

ZSFG JOINT CONFERENCE COMMITTEE MEETING

JUNE 22, 2026

MEDICAL STAFF REPORT

Contents:

1. Chief of Staff Report
2. Orthopaedic Surgery Service Report
3. Orthopaedic Surgery Rules and Regulations
4. Otolaryngology Service Report
5. Otolaryngology Rules and Regulations
6. Privilege lists and Standardized Procedures (May and June meetings):
 - a. Anesthesia Standardized Procedures and summary of changes
 - b. Credentialing Manual and summary of changes
 - c. CPC Nurse Practitioner/Physician Assistant standardized procedures and summary of changes
7. For Discussion and Action

Review and Recommend for Approval Revisions to ZSFG Medical Staff Bylaws
(Mary Mercer, MD, Chief of Medical Staff)

The Committee will hear a summary of the proposed revisions to the ZSFG Medical Staff Bylaws. A quorum of full members of the Medical Staff reviewed and approved this version for formal consideration by the JCC and the full Health Commission. Approval is requested to recommend these revisions to the Health Commission for final approval.

ZSFG CHIEF OF STAFF-OPEN SESSION ACTION ITEMS

**Presented to the JCC-ZSFG June 22, 2026
May and June 2026 MEC Meetings**

Clinical Service Report and Rules and Regulations:

1. Orthopaedic Surgery Service Report
2. Orthopaedic Surgery Rules and Regulations and summary of changes
3. Otolaryngology Service Report
4. Otolaryngology Rules and Regulations

Credentials Committee-Privilege List/Standardized Procedures (May and June meetings)

1. Anesthesia Standardized Procedures and summary of changes
2. Credentialing Manual and summary of changes
3. CPC Nurse Practitioner/Physician Assistant standardized procedures and summary of changes

For Discussion and Action

1. Review and Recommend for Approval Revisions to ZSFG Medical Staff Bylaws
(Mary Mercer, MD, Chief of Medical Staff)

The Committee will hear a summary of the proposed revisions to the ZSFG Medical Staff Bylaws. A quorum of full members of the Medical Staff reviewed and approved this version for formal consideration by the JCC and the full Health Commission. Approval is requested to recommend these revisions to the Health Commission for final approval.

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on June 22, 2026
May and June MEC Meetings

A. ORTHOPEDIC SURGERY CLINICAL SERVICE REPORTS: Theodore Miclau III, MD

The highlights of the Orthopedic Surgery report are as follows:

- X. Mission-** To mend the injured, inspire innovators, empower leaders to restore lives.
- Y. Vision-** To provide an interdisciplinary team of physicians, nurses, and other health care professionals who deliver the highest level of care to patients; to improve outcomes and quality of life for individuals in San Francisco and beyond while advancing education, research, and training in orthopaedic care; and to become a nationally and internationally recognized center of excellence in orthopaedic trauma care.
- Z. Scope of the Clinical Service-** The scope of practice at ZSFG includes orthopaedics, podiatry, rehabilitation, and orthotics and prosthetics. The service manages all general orthopaedic conditions, with only a small number of cases referred outside of ZSFG. Call coverage is provided entirely by full-time ZSFG staff. There are 17 weekly clinics, including sub-specialty clinics in sports medicine, foot and ankle, hand, pediatrics, spine, podiatry, diabetic foot, and rehabilitation. In addition, the service operates six elective OR blocks each week, consisting of three fast-track room blocks and five trauma room blocks. The total number of surgical procedures performed in fiscal year 2024–2025 was 16,032, and outpatient clinic visits totaled 11,095.

The service supplies orthopedic trauma expertise for the entire DPH and UCSF Health systems, with clinical activity extending to ZSFG, UCSF Orthopedic Institute, Mount Zion, Benioff Children's Hospital, Laguna Honda Hospital, Washington Health System, and emerging partnerships with Marin General and St. Mary's/Saint Francis through system acquisitions. The service manages approximately three quarters of all fractures in San Francisco and maintains high volume surgical, outpatient, and consultative services. Subspecialty support includes oncology, pediatrics, spine, hand, Podiatry, and arthroplasty, along with significant inpatient and emergency coverage. Orthotics and Prosthetics (O&P) continues to expand, offering daily coverage and essential support for inpatient and emergency care.

- AA. Faculty and Residents-** The ZSFGH/OTI Orthopaedic Surgery education program remains a highly regarded training site within UCSF. The UCSF Orthopaedic Residency Program is consistently ranked as a top-10 choice nationally, with the SFGH rotation regularly cited as a house staff favorite. Medical student clerkship evaluations for third- and fourth-year rotations remain strong, and the medical student casting course continues to be based at ZSFGH. All anatomy and core curriculum teaching sessions are conducted at ZSFG, underscoring the hospital's central role in orthopaedic education. The service is staffed by full-time, trauma-fellowship-trained orthopaedic faculty, including a uniquely high concentration of dual-fellowship-trained surgeons. The team is supported by trauma fellows, rotating UCSF residents, emergency medicine residents, interns, medical students, nurse practitioners, and orthotics and prosthetics residents. Leadership roles align with UCSF departmental priorities, with faculty involved in residency education, quality improvement, systems operations, and outpatient medical direction. Recruitment efforts are underway to support new institutional partnerships and expand trauma call coverage.

