol #12: Procedure: Esophagogastroduodenoscopy (EGD)
 Protocol #13: Procedure: Esophageal Manometry and Prolonged Ambulatory pH Monitoring
 Protocol #14: Procedure: Exercise Tread Mill Test
 Protocol #15: Procedure: High Resolution Anoscopy
 Protocol #16: Procedure: Incision and Drainage Skin Abscesses with Administration of Local Anesthesia
 Protocol #17: Procedure: Intraventricular Chemotherapy Administration via Ommaya Reservoir
 Protocol #18: Procedure: Lumbar Puncture
 Protocol #19: Procedure: Lumbar Puncture with the Administration of Intrathecal Chemotherapy
 Protocol #20: Procedure: Moderate Sedation
 Protocol #21: Procedure: Ordering Blood Transfusions
 Protocol #22: Procedure: Ordering Chemotherapy
 Protocol #23: Procedure: Skin Biopsies
 Protocol #24: Procedure: Thoracentesis
 Protocol #25: Procedure: Waived Testing
 Protocol #26: Procedure: Contraceptive Implant Insertion
 Protocol #27: Procedure: Contraceptive Implant Removal

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

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. Nurse Practitioners hired prior to the current Board requirement will be “grandfathered” in when up for reappointment.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider. Please note other certification may be required for specific procedures and ACLS may be required for procedures performed by cardiology and GI providers.
5. Possession of a National 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 and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the San

Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each practice site for each PA.

B. Specialty Training

1. Specialty requirements: NP Specialization in Acute Medicine, Family Medicine, Adult Medicine, Geriatric Medicine or Physician Assistant.
2. Two (2) years experience as a nurse practitioner/physician assistant in an adult medical clinic or an inpatient acute med/surg, critical care or Emergency Department setting or previous experience in Oncology within the last three (3) years preferred.
3. Clinical research and human subjects training (Research Unit only).
- 4.. All staff working in Occupational Health will receive training from an OHS Physician in:
 - a. California and CCSF Workers Compensation procedures.
 - b. Management of body fluid exposures.
5. Board certification or eligibility for board certification by the National Board for Certification of Hospice and Palliative Nurses (NBCHPN), as a Hospice & Palliative APN (HPAPN) (Palliative Care NP only).

VI. Evaluation

A. Evaluation of NP/PA Competence in performance of standardized procedures.

1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and other supervisors, as applicable will assess the NP/PA's ability to practice.
 - a. Clinical Practice
 - Length of proctoring period will be 3 months; review of cases and medical record reviews will be as listed in each protocol or procedure.
 - The evaluator will be Medical Director, Chief of Service and/or designated physician or privileged provider as applicable.
 - The method of evaluation in clinical practice will be five (5) chart reviews and direct observations, with at least one case representing each core protocol (combined core functions discharge of inpatients, and furnishing medications/drug orders). Additional proctoring requirements are specified in the remaining protocols.
2. Biennial Reappointment: Medical Director, and/or designated

physician must evaluate the NP/PA's clinical competence through five (5) chart reviews, with at least one case representing each core protocol (combined core functions discharge of inpatients, and furnishing medications/drug orders).and additional proctoring requirements as described in each procedure.

3. Follow-up: areas requiring increased proficiency as determined by the initial or biennial evaluation will be re-evaluated by the Medical Director, and/or designated physician, at appropriate intervals. If staff have not achieved competency within two years of initial appointment, provider may no longer operate under these standardized procedures.
4. Ongoing Professional Performance Evaluation (OPPE)

Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.

5. Physician Assistants:
 - a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are 1) Examination of the patient by Supervising Physician the same day as care is given by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

VII. Development and Approval of Standardized Procedure

A. Method of Development

1. Standardized procedures are developed collaboratively by the Nurse Practitioners, Physician Assistants, Nurse Midwives,

Registered Nurses, Pharmacists, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval

1. The CIDP, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to its implementation.

C. Review Schedule

1. The standardized procedure will be reviewed every three years by the NP/PA and the Medical Director and as practice changes.

D. Revisions

1. 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: Core Functions – Primary Care/Inpatient Units

A. DEFINITION

This protocol covers the procedure for health care management in primary care, specialty clinics, inpatient units and emergency department. Scope of care includes health care maintenance and promotion and management of common acute, subacute, and chronic illnesses within the Medicine Service.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
- c. Review of systems: present status of current symptoms (present, stable or absent).
- d. Pain history to include onset, location and intensity.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g. stable, unstable, or controlled, uncontrolled). Refine diagnoses as information becomes available and adjust treatment plans accordingly.

D. PLAN

1. Treatment

- a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.

- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol. Initiation or adjustment of medications as covered in Research Protocols.
 - c. Immunization update.
 - d. Referral to specialty clinics and supportive services, as needed.
 - e. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS (only relevant for GI and cardiology providers).
- 2. Patient conditions requiring Attending Consultation
 - 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. Uncommon, unfamiliar, unstable, and complex patient conditions
 - e. Upon request of patient, NP, PA, or physician
 - f. Initiation or change of medication other than those in the formulary/ies.
 - g. Problem requiring hospital admission or potential hospital admission.
 - h. Patients on Chemotherapy, referrals for radiation therapy.
 - i. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.
- 3. Education
 - a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
 - b. Anticipatory guidance and safety education that is age and risk factor appropriate.
 - c. Discharge information and instructions.
- 4. Follow-up

As indicated and appropriate to patient health status and diagnosis.

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). The electronic medical record (EMR) will be used to obtain and record patient information as required and appropriate. For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

Protocol #2: Core Functions – Primary Care

A. DEFINITION

This protocol covers the procedure for health care management in primary care, specialty clinics, inpatient units and emergency department. Scope of care includes health care maintenance and promotion and management of common acute, subacute, and chronic illnesses within the Medicine Service.

B. DATA BASE

3. Subjective Data

- e. History and review of symptoms relevant to the presenting complaint and/or disease process.
- f. Past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
- g. Review of systems: present status of current symptoms (present, stable or absent).
- h. Pain history to include onset, location and intensity.

4. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g. stable, unstable, or controlled, uncontrolled). Refine diagnoses as information becomes available and adjust treatment plans accordingly.

D. PLAN

3. Treatment

- f. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.

- g. Initiation or adjustment of medication per Furnishing/Drug Orders protocol. Initiation or adjustment of medications as covered in Research Protocols.
 - h. Immunization update.
 - i. Referral to specialty clinics and supportive services, as needed.
 - j. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS (only relevant for GI and cardiology providers).
4. Patient conditions requiring Attending Consultation
 - 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. Uncommon, unfamiliar, unstable, and complex patient conditions
 - e. Upon request of patient, NP, PA, or physician
 - f. Initiation or change of medication other than those in the formulary/ies.
 - g. Problem requiring hospital admission or potential hospital admission.
 - h. Patients on Chemotherapy, referrals for radiation therapy.
 - i. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.
 3. Education
 - d. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
 - e. Anticipatory guidance and safety education that is age and risk factor appropriate.
 - f. Discharge information and instructions.
 4. Follow-up

As indicated and appropriate to patient health status and diagnosis.

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). The electronic medical record (EMR) will be used to obtain and record patient information as required and appropriate. For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

Protocol #3: Discharge of Inpatients

A. DEFINITION

This protocol covers the discharge of inpatients from San Francisco General Hospital and Trauma Center. Direction to discharge patient will come from the attending physician.

B. DATA BASE

1. Subjective Data

- a. Review: health history and current health status

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Review medical record: in-hospital progress notes, consultations to assure follow-through.
- c. Review recent laboratory and imaging studies and other diagnostic tests noting any abnormalities requiring follow-up.
- d. Review current medication regimen, as noted in the MAR (Medication Administration Record).

C. DIAGNOSIS

Review of subjective and objective data and medical diagnoses, ensure that appropriate treatments have been completed, identify clinical problems that still require follow-up and that appropriate follow-up appointments and studies have been arranged.

D. PLAN

1. Treatment

- a. Review treatment plan with patient and/or family.
- b. Initiation or adjustment of medications per Furnishing/Drug Orders protocol.
- c. Assure that appropriate follow-up arrangements (appointments/studies) have been made.
- d. Referral to and communication with primary care, specialty clinics, skilled nursing facility providers, and support services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Upon request of patient, NP, PA or physician.
- c. Initiation or change of medication other than those in the formulary.

3. Education
 - a. Review inpatient course and what will need follow-up.
 - b. Provide instructions on:
 - follow-up clinic appointments
 - outpatient laboratory/ diagnostic tests
 - discharge medications
 - signs and symptoms of possible complications
4. Follow-up
 - a. Follow-up appointments
 - b. Copies of relevant paperwork will be provided to patient.

E. RECORD KEEPING

All information from patient hospital stay will be recorded in the medical record including a reconciled medication list and a discharge summary. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

Protocol #4: Furnishing Medications/Drug Orders

A. DEFINITION

“Furnishing “of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A “drug order” is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license. All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. If the PA has completed the education module, the certification must be attached to the PA's Delegation of Service Agreement.

Nurse practitioners may order Schedule II - V controlled substances when in possession of a DEA license. Schedule II - III controlled substances may be ordered for, but not limited to, the following conditions: patients presenting with acute and chronic pain and patients presenting with ADHD or other mental health-related disorders requiring the use of controlled substance II The practice site,, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol.

The formulary/ies to be use are: San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal (including Contract Drug List and formularies of managed care Medi-Cal plans), Healthy San Francisco, Medicare Part D plans, AIDS Drug Assistance Program, Blue Cross, Blue Shield, California Care, Pacific Care, Health Net, Healthy Families, United Healthcare, and Medicare Part D formularies. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

1. Subjective Data

- a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
- b. Pain history to include onset, location, and intensity.

2, Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Describe physical findings that support use for CSII-III medications.
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.

D. PLAN

1. Treatment

- a. Initiate, adjust, discontinue, and/or renew drugs and devices.
- b. When ordering respiratory treatments a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device, and frequency of treatments. Patient response will be monitored and documented.
- c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR/eCW, or in the Medication Administration Record (MAR). The protocol will include the following:
 - i. Location of practice
 - ii. Diagnoses, illnesses, or conditions for which medication is ordered
 - iii. Name of medications, dosage, frequency, route, quantity, amount of refills authorized and time period for follow-up.
- d. To facilitate patient receiving medications from a pharmacist provide the following:
 - i. name of medication
 - ii. strength
 - iii. directions for use
 - iv. name of patient and date of birth

- v. name of prescriber and title
- vi. date of issue
- vii. quantity to be dispensed
- viii. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation

- 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, nurse practitioner, physician assistant, or physician
- e. Initiation or change of medication other than those listed or approved by the formulary (ies)
- f. Problem requiring hospital admission or potential hospital admission
- g. Uncommon, unfamiliar, unstable, and complex patient conditions
- h. When requesting specialty consultation
- i. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.
- j. Acute, severe respiratory distress
- k. An adverse response to respiratory treatment, or lack of therapeutic response.
- l. Failure to improve pain and symptom management.

3. Education

- a. Instruction on directions regarding the taking of the medications in patient's own language.
- b. Education on why medication was chosen, expected outcomes, side effects, and precautions.

4. Follow-up

- a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record\LCR\MAR as appropriate. When a physician assistant writes a drug order for a controlled substance, the supervising physician must sign and date the chart containing such a drug order within seven (7) days.

Protocol #5: Routine Occupational Health Screening

A. DEFINITION

This protocol covers the procedures for screening history, physical examination, diagnostic evaluation of and appropriate preventive interventions for adult employees of the City and County of San Francisco (CCSF) and other affiliated clients within the Occupational Health Service. Relevant activities include:

1. Employment pre-placement, promotion and fitness-for-duty evaluations
 - a. Includes specific medical certifications such as California DMV Class A/B License, medical clearance for respirator use
2. Specific medical surveillance programs for occupational hazards (physical, chemical and biological)
 - a. Includes pertinent preventive interventions such as immunizations and N95 respirator fit-testing, including UCSF campus employees.

B. DATA BASE

1. Subjective Data
 - a. Screening: age- and examination/job-appropriate history that can include but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
 - b. Ongoing/Continuity: review of symptoms and history relevant to the patient's age, health history, examination type and job class
 - c. Pain history obtained to include onset, location, and intensity
2. Objective Data
 - a. Job description and other relevant qualification requirements/guidelines
 - b. Physical examination consistent with health history and examination type
 - c. Laboratory and imaging evaluation, as indicated, relevant to history and examination type
 - d. Previous medical records and clinical consultation reports, as needed

- e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

1. Assessment of data from the subjective and objective findings identifying risk factors, disease/injury/disability and medical qualification for work duties

D. PLAN

1. Action/Intervention
 - a. Age- and examination- appropriate screening/diagnostic testing or referral to primary health care system for consultation (as needed to complete occupational assessment)
 - b. Age- and examination/job-appropriate preventive interventions, including but not limited to:
 - 1) Education as described below
 - 2) Immunizations
2. Patient conditions requiring Physician consultation
 - a. Acute decompensation of patient situation, including hostile or threatening patient behavior
 - b. Any problem requiring transfer of care to an Emergency Department or specialist Physician
 - c. Unexplained historical, physical, or laboratory findings
 - d. Upon request of patient, NP, PA or Physician.
 - e. Conditions severe enough to warrant partial or total disability work status prescription
5. Education
 - a. Regarding occupational hazards and personal protection/safety measures
 - b. Regarding relevant health issues
 - c. Regarding relevant administrative/regulatory procedures
4. Follow-up
 - a. As indicated to complete assessment and disposition

E. RECORD KEEPING

All information relevant to patient evaluation/care will be recorded in the patient's OHS medical record, which is maintained in the OHS clinic.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites
a. Onsite training of procedures by a qualified provider. b. Review of departmental policy and procedure
Proctoring Period
a. 5 chart reviews and 1 direct observation of both protocol #5 and #6
Reappointment Competency
a. 5 chart reviews to cover both Occupational Health protocols #5 and #6

PROTOCOL #6: Evaluation and Treatment of Occupational Illness/Injury and Exposure to Physical, Chemical and Biological Hazards

A. DEFINITION

This protocol covers the procedures for screening history, physical examination, diagnostic evaluation and treatment of adult employees of the City and County of San Francisco (CCSF) and other affiliated clients who present to the Occupational Health Service with specific occupational health complaints or concerns. Relevant activities include:

1. Diagnosis and treatment of occupational injury or illness
2. Assessment and appropriate intervention following potentially significant occupational exposure to hazards (e.g. tuberculosis, human body fluids, chemical agents etc.).

B. DATA BASE

1. Subjective Data
 - a. Initial visit: Age- and incident-appropriate history that can include but is not limited to: history of current problem and detailed mechanism of injury or exposure, current symptoms, past medical history including relevant hospitalizations/injuries/immunizations, past surgical history, family history, psychosocial history, occupational history, allergies, current medications, treatments, and review of systems
 - b. Subsequent visits: Interval history to include current symptoms, response to treatment, impact of injury/illness on function
 - c. Pain history obtained to include onset, location, and intensity
2. Objective Data
 - a. Focused physical examination
 - b. Focused diagnostic testing
 - c. Review of relevant past medical records, exposure data
 - d. Job description or other knowledge of essential job duties
 - e. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

1. Assessment of data from the subjective and objective findings identifying diagnosis of illness/ injury or exposure risk factors.
2. Assessment of need for prescribed work restrictions or total disability

D. PLAN

1. Treatment

- a. Pharmaceutical agents (see Furnishing Medications/Drug Orders Protocol)
 1. As needed to cure or relieve injury/illness symptoms or conditions
 2. As needed prophylaxis following exposure to hazards
- b. Referrals as clinically indicated
 1. To primary care clinician (for non-occupational conditions)
 2. To Emergency Department
 3. To Physician specialist
 4. To mental health clinician
 5. To nurse case manager or claims adjuster (for issues of disability benefit management)
- c. Prescription of appropriate work and other activity restrictions
- d. Education as described below

2. Patient conditions requiring Physician consultation

- a. Acute decompensation of patient situation, including hostile or threatening patient behavior
- b. Any problem requiring transfer of care to an Emergency Department or specialist clinician
- c. Unexplained historical, physical, or laboratory findings
- d. Problem that is not resolved after reasonable trial of therapies
- e. Unexplained historical, physical, or laboratory findings
- f. Upon request of patient, NP, PA or Physician.
- g. Initiation or change of medication other than those in the formulary (ies).
- h. Conditions severe enough to warrant partial or total disability work status prescription

3. Education

- a. Regarding injury/illness diagnosis, treatment options, prognosis, activity restrictions/disability, follow-up plan
- b. Regarding risk of exposure to specific hazard, prevention/prophylaxis options, follow-up plan
- c. Regarding workers' compensation and other disability benefit programs

4. Follow-up

- a. As indicated to complete assessment and disposition

E. RECORD KEEPING

1. All information relevant to patient evaluation/care will be recorded in the patient's OHS medical record, which is maintained in the OHS clinic.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites a. Onsite training of procedures by a qualified provider. b. Review of departmental policy and procedure
Proctoring Period a. 5 chart reviews and 1 direct observation of both protocol #5 and #6 - b.
Reappointment Competency a. 5 chart reviews to cover both Occupational Health protocol #5 and #6

Protocol #7: Procedure: Abdominal Paracentesis

- A. Definition - Abdominal paracentesis is a procedure that entails inserting a trocar and cannula through the abdominal wall under local anesthetic for aspiration of peritoneal fluid (ascites). The term ascites denotes the accumulation of fluid in the peritoneal cavity.
1. Locations to be performed: Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Outpatient Infusion Center, 3D GI Clinic, , and Inpatient units.
 2. Performance of Procedure: (When possible any paracentesis should be performed bedside with ultrasound guidance or have fluid localized by radiology and transport patient on same bed used for marking. Procedure may be performed without ultrasound or radiologic guidance.)
 - i. Indications:
 - a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhosis related, for example).
 - b. Pt with ascites, fever, abdominal pain (to evaluate for spontaneous bacterial peritonitis).
 - c. Symptomatic treatment of tense ascites.
 - ii. Precautions;
 - a. Patients with INR greater than 2.0 should receive FFP prior to procedure Patients with platelets less than 20 should receive platelet infusion prior to procedure
 - b. Intra-abdominal adhesions or suspicion for loculated fluid.
 - c. Pregnancy
 - d. Necessity for ultrasound guided paracentesis if any conditions listed above are present.
 - e. Peritoneal dialysis
 - iii. Contraindications:
 - a. Fibrinolysis or DIC.
 - b. Cellulitis at puncture site
 - c. Acute abdomen requiring surgical intervention.
- B. Data Base
1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.

- b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
 - 2. Objective Data
 - a. Physical exam appropriate to presenting symptoms.
 - b. Laboratory (including platelet count, PT/PTT), Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.
- C. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes.
- D. Plan
 - 1. Therapeutic Treatment Plan.
 - a. Informed consent obtained prior to procedure and according to hospital policy.
 - b. Time out performed according to hospital policy.
 - c. Diagnostic tests for purpose of identifying disease etiology. Sent for cytology as relevant.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders Protocol.
 - e. Referral to specialty clinic, supportive services for provider as needed.
 - 2. Patient conditions requiring attending consultation
 - a. All patients with any condition listed in precaution section.
 - b. Acute decompensation of patient.
 - c. Upon the request of the patient, PA, NP or physician.
 - 3. Education
 - a. Appropriate and relevant patient and family education in written and/or verbal format.
 - b. Contact information for follow up should needle puncture site result in leaking ascitic fluid.
 - 4. Follow-up
 - a. As indicated and appropriate for procedure performed.
- E. Record Keeping

Patient visit, consent forms, and other documents will be included in the medical record, and other patient data bases, as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.
- F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: 1. Training by a privileged provider or documentation of previous training.
Proctoring: 1. Providers new to procedure must complete a minimum of 4 observed successful procedures and 4 chart reviews prior to completion of proctoring period. One of the procedures may be performed on a simulated model 2. Experienced providers must complete a minimum of 2 successful procedures prior to completion of proctoring period. Designation of experienced practitioner requires documentation of 1) Previous proctoring and 2) ongoing performance assessment within the past two years.
Reappointment Evaluation: 1. To maintain ongoing competency a minimum of 4 procedures every 2 years must be met. One of the procedures may be performed on a simulated model. If requirements not met, provider will be proctored through 1 successful procedure. 2. Four chart reviews every two years. 3. Evaluation must be done by Medical Director or designated physician.

Protocol #8: Procedure: Arthrocentesis & Intraarticular Injections

A. DEFINITION

This protocol covers arthrocentesis and injection of corticosteroids and/or lidocaine preparations for pain relief. The procedure is insertion of a needle into the joint space to aspirate fluid for analysis and/or inject medicine.

1. Location to be performed: Inpatient Units, Adult Medical Clinic and Medical Specialty Clinics on Ward 92 and the Emergency Department.
2. Performance of procedure:
 - a. Indications
 - Acute and chronic inflammatory musculoskeletal diseases/ disorders such as osteoarthritis, tenosynovitis, bursitis, and entrapment neuropathies.
 - Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of the joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of fluid will help distinguish among hemarthrosis, effusion, fracture, and septic arthritis.
 - b. Precautions
 - Patients with a coagulopathy.
 - c. Contraindications
 - Severe dermatitis or soft tissue infection overlying the joint
 - Acute trauma to the area.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. The procedure is performed following standard medical technique.
 - c. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.

- d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained, consistent with hospital policy, prior to start of procedure.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - e. Referral to orthopedic physician, specialty clinic, and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
 - a. All patients requiring this procedure.
3. Education
Discharge information and instructions.
4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the electronic medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

- a. The NP/PA will observe a qualified provider 1 time if experienced and if new, 2 times.
- b. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.

Proctoring Period

A minimum of 2 successful observed demonstrations and 2 chart reviews.
Reappointment Competency: An attending physician or designated qualified provider will be the evaluator. Provider must: 1. Perform a minimum of 4 procedures every 2 years 2. 2 chart reviews needed every 2 years.

Protocol #9: Procedure: Bone Marrow Aspiration and Biopsy

A. Definition – Bone marrow may be removed by aspiration or needle biopsy under local anesthesia and both are often used concurrently to obtain the best possible marrow specimens.

1. Procedure may be performed in the 4C Infusion center and Inpatient Units.
2. Performance of procedure:
 - a. Indications:
 - To diagnose cytopenias, hematological malignancies, granulomas, and aplastic, hypoplastic, and pernicious anemias.
 - To diagnose primary and metastatic tumors.
 - To determine the cause of infection.
 - To aid in the staging of disease, such as Hodgkin's disease.
 - To evaluate the effectiveness of chemotherapy and help monitor myelosuppression.
 - b. Relative contraindications include infection at the site of biopsy, thrombocytopenia less than 30K or uncorrected coagulopathy.

B. Data Base

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
2. Objective Data
 - a. Physical exam appropriate to presenting symptoms.
 - b. Laboratory including CBC and coags, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of disease (e.g. stable, unstable, and uncontrolled).

D. Plan

1. Therapeutic Treatment Plan.

- a. Obtain informed consent prior to procedure and according to hospital policy.
- b. Time out performed per hospital policy.

2. Patient conditions requiring attending consultation

- a. inability to obtain adequate sample
- b. upon request of NP, PA or physician.

3. Education

Appropriate and relevant patient and family education/counseling in written and/or verbal format.

4. Follow-up

As indicated and appropriate to client health status and diagnosis.

E. Documentation

Post-procedure note recorded in the medical record and will include all necessary documentation including consent form. For PAs using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites

- a. Will be trained on site by a privileged provider (MD, NP or PA)
- b. Documentation of previous training.

Proctoring period:

- a. new practitioners to procedure will complete a minimum of 3 successful observed demonstrations and chart review.
- b. experienced practitioners will complete a minimum of 2 successful observed demonstrations and Chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.

Reappointment Competency Documentation

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| <ul style="list-style-type: none">a. Evaluation of competency will include a letter from clinical director with input from attending hematologist regarding practitioners' proficiency as well as annual observation of 1 successful completion of procedure by attending hematologist and 2 chart reviews.b. Evaluation will be done by the Medical Director or Physician/NP designee. |
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Protocol #10: Procedure: Colonoscopy (Requires ACLS certification)

A. DEFINITION

Colonoscopy is the examination of the rectum and colon extending to the cecum and possibly terminal ileum through the use of a flexible video scope (and does encompass flexible sigmoidoscopy). It is performed as a screening measure, as a diagnostic tool and for research purposes. For the purposes of this protocol, these examinations are conducted at the 3D GI Endoscopy Center, 5B Research Unit, or designated endoscopy center at the San Francisco General Hospital and Trauma Center.

Indications:

Colonoscopy is usually indicated, but not limited to:

1. Colon cancer screening in individuals over age 50 at average-risk for development of cancer.
2. Colon cancer surveillance in individuals who have had a previous history of adenomatous polyps or cancer.
3. Colon cancer surveillance in persons with increased risk for development of cancer (inflammatory bowel disease, personal/family history of colon cancer).
4. Evaluation of the colon for symptoms or signs referable to the colon and/or terminal ileum.
5. Documentation of inflammatory disease of the rectum, colon or small intestine.
6. To determine extent and/or severity inflammatory bowel disease.
7. Presence of occult or overt blood in the stool.
8. Radiographic demonstration of possible neoplasm in the rectum or colon.
9. Performance of colonoscopic biopsies for research purposes.

Contraindications:

1. Inability to obtain informed patient consent.
2. When patient's cardiovascular status will not permit positioning in a recumbent position.
3. Perforated or suspected perforated viscous.

Therapeutic techniques:

The following table outlines endoscopic therapies associated with colonoscopy

and the level of attending physician participation within the procedure room that is required if a nurse practitioner/physician assistant is performing the endoscopic procedure and such therapy is required.

	No attending physician required	Attending physician presence required, but NP/PA can perform therapy	Attending physician only
Diagnostic (no therapy)	X		
Biopsy	X		
Polypectomy for polyps < 1 centimeter (e.g. cold snare, etc.)	X		
Tattooing for tumor marking	X		
Polypectomy for polyps > 1 centimeter		X	
Argon plasma coagulation (APC) therapy		X	
Saline lift for polypectomy		X	
Placement of endoscopic clips			X
Endoscopic banding			X
Sclerotherapy			X
Inability to complete the procedure			X
Adverse event that develops during the procedure			X

B. DATA BASE

1. Subjective Data

- History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include drug allergies.
- Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.

- c. Personal/family history related to the colon and colorectal disease.
- 2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. The procedure is performed following standard medical technique according to the departmental guidelines and an attending physician must be physically present and readily available for consultation in the endoscopy center or research unit when a colonoscopy is being performed by an NP/PA.
 - c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS/ASSESSMENT

Determine the indication for Colonoscopy

- 1. Diagnostic Evaluation:
History and/or physical examination findings suggestive of colorectal pathology.
- 2. Screening Evaluation:
The individual is asymptomatic and 50 years of age or over.
- 3. Preparation:
Bowel cleaning: utilize departmental approved regimen.
Aspirin/NSAIDs/antiplatelet/anti-thrombin/Coumadin: will be determined on a case by case basis and in accordance with ASGE guidelines for the Management of Antithrombotic Agents for Endoscopic Procedures.
Iron supplementation stopped 7 days prior to exam.
No intake by mouth for 8 hours (solids) and 2 hours (clear liquids).
- 4. Need for antibiotic prophylaxis is assessed on a case-by-case basis utilizing current American Society for Gastrointestinal Endoscopy antibiotic prophylaxis recommendations.

D. PLAN

- 1. Therapeutic Plan
 - a. Discuss with patient the objectives, alternatives, limitations, risks and benefits of the procedure.
 - b. Patient consent must be obtained before the procedure is performed. A "time out" is performed prior to each procedure to verify the right test is being performed on the right patient.
 - c. Biopsied/removed tissue is labeled and sent to pathology.
 - d. Referral to physician, specialty clinics, and supportive services, as needed.
- 2. Patient conditions requiring attending consultation
 - 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, affiliated staff, or physician.
 - e. Problem requiring hospital admission or potential hospital admission.
 - f. Problem requiring invasive or surgical procedure.
 - g. Need for transfusion.
 - h. Review of electrocardiograms, if no prior interpretation or change from previous recording.
 - i. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.
 - j. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
 - k. Any problem requiring transfer of care to the Emergency Department.
- 3. Education: Discharge information, instructions and follow-up appropriate to examination findings.
 - 4. Follow-up: Pathology results will be reviewed from patients whom biopsies or polypectomies were performed. The patient will be provided pathology results via the primary care provider, letter, telephone, or an appointment in the GI clinic.

E. RECORD KEEPING

- a. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointment and procedure information, if indicated.
- b. Document all findings, impression and recommendations in the computerized procedure database. Procedure documentation is automatically exported to electronic medical record.

F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

- 1. Indications for procedures.
- 2. Risks and benefits of procedures.
- 3. Related anatomy and physiology.
- 4. Bowel preparation procedures.
- 5. Informed consent process.
- 6. Use of required equipment.
- 7. Steps in performing procedures.
- 8. Ability to interpret results and formulate follow-up plans.
- 9. Documentation.
- 10. Ability to recognize a complication.

11. Prostate examination in males 50 years of age and older with referral of significant abnormalities to the Supervising Physician.
12. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.
13. Proof of ACLS certificate

B. Protocol Specific Training

1. View the videotapes from the ASGE Video Library: colonoscopy and polypectomy (GE-10), colonoscopy – insertion to cecum (GE-53), colonoscopy – polypectomy techniques I (GE-54), colonoscopy – polypectomy techniques II (GE-55), colonoscopy polyps and tumors of the colorectum and management of large colorectal polyps (GE-56).
2. Observe and demonstrate by repeat performance the proper set-up, usage and sterilization of the colonoscope and the proper use of the video processor.
3. Read Hospital Policy 19.8” Procedural Sedation: Moderate and Deep” and take test on Procedural Sedation. Learn the GI Division Protocol for moderate sedation, and achieve competency for administration of moderate sedation based on the SFGH privileging process.
4. Learn the use of the clinical software in order to capture procedure images and generate procedure reports.
5. Review appropriate infection control guidelines pertaining to colonoscopy.

Proctoring

Initial Proctoring Period: NP/PA’s will be proctored through direct observation by a GI attending physician credentialed in endoscopy for a minimum of 150 colonoscopy procedures with administration of procedural sedation (including the performance of at least 50 routine colonic mucosal biopsies and 50 colonoscopic polypectomies). An experienced practitioner to colonoscopy requires a minimum of 10 successful observed demonstrations (including the performance of at least 5 colonic mucosal biopsies and 5 colonoscopic polypectomies). As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent colorectal anatomy and pathology. At the conclusion of the standardized procedure training the Clinical Chief of Gastroenterology or designated Physician will assess the NP/PA’s ability to practice, including an evaluation of the NP/PA’s clinical skills in taking a history, performing an appropriate physical examination, obtaining informed consent, the ordering and interpretation of laboratory and radiographic studies pertinent to the specific clinical situation, documentation of an endoscopic procedure and initiating a treatment plan.

Competency in Performing Standardized Procedure

- a. Review of the post test of Education Module by the Clinical Chief of Gastroenterology.
- b. Review of 75 procedure notes by the Clinical Chief of Gastroenterology.

Reappointment Competency

1. Biannual Evaluation (every 6 months):

- a. Review will include chart review, collaboration with and eliciting information from attending physicians and advanced practice staff.
- b. Ongoing competency will include the successful observed completion of ten (10) colonoscopies, five (5) colonoscopies with mucosal biopsy's and five (5) colonoscopic polypectomies procedures.
- c. 20 chart reviews.
- d. Maintenance of ACLS Certification.
- e. Passing of Procedural Sedation test with passing score of 80%.
- f. Review of any adverse event(s) that occurred during a colonoscopy.
- g. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of a colonoscopy
- h. Successful achievement of all OPPE metrics with no identified deficiencies
- i. Documentation of required continuing medical education (CME)

Protocol #12: Procedure: Esophageal Manometry and Prolonged Ambulatory pH-Monitoring (ACLS required)

A. DEFINITION

Esophageal manometry is the clinical evaluation of esophageal contractile activity, and is performed to assess esophageal motor function (often pre-operatively) and for the diagnosis of suspected esophageal motor disorders. The study measures the strength, function, and coordination of the upper and lower esophageal sphincters (UES and LES, respectively), and the body of the esophagus in response to swallows. Recordings are made of the amplitude and coordination of contractions within the pharynx and esophagus. Ambulatory Esophageal pH monitoring (24-hour pH probe) is sometimes performed in conjunction with esophageal manometry. During this procedure, an intra-nasal catheter is placed in reference to the manometrically-defined lower esophageal sphincter, and records acid reflux events over a 24-hour period. Esophageal manometry is conducted on the GI Endoscopy Center at San Francisco General Hospital and Trauma Hospital.

Indications:

Esophageal Manometry is usually indicated, but not limited to:

1. Evaluation of suspected esophageal motor dysfunction, such as esophageal spasm, achalasia, or the 'nutcracker' esophagus.
2. Evaluation of patients with unexplained ('non-cardiac') chest pain or dysphagia.
3. Preoperative evaluation of esophageal motor function prior to esophageal/gastric surgery
4. Assisting in accurate placement of ambulatory esophageal pH probes.
5. Evaluation of patients with neuromuscular disorders affecting esophageal function and/or swallowing (e.g., scleroderma, muscular dystrophy, and strokes).
6. Evaluation of patients with symptoms that may represent reflux disease, such as chronic cough, asthma, hoarseness.
8. Preoperative evaluation of esophageal reflux prior to esophageal/gastric surgery
9. Assess reflux patients not responding to standard medical/pharmacologic therapy.