- BB. Performance Improvement and Patient Safety (PIPS) initiatives-** Performance Improvement and Patient Safety initiatives continue to show strong results across Orthopaedics, with quality metrics consistently exceeding national benchmarks, including leading times to antibiotic administration, timely operative stabilization of fractures, and effective management of geriatric hip fractures. Appointment access remains within the 21-day standard except during brief staffing gaps. The service maintains active participation in institutional committees and operates a structured internal QA process reviewing all cases through ED review, indications conference, and M&M. The primary ongoing challenge is limited arthroplasty access, historically resulting in long wait times. Recent expansions—including added fast-track arthroplasty sessions, increased OR availability with OR 9 and upcoming OR 10, and redistribution of new referrals—are helping reduce backlog, though further OR capacity may still be needed. Similar workflow and scheduling improvements are underway in Podiatry and Physiatry to address delays in OR access, injections, and EMG scheduling. Overall, the service continues to provide high-quality patient care while implementing targeted operational improvements.

- CC. Education and Research-** The UCSF residency program is a top-10 choice, the ZSFG rotation is rated as a house staff favorite, and the medical student clerkship consistently receives high ratings. The department maintains one of the most comprehensive orthopedic research programs nationally, spanning molecular biology, biomechanics, clinical and procedure-based research. The biomechanics testing facility expanded with increased cross campus utilization and integrating additional ortho residency from St. Mary's and St. Francis. Digital Science Laboratory includes innovation projects. Ongoing orthopaedic trauma and spine health-related clinical projects are funded by the government, non-profit organizations, and industry partners. This includes international and collaborative network partnerships.

- DD. Financial Report-** The department manages an annual operating budget of approximately \$11–12M. Revenue sources include city contracts (52%), ZSFG (20%), UCSF clinical activity (11%), Washington Health (5%), Laguna Honda (2%), and grants/contracts (10%). Payer mix shows increasing proportions of Medicare and managed care while maintaining a steady portion of medically indigent patient care supported through departmental pooled funds. RVU and wRVU production show steady incremental growth,

supported by a rising proportion of insured ED patients and increased system wide referrals. Strategic endowments have been successfully established to support faculty positions and resident awards, contributing to long term sustainability.

- EE. Goals-** For 2025–2026, the department aims to adapt to the growing demand for orthopaedic trauma services, continue strengthening integration with the UCSF campus, and address existing gaps in care, including reducing wait times for arthroplasty, sports medicine, and podiatry services. Strengthening financial performance remains a key focus through improved revenue capture, expanded referral pathways, and coordinated system-wide planning.
- FF. Orthopedic Surgery Rules and Regulations-**The Committee members expressed appreciation to Dr. Theodore Miclau and the Orthopedic Surgery Department team for their commitment to delivering high-quality care with compassion and respect. Dr. Miclau was acknowledged for his leadership, dedication and continued innovation. A motion for the committee to approve the updated Orthopedic Surgery Rules and Regulations was made and approved. Approval from the Health Commission is requested for the Orthopedic Surgery Service Rules and Regulations.

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on June 22, 2026
June MEC Meetings

OTOLARYNGOLOGY CLINICAL SERVICE REPORTS: Megan Durr, MD

The highlights of the Otolaryngology–Head and Neck Surgery (OHNS) report are as follows:

- I. Mission-** The Otolaryngology–Head and Neck Surgery (OHNS) service mission is to provide comprehensive and compassionate Otolaryngologic care to the diverse communities of San Francisco. The service also emphasized its commitment to training the next generation of Otolaryngologists and ensuring that all patients have equitable access to the highest quality care.
- II. Scope of the Clinical Service-** The service operates a growing clinical enterprise centered in the 4J Clinic, with four days of outpatient clinic and expanded use of updated equipment, including microscopes, scopes, and ultrasound. OR access has increased to three and a half days weekly, including a newly added Thursday block. The team provides full 4 full days outpatient clinic, inpatient consultation coverage, emergency services, e-consults, and ongoing care for Laguna Honda patients. Demand continues to grow, especially in general otolaryngology, trauma, and audiology.
- III. Faculty and Residents-** The Otolaryngology–Head and Neck Surgery (OHNS) team consists of 50 full-time faculty members, 25 residents, 4 fellows, 18 APPs, 17 audiologists, 8 speech-language pathologists, and volunteer clinical faculty. Eight clinical OHNS faculty members provide services at ZSFG. Two APPs are full-time at ZSFG, and two clinical fellows rotate through the hospital. In addition, four audiologists and three OHNS clinical volunteers are dedicated to ZSFG.