Contraindications to Esophageal Manometry/pH Monitoring:

1. Inability to obtain informed patient consent.
2. Undiagnosed potential trauma to the nasal passages, nasopharynx, oropharynx, esophagus and/or the stomach.
3. When patient's health status/physical limitations will not permit placement of a flexible catheter through the nose and/or into the esophagus.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure to be performed, to include diet, medications, and allergies.
 - b. Past medical history pertinent to presenting problem or procedure including surgical history, hospitalizations, and habits.
 - c. Family history to include peptic ulcer disease, cancer, diabetes.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines) and an attending physician must be physically present and readily available for consultation when an esophageal manometry is being performed by an NP/PA.
 - c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS/ASSESSMENT

1. Obtain patient's medical history to determine indications for esophageal manometry and/or pH monitoring.
2. Preparation: Patient is to be NPO after midnight before the procedure.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Discuss with patient the objectives, alternatives, risks and benefits of the procedure.
 - b. Verify NPO status so that procedure can be performed in a safe and appropriate manner.
 - c. Obtain informed consent, utilizing interpreter services as necessary.
2. Patient conditions requiring Attending Consultation:
 - a. Emergent conditions requiring prompt medical intervention.
 - b. Acute decompensation of the patient.
 - c. Historical, physical or diagnostic findings that seem unusual.
 - d. A problem, which is not resolving as anticipated.

- e. Upon request of patient, NP, PA, or physician
 - f. Initiation or adjustment of medication other than those in the formularies.
 - g. Problem requiring hospital admission or potential hospital admission.
 - h. When ordering complex imaging studies or procedures.
- 3. Education: Discharge information, instructions and follow-up appropriate to examination findings.
 - 4. Follow-up: Patients will be evaluated in the appropriate gastroenterology clinic to follow up on the results of pH and manometry tests.
- E. RECORD KEEPING
- 1. Provide patient with discharge instructions at end of procedure, as well as any follow-up appointments and procedure information, if any.
 - 2. Document all findings in the computerized procedure database. Procedure documentation is automatically exported to the electronic medical record
- F. SUMMARY OF PREREQUISITES, PROCTORING, & REAPPOINTMENT COMPETENCY

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

- 1. Indications for procedures.
- 2. Risks and benefits of procedures.
- 3. Related anatomy and physiology.
- 4. Bowel preparation procedures.
- 5. Consent process.
- 6. Use of required equipment.
- 7. Steps in performing procedures.
- 8. Ability to interpret results and formulate follow-up plans.
- 9. Documentation.
- 10. Ability to recognize a complication.
- 11. Ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.
- 12. Review relevant literature available on the GI unit regarding esophageal Manometry / pH monitoring procedure and familiarize self with "Manometry Set-up Procedure" in the Policy and Procedure section of the GI Division Operations Manual.
- 13. Observe and demonstrate by repeat performance the set-up, calibration, and operational procedures for esophageal Manometry and pH catheter assembly.
- 14. Possession of an ACLS Certificate

Proctoring

NP/PA's will be proctored through direct observation by GI attending staff credentialed in endoscopy for a minimum of 5 esophageal manometry and pH monitoring procedures prior to performing such procedures independently. An experienced practitioner to the procedure will require a minimum of 3 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.

As part of the proctoring process, the NP/PA will be assessed for knowledge of pertinent nasopharyngeal, esophageal and stomach anatomy.

Competency in Performing Standardized Procedures

- a. Review of the post test of Education Module by the Medical Director.
- b. Review of 20 procedure notes by the Clinical Chief of Gastroenterology.

Reappointment Competency

1. Evaluation:
 - a. Ongoing competency will include completion of five (5) esophageal Manometry and pH monitoring procedures every year.
 - b. Review of any adverse event(s) that occurred during an esophageal manometry.
 - c. Review of any unusual occurrence, sentinel event, or patient complaint that involved an NP/PA during the performing of an esophageal manometry.
 - d. Successful achievement of all OPPE metrics with no identified deficiencies
 - e. Documentation of required continuing medical education (CME)

Protocol #13: Procedure: Exercise Treadmill Test (ACLS required)

A. DEFINITION

This test is to use incremental exercise modality to diagnose, evaluate and assess the following:

1. Aid in the diagnosis of coronary artery disease
2. Evaluate severity of ischemia in patients with known coronary artery disease (angina, post infarction, positive angiogram, post-AC bypass or PCI).
3. Effort tolerance (EKG may or may not be normal)
4. Chronotropic competence
5. Exercise BP
6. Exercised - induced arrhythmia

Location to be performed: This test will be done in: Cardiology outpatient setting.

Patient preparation

- a. Patient must be able to walk unassisted (i.e. without cane or other aid).
- b. For patients who had chest pain, when in the Emergency Department, must have had a negative troponin test.
- c. Nothing by mouth if test is done in AM, light meal for PM.
- d. Stop smoking one hour prior to the test.
- e. Hold anti-glycemic medication prior to the test as indicated.
- f. For the purpose of diagnosis of CAD, beta-blockers should be discontinued 24-36 hours prior the test, if possible.

Performance of procedure

- a. Precautions: Never push the patient above his/her exercise capability.
- b. Contraindications
 1. Severe or critical aortic stenosis
 2. Unstable angina with rest
 3. Suboptimum treated congestive heart failure
 4. Pericarditis
 5. Uninterruptible ECG for any reason, e.g. LVH, LBBB or WPW
 6. Patient with murmur, unknown reason
 7. Uncontrolled HTN (Baseline SBP>180)

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify myocardial ischemia during the exercise treadmill test.

D. PLAN

1. Therapeutic Treatment Plan

- a. Diagnostic tests for purposes of disease identification.
- b. Screening tests performed as part of appropriate health maintenance.
- c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:

- a. Acute decompensation of patient situation.
- b. Unexplained historical, physical, laboratory or study findings.
- c. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient, NP, PA, or physician
- e. Initiation or adjustment of medication other than those in the formularies.
- f. Problem requiring hospital admission or potential hospital admission.

3. Education

- a. Patient education as appropriate to procedure
- b. Discharge information and instructions.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. There will be documentation of all vital signs, blood pressure, heart rate, oxygen saturation, as well as any symptomatology during testing. All changes in 12 lead EKG during procedure will be documented. The attending cardiologist will complete final reading and sign the report in the LCR. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: a. Review of departmental policy and procedure. b. Two direct observations of procedure being performed by a qualified provider. c. Completion of a 12 lead EKG Course or completion of 12 lead EKG training by qualified Cardiology staff.
Proctoring Period: a. 3 successful observed demonstrations for provider new to this procedure. b. 2 successful demonstrations for provider experienced in this procedure. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. c. Chart review of all observed cases.
Reappointment Competency Documentation: a. Perform 2 procedures every 2 years. b. 2 chart reviews every 2 years.

Protocol #14 Procedure: High Resolution Anoscopy

A. DEFINITION

Men and women with abnormal anal pap smears will be evaluated by high resolution anoscopy (HRA) with biopsy of suspicious lesions and treatment or referral as indicated.

1. Performance of procedure:

- i. Indications: Patients with abnormal anal pap smears, anal lesion visible by gross examination or a history of anal warts or anal dysplasia.
- ii. Precautions/Contraindications: Consult an MD before performing biopsies on patients with Thrombocytopenia, Neutropenia, infection of anal canal, use of anticoagulants, history of abnormal heart valve or endocarditis.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
- b. Time out performed per hospital policy.
- c. Diagnostic tests for purposes of disease identification.
- d. Biopsy tissue is sent to pathology.

- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
 - a. As specified under precautions.
 - b. Upon request of patient, NP, PA, or physician
 - c. Initiation or adjustment of medication other than those in the formularies.
 - d. Problem requiring hospital admission or potential hospital admission.)
 3. Education
Discharge information and instructions.
 4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Completion of a one week course in theory and practice of cervical colposcopy from the University of California or a recognized university.
Proctoring : a. Performance of 50 high resolution anoscopy procedures (anal colposcopy with biopsy) under supervision of an experienced colposcopist. b. Review of 3 medical records.
Reappointment Competency Documentation: a. Minimum of 20 procedures that must be completed every two years. b. Minimum of 3 chart reviews needed every two years.

Protocol #15: Procedure: Incision and drainage of skin abscesses with administration of local anesthesia

A. DEFINITION

Abscesses resolve with drainage. Abscesses that do not respond to more conservative measures may need incising in order to facilitate drainage and hasten resolution.

1. Performance of procedure.

a. Indications:

Palpable, fluctuant skin abscesses

b. Precautions:

Large abscesses that require extensive incising or debridement

c. Contraindications:

1. Deep abscesses that may require more extensive anesthesia

2. Abscesses that invade the palmar or plantar spaces

3. Suspected pseudo aneurysm (must be ruled out by further diagnostic evaluation)

d. Exclusions:

Abscesses on the face, neck, perirectal area, and genitalia

B. DATA BASE

1. Subjective Data

a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

a. Physical exam appropriate to the procedure to be performed.

b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - e. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation.
 - b. Unexplained historical, physical, or laboratory findings
 - c. Upon request of patient, NP, PA, or physician
 - d. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
3. Education - Discharge information and instructions.
4. Follow-up - As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. The NP/PA will be trained to successfully perform the procedure through instruction and proctoring by the Medical Director or his/her designee.
Proctoring: a. New practitioner to procedure, a minimum of 2 successful observed demonstrations. b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. c. Chart review of all observed procedures.
Reappointment Competency: a. The number of procedures needed to maintain proficiency will be 2 procedure every 2 years.

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| <ul style="list-style-type: none">b. The number of chart reviews needed to monitor ongoing competency for annual review will be 2 chart every 2 years. |
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Protocol #16: Procedure: Intraventricular Chemotherapy Administration
via Ommaya Reservoir

A. Definition - The administration of chemotherapy via Ommaya Reservoir into cerebrospinal fluid (CSF) for treatment of previously diagnosed central nervous system (CNS) involvement by leukemia and lymphoma or other malignancies. The procedure is also used for withdrawal of CSF for laboratory analysis in patients with known CNS malignancy.

1. May be performed in the 4C Infusion Center Or Inpatient Units

i. Indications

- a. Patients with surgically implanted Ommaya reservoir and recent diagnosis or history of leptomeningeal malignancy
- b. Patients with Ommaya reservoir and meningeal signs or symptoms such as nuchal rigidity and headaches, without evidence of increased intracranial pressure.
- c. Withdrawal of CSF may be done as part of evaluation of fever (as indicated) in patients with Ommaya reservoir.

ii. Precautions

- a. Precautions: Evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, papilledema, bulging Ommaya or significant decrease in the level of consciousness; evidence of focal neurological findings.

iii. Contraindication: Cutaneous infection at the site of puncture.

B. Data Base:

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data

- a. Physical exam appropriate to presenting symptoms.
- b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of disease (e.g. stable, unstable, and uncontrolled).

D. Plan

1. Therapeutic Treatment Plan
 - a. Obtain informed consent prior to procedure and according to hospital policy.
 - b. Time out performed according to hospital policy.
 - c. CSF may be sent for evaluation for infection or malignancy.
2. Patient conditions requiring attending consultation:
 - a. Acute decompensation of patient situation.
 - b. Unexplained physical or laboratory findings.
 - c. Initiation or adjustment of medication other than those in the formularies.
3. Education
 - a. Appropriate and relevant patient and family education/counseling in written and/or verbal format.
4. Follow-up
 - a. As indicated and appropriate to client health status and diagnosis.

E. Documentation

Post-procedure note recorded in the medical record in addition to consent forms and other procedure specific documents as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the PA within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite

Training will consist of instruction by clinical directors or physician/NP designee.
Proctoring Period a. Proctoring period for practitioners will be a minimum of 3 successful observed demonstrations within the proctoring period, if there are insufficient opportunities within the proctoring period, and then procedure will be supervised until the minimum requirement is met.
Reappointment a. A minimum of 2 procedures within a 2 year period. If no opportunities occur within a 2 year period, provider will be supervised for 1 additional procedure when the opportunity occurs. b. 2 chart reviews every 2 years.

Protocol # 17: Procedure: Lumbar Puncture

A. DEFINITION

A diagnostic procedure used to identify infectious, neoplastic, and autoimmune processes of the central nervous system. Lumbar puncture may also be performed to determine the intracranial pressure.

1. Location to be performed: Inpatient Units and the 4C Outpatient Infusion Center
2. Performance of Lumbar Puncture
 - a. Indications
 1. To obtain Cerebral Spinal Fluid (CSF) for diagnosis of infectious, inflammatory or neoplastic diseases
 - b. Precautions

Indications for brain CT scan prior to LP include the following

 1. Age >60 years
 2. Immunocompromised patients
 3. Known CNS lesions
 4. Recent seizure activity
 5. Abnormal level of consciousness
 6. Focal findings on neurological examination
 - c. Contraindications
 1. Increased Intracranial Pressure
 2. Soft tissue infection at the entry site
 3. Coagulopathy
 4. Known spinal cord arteriovenous malformations
 5. Patient refusal

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure to be performed including but not limited to presence of headache or meningitic symptoms, motor/sensory deficits, and new/persistent CSF leak.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-

containing-products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination, assessment of papilledema, and integrity of the lumbar skin site.
- b. The procedure is performed following standard medical technique according to The Handbook of Neurosurgery by Mark Greenberg, Section 23.7.3. Lumbar Puncture.
- c. Laboratory evaluation to include CBC with platelets, PT, PTT, and INR. Imaging evaluation, including CT head to rule out a mass lesion, a posterior fossa lesion, or subarachnoid hemorrhage, as indicated by history and physical exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent, consistent with hospital policy, obtained before procedure is performed.
- b. Timeout conducted consistent with hospital policy.
- c. Diagnostic tests on the CSF for purposes of disease identification may include chemistry, gram stain, culture and sensitivity, blood cell count and differential, and measurement of CSF pressure. Additional diagnostic tests may be sent, as indicated
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. All patients requiring this procedure will receive Attending Consultation

3. Education

- a. Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print-outs titled "Lumbar Puncture" and "Having a Lumbar Puncture" can be provided to patients to assist with pre- and post-procedural education.

4. Follow-up

As appropriate for lumbar puncture.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this procedure. b. Completion of onsite training by qualified provider if no prior experience.
Proctoring a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations and 3 chart reviews b. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations and 2 chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. c. Proctoring for 1 of the procedures may be performed on a simulated model
Reappointment a. The evaluator will be an attending physician or another designated clinician that has unrestricted privileges to perform lumbar punctures b. Ongoing Competency Evaluation 1. Three Lumbar Punctures will be needed to maintain proficiency every 2 years. 2. Three chart reviews will be needed every 2 years. c. Proctoring for 1 of the procedures may be performed on a simulated model

Protocol #18 Procedure: - Lumbar puncture with the Administration of Intrathecal Chemotherapy

A. Definition – The lumbar puncture (LP) may assist in diagnosis of central nervous system (CNS) infections, malignancies and subarachnoid hemorrhage. The LP also facilitates the intrathecal administration of chemotherapy into CSF in previously diagnosed lymphoma and leukemia patients with leptomeningeal involvement or high risk for leptomeningeal involvement.

1. Location of procedure may include 4C Infusion Center, Inpatient rooms and fluoroscopy room in Radiology.
 - a. Indications - Patients with recent diagnosis of CNS malignancy, history of CNS malignancy, therapy related complications of the CNS, or signs and symptoms of infections of the CNS, acute leukemia or lymphoma (as staging or CNS prophylaxis).
 - b. Precautions/Contraindications:
 - Patients with evidence of increased intracranial pressure: increased blood pressure with widening pulse pressure, altered mental status, or focal neurological deficits should undergo a neuroimaging study before a LP is performed and requires physician consultation.
 - New focal neurologic findings and/or lesions, or imaging studies revealing significant mass effect. Requires physician consultation.
 - Use caution with patients with a history of low back pain, sciatica pain, or lower extremity neuralgia. Any patients with prior back surgery shall be evaluated by the attending physician prior to the procedure.
 - Patients with meningeal signs or symptoms, such as nuchal rigidity and headache with or without evidence of increased intracranial pressure, fever or altered mental status should be done in the hospital after appropriate CT scanning and prior physician consultation.
 - Patients with either thrombocytopenia (platelet count less than 30,000), INR > 1.4, PTT >40 Consult with physician before performing the procedure. Patients may require additional studies or blood products to correct the platelet count and/or coagulation factor deficiencies.

B. Data Base

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-containing products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data

- a. Physical exam appropriate to presenting symptoms.
- b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis

Assessment of data from the subjective and objective findings to identify disease processes.

D. Plan

1. Therapeutic Treatment Plan

- a. Obtain informed consent prior to procedure and according to hospital policy.
- b. Time out performed per hospital policy.
- c. Diagnostic tests for clarification of disease state or infection.
- d. Initiation or adjustment of medication per chemotherapy order writing protocol.

2. Patient conditions requiring attending physician consultation

- a. Acute decompensation of patient.
- b. Unexplained physical or laboratory findings
- c. Upon request of patient, NP, PA or physician
- d. Any precautions listed under A1b

3. Education

Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print outs titled "Lumbar Puncture" and "Having a Lumbar Puncture" can be provided to patients to assist with pre and post-procedural education.

4. Follow-up

As indicated and appropriate to client health status and diagnosis.

E. Documentation

Post-procedure note recorded in the medical record and LCR as appropriate and will include all necessary documentation. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign

and date a minimum of five (5%) sample of medical records of patients treated by the PA within thirty (30) days of the procedure. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites a. Preferably, the NP/PA will have prior training on the lumbar puncture procedure in their training program. However, no prior experience or expertise is required for this minor procedure. b. Completion of onsite training by a qualified provider if no prior experience.
Proctoring a. New practitioner to lumbar puncture, a minimum of 3 successful observed demonstrations and chart reviews. b. Experienced practitioner to lumbar puncture, a minimum of 2 successful observed demonstrations and chart reviews. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
Reappointment a. The evaluator will be the Clinical Service Chief or another designated physician that has unrestricted privileges to perform lumbar punctures. b. Ongoing Competency Evaluation 1. 2 Lumbar Punctures will be needed every 2 years. 2. 2 chart review will be needed every 2 years.

Protocol #19: Procedure: Procedural Moderate Sedation

A. DEFINITION

Procedural/Moderate Sedation/Analgesia: is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light or tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation (SFGH policy number 19.08 titled, "Procedural Sedation: Moderate and Deep") by the Nurse Practitioner/Physician Assistant during procedures in adults within a monitored setting. For the purpose of this protocol, the setting is specifically in the Gastroenterology Department. The Nurse Practitioner/Physician Assistant practices under the supervision of the Chief of Gastroenterology or designee. Practitioners producing a level of sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes, and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedure may only be done in 3D GI Service or in the 5B Research Unit.

Materials necessary for procedural sedation and rescue include:

- a. Appropriate monitoring equipment.
- b. Emergency medications and equipment for care and resuscitation, including cardiac defibrillator must be immediately available. Medications include, but are not limited to reversal agents (naloxone and flumazenil) and vasoactive medications (phenylephrine and dopamine).
- c. Supplemental oxygen and positive pressure ventilation equipment.
- d. Suction equipment/supplies.
- e. Intravenous access.

Indications:

- a. Procedural sedation may be indicated, but not limited to colonoscopy and esophagogastroduodenoscopy (EGD).

Precautions/Contraindications:

- a. Inability to obtain informed patient consent.
- b. Anticipated difficult intubation.

- c. The patient's American Society of Anesthesiologists (ASA) physical status; consultation with Anesthesia Service should be considered for patients who have an ASA score of 3 or above. A procedure requiring sedation would not be done on a patient with an ASA score above a three (3) without anesthesia assistance.
- d. When the patient's cardiovascular status will not permit positioning in a recumbent position.
- e. Undiagnosed potential trauma to the gastrointestinal tract.

B. DATA BASE

1. Subjective Data

- a. Obtain a history within 24 hours of the procedure and sedation. If completed prior to 24 hours, an interim history must be obtained.
- b. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
- c. Pertinent past medical history, surgical history, hospitalizations, habits, anesthetic, allergy and drug history.

2. Objective Data

- a. Physical exam within 24 hours of procedure and sedation. If completed prior to 24 hours, an interim physical must be obtained.
The exam is to include airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight), and IV access.
- b. Diagnostic data, as appropriate.
- c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.
- d. Laboratory and imaging results, as indicated, relevant to the history and physical exam.

C. DIAGNOSIS/ASSESSMENT

- 1. A judgment as to the appropriateness of the procedure and safety of sedation for the particular patient, that includes consideration of the patient's age, medical condition, and the procedure and sedation side effects and risks.
- 2. Assignment of an ASA physical status. Patients with a Physical ASA class of IV or V will not undergo moderate sedation by the Nurse Practitioner/Physician Assistant in the Gastroenterology Department.
- 3. Assignment of the pre-procedure Modified Aldrete Score.
- 4. Evidence of verification of compliance with the NPO status (adult: minimum 8 hours (solids) and 2 hours (clear liquids) before procedure to decrease risk of aspiration).
- 5. Assess and document the benefits of sedation against the risk of possible aspiration.
- 6. A responsible adult is available to take the patient home after the procedure.

D. PLAN

1. Therapeutic Treatment Plan shall follow SFGH policy number 19.08 titled "Procedural Sedation: Moderate and Deep"
 - a. Informed consent for the procedure and sedation must be obtained and documented by the nurse practitioner/physician assistant prior to the delivery of sedation. The consent form must list the procedure to be performed as well as the sedation planned.
 - b. Pre-Procedure patient education shall be given and documented, to include, but not be limited to:
 1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
 2. Risks, benefits, and alternatives.
 3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
 4. Date/time of procedure.
 5. Necessity of an escort for discharge to home and/or an appropriate mode of transportation home.
 - c. Re-assessment immediately prior to the procedure to include:
 1. Indication for procedure.
 2. Two patient identifiers.
 3. A "time out" documented.
 4. Immediate pre-procedure vital signs (blood pressure, heart rate and oxygen saturation).
 5. An assessment of level of movement and consciousness, and responsiveness.
 - d. The Procedure:
 1. Verify pre-procedure assessment and monitoring guidelines.
 2. Administer appropriate medications as indicated.
 3. Continuously assess the patient's response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, ETCO₂, EKG rhythm, and pain level).
 5. Reversal agents, if indicated.
 - e. Post-procedure
 1. Monitor level of consciousness, respiratory (RR, SaO₂) and cardiovascular parameters, and pain level.
 - f. Termination of Treatment
 1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.
2. Patient conditions requiring Attending Consultation
 - a. Physical ASA status 3 or above.
 - b. Aspiration.
 - c. Acute decompensation of patient situation.
 - d. Unexplained historical, physical or laboratory findings.
 - e. Upon request of patient, NP, PA, or physician.
 - f. Problem requiring hospital admission or potential hospital admission.

3. Education

Patient will be instructed on signs and symptoms of complications. A 24 hour emergency advice number will be given to the patient for any post-procedural problems. Examination findings/pathology results will be provided to the patient by the primary care provider, telephone, or during an appointment in the GI Clinic.

4. Follow-up

A. If the patient is transferred to the recovering unit:

1. The patient must be accompanied by trained and/or licensed personnel.
2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:
 - a. Pertinent medical history
 - b. The procedure performed.
 - c. The condition of the patient; including pain score.
 - d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
 - e. Any significant clinical events occurring during and post-procedure.
 - f. Any additional physician orders relating to the post-procedural/moderate sedation care.

B. Any patient receiving a reversal agent (narcan or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re-sedation. In addition an Unusual Occurrence Report must be completed. See Hospital Policy 19.08 for other criteria requiring submission of an unusual occurrence report.

C. The outpatient is discharged "to home":

1. By a specific discharge order from a physician or nurse practitioner/physician assistant; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.
2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
3. Outpatients who are discharged to home must be accompanied by a responsible adult and have an appropriate mode of transportation.

E. RECORD KEEPING

Patient visit, consent forms, other procedure specific documents, and a post procedure note will be recorded in the Medical record as appropriate. The patient status and compliance with discharge criteria must be documented in the patient's medical record by the physician, nurse practitioner, physician assistant, or registered nurse discharging the patient. Document all findings

in the computerized procedure database. Procedure documentation is automatically exported to the Lifetime Clinical Record (LCR).

F. Summary of prerequisites, proctoring & reappointment of competency

Prerequisites

A. Specialty Training

The NP/PA will be able to demonstrate knowledge of the following:

1. Indications for procedures.
2. Risks and benefits of procedures.
3. Related anatomy and physiology.
4. Bowel preparation procedures.
5. Informed consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.

B. Training Program

1. Completion of the SFGH Procedural Sedation Test with a passing score of 90%.
2. Completion of (BLS) training.
3. Completion of the Registered Nursing Moderate Sedation Education Module.
4. Furnishing License and/or DEA number.

Proctoring

- A. Direct observation by GI attending staff credentialed in moderate sedation for a minimum of 30 procedures with moderate sedation, while an experienced practitioner to moderate sedation requires a minimum of 10 successful observed demonstrations. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
- B. Successful completion of Education Module post test.
- C. Review of 30 procedure notes by the Chief of Gastroenterology.

Reappointment

- A. Ongoing competency will include the successful observed completion of three procedures every 2 years.
- B. Direct observation of one patient clinic encounter will be conducted by the Medical Director or other designated attending physicians every 2 years.
- C. Maintenance of BLS Certification.
- D. Passing of Procedural Sedation test with a passing score of 90%

Protocol #20: Procedure: Ordering Blood Transfusions

A. DEFINITION

Ordering the administration of whole blood or blood components i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate. Exchange transfusion is the withdrawal of blood prior to a transfusion to keep hemoglobin unchanged.

1. Location to be performed: Inpatient hospital units, Hematology/Oncology Clinic, 4C Infusion Center and the Positive Health Clinic. Exchange transfusions will only be done in the 4C Infusion Center.
2. Performance of procedure:
 - a. Indications
 1. Anemia
 2. Thrombocytopenia or platelet dysfunction
 3. Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means.
 4. Exchange transfusions for sickle cell patients with the following, but not limited to: acute chest syndrome, stroke, severe infection, severe anemia, preoperatively, during pregnancy and to prevent recurrent acute chest pain.
 - b. Precautions
 1. Blood and blood components must be given according to SFGH guidelines.
 2. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.
 - c. Contraindications

Absolute: none

Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenia purpura (TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and reason for transfusion.
- b. Transfusion history, including prior reactions, minor red cell antibodies and allergies.

2. Objective Data

- a. Physical exam relevant to the decision to transfuse.
- b. Laboratory evaluation.
- c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to direct transfusion therapy and identify contraindications to transfusion.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent must be obtained before writing transfusion orders.
- b. Outpatients must be provided with post-transfusion instructions. (SFGH Form).
- c. Appropriate post-transfusion laboratory studies are ordered to assess therapeutic response.
- d. Referral to physician, specialty clinics and supportive services as needed,

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained historical, physical or laboratory findings
- c. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient, NP, PA, or physician

3. Education

Discharge information and instructions, post-transfusion orders for outpatients.

4. Follow-up

As appropriate for patients condition and reason transfusions were given.

E. RECORD KEEPING

Patient visit, consent forms, and other transfusion-specific documents(completed transfusion report and “blood sticker” will be included in the medical record, ICIP, LCR and other patient data bases, as

appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Successful completion of the San Francisco General Hospital and Trauma Center Transfusion Training course. b. Successful completion of Transfusion Training course test on blood ordering and informed consent. c. Must have an 80% test score on both examinations.
Proctoring: a. Read and Sign the SFGH Administrative Policy and Procedure 2.3 "Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options". b. Review of SFGH Transfusion Guidelines in Laboratory manual. c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.
Reappointment: a. Completion of the two education modules and completion of the two examinations with a passing score of 80%. b. Performance of 2 transfusion orders every 2 years and 2 medical record reviews every 2 years. c. Review of any report from the Transfusion Committee.

Protocol #21: Procedure: Ordering Chemotherapy

- A. Definition: Chemotherapy is the use of anti-cancer, immunotherapy and growth factor drugs to treat malignancies. Selection of specific drugs or protocols is based on results of prior and on-going clinical trials.
1. Location for ordering chemotherapy: Hematology/Oncology Clinic and the 4C Infusion Center.
 2. Policy – The standardized procedures enables the NP/PA to initiate or change, in consultation with the attending physician(s) as appropriate, chemotherapy regimens. The NP/PA shall also write chemotherapy orders
- B. Data Base:
1. Subjective Data
 - a. Screening: appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems.
 - b. Continuity: review of symptoms and history relevant to the disease process or presenting complaint and relevant to treatment.
 - c. Pain history to include onset, location, and intensity.
 2. Objective Data
 - a. Physical exam consistent with history and clinical assessment of the patient.
 - b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.
- C. Diagnosis
Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (ie. Stage of cancer)
- D. Plan
1. Chemotherapy orders procedure
 - Verify patient height and weight and calculate BSA, CrCl and other needed parameters according to protocol guidelines
 - Confirm doses and dose parameters specific to chemotherapy protocols.

- Order pre-chemotherapy checklist labs as per hospital protocol
- Write anti-emetics and pre-medication orders appropriate to chemotherapy protocol.
- Write chemotherapy orders in consultation with the Attending Physician as appropriate.

2. Client conditions requiring consultation

- a. Acute decompensation of patient situation
- b. Unexplained physical or laboratory findings
- c. Upon request of patient, NP, PA or physician
- d. Problem requiring hospital or potential hospital admission

3. Education

- a. Instruction and directions regarding the taking of the medications.
- b. Education on why medication was chosen, expected outcomes, side effects, and precautions.

4. Follow-up

Patients shall be closely monitored, as indicated, for excessive toxicities appropriate to the drug and/or regimen, progression of disease, or development of new or exacerbation of concurrent medical problem that would contraindicate receiving treatment or necessitate an appropriate change in the regimen.

E. Record Keeping

Chemotherapy orders are written on the standard SFGHMC Chemotherapy Order Sheet and will include all necessary documentation according to hospital policy. Patient visit, consent forms and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistant, using protocols for supervision the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within 30 days after completion of proctoring period. The physician shall select for review those cases that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisite, Proctoring, and Reappointment Competency

Prerequisites
Training will include a weekly didactic meeting with the clinical director during the three month proctoring period and may be extended depending upon the evaluation of the clinical director or Heme Onc attending at the completion of proctoring.
Proctoring

- | |
|---|
| <ul style="list-style-type: none">a. All NPs/PAs who are recently hired will have their chemotherapy orders cosigned for the duration of their proctoring period, 3 months for full time employees and 6 months for part time employees.b. Experienced practitioner will have 2 chemotherapy orders reviewed by clinical director. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years. |
| Reappointment |
| <ul style="list-style-type: none">a. Evaluation will be done by the Medical Director or designated Physician.b. Ongoing competency evaluation.<ul style="list-style-type: none">1. Three chemotherapy orders reviewed every 2 years.2. Three chart reviews needed every 2 years. |

Protocol #22: Procedure: Skin Biopsies

A. DEFINITION

Removal of a small portion of abnormal skin to be treated in a laboratory. There are three types of skin biopsy:

- Shave biopsy: the outer part of the suspect area is removed.
- Punch biopsy: a small cylinder of skin is removed using a punch tool.
- Excision biopsy: the entire area of abnormal growth is removed.

1. Performance of procedure:

a. Indications

1. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.

b. Precautions

1. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
2. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
3. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.

c. Contraindications: None

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources.
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

- d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Biopsy tissue is sent to pathology if indicated.
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation.
 - b. Unexplained historical, physical or laboratory findings
 - c. Uncommon, unfamiliar, unstable, and complex patient conditions
 - d. Upon request of patient, NP, PA, or physician
 - e. Initiation or adjustment of medication other than those in the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
3. Education

Pre-procedure and post procedure education as appropriate and relevant in verbal or written format.
4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites

a. Onsite training of procedures by a qualified provider. b. Review of aseptic technique c. Review of departmental policy and procedure
Proctoring Period a. New practitioner to procedure, a minimum of 2 successful observed demonstrations and chart reviews of each procedure b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstration and chart review of each procedure. Designation of experienced practitioner requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.
Reappointment Competency a. Evaluator will be the Medical Director or other qualified provider b. Competency 1. Perform 1 procedures of each type every 2 years. 2. 1 chart review of each type every 2 years.

Protocol #23: Procedure: Thoracentesis

- A. **DEFINITION:** Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid. This procedure can be done in the Inpatient hospital units.

1. Performance of procedure

Indications

- a. For the purposes of this protocol, thoracentesis may be used to determine the cause of a pleural effusion or
- b. To relieve the symptoms of non-acute respiratory distress

Contraindications

- a. Infection in the tissues near the puncture site.
- b. Acute respiratory compromise
- c. Coagulopathy
- d. Significant pulmonary parenchymal disease

B. **DATA BASE**

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. **DIAGNOSIS**

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Time out performed per hospital policy.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - e. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
All patients needing procedure
3. Education
Discharge information and instructions.
4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite
a. Onsite training by a qualified provider.
Proctoring Period
a. New provider to procedure, a minimum of 3 successful observed demonstrations and 3 chart reviews
b. Experienced provider to procedure, a minimum of 2 successful observed demonstrations. Designation of experienced practitioner

requires documentation of 1) previous proctoring and 2) ongoing performance assessment within the past two years.

- c. Proctoring for 1 of the procedures may be performed on a simulated model

Reappointment Competency

- a. The evaluator will be an Attending Physician or another clinician that has unrestricted privileges to perform thoracentesis
- b. Ongoing competency evaluation.
 - 1. Perform a minimum of 3 procedures every 2 years.
 - 2. Three chart reviews every 2 years.
- c. Proctoring for 1 of the procedures may be performed on a simulated model

Procedure #24: Procedure: Waived Testing

A. DEFINITION

Waived testing relates to common laboratory tests that do not involve an instrument and are typically performed by providers at the bedside or point of care.

1. Location where waived testing is to be performed: Adult Medical Clinic, Specialty Clinics on Ward 92, 4C Infusion Center, 5B Research Unit, Occupational Health Services, Positive Health Clinic, Ward 17 Renal Dialysis Center and Inpatient Units.
2. The following non-instrument based waived tests are currently performed at SFGH:
 - a. Fecal Occult Blood Testing (Hemocult ®)
Indication: Assist with detection or verification of occult blood in stool.
 - b. Vaginal pH Testing (pH Paper)
Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.
 - c. SP® Brand Urine Pregnancy
Indication: Assist with the diagnosis of pregnancy.
 - d. Chemstrip® Urine Dipstick
Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

1. Subjective Data
Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed
2. Objective Data

Each waived test is performed in accordance with approved SFGH policies and procedures specific for each test as well as site-specific protocols and instructions for:

- a. Indications for testing
- b. Documentation of test results in the medical record or LCR
- c. Actions to be taken (follow-up or confirmatory testing, Attending consultation, referrals) based on defined test results.
- d. Documentation or logging of tests performed

C. DIAGNOSIS

Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.