Fifteen OHNS residents rotate at ZSFG per year and are receiving training in outpatient clinic management, OR cases, in-house consults, and facial trauma. Residents consistently rate this rotation highly, noting strong leadership development. Additional education and training included CME courses, educational conferences, simulation sessions, leadership development curriculum, and faculty wellness programs.
- IV. Performance Improvement and Patient Safety (PIPS) initiatives-**The service advanced multiple performance improvement initiatives, including standardized language-concordant discharge instructions and pre-operative patient education materials in multiple languages. It also continued ongoing monitoring of OR block utilization, which remains above 80%. New initiatives include integrating dental preventive care into OHNS cancer surveillance, such as providing fluoride treatments for cancer patients. Last year, OHNS received grant funding from the SFGH Foundation Equity and Inclusion Grant and Hearing Research Inc to launch an automated audiometry hearing screening program aimed at reducing long audiology wait times.
- V. Research-** Research productivity includes presentations at national meetings and publications on access to care, traumatic injury and cancer care. Community outreach and global health engagement remain active and expanding. Recent community outreach initiative includes hearing screening at Chinatown and other global health initiative projects.
- VI. Financial Report-** In FY25–26, ambulatory visit volume increased to 5,165, while E-consults rose to 2,637. OR volume has remained steady over the past several years at approximately 100 cases per year. Audiology clinic volume has also grown rapidly. Financial performance shows significant improvement through diligent billing practices, increased support from APP driven procedures, and stronger follow up on claims and appeals. Professional fee revenue and collection ratios continue to rise. Operationally, the service has grown its clinical volume, strengthened team communication through quarterly 4J meetings, and expanded community partnerships and educational programs.
- VII. Summary**

Strengths-The strengths of the OHNS team include its people and a mission-driven commitment to ZSFG’s True North Metrics. The department has a strong residency program supported by ample educational activities, as well as a growing clinical enterprise with expanded scheduling and updated equipment. The team has recently added OR block time and continues to build a robust research enterprise. In addition, the department operates with a financially lean structure and staffing model.

Challenges-The current challenges include meeting clinic demand—particularly in Audiology—amid a growing work queue. Additional needs involve outfitting and staffing the second audiology as well as addressing limited faculty office space.

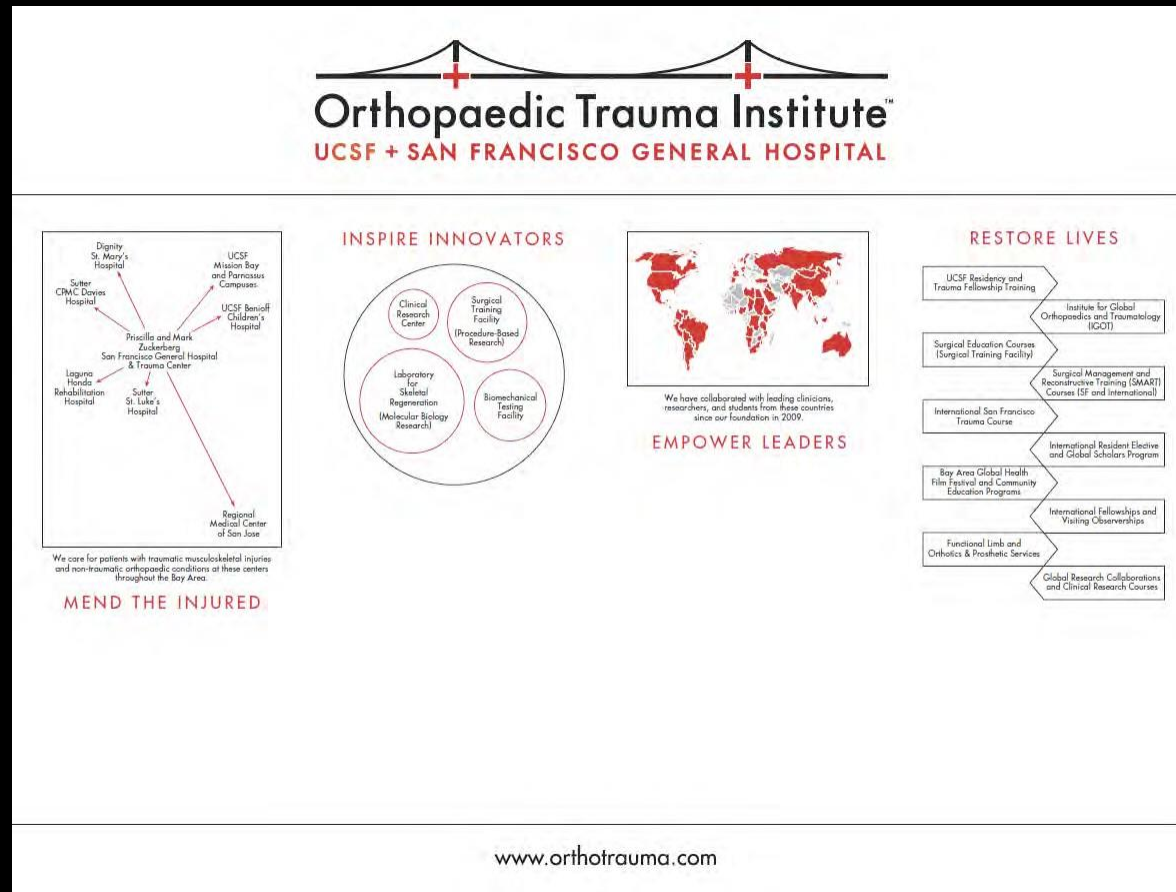
Goals-The goals include improving access to care, particularly in Audiology, and securing permanent office space for faculty. The department also aims to continue expanding its research enterprise and to enhance access to sub-specialists.
- VIII. Otolaryngology Rules and Regulations-**The MEC members expressed appreciation to Dr. Megan Durr for her excellent leadership. They highlighted the positive impact of team-building activities, professional development efforts and an inclusive structure that supports all staff. The OHNS department’s significant impact, resourcefulness, and consistent alignment with its mission was emphasized. A motion to approve the updated Otolaryngology–Head and Neck Surgery (OHNS) service report and OHNS Rules and Regulations was made and approved. Approval from the Health Commission is requested for the Otolaryngology-Head and Neck Surgery (OHNS) Service Rules and Regulations.