D. PLAN

1. Testing

- a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
- b. Use gloves and other personal protective equipment, as appropriate.
- c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.

Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.

- d. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?

2. Test Results requiring Attending Consultation

- a. Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

3. Education

- a. Inform patient of test results and need of additional tests, as necessary

4. Follow-up

- a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

Test and control results will be recorded in the medical record as per site-specific protocols (may be in paper charts or entered in electronic data bases).

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,

Proctoring:

Successful completion of Health stream quizzes for each of the waived tests the practitioner is performing at SFGH, achievement of passing scores of at least 80% on each module.

Reappointment Competency Documentation:

Renewal required every two years with documentation of successful completion of the required Health stream quizzes. Provider must have passed each required module with a score of 80%.

Protocol #26: Procedure: Contraceptive Implant Insertion

A. DEFINITION

The transdermal contraceptive implant is placed under the skin of the upper arm via a preloaded inserter and remains effective for five years. Insertion is performed under local anesthetic using aseptic technique.

1. Location to be performed will be all appropriate sites within the DGIM department.
2. Performance of procedure:
 - a. Indications
 - i. Women desires long acting, reversible contraceptive.
 - b. Precautions
 - i. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.
 - ii. May have drug interactions with anti-HIV medications and some herbal products.
 - iii. See drug precautions/interactions in contraceptive implant prescribing information.
 - c. Contraindications
 - i. Known or suspected pregnancy
 - ii. Current or past history of thrombotic disease
 - iii. Hepatic tumors, active liver disease
 - iv. Known, suspected or history of breast cancer
 - v. Undiagnosed abnormal genital bleeding
 - vi. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to presenting complaint or procedure/surgery to be performed, including sexual history to rule out preexisting pregnancy.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, including over-the-counter and herbal remedies, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam, including a negative pregnancy test.
 - c. All Point of Care Testing (POCT) will be performed according to

ZSFG Admin POCT policy and procedure #16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
- b. Timing of insertion: see prescribing information.
- c. Implant insertion as described in prescribing information.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Difficult insertions.
- b. Acute decompensation of patient situation.
- c. Upon request of NP, PA or physician

3. Education

Discharge information and instructions for care of site, expected side effects, precautions and urgent/emergent symptoms.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring, and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
--

- | |
|---|
| <ol style="list-style-type: none">a. Completion of a company sponsored training program |
|---|

Proctoring:

- | |
|---|
| <ol style="list-style-type: none">a. Direct observation of 2 insertions by a qualified provider for providers new to this procedure.b. Direct observation by a qualified provider of 1 insertion for an experienced provider (as defined by proctoring at another institution with |
|---|

ongoing performance assessment documented within the past 2 years).
c. Chart review of all observed cases.

Reappointment Competency Documentation:
a. A minimum of 6 insertions every 2 years.
b. 1 chart review needed every 2 years.

Protocol #27: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm and remains effective for five (5) years. Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications
Woman desires removal of implant or implant is expired.
 - b. Precautions: See prescribing information.
 - c. Contraindications: See prescribing information.

B. DATA BASE

1. Subjective Data
 - a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
 - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
 - a. Physical exam appropriate to the procedure to be performed.
 - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 - c. All Point of Care Testing (POCT) will be performed according to ZSFG Admin POCT policy and procedure #16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
 - a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
 - b. Diagnostic tests for purposes of disease identification.
 - c. Timing of removal: See prescribing information
 - d. Removal: as described in prescribing information
 - e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
 - a. Acute decompensation of patient situation.
 - b. Difficult Implant removal.
 - c. Upon request of patient, affiliated staff or physician
 - d. If patient desires removal and rod is not readily palpable.
3. Education
Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.
4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of a company sponsored training class
Proctoring Period: a. Performance of a minimum of 6 removals for a new provider and 2 removals for a provider who has prior experience with independent removal. b. Proctor must be a qualified provider. c. Chart review of all observed cases.
Reappointment Competency Documentation: a. Performance of 8 removals every 2 years. b. 2 chart review needed every two years.



Summary of Changes

Document Name:	Standardized Procedure: Department of Medicine
Clinical Service:	Pulmonary Medicine
Date of last approval:	n/a
Summary of SOP updates:	Addition of Clinical Site: I. Policy Statement B. 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 5K1 Pulmonary Office, 1M Clinic room 1M 13, Cardiology 5G1, Cardiac Catheterization Lab, Unit 5B Nurse Lounge, GI Fellows Conference Room, Hematology/Oncology Administration Office, GI Conference Room 3D22, Occupational Health Clinic, HERO Medical record system and on file in the Medical Staff Office. III. Circumstances Under Which NP/PA May Perform Function A. Setting 1. Location of practice is: Inpatient Units, GCRC, Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Infusion Center, 3 D Gastroenterology Clinic, Occupational Health Service, Positive Health Clinic, Hematology/Oncology Clinic, 1M and 5F Cardiology Clinics, Ward 17 Renal Dialysis, Pulmonary Outpatient Diagnostic Service (PODS), the Bronchoscopy Suite in Endoscopy Center, and the Emergency Department. B. Supervision 4. For Cardiology, GI, and Pulmonary Medicine providers only: NP/PA management of medical emergencies, including cardio-pulmonary arrest, shock and life-threatening bleeding shall include initial evaluation and stabilization of the patient through the utilization of Advanced Cardiac Life Support (ACLS), alerting the supervising physician and activation of the Code Blue Team by dialing X61122.
Scope of Practice:	Protocol #1: Core: Acute/Urgent Care Protocol #2: Core: Primary Care Protocol #3: Discharge of Inpatient Protocol #4: Furnishing Medications/Drug Orders Protocol #20: Procedure: Moderate Sedation



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

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Rape Treatment Center (RTC)/Trauma Recovery Center (TRC) and Child and Adolescent Support, Advocacy and Resource Center (CASARC) ZSFG Department of Psychiatry

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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). Membership 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 Title 16, CCR Section 1474.
- B. 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 Psychiatry Department Office and on file in the Medical Staff Office.

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II. Functions to be Performed

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 interprets tests, counsels on preventative health care, assists in surgery, performs invasive procedures, and furnishes 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 outpatient clinic at ZSFG and inpatient units at ZSFG as well as the Trauma Recovery Center 2727 Mariposa St., Suite 100.
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 specific unit Medical Director, Chief of Service, designated supervising physician or attending and other supervisors as applicable.
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.

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IV. Scope of Practice

- Protocol #1 Health Care Management: Acute/Urgent Care
Protocol #2 Evaluation of Pregnancy Risk and Treatment Options
Protocol #3 Evaluation of Exposure to Sexually Transmitted Diseases and Treatment Options
Protocol #4 Furnishing and Dispensing Drugs and Devices
Protocol #5 Sexual Assault Forensic Services

V. Requirements for the Nurse Practitioner/Physician Assistant

- A. Basic Training and Education
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 Zuckerberg 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 FNP (for NPs)
 - b. Successful completion of the following trainings as required by the ZSFG Medical Staffing Office within 3 months of unit-based training start date:
 - a. California Sexual Assault Forensic Examiner Association (CalSAFE) Combined Adult/Adolescent and Pediatric SAFE Training, or
 - b. CCFMTC Adult/Adolescent Sexual Assault Forensic Examiner ~~training-training~~; and
 - c. CCFMTC Child/Adolescent Sexual Assault Forensic Examiner ~~training-training~~.
- C. 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.

1. Length of proctoring period will be 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 the specific unit Medical Director, Chief of Service, or designated clinical provider.
2. The evaluator will be the specific unit Medical Director or designated clinical provider.
3. 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

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Follow-up: areas requiring increased proficiency as determined by the initial or reappointment evaluation will be re-evaluated by the Medical Director and/or designated clinical supervisor at appropriate intervals until acceptable skill level is achieved.

Biennial Reappointment: Medical Director and/or designated clinical provider must evaluate the NP/PA's clinical competence. [Requirement of 3 chart reviews by RTC/CASARC peer or designee per Chief of Service to assess medical triage, evaluation and treatment, medications prescribed, labs ordered and documentation, every 2 years.](#)

[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.
- B. Approval
The CIDP, Credentials, Medical Executive Committee, and Joint Conference Committee must approve all standardized procedures prior to 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 Chief of Service, CIDP, Credentials, Medical Executive Committee, and Joint Conference Committee must approve all revisions to standardized procedures prior to implementation.

Protocol #1: Health Care Management – Acute/Urgent Care

- 1) Definition
This protocol covers the procedure for patient visits for urgent medical issues related to sexual assault, sexual abuse and/or child physical abuse.
- 2) Database
 - a) Subjective Data
 - i) History and review of symptoms relevant to the presenting complaint and/or disease process.
 - ii) Pertinent past medical/surgical/psychiatric history, substance use, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
 - b) Objective Data
 - i) Physical exam appropriate to presenting symptoms.
 - ii) Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- 3) Diagnosis
Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of disease.
- 4) Plan
 - a) Therapeutic Treatment Plan
 - i) Diagnostic tests for purposes of disease identification.
 - ii) Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - b) Patient conditions requiring physician consultation: see section III.
- 5) Education
Patient education should include treatment modalities, discharge information and instructions.
- 6) Follow-up
As appropriate regarding patient health status and diagnosis.
- 7) Record Keeping
All information from patient medical encounter will be recorded in the medical record.

Protocol #2: Evaluation of Pregnancy Risk and Treatment Options

- 1) Definition
This protocol describes the process for assessing the risk of pregnancy from sexual assault victim/survivors at risk of pregnancy.
- 2) Background: The California Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims includes an assessment of the risk of pregnancy resulting from sexual assault for victim/survivors at risk for pregnancy. This assessment includes performance of a baseline pregnancy test and discussing treatment options with clients.
- 3) Data Base
 - a) Subjective Data
 - i) Includes Menstrual and Contraceptive history.
 - ii) Includes relevant assault history/sexual assault that occurred within the past 120 hours.
 - b) Objective Data
 - i) Result of baseline pregnancy test
- 4) Diagnosis
Should include determination of patient's risk of pregnancy
- 5) Plan
 - a) Treatment
 - i) Discuss the probability of pregnancy, given the specific risk factors for the patient.
 - ii) Discuss all medically appropriate options, including immediate and non-immediate treatments.
 - iii) Administer post-coital emergency contraception as appropriate per formulary.
 - b) Patient conditions requiring physician consultation: see section III.
- 6) Education
 - a) If the patient chooses an option other than emergency contraception, provide appropriate referrals.
 - b) If the patient chooses to take emergency contraception, discuss mechanism of action, efficacy, instructions for use, common side effects, danger/warning signs and possible complications.
 - c) Inform patient that if they vomit within 2 hours of dose, they should repeat the dose. If they vomit more than 2 hours after taking dose, they do not need to repeat any doses.
- 7) Follow-up
As appropriate regarding patient health status and diagnosis.

8) Record Keeping

All information from patient medical encounter will be recorded in the medical record.

Protocol # 3: Evaluation of Exposure to Sexually Transmitted Infections and Treatment Options

- 1) Definition: This protocol describes the process for assessing the risk of exposure to sexually transmitted infections from sexual assault and the various treatment options.
- 2) Background: The California Medical Protocol for the Examination of Sexual Assault and Child Sexual Abuse Victims recommends evaluating the possibility of exposure to sexually transmitted infections and offering prophylactic treatment options against those infections.
- 3) Data Base
 - a) Subjective Data
 - i) Includes relevant assault history/sexual assault that occurred within the past 120 hours
 - b) Objective Data
 - i) Should include assessment and documentation of patient's allergy status AND known medical conditions.
- 4) Diagnosis
Should include assessment of patient's risk for exposure to STI's and patient's desire to receive testing and prophylaxis for such diseases.
- 5) Plan
 - a) Testing
 - i) Perform STIs and HIV testing based on assessment, abuse and assault history, clinical indication, and practice guidelines.
 - b) Treatment
 - i) **12 and older:** Assess the risk of exposure and offer prophylaxis as appropriate for chlamydia, gonorrhea, HIV, and trichomoniasis.
 - ii) **<12 years old:** Providers should consult with the admin back up and/or CASARC pediatrician to discuss treatment.
 - c) Patient conditions requiring physician consultation: see section III.
- 6) Education
STI and PEP information and teaching.
- 7) Follow-up
As appropriate regarding patient health status and diagnosis.
- 8) Record Keeping
All information from patient medical encounter will be recorded in the medical record.

Protocol #4: Furnishing and Dispensing Drugs and Devices

A. Definition

"Furnishing" of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license.

All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively:

- PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the California Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistants Delegation of Service document.
- Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol.
- PAs, NPs and CNMs with an x-waiver may prescribe medications containing buprenorphine for the purpose of treating patients with opioid use disorder.

The scope of practice of the NP/PA, as well as Service Chief and/or Supervising Physician(s) determine what formulary/ies will be listed for the protocol. The formulary/ies to be used include Zuckerberg San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows ZSFG Administrative policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no.13.05).

Database:

1. Subjective Data

- a. Appropriate history and review of systems relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
- b. Pain history to include onset, location, and intensity.

a) Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Describe physical findings that support use for CSII-III medications.
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

C. Diagnosis

Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.

D. Plan

1. Treatment

- a. Initiate, adjust, discontinue, and/or renew drugs and devices.
- b. Schedule II - V controlled substances may be ordered for patients with the following patient specific protocols. These protocols may be listed in the patient chart. The protocol will include the following:
 - i. location of practice
 - ii. diagnoses, illnesses, or conditions for which medication is ordered
 - iii. parameters for acute conditions including maximum daily morphine equivalents and duration of treatment
 - iv. parameters for treatment with chronic opioids including checking CURES, toxicology screening, treatment plan and clinic specific policies
 - v. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
- c. To facilitate patient receiving medications from a pharmacist provide the following:
 - i. name of medication
 - ii. Strength
 - iii. directions for use
 - iv. name of patient
 - v. name of prescriber and title
 - vi. date of issue
 - vii. quantity to be dispensed
 - viii. license no., furnishing no., and DEA no. if applicable

E. Patient conditions requiring physician consultation: see section III.

F. Education

1. Instruction on directions regarding the taking of the medications in patient's own language.
2. Education on why medication was chosen, expected outcomes, side effects, and precautions.

G. Follow-up

As appropriate regarding patient health status and diagnosis.

H. Record Keeping

All information from patient medical encounter will be recorded in the medical record.

Protocol #5: Sexual Assault Forensic Services

A. Definition

This protocol covers the procedure for patient visits involving forensic services related to sexual assault, sexual abuse and/or physical abuse.

B. Database

a. Subjective Data

- i. History and review of symptoms relevant to the presenting complaint and/or disease process.
- ii. Pertinent past medical history as well as social determinants of health.

b. Objective Data

- i. Must be medically and psychiatrically stable before receiving forensic services
- ii. Patient ability to consent for forensic services or search warrant obtained (12 yo and older)
- iii. Non-offending parent/guardian consent, exigency per CPS or Law Enforcement documented, or search warrant obtained (under 12 yo)

C. Plan

- a. Forensic examination options explained to patient
- b. Consent for forensic examination or declination documented for patients ≥ 12 yo or non-offending parent/guardian for patients < 12 yo
- c. If indicated, exigency document or search warrant obtained
- d. Mandated reporting completed including:
 - i. Law enforcement, CPS, APS reporting as indicated
 - ii. Parental notification as indicated.

D. Patient conditions requiring physician consultation: see section III.

E. Education

Patient education should include options counseling related to sexual assault reporting per PC 11160.

F. Record Keeping

- a. Forensic reports, forensic photos and chain of custody logs are property of law enforcement and should not be stored in the medical chart.
- b. All information related to ability to consent, consent or declination obtained, and reporting will be recorded in the medical record.



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.Aspeticueta@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:	RTC-CASARC Rape Treatment Center (RTC)/Trauma Recovery Center (TRC) and Child and Adolescent Support, Advocacy and Resource Center (CASARC) ZSFG Department of Psychiatry
Department:	Psychiatry
Dept Chief:	Mark Leary
SP Author(s):	Jessica Marques Jessica Thayer
Update #1:	Revised preamble/updated language (as described below)
Update #2:	Removed 'psychologists' from list of providers
Update #3:	Decreased biennial reappointment criteria from 5 to 3 cases every 2 years.

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below.

Preamble	 2023 CIDP SP Preamble DRAFT (1). • 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	Insert the following after every use of words “qualified provider:” who has completed proctoring and subsequently maintained their eligibility for performing the procedure. <i>Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.</i> (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)

Medical Executive Committee
(MEC) Summary of Changes

Document Name:	Standardized procedure - Nurse Practitioner/Physician Assistant
Clinical Service:	CHN Primary Care
Date of last approval:	2015
Summary of SOP updates:	Updated language and removed redundant phrases, added protocols and deleted protocols no longer in practice, updated requirements for proctoring and reappointment based on FCM SP, removed 3 forms of supervision no longer required for PAs, expand consultation and proctoring to include other credentialed/qualified providers and not just MDs or the supervising physician, and edit format of document
Update #1:	Updated Protocol <u>Protocol #1 Health care management – Prenatal Care</u> • Current: Reviews routine prenatal care of essentially healthy women • Proposed: Update plan to match current prenatal care guidelines and removed section on “Management of HIV-infected Pregnant Women at The Bay Area Preinatal Aids Center (BAYPAC)
Update #2:	Updated Protocol Protocol #4 Furnishing Medications/Drug Orders • Current: Reviews NP and PA routine ordering of drugs including controlled substances and that all controlled substances must be approved by supervision physician before being issued or carried out. • Proposed: Update language to match code 2836.1 so that controlled substances shall be furnished or ordered in accordance with patient-specific protocols approved by the treating or supervision physician.
Update #3:	Updated Protocol Protocol #5 Arthrocentesis and Intraarticular Injections • Current: protocol covered arthrocentesis of knee and elbow only

	Proposed: Update language to include all joints for arthrocentesis and intraarticular injections to match current FCM SP – i.e. language now covers trigger finger and shoulder joints.
Update #4:	Added Protocol Protocol #6 Musculoskeletal Soft Tissue Injections/Aspirations - Proposed ADD: Covers the aspiration of and/or injection of medications into soft tissue structures such as bursa, tendon sheaths, cysts, trigger points and carpal tunnel, for therapeutic or diagnostic purposes. - Adapted from current FCM SP
Update #5:	Updated Protocol Protocol #10 Contraceptive Implant Removal - Current: Proctoring period requires minimum of 6 removals for new provider - Proposed: update to a minimum of 3 removals for new provider (in line with current “Standardized procedures Initial and Reappointment Criteria” document) - Current: Reappointment requires performance of 8 removals and 2 chart reviews very 2 years. - Proposed: update to a minimum of 4 removals 1 chart review very 2 years (in line with current “Standardized procedures Initial and Reappointment Criteria” document)
Update #6:	Added Protocol Protocol #16 Nail Debridement - Proposed ADD: Covers removal of elongated overgrown nail material - Adapted from current FCM SP
Update #7:	Added Protocol Protocol #17 Nail Removal/Mastriectomy - Proposed ADD: Covers complete removal or partial removal of the nail bed and nail plate - Adapted from current FCM SP
Update #8:	Added Protocol Protocol #18 Skin biopsy

City and County of San Francisco



Zuckerberg San Francisco General
Hospital and Trauma Center

Department of Public Health

London Breed

Gabriel Ortiz, MD, PhD
Chief of Staff

	• Proposed ADD: Covers removal of a small portion of abnormal skin to be tested in a laboratory • Adapted from current FCM SP
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San Francisco Community Health Network of San Francisco
Committee on Interdisciplinary Practice

**STANDARDIZED PROCEDURE – NURSE PRACTITIONER /PHYSICIAN
ASSISTANT**

These standardized procedures are for the following **Community Primary Care**
Clinics:

Castro Mission Health Center
Chinatown Public Health Center
Community Health Programs for Youth
Curry Senior Center
Maxine Hall Health Center
Medical Respite and Sobering Center
Ocean Park Health Center
Potrero Hill Health Center
Silver Avenue Health Center
Southeast Health Center
Special Programs for Youth
Tom Waddell Urban Health

PREAMBLE

Title: Community Primary Care

I. Policy Statement

- A. It is the policy of the Community Health Network and
Zuckerberg San Francisco General Hospital and Trauma
Center (**ZSFG**) that all standardized procedures are developed

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collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Certified Nurse –Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

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B. 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 individual clinical sites within the Community Primary Care Clinical Service and on file in the Medical Staff Office.

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II. Functions To Be Performed

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Each practice area will vary in the functions that will be performed, such as primary care in a clinical, specialty clinic care setting or inpatient care in 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.

~~A Certified Nursing Midwife (CNM) is a registered nurse who has had additional training in mid-wifery and who has met the requirements of Section 1460 of the Nurse Practice Act. The Scope of Practice of the CNM includes the care of women during the antepartal, intrapartal, postpartal, interconceptual periods, provides family planning planning, conducts deliveries and cares for the newborn and infant.~~

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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 six ten years. 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 San Francisco Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and ~~Delegation of Services Agreement~~ Ppractice Agreement. ~~(documents supervising agreement between supervising physician and PA).~~

I

~~The NP/CNM/PA conduct physical exams, diagnoses and treats illness, order and interpret tests, counsel on preventative health care, assists in surgery, performs invasive procedures and furnish medications/issue drug orders as established by state law.~~

III. Circumstances Under Which NP/CNM/PA May Perform Function

A. Setting

1. Location of practice is the various clinical sites within the Community Primary Care Service.
2. Role in each setting may include primary and urgent care in all settings, and may include performing physical exams, diagnosing, and treating illnesses, ordering, and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications.

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B. Supervision

1. Overall Accountability:

The NP/CNM/PA is responsible and accountable to: the clinic Medical Director, Chief of Service, supervising physician and other supervisors as applicable.

2. A consulting attending physician, will be available to the NP/CNM/PA, by phone, in person, or by other electronic means at all times.

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, affiliated staff, or physician.
- e. Initiation or change of medication other than those in the formulary (ies).
- f. Problem requiring hospital admission or potential hospital admission.
- g. ~~Acute, severe respiratory distress~~
- h. ~~An adverse response to respiratory treatment or a lack of Therapeutic response.~~

IV. Scope of Practice

IV.

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8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center ~~Delegation of Service Agreement (DSA)~~. Copies of ~~DSA~~ Practice Agreement must be kept at each practice site for each PA.

B. Specialty Training

1. Specialty requirements: FNP, CNM, ANP, PNP.

Note:

Pediatric Nurse Practitioners may treat all patients up to age 21 years.

-Adult Nurse Practitioners may treat all patients from age 13 and above.

-Family Nurse Practitioners and Physician Assistants can treat patients of all ages.

2. At least two (2) years of Clinical Experience in specialty area desired.

C. Evaluation of NP/CNM/PA Competence in performance of standardized procedures.

1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and/or other supervisors, as applicable will assess the NP/CNM/A's ability to practice.

a. Clinical Practice

- Length of proctoring period will be 3 months and will include 5 chart reviews and 1 case of direct observation.
- The evaluator will be the Medical Director, Chief of Service or physician designee.

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2. ~~Bi-Annual~~Biennial Reappointment: Medical Director, and/or designated physician and/or supervisor must evaluate the NP/~~CNM~~PA's appropriate clinical competency for the setting by review of 5 charts and direct observation as determined by the evaluator.

3. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician and/or supervisor at appropriate intervals until acceptable skill level is achieved.

4. Ongoing:

a. ~~Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are 1) Examination of the patient by Supervising Physician the same day as care is given by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all~~ tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

VI. Development and Approval of Standardized Procedure

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A. Method of Development

1. Standardized procedures are developed collaboratively by the Nurse Practitioners/Physician Assistants, Nurse Midwives, Pharmacists, Physicians, and Administrators and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

B. Approval

1. The CIDP, Credentials, Medical Executive and Joint Conference Committees must approve all standardized procedures prior to its implementation.

C. Review Schedule

1. The standardized procedure will be reviewed every three years by the NP/PA and the Medical Director and as practice changes.

D. Revisions

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

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Protocol #1: Health Care Management – Primary Care

A. DEFINITION

This protocol covers the procedure for age-appropriate health care management in primary care, clinics within the Community Primary Care Clinical Service, including health centers, health center satellite locations, and the Ambulatory Care Call Center. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses.

B. DATA BASE

1. Subjective Data

- a. Screening: age-appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems.
- b. Ongoing/Continuity: review of symptoms and history relevant to the disease process or presenting complaint.
- c. Pain history to include onset, location, and intensity.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying risk factors and disease processes. May include a statement of current status of disease (e.g. stable, unstable, and uncontrolled).

D. PLAN

1. Treatment

- a. Age-appropriate screening tests, and /or diagnostic tests for purposes of disease identification.

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- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- c. Immunization update.
- d. Referral to specialty clinics and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- 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.

3. Education

- a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
- b. Anticipatory guidance and safety education that is age and risk factor appropriate.

4. Follow-up

As indicated and appropriate to patient health status and diagnosis.

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days.

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The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

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Protocol #2: Health Care Management – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions at health sites within the Community Primary Care Clinical Service, including health centers, health center satellite locations, and the Ambulatory Care Call Center.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint and/or disease process.
- b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data

- a. Physical exam appropriate to presenting symptoms.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes and a statement of the current status of the disease.

D. PLAN

1. Therapeutic Treatment Plan

- a. Diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- c. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- 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. Uncommon, unfamiliar, unstable, and complex patient conditions
- e. Upon request of patient, NP, PA, or physician
- f. Initiation or change of medication other than those in the formularies.
- g. Any Problem requiring hospital admission or potential hospital admission.

3. Education

Patient education should include treatment modalities.
Discharge information and instructions.

4. Follow-up

As appropriate regarding patient health status and diagnosis.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)
For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

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Protocol # 3; Health Care Management – Prenatal Care

A. DEFINITION

This protocol covers the procedure for the routine prenatal care of essentially healthy women. This includes the provision of comprehensive education and primary care during the prenatal and postpartum period and the promotion of a healthy pregnancy and optimal outcome in all appropriate sites within the Community Primary Care clinical service.

B. DATA BASE

1. Subjective Data

- a. Complete appropriate history.
- b. Symptoms relevant to the prenatal health process.

2. Objective Data

- a. Initial prenatal visit includes a complete physical examination with sizing of uterus and fetal heart tones if at least 10 weeks.
- b. Routine follow-up visits, the physical exam to include:
 1. Blood pressure
 2. Weight and weight gained or lost since last visit.
 3. Urinalysis at initial visit and then at every visit ≥ 26 weeks gestation or prn based on risk factors.
 4. Fetal heart tones
 5. Abdominal exam for fundal height (starting at 20 wks gestation) and presentation (starting at 36 weeks).
 6. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
 7. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.
- c. Pelvic examination when indicated by history.

C. DIAGNOSIS

Assessment and diagnosis of pregnancy status, risk factors, or disease process consistent with the subjective and objective findings.

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D. PLAN

1. Therapeutic Treatment Plan

a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.

1. Routine prenatal labs, including but not limited to: blood type and screen, Rubella titer, CBC, hemoglobinopathy evaluation, HBsAG, RPR, HIV antibody, pap smear (if indicated), clean catch urine culture, chlamydia, gonorrhea, and GBS culture, and genetic carrier screen.

2. First trimester genetic screen or NIPT and Second Trimester integrated genetics screening, and NT ultrasound if desired by patient.

3. Glucose Load Test (GLT) at 24 to 28 weeks Gestational Age (GA). Do 1 hr. GLT at 1st visit (if 13-24 weeks GA) or hgb a1c (If <13 weeks GA) if at high-risk for Diabetes (as per SFGH GDM Screening Protocol). Do a 3 hr GTT if 1 hr GLT elevated.

4. If patient is RH Negative repeat antibody screen and order Rhogam at 28 weeks.

5. Order and review all imaging studies as appropriate.

b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.

1. Furnishing of prenatal vitamins.

c. Immunization update.

d. Referral to specialty clinics and supportive services as needed (e.g. nutritionist, social work, health education WIC).

2. Patient conditions requiring consultation as per Preamble section III b 2.

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, affiliated staff or physician.

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e. Initiation or change of medication other than those in the formulary (ies).

f. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.

g. Patient conditions requiring physician consultation:

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3. Education

a. Normal process and progression of pregnancy.

b. Psychosocial issues pertinent to pregnancy, age of client and home situation.

c. Signs and symptoms of complications

d. Fetal kick counts.

e. Stages of labor.

f. Pain management during labor and delivery.

g. Infant nutrition: breast or formula feeding.

h. Postpartum family planning.

4. Follow-up (Intervals determined by risk factors)

a. Every 4-8 weeks until 28 weeks gestational age.

b. Every 2 to 4 weeks from 28 to 38 weeks gestational age.

c. Every week after 38 weeks gestational age.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record

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~~All information from patient visits will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within 30 days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

F. Management of HIV Infected Pregnant Women at The Bay Area Perinatal Aids Center (BAYPAC)

1. ~~Obstetric and HIV care of BAYPAC patients by the BAYPAC nurse practitioner will be co-managed by the BAYPAC attending, Reproductive Infectious Disease fellow and/or other OB attending.~~
2. ~~Obstetric care will be transferred to the OB attending (with continued NP management of HIV care co-managed by the OB attending) for the following conditions:~~
 - a. ~~Renal insufficiency or failure.~~
 - b. ~~Heart disease, Class II or greater.~~
 - c. ~~Hyperthyroidism.~~
 - d. ~~Rh isoimmunization.~~
 - e. ~~Uncontrolled seizure disorder.~~
 - f. ~~Neoplasia.~~
 - g. ~~High order multiple gestations (>2 fetuses).~~
 - h. ~~Twin gestation other than dichorionic, diamniotic, concordant growth.~~
 - i. ~~Acute hepatitis.~~
 - j. ~~Psychiatric conditions with psychosis.~~
 - k. ~~Isoimmune thrombocytopenia.~~
 - l. ~~Severe anemia (hemoglobin <7, not responding to iron and nutrition therapy).~~
 - m. ~~Uterine or cervical malformation or incompetence.~~
 - n. ~~Significant chronic illness (i.e., lupus, RA, Crohns).~~
 - o. ~~Preterm pre-eclampsia.~~
 - p. ~~Severe pre-eclampsia.~~

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3. Record Keeping

- a. Patient visit, consent forms, and other procedure-specific documents will be recorded in HERO and LCR as appropriate.

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Protocol #4: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing" of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II-V with possession of an appropriate DEA license. All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistants Delegation of Service document. Nurse practitioners and midwives may order Schedule II-V controlled substances when in possession of an appropriate DEA license. Schedule II-III medications for management of acute and chronic illness need a patient specific protocol. The practice site, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies to be used are San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program). This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no.13.5)."Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II-V with possession of a DEA number.

Nurse practitioners may order Schedule II-V controlled substances when in possession of a DEA number. Schedule II-III controlled

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substances may be ordered for, but not limited to, the following conditions: patients presenting with acute and chronic pain and patients presenting with ADHD or other mental health-related disorders requiring the use of controlled substance II medications. When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order. The practice site, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol.

These formularies include ZSFG/ Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal (including Contract Drug List and formularies of managed care Medi-Cal plans), AIDS Drug Assistance Program, Anthem Blue Cross, Blue Shield, California Care, Pacific Care, Health Net, Healthy Families, United Healthcare, and Medicare Part D formularies.

This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

1. Subjective Data

- a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.

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- b. History and review of symptoms relevant to the presenting complaint and/or disease process. Pain history to include onset, location, and intensity.

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2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient.
- b. Describe physical findings that support use for CSII-III medications.
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

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C. DIAGNOSIS

Assessment of data from the subjective and objective findings identifying disease processes, results of treatments, and degree of pain and/or pain relief.

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D. PLAN

1. Treatment

- a. Initiate, adjust, discontinue, and/or renew drugs and devices.
- b. When ordering ~~respiratory~~ treatments, a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device and frequency of treatments. Patient response will be monitored and documented.
- c. Nurse Practitioners may order Schedule II—III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
- i. location of practice
- ii. diagnosis, illness, or condition for which medication is ordered

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~~iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow up.~~

~~d.c.~~ To facilitate patient receiving medications from a pharmacist provide the following:

- i. name of medication
- ii. strength
- iii. directions for use
- iv. name of patient
- v. name of prescriber and title
- vi. date of issue
- vii. quantity to be dispensed
- viii. license no., furnishing no., and DEA no. if applicable

~~2.~~ Patient conditions requiring physician consultation

~~a. Problem which is not resolved after reasonable trial of therapies.~~

~~b. Initiation or change of medication other than those in the formulary.~~

- 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
- g. Uncommon, unfamiliar, unstable and complex patient conditions
- h. Patient visits involving workers' compensation claims for which patient required more than 3 calendar days off them work or determination of temporary disability

~~g.~~ Problem requiring hospital admission or potential hospital admission.

~~3.~~ Education

~~e. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).~~

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Anticipatory guidance and safety education that is age and risk factor appropriate.

d.

c. Unexplained historical, physical or laboratory findings.

d. Upon request of patient, NP, PA, or physician.

e. Failure to improve pain and symptoms management.

f. Acute, severe respiratory distress

g. An adverse response to respiratory treatment or lack of therapeutic response.

h. Patients on maintenance buprenorphine

3. Education

a. Instruction on directions regarding the taking of the medications in patient's own language.

b. Education on why medication was chosen, expected outcomes, side effects, and precautions.

4. Follow-up

a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record LCR/MAR as appropriate

The medical record of any patient cared for by a PA for whom the supervising physician and surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.