Zuckerberg San Francisco General
Orthopaedic Surgery
2025-2026



Mission

To mend the injured, inspire innovators, and empower leaders to restore lives.



Vision

- To provide an interdisciplinary team of physicians, nurses and other health care professionals that deliver the highest level of care for its patients.
- To improve the outcomes and quality of life for patients in San Francisco and beyond, and to support education, research, and training efforts that improve the care of orthopaedic conditions.
- To be a nationally/internationally recognized center of excellence for orthopaedic trauma care.

Orthopaedic Trauma Institute (Founded 2/19/09)

- **Clinical:**

- Orthopaedic Subspecialties (Trauma)
- Physical Medicine and Rehabilitation
- Podiatry
- Orthotics and Prosthetics

- **Education:**

- Student, Resident and Fellow Training
- Orthopaedic Trauma Course
- Surgical Training Facility

- **Research:**

- Laboratory for Skeletal Regeneration
- Biomechanical Testing Facility
- Clinical Research Center
- Procedure Based Research

- **Outreach**



 PATIENT CARE	 RESEARCH	 EDUCATION	 OUTREACH
+ San Francisco General Hospital: City's only Trauma Center (Level I) + Multi-specialty Orthopaedic Trauma Care + Plastic, Reconstructive, & Orthopaedic Surgery (PROS) Center at St. Mary's Hospital (Opened 2007)	+ Biomechanical Testing Facility (Opened 2007) + Clinical Research Center (Opened 2006) + Laboratory for Skeletal Regeneration (Opened 2004)	+ Surgical Training Facility (Opened 2007) + Annual San Francisco Trauma Course (Since 2006) + Fellowship Training (Since 2004) + Residency Training	+ IGOT: Institute for Global Orthopaedics & Traumatology (Founded 2006) + San Francisco General Hospital Foundation Community Programs

+ www.orthotrauma.com +



Clinical

Service Scope of Practice: ZSFG

- Includes orthopaedics, podiatry, rehabilitation, and orthotics and prosthetics
- Service manages all general orthopaedic problems; few cases referred out of ZSFG
- Call coverage provided entirely by ZSFG – full-time staff
- 17 weekly clinics total, including sub-specialty clinics in sports medicine, foot and ankle, hand, pediatrics, spine, podiatry, diabetic foot, and rehabilitation
- 6 elective OR blocks (3 fast track room + 5 trauma room blocks weekly)

The OTI's Clinical Scope 2025-26

Provides additional surgical volume and financial support:

- UCSF Orthopaedic Institute / UCSF Parnassus Campus (UCSF) - 2010
 - Outpatient visits / Inpatient referrals / Consultations / Surgery (Trauma Chief: S. Morshed)
- Benioff Children's Hospital
 - Pediatric orthopaedic trauma back-up coverage
- Washington Hospital Health System (Stand-alone) - 2024
 - 24/7 Trauma Coverage (Medical Director: A. Matityahu)
 - Encounters / Consultations/Surgery
- Laguna Honda Hospital (SF Dept. of Public Health)
 - Orthopaedics, Hand, and Podiatry Clinics
 - Orthotics and Prosthetics; Rehabilitation (Medical Director: L. Pascual)
 - Inpatient follow-up visits / Consultations

Orthopaedic Surgery Clinical Service 25/26

- Attendings
 - 14 Full-time ortho faculty
 - 1 Full-time podiatry faculty
 - 3 Full-time rehabilitation faculty
- 2 Fellows (2 Trauma)
- Residents
 - 2 Teams (each with a PGY-5, PGY-4, PGY-3, PGY-2)
 - Emergency Medicine resident
 - Interns: 3 (GS, Ortho)
- Students