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Protocol #5: Arthrocentesis and Intraarticular Injections

A. DEFINITION

This protocol covers arthrocentesis of the knee and elbow. The procedure is insertion of a needle into the joint space to aspirate fluid for analysis and/or inject medicine. This protocol covers joint arthrocentesis and the injection of corticosteroids and/or anesthetic preparations for pain relief or diagnostic purposes. The procedure includes inserting a needle into the joint space to aspirate fluid for analysis and/or to introduce medications.

1. This procedure can be completed at any health site within the Community Primary Care Clinical Service.

2. Performance of procedure:

a. Indications

- Acute and chronic inflammatory musculoskeletal conditions such as osteoarthritis, rheumatoid arthritis, and other joint arthropathies
- Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of the joint effusion is unknown.

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Aspiration of the affected joint and subsequent analysis of this will distinguish among hemarthrosis, effusion, fracture and septic arthritis.

b. Precautions

- Patients with a coagulopathy

c. Contraindications

- Severe dermatitis or soft tissue infection overlying the joint.
- Acute trauma with open wound
- Medication allergy

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- c. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained, consistent with hospital policy,

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- before procedure is performed.
- b. Time out performed per hospital policy.
 - b. The procedure is performed following standard medical technique.
 - c. Diagnostic tests for purposes of disease identification.
 - d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
 - e. Referral to orthopedic physician, clinic, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. All patients requiring this procedure.
 - a. Acute decompensation of patient situation
 - b. Unexplained historical, physical or laboratory findings
 - c. Upon request of patient, NP, PA, or physician
 - d. Any problem requiring hospital admission or potential hospital admission.

3. Education

Patients will be informed that pain relief may occur immediately due to the early onset of certain drug preparations, but the longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. All information from patient visits will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The

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~~physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. Summary of Prerequisite, Proctoring and Reappointment Competency

Prerequisite Requirements to be completed prior to initiation proctoring and provision of direct patient care:

Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience, defined as active privileges for this procedure at another institution within the past six months. If the NP/PA has experience, direct observation is still required (see proctoring).

Prerequisite

1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
2. Training will include NP/PA being able to demonstrate knowledge of the following:
 - a. Indications for procedure and treatment.
 - b. Risks and benefits of procedure and medication.
 - c. Related anatomy and physiology.
 - d. Consent process consistent with hospital policy.
 - e. Time out policy and procedure.
 - f. Wound infection and wound healing mechanisms.
 - g. Use of required equipment.
 - h. Steps in performing procedures.
 - i. Ability to interpret results and formulate follow-up plans
 - jj. Ability to recognize complications
 - k. Documentation and CPT and ICD-10 coding

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Proctoring Period

1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator.
2. New provider to procedure, a minimum of 22 successful observed demonstrations.
23. Experienced provider to procedure, a minimum of 1 successful observed demonstration.
34. Explanation needed for any exceptions to minimum requirements.
45. Chart review will be done on all observed procedures.
56. Documentation of completion of training must be sent to the Medical Staff office.

Reappointment Competency Documentation

1. ~~The evaluator will be an Attending Physician.~~ A qualified provider who has completed proctoring and subsequently maintained their eligibility.
2. Perform a minimum of 1 procedure and 1 chart review every two years.
3. ~~One chart review every two years.~~

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Protocol #6: Musculoskeletal Soft Tissue Injections/Aspirations

A. DEFINITION

This protocol covers the aspiration of and/or injection of medications into soft tissue structures such as bursa, tendon sheaths, cysts, trigger points and carpal tunnel, for therapeutic or diagnostic purposes.

1. Location to be performed: This procedure may be completed at all health care sites within the Community Primary Care Clinical Service.

2. Performance of procedure:

a. Indications

i. Acute or chronic inflammatory conditions that impair function or cause discomfort, loss of motion or paresthesias.

b. Precautions for injection:

i. Chronic overlying dermatitis

ii Diabetes

iii Coagulopathy

iv. Close proximity to neurovascular (arterial) structures

c. Contraindications

i. Allergy to medication

ii. Severe dermatitis or soft tissue infection overlying the joint or

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injection site.

iii. Acute trauma

B. DATA BASE

1. Subjective Data

a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, and allergies.

2. Objective Data

a. Physical exam appropriate to the procedure to be performed.

b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.

b. Time out performed per hospital policy.

c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

d. Diagnostic tests for purposes of disease identification.

e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient conditions requiring Attending Consultation

a. Acute decompensation of patient situation

b. Unexplained historical, physical or laboratory findings

c. Upon request of patient, NP, PA, or physician

d. Any problem requiring hospital admission or potential hospital admission.)

3. Education

Patients will be informed that pain relief may occur immediately due to the early onset on xylocaine preparations, but the longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also

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be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

4. Follow-up

Patient follow-up determined based on whether procedure performed was diagnostic versus a therapeutic injection.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation proctoring and provision of direct patient care: Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience, defined as active privileges for this procedure at another institution within the past six months. If the NP/PA has experience, direct observation is still required.

Prerequisite

1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
2. Training will include NP/PA being able to demonstrate knowledge of the following:
 - a. Indications for procedure and treatment.
 - b. Risks and benefits of procedure and medication.
 - c. Related anatomy and physiology.
 - d. Consent process consistent with hospital policy.
 - e. Time out policy and procedure.
 - f. Wound infection and wound healing mechanisms.
 - g. Use of required equipment.
 - h. Steps in performing procedures.
 - i. Ability to interpret results and formulate follow-up plans
 - k. Ability to recognize complications
 - h. Documentation and CPT and ICD-10 coding

Proctoring Period

1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the

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<u>procedure will be the evaluator.</u> <u>2. New provider to procedure will have a minimum of 3 successful observed demonstrations.</u> <u>3. Experienced provider to procedure will have a minimum of 1 successful observed demonstration.</u> <u>4. Explanation needed for any exceptions to minimum requirements.</u> <u>5. Chart review of all observed cases.</u> <u>6. Documentation of completion of training must be sent to the Medical Staff office.</u>	
<u>Reappointment Competency Documentation</u> <u>1. A qualified provider who has completed proctoring and subsequently maintained their eligibility.</u> <u>2. Perform a minimum of 1 procedure and 1 chart review every two years.</u>	

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Protocol # 7: Endometrial Biopsy

A. DEFINITION

Evaluation of the endometrium by obtaining tissue for pathological diagnosis.

1. Indications:

Women considered at increased risk for endometrial cancer (including but not limited to: abnormal uterine bleeding, endometrial cells on Pap, unopposed estrogen therapy, tamoxifen therapy) will be evaluated by endometrial biopsy as well as others requiring evaluation of endometrial tissue (infertility, infection) will be evaluated by endometrial biopsy.

2. Precautions:

Consult an MD before performing biopsies on women with extreme retroversion or anteversion of the uterus. Also, consult when the procedure requires manual dilatation of the cervix.

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B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed,
- b. Diagnostic tests for purposes of disease identification.
- c. Screening tests performed as part of age-appropriate health maintenance.
- d. Biopsy tissue is sent to pathology.
- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained historical, physical or laboratory findings
- c. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient, NP, PA, or physician

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- e. Initiation or adjustment of medication other than those in the formularies.
- f. Problem requiring hospital admission or potential hospital admission.

3. Education

Discharge information and instructions.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, counter sign and date a minimum of five percent (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problems, treatment or procedure represent in his/her judgment the most significant risk to patients. All information from patient visits will be recorded in the medical record.

F. SUMMARY OF PREREQUISITES, PROCTORING AND REAPPOINTMENT COMPETENCY

Prerequisites:

1. At least 6 months experience in women's health care.
2. Provider will observe a qualified provider do procedure 2 times

Proctoring Period:

1. New provider to procedure, a minimum of 32 successful observed demonstrations
2. Experienced provider to procedure, a minimum of 1 successful observed demonstrations
3. Explanation needed for any exceptions to minimum requirements Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations

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<u>4. Two chart reviews-3. Chart review of 2 cases</u>
<u>Reappointment Competency Documentation:</u> 1. <u>A qualified provider who has completed proctoring and subsequently maintained their eligibility.</u> 2. <u>Perform a minimum of 1 procedure and 1 chart review every two years.</u>
<u>1. The evaluator will be an attending physician.</u> <u>2. Perform a minimum of 1 procedure every 2 years.</u> <u>3. 1 chart review every 2 year.</u>

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Protocol #8: Incision and drainage of skin abscesses

A. DEFINITION

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Incision and Drainage (I&D) of abscesses involves making an incision in the skin to draw pus from the abscess. This protocol excludes abscesses on the face, neck, perirectal and genitalia.

1. Location to be performed: For the purposes of this protocol, the procedure may be completed at all of the health care sites within the Community Primary Care Clinical Service.

2. Performance of procedure:

i. Indications:

- Abscess amenable by size and location to I&D with local anesthesia
- Known allergies/adverse reactions to material used for incision and drainage, immunocompromised

ii. Precautions:

- Large abscesses that require extensive incising or debridement

iii. Contraindications:

- Deep abscesses that may require more extensive anesthesia
- Abscesses that invade the palmar or plantar spaces
- Suspected pseudo aneurysm must be ruled out by further diagnostic evaluation

iv. Exclusions:

- Abscesses on the face, neck, perirectal area, and genitalia

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes

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D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
- b. Explain procedure to the patient
- c. Time out performed per hospital policy.
- d. Diagnostic tests for purposes of disease identification.
- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained historical, physical, or laboratory findings
- c. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient, NP, PA, or physician
- e. Initiation or adjustment of medication other than those in the formularies.
- f. Problem requiring hospital admission or potential hospital admission.

3. Education - Discharge information and instructions.

4. Follow-up - As appropriate for procedure performed.

E. RECORD KEEPING

~~Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LGR as appropriate. All information from patient visits will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. Summary of Prerequisites, Proctoring and Reappointment Documentation

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Prerequisite

1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
2. Procedure performed following standard medical technique according to departmental standards.
3. One year experience in wound care.
4. Training will include:
 - a. Indications for procedure and treatment
 - b. Risks and benefits of procedure and medications
 - c. Related anatomy and physiology
 - d. Consent process consistent with hospital policy
 - e. Wound infection and healing mechanisms
 - f. Use of required equipment
 - g. Steps in performing procedure
 - h. Ability to interpret results and formulate follow up plans
 - i. Ability to recognize complications

Proctoring Period

1. New provider to procedure will have a minimum of 2 successful observed demonstrations.
2. Experienced provider to procedure will have a minimum of 1 successful observed demonstration.
3. Explanation will be needed for exceptions to the minimum requirements.
4. ~~Documentation of training or experience will be sent to the Medical Staff Office-Chart review of all cases~~

Reappointment -Competency Documentation

1. A qualified provider who has completed proctoring and subsequently maintained their eligibility.
2. Perform a minimum of 1 procedure and 1 chart review every two years.

1. ~~The evaluator will be an Attending Physician~~
2. ~~Perform a minimum of 1 procedure every 2 years.~~
3. ~~1 chart review every 2 years.~~

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Protocol #9: Procedure: Insertion of Contraceptive Implant

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A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm via a preloaded inserter.

1. Location to be performed: This procedure can be completed at all Community Primary Care clinical sites.

2. Indications:

a. A woman desires long acting, reversible contraception.

b. Precautions:

i. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.

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ii. May have drug interactions with anti-HIV medications and some herbal products.

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iii. See drug precautions/interactions in implant prescribing information.

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c. Contraindications:

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- i. Known or suspected pregnancy
- ii. Current or past history of thrombotic disease
- iii. Hepatic tumors, active liver disease
- iv. Known, suspected or history of breast cancer
- v. Undiagnosed abnormal genital bleeding
- vi. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective data

- a. History and review of symptoms relevant to implant insertion, including sexual history to rule out preexisting pregnancy.
- ~~b.~~ Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

~~b.~~

2. Objective data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam, including a negative pregnancy test.
- d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify if patient is eligible for implant insertion/removal.

D. PLAN

1. Therapeutic treatment plan

- ~~a.~~ Patient consent obtained before procedure is performed.
- ~~a.~~
- b. Timing of insertion: see prescribing information.
- c. Implant inserted/removed as described in prescribing information.
- d. Initiation or adjustment of medication per furnishing/drug orders protocol.
- ~~e.~~ Referral to physician, specialty clinics, and supportive services, as needed.

~~e.~~

2. Patient conditions requiring attending consultation

- a. Difficult insertions/removals.

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- b. Acute decompensation of patient situation.
 - c. Upon request of patient, NP, CNM, PA, or physician
- c.
3. Education
 - Discharge information and instructions for care of site, expectant side effects, precautions and urgent/emergent symptoms.
- Follow-up
4.
 - As appropriate for implant insertion/removal.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients. All information from patient visits will be recorded in the medical record.

F. Summary of prerequisites, proctoring, and reappointment competency

Prerequisites:
1. Completion of a company- sponsored training program
Proctoring period:
1. For a new provider to procedure, a minimum of 2 successful observed demonstrations of insertions <u>by a qualified provider.</u>
2. For an experienced provider to pro a minimum of 1 successful observed demonstration of an implant insertion.
Reappointment- competency documentation:
1. <u>A qualified provider who has completed proctoring and subsequently maintained their eligibility.</u>
2. <u>A minimum of 4 insertions every 2 years</u>
3. <u>1 chart review needed every 2 years.</u>
~~A minimum of 6 insertions every 2 years~~
~~2. 1 chart review needed every 2 years.~~

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Protocol #10: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm and remains effective for 3 years. Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within the OB/GYN service-CPC.

2. Performance of procedure:

a. Indications

Woman/Patient desires removal of implant or implant is expired.

b. Precautions: See prescribing information.

c. Contraindications: See prescribing information.

B. DATA BASE

1. Subjective Data

a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

a. Physical exam appropriate to the procedure to be performed.

b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

c. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

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a. Patient consent obtained before procedure is performed and obtained according to hospital policy.

bb. Diagnostic tests for purposes of disease identification.

ce. Timing of removal: See prescribing information

dd. Removal: as described in prescribing information

ee. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

ff. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.

a. Acute decompensation of patient situation.

b. Difficult Implant removal.

c. Upon request of patient, affiliated staff or physician

d. If patient desires removal and rod is not readily palpable.

3. Education

Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure-specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients. All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

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Prerequisite:

- a. Completion of a company sponsored training class

Proctoring period:

- a. Performance of a minimum of 63 removals for a new provider and 2 removals for a provider who has prior experience with independent removal.
- b. ~~Proctor must be a qualified provider. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator~~

c. Chart review of all observed ceases

Reappointment Competency Documentation:

- a. Performance of 84 removals every 2 years.
- b. 21 chart review needed every two years.

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Protocol #11: Procedure: Insertion of Intrauterine Device

A. DEFINITION

Intrauterine devices offer a highly effective, safe, long-term contraception.

1. Indications: Patient desires intrauterine device.

2. Precautions:

- a. Abnormalities of the uterus resulting in distortion of the uterine cavity
- b. Postpartum endometritis or postabortal endometritis in the past 3 months

3. Contraindications:

- a. Pregnancy or suspicion of pregnancy
- b. Acute pelvic inflammatory disease or current behavior suggestion of a high risk for pelvic inflammatory disease
- c. Known or suspected uterine or cervical malignancy
- d. Genital bleeding of unknown etiology
- e. Mucopurulent cervicitis
- f. Wilson's disease (for Paraguard IUD (TM))
- g. Allergy to any component of Paraguard IUD™
- h. A previously placed IUD that has not been removed

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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- d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. **DIAGNOSIS**

Assessment of subjective and objective data to identify disease processes.

D. **PLAN**

1. **Therapeutic Treatment Plan**

a.

- a. Patient consent obtained before procedure is performed,
- b. Timeout performed per hospital policy
- c. Diagnostic tests for purposes of disease identification.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. **Patient conditions requiring Attending Consultation**

- a. Acute decompensation of patient situation.
- b. Unexplained historical, physical or laboratory findings
- c. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient, NP/CNM/PA, or physician
- e. Initiation or adjustment of medication other than those in the formularies.
- f. Problem requiring hospital admission or potential hospital admission.

3. **Education**

- a. Discharge information and instructions.

4. **Follow-up**

- a. As appropriate for procedure performed.

E. **RECORD KEEPING**

All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and

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~~date a minimum of five (5) per cent sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

1. ~~Prior experience or training required for this procedure.~~
2. ~~6 months experience in women's health care.~~
3. ~~Review of departmental policies and procedures.~~

Proctoring:

1. ~~Direct observation of 2 successful insertions by a qualified provider. a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator.~~
2. ~~Documentation of training course completion.~~

Reappointment Competency Documentation:

1. ~~Performance of one procedure every 2 years.~~
2. ~~One chart review every 2 years.~~

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Protocol # 12: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the Community Primary Care Clinical Service that are beyond simple cuts and abrasions. These wounds may require local anesthesia and suturing.