Full-time Clinical Faculty (2025-26)

Physician

Comtock, Curt
Ding, Anthony
El Naga, Ashraf
Gendelberg, David
Kandemir, Utku
Marmor, Meir
Matityahu, Amir
Miclau, Theodore
Morshed, Saam
Shearer, David
Toogood, Paul
Usmani, Kudret
Xu, Mark
Lee, Nicolas
Cohn-Goldrei, Jennifer
Del Rosario, Karina
Nagao, Masato
Mostovoy, Amelia

Specialty

Trauma
Trauma, Hand/Microvascular
Trauma, Spine
Trauma, Spine
Trauma, Sports
Trauma, Arthroplasty
Trauma
Trauma, Trauma, Basic Research
Trauma, Clinical Research
Trauma, Foot and Ankle
Trauma, Arthroplasty/Reconstruction
Trauma/Arthroplasty
Trauma, Spine
Hand/Microvascular
Physical Medicine & Rehabilitation
Physical Medicine & Rehabilitation
Physical Medicine & Rehabilitation
Podiatry

Part-Time Faculty (2025-2026)

Physician

Delgado, Eliana (pediatrics)

Dini, Monara (podiatry)

Hewitson, Joseph (podiatry)

Parks, Charles (podiatry)

Pascual, Lisa (physiatry)

Schroeder, Nikki (hand)

Wustrack, Rosie (tumor)

Part-time

1 day/week

1 day/week

½ day/week

2½ Week

1 Week

½ Week

1 day/month

Patient Care: Surgical Procedures

	2025/26	2024/25	2023/24	2022/23	2021/22
Cases					
Ortho/Podiatry/Physiatry	1,737	2,670	2,486	2,497	2,135
Total OR Cases	10,890	16,032	16,210	15,691	10,343
% Ortho/Ttl OR Cases	16%	17%	15%	16%	21%
Minutes					
Ortho/Podiatry/Physiatry	216,888	326,911	309,842	320,838	312,221
Total OR Mins	876,999	1,344,690	1,322,295	959,493	933,898
% Ortho/Total OR Mins	25%	24%	23%	33%	33%

Patient Care Productivity: Outpatient Orthopaedic Clinics

Outpatient	FY25/26	FY 24/25	FY 23/24	FY 22/23	FY21/22
Clinic Completed Visits					
Hand**	2,767	4,220	3,820	3,942	3,962
Blue Team	-	-	-	No longer exists in Epic System	No longer exists in Epic System
Gold Team	-	-	-	No longer exists in Epic System	1,003
Arthroplasty**	1,784	1,803	1,421	1,439	1,566
Pediatrics	339	47	385	408	450
Physiatry**	310	678	590	611	655
Spine	776	1,101	1,095	933	892
Sports	1,520	2,288	2,055	2,432	2,573
Surgery	684	958	871	844	N/A
Total	10,845	11,095	10,237	13,910	11,101

Orthopaedic Surgery: Visit Types

(2024-25 vs 2025-26)

<u>Orthopaedic Surgery</u>	<u>Jul-24</u>	<u>Aug-24</u>	<u>Sep-24</u>	<u>Oct-24</u>	<u>Nov-24</u>	<u>Dec-24</u>	<u>Jan-25</u>	<u>Feb-25</u>	<u>Mar-25</u>	<u>Apr-25</u>	<u>May-25</u>	<u>Jun-25</u>	<u>Total</u>
eConsult Volumes	366	356	375	351	302	316	330	295	344	378	394	337	4144
Total Completed Visits	1250	1323	1233	1411	1096	1035	1264	1184	1186	1193	1273	1246	14694
In Person Visits	1240	1306	1221	1402	1090	1022	1251	1171	1173	1182	1267	1235	14560
Phone Visits	10	17	12	9	6	13	13	12	13	11	6	11	133
Video Visits	0	0	0	0	0	0	0	1	0	0	0	0	1
No Show Rate	19%	19%	19%	20%	17%	18%	19%	19%	18%	18%	16%	16%	

<u>Orthopaedic Surgery</u>	<u>Jul-25</u>	<u>Aug-25</u>	<u>Sep-25</u>	<u>Oct-25</u>	<u>Nov-25</u>	<u>Dec-25</u>	<u>Jan-26</u>	<u>Feb-26</u>	<u>Mar-26</u>	<u>Total</u>
eConsult Volumes	860	844	862	884	738	698	832	779	930	7427
Total Completed Visits	1301	1236	1284	1186	1011	1065	1210	1052	1227	10572
In Person Visits	1276	1228	1283	1183	1007	1065	1208	1049	1224	10523
Phone Visits	25	8	1	3	4	0	2	3	3	49
Video Visits	0	0	0	0	0	0	0	0	0	0
No Show Rate	19%	17%	19%	18%	18%	22%	18%	19%	16%	

Call Services

Call Service	Description	Availability
Ortho Trauma / General	Call and back-up call coverage provided by ZSFG-based staff	24hrs/7days/52 wks
Ortho Hand	Call coverage shared 50-50 with plastics	24hrs/7days/26 wks
Ortho Spine	Call coverage shared 50-50 with neurosurgery	24hrs/7days/26 wks

Podiatry Service

Consultation Services

- ED, Inpatient, Outpatient

Outpatient Care

- 3M Clinics: M-F
- Foot orthotics
- Functional Limb Service support

Surgical

- Urgent and elective coverage

Teaching

- Students: Samuel Merritt University (2nd – 4th year students)
- Residents:
 - UCSF Ortho Residents – inpatient, outpatient, OR
 - Family Medicine Residents 2 x a month outpatient clinic
- UCSF (Podiatric Limb Salvage Fellow)

Patient Care Productivity: Outpatient Podiatry Clinics

Outpatient	FY 25/26	FY 24/25	FY 23/24	FY 22/23	FY 21/22
Clinic Completed Visits					
Diabetic Foot	2,665	4,374	3,980	3,301	3,365

- Samuel Merritt College continues to send Podiatry Students to SFGH

Podiatry Service Challenges (2026-27)

- Single full time podiatry provider
- Outpatient backlog with lack of OR access
- Reduction of ORs resulted in loss of OR time causing inpatient urgent care delays to OR, scheduling challenges with running concurrent emergent surgery and daily scheduled clinic, and delay in scheduling elective cases (6-8 week wait time)
- Second podiatry provider
- Improved outpatient backlog (3-week wait)
- Increased OR time, starting June 15, 2026, 2 OR days a month increased time. This will improve OR access for elective surgery (6-8 weeks ideally down to 4 weeks) and urgent inpatient care needs

Physiatry: Program Updates 2025-26

New Leadership

- Welcomed **Jennifer Amica Cohn, MD** as Chief of Rehabilitation
- Workforce Update
- Experienced temporary staffing reductions (Aug–Jan) due to leave
- Now fully staffed (at full FTE), restoring service capacity
- Upgraded Diagnostic Capabilities
- Replaced legacy EMG equipment with a new EMG system
 - Enables integration with Epic, improving documentation, data access, and workflow efficiency
- Enhanced US machine in 3M with voice integration

Physiatry: Clinics/Procedures 2025-26

Clinic	Scheduled Visits
3M Physiatry	20 visits/week
3M Physiatry Spine Clinic	15-16 visits/week
3M Multidisciplinary Spine	55-60 visits/week
EMG	15-18 visits/week
	207 studies performed (Aug 2025-March 2026)
Functional Limb Service	9-10 visits/month
Consult Visits	248 (Aug 2025-March 2026)
MSK Procedures (OR)	205 (Aug 2025-March 2026)
E-consults Processing	785 (Aug 2025-March 2026)

Physiatry Service: Current Priorities & Opportunities (2025-26)

- Ongoing limited OR availability for physiatric pain procedures continues to impact patient access (1 month wait for hip and SI joint, 2.5-3 months for lumbar spine)
- Completing integration of the new EMG system with EMR to streamline documentation and reporting
- Ongoing efforts to strengthen consult service
 - Building partnerships to improve coordination and clinical impact

SFGH Orthotics and Prosthetics Service

- Staff – 1.5 residents, 4 Clinicians and 2 Administrative personnel
- Regular coverage - 8am to 5pm
No weekend on-call coverage
Holiday weekday on-call coverage
- Clinic support -
Inpatients - All floors, Emergency department, OR, Outpatients - 3M, 4A, Pediatrics, 1M, Laguna Honda Hospital, Functional Limb Service
- Provides regular in-services and in-house training to other healthcare providers



O&P Comparison Statistics

2023-2024 vs 2024-2025

	2023-2024	2024-2025	% Increase
Volume of Outpatient Referrals	4314	4548	5%
Volume of Outpatients Seen	4035	4449	10%
Volume of Inpatient Consults	978	1048	7%
Total Charges Billed	6,246,374.62	6,503,752.18	4%
Total Payments Received	1,118,889.43	1,121,244.26	0%

Orthopaedic Surgery: Quality Measures PIPS (2025)