1. Location to be performed: this procedure can be completed any all health sites within the Community Primary Care Clinical Service.
2. Performance of procedure/minor surgery:
 - a. Indications: This protocol covers patients presenting to the Community Primary Care Service for assessment and treatment of lacerations, avulsions, bites and stings, burns and abscesses.
 - b. Precautions
 - Immunocompromised patients.
 - c. Contraindications:
 - Wound infection
 - Wound that has remained open for longer than six (6) hours.
 - Lacerations to the hand greater than 6 hours old. Noninfected wound caused by clean object that has remained open for longer than eighteen (18) hours (or twenty-four [24] hours for head wounds).
 - Vascular compromise or cases when direct pressure does not stop bleeding.
 - Wounds requiring large areas of debridement or excision prior to closure.
 - Wounds with bone fragments involved.
 - Wounds with tendon, ligament, vessel or nerve involvement.
 - Head lacerations where galea disruption is greater than 2 cm.
 - Facial lacerations with cosmetic considerations (i.e., eyelids and vermillion borders).
 - Lacerations penetrating into joints.

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- Patients requiring conscious sedation.

B. DATA BASE

1. Subjective Data

- History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- Pertinent past medical history, surgical history, family history, hospitalizations, habits, tetanus prophylaxis history, current medications, allergies.

2. Objective Data

- Physical exam appropriate to the procedure to be performed.
- ~~The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).~~
- ~~b.~~ Appropriate motor, sensory and vascular exam of the involved area according to the departmental resources (i.e. specialty guidelines).
- ~~c.~~ Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- ~~d.~~ All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- Patient consent obtained consistent with hospital policy before procedure is performed.
- Time Out performed per hospital policy.
- ~~b.~~ ~~c.~~ The procedure is performed following standard medical technique
- ~~d.~~ Diagnostic tests for purposes of disease identification.
- ~~e.~~ Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

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e.f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation
- b. Unexplained historical, physical, or laboratory findings
- c. Upon request of patient, nurse practitioner, physician assistant, or physician
- d. Initiation or change of medication other than those in the formulary(ies)
- e. Problem requiring hospital admission or potential hospital admission

3. Education

Discharge information and instructions.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

~~Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. All information from patient visits will be recorded in the medical record.~~

~~For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five percent (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. SUMMARY OF PREREQUISITES, PROCTORING AND REAPPOINTMENT COMPETENCY

Prerequisite

1. New provider will attend a wound care/suturing course or lab at AN outside facility or through SFGH.

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2. Training will Include:

- a. Indications for procedure and treatment
- b. Risks and benefits of procedure
- c. Related anatomy and physiology
- d. Consent process consistent with hospital policy
- e. Time out process consistent with hospital policy
- f. Wound infection and wound healing mechanisms
- g. Use of required equipment
- h. Steps in performing procedure
- i. Ability to recognize complications.

Proctoring Period

1. New provider to procedure, a minimum of 2 successful observed demonstrations with chart review of all observed cases.
2. Experienced provider to procedure, a minimum of 1 successful observed demonstration. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstration. Chart review of all observed cases
3. Explanation needed for any exceptions to minimum requirements.
4. Documentation of completion of training must be sent to the medical staff office

Reappointment Competency

1. Evaluator will be the Medical Director, Physician in Charge or other attending physician. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator.
2. Must perform wound care/suturing a minimum of 1 time every two years.
3. One chart review every two years.

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Protocol #13: Splinting

A. DEFINITION

Splinting involves the immobilization of joints and/or limbs or appendages to stabilize and protect fractures, and/or to provide comfort for patients with fractures, sprains, or other musculoskeletal injuries.

1. Location to be performed: This procedure may be completed at all health care sites within the Community Primary Care Clinical Service.

2. Performance of procedure:

- a. Indications: fractures, sprains, tendon injuries, other musculoskeletal injuries and conditions for which splinting may be part of the standard of care for treatment
- b. Precautions: known allergies/adverse reactions to materials used for splinting
- c. Contraindications: open fractures, otherwise complicated fractures or other musculoskeletal conditions, coagulation disorder

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to SFGH POCTMC policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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1. Therapeutic Treatment Plan

- a. Patient consent obtained consistent with hospital policy before procedure is performed.
- b. Time out performed per hospital policy.
- c. Explain procedure to the patient.
- d. Diagnostic tests for purposes of disease identification.
- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- 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, nurse practitioner, physician assistant, or physician
- e. Initiation or change of medication other than those in the formulary (ies)
- f. Problem requiring hospital admission or potential hospital admission

3. Education

Discharge information and instructions.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)

For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases

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~~which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites

1. Procedure performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
2. Training will include:
 - a. Indications for procedure and treatment
 - b. Risk and benefits of procedure
 - c. Related anatomy and physiology
 - d. Obtain Consent consistent with hospital policy
 - e. Perform a time Out consistent with hospital policy.
 - f. Use of required equipment
 - g. Steps in performing procedure
 - h. Ability to interpret results and formulate follow up plans.
 - i. Ability to recognize complications.

Proctoring Period

1. New provider to procedure, a minimum of 2 successful observed demonstrations.
2. Experienced providers to procedure, a minimum of 1 successful observed demonstration.
3. Explanation needed for any exceptions to minimum requirements.
4. Documentation of completion of training must be sent to the Medical Staff Office.

Reappointment Competency Documentation

1. ~~The Medical Director, Physician in Charge or other attending physician shall be the evaluator. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator.~~
2. Perform 1 procedure every two years.
3. 1 Chart review every two years.

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Protocol #14: Waived Testing

A. DEFINITION

Waived testing relates to common laboratory tests that do not involve an instrument and are typically performed by providers at the bedside or point of care.

- 1) Location where waived testing is to be performed: any in- or outpatient location providing emergency or primary care
- 2) The following non-instrument based waived tests are currently performed at SFGH:
 - a. Fecal Occult Blood Testing (Hemocult ®)
Indication: Assist with detection or verification of occult blood in stool.
 - b. Vaginal pH Testing (pH Paper)
Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.
 - c. SP® Brand Urine Pregnancy
Indication: Assist with the diagnosis of pregnancy.
 - d. Chemstrip® Urine Dipstick
Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

- 1) Subjective Data
Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed
- 2) Objective Data
Each waived test is performed in accordance with approved SFGH policies and procedures specific for each test as well as site-specific protocols and instructions for:
 - a. Indications for testing
 - b. Documentation of test results in the medical record or LCR
 - c. Actions to be taken (follow-up or confirmatory testing, attending consultation, referrals) based on defined test results.

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- d. Documentation or logging of tests performed
- C. DIAGNOSIS
- Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.
- D. PLAN
1. Testing
 - a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
 - b. Use gloves and other personal protective equipment, as appropriate.
 - c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.
 2. Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.
 - a. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?
 3. Test Results requiring Attending Consultation
Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.
 4. Education
 - a. Inform patient of test results and need of additional tests, as necessary
 5. Follow-up
 - a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

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~~Test and control results will be recorded in the medical record as per site specific protocols (may be in paper charts or entered in electronic data bases).~~ Tests and control results will be recorded in the medical record.

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,

Proctoring:

Successful completion of Halogen quizzes for each of the waived tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module.

Reappointment Competency Documentation:

Renewal required every two years with documentation of successful completion of the required Halogen quizzes. Provider must have passed each required module with a score of 80%.

Any additional comments: N/A

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Protocol #15: Tattoo Removal

A. DEFINITION

The removal of a tattoo (or multiple tattoos) from a patient's skin using the medlite CB laser. The treatment is always conducted in conjunction and consultation with a laser technician from Monarch Laser Services (or company that is contracted to provide laser services to SFDPH), the company which rents the laser to the City and County of San Francisco. Treatment is scheduled every six to eight weeks, until such time as the desired cosmetic outcome is achieved or complications arise requiring the cessation, suspension, or modification of therapy.

1. Location to be performed: San Francisco General Hospital and Trauma Center and affiliated SFDPH ambulatory settings.

2. Performance of procedure:

a. Indications:

1. The presence of one or more tattoos on the patient's skin, with a primary focus on gang-related tattoos or "bad choice" tattoos, especially in areas not usually covered by clothing (face, neck, hands, forearm's etc.)

b. Precautions:

1. A health screening questionnaire is completed by all program participants prior to acceptance into the program.

2. Providers check in with patients prior to each treatment session.

3. Extensive post-treatment counseling regarding after-care is conducted following each treatment session, along with any supplies needed to properly care for the treatment site.

c. Contraindications:

1. Immunodeficiency

2. Pregnancy/breastfeeding

3. Acute intoxication

4. Open wounds at or near treatment site

5. Acute infection at or near treatment site

6. Severe reaction to laser treatment

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B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to tattoo removal
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to tattoo removal.
- b. The tattoo removal is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

C. DIAGNOSIS

Assessment of subjective and objective data to identify eligibility for tattoo removal.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed. If patient is minor, parent/guardian consent must be obtained
- b. Time out performed.
- c. Diagnostic tests for purposes of disease identification.
- d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained historical, physical or laboratory findings
- c. Uncommon, unfamiliar, unstable, and complex patient conditions
- d. Upon request of patient, NP, PA, or physician
- e. Problem requiring hospital admission or potential hospital admission.

3. Education

Discharge information and instructions.

4. Follow-up

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Six to eight weeks following treatment or as needed to address any concerns or complications.

E. RECORD KEEPING

~~Patient visit, consent forms, and other procedure specific documents will be recorded in the electronic medical record (EMR), EPIC as appropriate. All information from patient visits will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:

- a. Observation of twenty five tattoo removal clinic sessions. Completion of the laser safety module prepared by the SFGH Laser Safety Committee and baseline eye examination within the previous 1 year.

Proctoring Period:

- a. 10 cases by a provider with active privilege for tattoo removal or who has met proctoring and reappointment competency requirements as outlined in the SP.

Reappointment Competency Documentation:

- a. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator
- b. Competency
 1. Completion of 5 procedures every 2 years.
 2. Completion of 5 chart reviews every 2 years.
- ~~a. Completion of 5 procedures every 2 years.~~
- ~~b. Completion of 5 chart reviews every 2 years.~~

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Protocol # 16: Procedure: Nail Debridement

A. DEFINITION

Nail debridement is the removal of elongated overgrown nail material.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications: Elongated nail material, overgrowth, thick nail, painful fungal nails.
 - b. Precautions: Vascular status, caution to amount of nail removed.
 - c. Contraindications: none.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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- c. All Point of Care Testing (POCT) will be performed according to ZSFG Admin POCT policy and procedure #16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Trim nails with use of sterile instrumentation.
- b. Diagnostic tests for purposes of disease identification.
- c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:

- a. Acute decompensation of patient situation
- b. Unexplained historical, physical, or laboratory findings
- c. Upon request of patient, nurse practitioner, physician assistant, or physician
- d. Problem requiring hospital admission or potential hospital admission
- e. Uncommon, unfamiliar, unstable, and complex patient conditions

3. Education

Discharge information and instructions. Instructions will include signs and symptoms of infection and follow-up if infection occurs.

4. Follow-up

Will be determined based on individual needs for interval palliative survey.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

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F. Summary of Prerequisites, Training, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

1. Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience. If has experience will still require direct observation.

2. Training will include:

- Indications for procedure and treatment.
- Risks and benefits of procedure and medication.
- Related anatomy and physiology.
- Consent process
- Wound infection and wound healing mechanisms assessment
- Use of required equipment.
- Steps in performing procedures.
- Ability to interpret results and formulate follow-up plans.
- Documentation and CPT and ICD-10 coding
- Ability to recognize complication.

Proctoring:

- New practitioner to procedure will have a minimum of 2 successful observed demonstrations.
- Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration.
- Chart review of all observed cases.

Reappointment Competency:

- A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator
- Competency
 - Perform 1 procedure and 1 chart review every 2 years.

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Protocol # 17: Procedure: Nail Removal/Matrisectomy

A. DEFINITION

Nail removal or Matrisectomy is the complete or partial removal of the nail bed and nail plate.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
 - a. Indications: Chronic or acute nail infection (including fungal) or ingrown nails.
 - b. Precautions: Severe infections that would indicate major surgical intervention and vascular status.
 - c. Contraindications: Poor blood flow and other diagnoses not ruled out.

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

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2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. The procedure is performed following standard medical technique
- c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- d. All Point of Care Testing (POCT) will be performed according to ZSFG Admin POCT policy and procedure #16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
- b. Time out performed per hospital policy.
- c. Diagnostic tests for purposes of disease identification.
- d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:

- a. Acute decompensation of patient situation
- b. Unexplained historical, physical, or laboratory findings
- c. Upon request of patient, nurse practitioner, physician assistant, or physician
- d. Problem requiring hospital admission or potential hospital admission

3. Education

Patient will be informed of post matrisectomy care. Will be instructed in signs and symptoms of infection and follow up if infection occurs.

4. Follow-up

High risk patients will be followed at intervals for nail care. Post matrisectomy patients will be followed as needed to evaluate healing.

E. RECORD KEEPING

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All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Training, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

1. Training in above procedures will occur on site during orientation period.

If NP/PA does not have previous experience. If has experience will still require direct observation.

2. Training will include NP/PA being able to demonstrate knowledge of the following:

- a. Indications for procedure and treatment.
- b. Risks and benefits of procedure and medication.
- c. Related anatomy and physiology.
- d. Consent process
- e. Wound infection and wound healing mechanisms assessment
- f. Use of required equipment.
- g. Steps in performing procedures.
- h. Ability to interpret results and formulate follow-up plans.
- i. Documentation and CPT and ICD-10 coding
- j. Ability to recognize complication.

Proctoring:

1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations.

2. Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration.

3. Chart review of all observed cases.

Reappointment Competency:

a. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator

b. Competency

1. Perform procedure and 1 chart review every 2 years.

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Protocol # 18: Procedure: Skin Biopsy

A. DEFINITION

Removal of a small portion of abnormal skin to be treated in a laboratory. There are three types of skin biopsy:

- Shave biopsy: the outer part of the suspect area is removed.
- Punch biopsy: a small cylinder of skin is removed using a punch tool.
- Excision biopsy: the entire area of abnormal growth is removed.

1. Location to be performed: all sites within the FCM department.

2. Performance of procedure:

a. Indications

i. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.

b. Precautions

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- i. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
- ii. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
- iii. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.
- c. Contraindications: None

B. DATA BASE

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed.
- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
- c. All Point of Care Testing (POCT) will be performed according to ZSFG Admin POCT policy and procedure #16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

- a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
- b. Time out performed per hospital policy.
- c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
- d. Diagnostic tests for purposes of disease identification.
- e. Biopsy tissue is sent to pathology as appropriate.

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- e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- f. Referral to physician and supportive services, as needed.
- 2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation.
 - b. Unexplained historical, physical or laboratory findings
 - c. Uncommon, unfamiliar, unstable, and complex patient conditions
 - d. Upon request of patient, NP, PA, or physician
 - e. Initiation or adjustment of medication other than those listed in or approved by the formularies.
 - f. Problem requiring hospital admission or potential hospital admission.
- 3. Education
Pre-procedure and post procedure education as appropriate and relevant in verbal or written format.
- 4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

- a. 2 direct observations of a qualified provider doing each procedure
- b. Review of aseptic technique
- c. Review of departmental policy and procedure

Proctoring Period

- a. New practitioner to procedure, a minimum of 2 successful observed demonstrations of each procedure
- b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations of each procedure

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c. Chart review of all observed cases.

Reappointment Competency

a. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator

b. Competency

1. Perform 1 of each procedure every 2 years.

2.1 chart review of each procedure every 2 years.

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Delineation Of Privileges
AFF Optometry

Provider Name:

Privilege	Status	Approved
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AFF Optometry

CORE PRIVILEGES

- Core privileges in Optometry includes the following, as specified by the California Board of Optometry licensure practice:
- Perform primary eye care examinations, including ophthalmic history and refraction
 - Diagnose vision problems and eye diseases
 - Test patients’ visual acuity, depth and color perception, and ability to focus and coordinate their eyes
 - Analyze test results and develop treatment plan
 - Provide pre- and postoperative care to cataract patients as well as those who have had other eye surgery as indicated
 - Provide emergency eye care services
 - Diagnose conditions due to systemic diseases such as diabetes and high blood pressure, referring patients to other health practitioners as needed
 - Application of eye drops for both diagnosis and treatment as outlined in California State Therapeutic Pharmaceutical Agent certification
 - Contact lens fitting
 - Low vision evaluation and treatment

PREREQUISITES:
Successful completion of a Doctor of Optometry (O.D.) program accredited by the Accreditation Council on Optometric Education (ACOE) AND current active California state licensure to practice optometry. Possession of a valid Therapeutic Pharmaceutical Agent (TPA) certificate.

PROCTORING: review of 5 cases

REAPPOINTMENT: minimum of 3 cases in the past 24 months.

APPROVED BY

Division Chief	Date
Service Chief	Date



Department of Public Health

London Breed
Mayor

Addition of Privileges

New	
Privilege Title:	Advanced Management of Complex Sleep Disorders
Description:	Advanced evaluation and non-surgical management of complex sleep disorders
Prerequisites:	Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Anesthesiology, American Board of Family Medicine, American Board of Internal Medicine, American Board of Otolaryngology, American Board of Pediatrics, <u>OR</u> American Board of Psychiatry and Neurology <u>AND</u> certification in Sleep Medicine by the Sleep Medicine Certification Program, administered through ABIM <u>AND</u> completion of a Sleep Medicine fellowship with board eligibility.
Proctoring:	5 case reviews
Reappointment:	3 case reviews