	True North Category	Measure Name	Owner	Measure Units	Baseline FYTD (2025)	CURRENT FYTD (2025)			PROPOSED PI PLAN	
						Actual Performance; Color:  /  - Target	Desired Direction = (Up/Down)	12M Target	Driver/ Watch, or Retire Metric?	New 12M Target
DRIVERS	Care Experience/Equity	Arthroplasty Waiting time to surgery	Meir Marmor	Day (average)	215.2	157.1 (mean) 106.0 (median)	Down	150	Driver	100
	Financial Stewardship/Equity	Arthroplasty: Length of Stay (New)	Meir Marmor	Days (average)	3.5	4.3 (mean) 3.4 (median)	Down	2	Driver	3
WATCH	Safety	Surgery Site infection: Arthroplasty	Meir Marmor	%	0%	Knee: 4.1% (3/50) Hip: 4.0% (2/73)	Down	Knee: 0% Hip: 0%	Watch	0%?/0%?
	Care Experience	Specialty Care: TNAA	T. Miclau	# of Clinics TNAA < 21 days (Avg/yr)	8 of 8 < 11.6 days	8 of 8: RM&R	Down	8	Watch	8
	Safety	Preventable Mortality	P. Toogood	# non-1A Deaths	0	0	Remain	0	Watch	0
	Care Experience	Specialty Care: eConsult Turnaround Time <5 Days	N. Lee	% <5 days	>90%	96%	Up	90%	Watch	90%?
	Care Experience	Periop: Block Utilization %	T. Miclau	%	>80%	81%	Up	>80%	Watch	>80%
	Quality	PROM Collection in	Meir Marmor	% collected	100%	100%	Up	100%		100%

Orthopaedic Surgery: Quality Measures PIPS (2025)

ID	True-North-Category	Measure-Name	Owner	Measure-Units	Baseline-FYTD-(2025)	CURRENT-FYTD-(2025)			PROPOSED-PI-PLAN	
						Actual-Performance;-Color:-On/Off-Target-	Desired-Direction-=(Up/Down)	12M-Target	Driver/Watch, or-Retire-Metric?	New-12M-Target
1	Quality	PROM-Collection-in-3M-Clinic-(New)	Meir-Marmor	%-collected-of-eligible-patients	100%	100%	Up	100%		100%
	Quality/Equity	Geriatric-Hip-Fractures---Time-to--Surgery-(ED---Date-&-Time)	Meir-Marmor	Hours-(average)	New	28.5	Down	48	Watch	24.0?
	Quality/Equity	Geriatric-All-Fractures-LOS	Meir-Marmor	Average-Days	5	6.4	Down	5.00	Watch	5.0?
	Quality/Equity	Geriatric-Hip-Fracture-LOS	Meir-Marmor	Average-Days	New	5.8	Down	N/A	Watch	5.0?

Orthopaedic Surgery: Quality Measures TQIP (2025)

Table 19: Operative Irrigation and Debridement in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Irrigation and Debridement	Time to First Irrigation and Debridement (hours)	Irrigation and Debridement more than 24 Hours	Unknown Time to Irrigation and Debridement
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	8,082	7,735 (95.7)	7.8 (2.75-16)	657 (8.5)	19 (0.2)
Your Hospital	28	27 (96.4)	3.88 (1.27-15.5)	3 (11.1)	0 (0.0)

Table 20: Flap in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Flap	Time to Flap (days)	Flap after more than 7 Days	Unknown Time to Flap
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	8,082	350 (4.3)	7.5 (4-13)	175 (50.0)	0 (0.0)
Your Hospital	28	2 (7.1)	5.5 (1-10)	1 (50.0)	0 (0.0)

Table 22: Antibiotic Therapy in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Antibiotic Therapy	Time to Antibiotic Therapy (minutes) ¹	Time to Antibiotic Therapy more than 60 Minutes	Unknown Time to Antibiotic Therapy
Group	N	N (%)	Median (IQR)	N (%) ¹	N (%)
All Hospitals	8,071	7,928 (98.7)	20 (10-55)	1,574 (23.3)	118 (1.5)
Your Hospital	28	28 (100.0)	31 (20-55)	5 (17.9)	0 (0.0)

¹ Among patients receiving Antibiotic Therapy after Hospital/ED Arrival

Orthopaedic Surgery: Quality Measures TQIP (2025)

Table 16: First Operative Internal or External Fixation in Elderly Patients with Isolated Hip Fracture

	Isolated Hip Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Operative Fixation more than 48 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)	N (%)
All Hospitals	76,200	69,385 (91.1)	21.12 (15.73-27.53)	25,021 (36.1)	4,643 (6.7)	122 (0.2)
Your Hospital	68	63 (92.6)	22.42 (16.25-30.33)	25 (39.7)	7 (11.1)	0 (0.0)

Table 17: First Operative Internal or External Fixation in Patients with Femoral Shaft Fracture

	Femoral Shaft Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	28,199	25,953 (92.0)	17.38 (10.23-24.82)	6,955 (26.9)	60 (0.2)
Your Hospital	41	41 (100.0)	16.97 (11.55-23.17)	9 (22.0)	0 (0.0)

Table 18: First Operative Internal or External Fixation in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	8,082	7,539 (93.3)	8.48 (2.87-16.35)	709 (9.4)	24 (0.3)
Your Hospital	28	27 (96.4)	6.88 (1.6-15.5)	3 (11.1)	0 (0.0)

Orthopaedic Surgery: Quality Measures

TNAA (2024-25 vs 2025-26)

<u>TNAA (Avg. Wait Days)</u>	<u>24-Jul</u>	<u>24-Aug</u>	<u>24-Sep</u>	<u>24-Oct</u>	<u>24-Nov</u>	<u>24-Dec</u>	<u>25-Jan</u>	<u>25-Feb</u>	<u>25-Mar</u>	<u>25-Apr</u>	<u>25-May</u>	<u>25-Jun</u>	<u>Total</u>
Arthroplasty	80	64	19	23	41	14	9	11	8	6	7	4	286
Orthopaedic Surgery	11	8	10	16	8	17	14	10	14	19	26	15	168
Orthopaedic Surgery Foot	3	4	3	3	2	2	2	2	1	2	1	2	27
Orthopaedic Surgery Hand	23	28	22	9	13	8	10	11	10	8	8	10	160
Orthopaedic Surgery Pediatrics	12	10	14	20	13	7	16	14	7	8	16	10	147
Orthopaedic Surgery Physiatry	8	7	5	12	17	10	6	4	5	4	13	7	98
Orthopaedic Surgery Spine	15	5	12	6	12	12	13	8	13	16	4	17	133
Orthopaedic Surgery Sport	22	20	22	31	13	15	11	14	12	10	13	8	191

<u>TNAA (Avg. Wait Days)</u>	<u>25-Jul</u>	<u>25-Aug</u>	<u>25-Sep</u>	<u>25-Oct</u>	<u>25-Nov</u>	<u>25-Dec</u>	<u>26-Jan</u>	<u>26-Feb</u>	<u>26-Mar</u>	<u>Total</u>
Arthroplasty	4	4	4	4	4	4	5	5	6	40
Orthopaedic Surgery	11	6	14	16	9	13	9	5	8	91
Orthopaedic Surgery Foot	1	1	3	2	3	3	0	2	3	18
Orthopaedic Surgery Hand	12	11	9	12	15	12	14	18	23	126
Orthopaedic Surgery Pediatrics	14	18	11	13	10	9	10	9	9	103
Orthopaedic Surgery Physiatry	86	70	40	36	34	15	3	3	5	292
Orthopaedic Surgery Spine	10	6	8	18	12	15	6	8	4	87
Orthopaedic Surgery Sport	15	10	10	6	8	9	6	5	7	76

Faculty Committee Participation (ZSFG Campus)

Physician

Marcucio, Ralph
Miclau, Theodore

Toogood, Paul

Nagao, Masato
Cohen, Amica

Parks, Charles

Committees

UCSF Research and Animal Subcommittee

ZSFG Risk Management, Medical Executive,
OR/Block Committee, PEMT, CPG Board

UCSF Graduate Medical Education, Trauma
Multidisciplinary

Pain Management

TPOPP (Trauma Program Operational Process
Performance Improvement); LHH

Committees; Neuroscience Quality Council
Functional Limb Service, Radiation Safety,
CPG Compliance, Physician Wellness

Faculty Leadership Positions

Positions	Functions
Chief (Unit) – Miclau	Oversee Clinical Services and Dept. Personnel, Administration and Finances
Executive Leadership Committee Orthopaedic Trauma Institute (Miclau/Morshed/Matityahu/Meinberg/Kandemir)	
	Integrate/Coordinate Clinical and Academic Operations at all sites
Service Chiefs (Blue/Gold) – Marmor/Kandemir	Oversee Service Care Issues, review resident performance
Med Director (Clinic) – Lee	Oversee Outpatient Services
Med Director (Podiatry) – Mostovoy	Oversee Podiatric Services, Clinical Evaluation/Credentialing of DPH Podiatrists, Co-Director of Limb Salvage Service
Med Director (Physiatry) – Cohen	Oversee PM&R Clinical Service, Organize Intraservice Collaborations, Medical Director, Trauma Service Rehabilitation (required for Level 1 Centers)
Med Director (Quality Assurance) – Marmor	Oversee Dept. QA (M&M), Trauma Liason, Clinical Practice Guidelines

Faculty Leadership Positions

Lowenberg Family Endowed Professorship in Orthopaedic Trauma Reconstruction

honoring

Saam Morshed, MD, MPH, PhD

Chief, Division of Orthopaedic Trauma

Surgical Director, UCSF Mount Zion Hospital

Director, Clinical Research Center, UCSF Institute for
Global Orthopaedics and Traumatology

Tuesday, May 26, 2026

3:30-5:30 p.m.

UCSF Mission Bay Campus

Genentech Hall, Byers Auditorium
600 16th Street, San Francisco

Faculty Leadership Positions

Physician

Jennifer Cohn-Goldrei, MD

Tony Ding, MD

David Gendelberg, MD

Theodore Miclau, MD

Saam Morshed, MD, PhD

Paul Toogood, MD

Leadership/Committee

Physician Champion for DPH Network Optimization

Program Director, UCSF Orthopaedic Surgery Residency Program

Director of Physician Experience, UCSF Department of
Orthopaedic Surgery

Vice Chair, Systems and Operations, Dept. of Orthopaedic Surgery

Chief, Orthopaedic Trauma, UCSF; Triad Lead, Mt. Zion

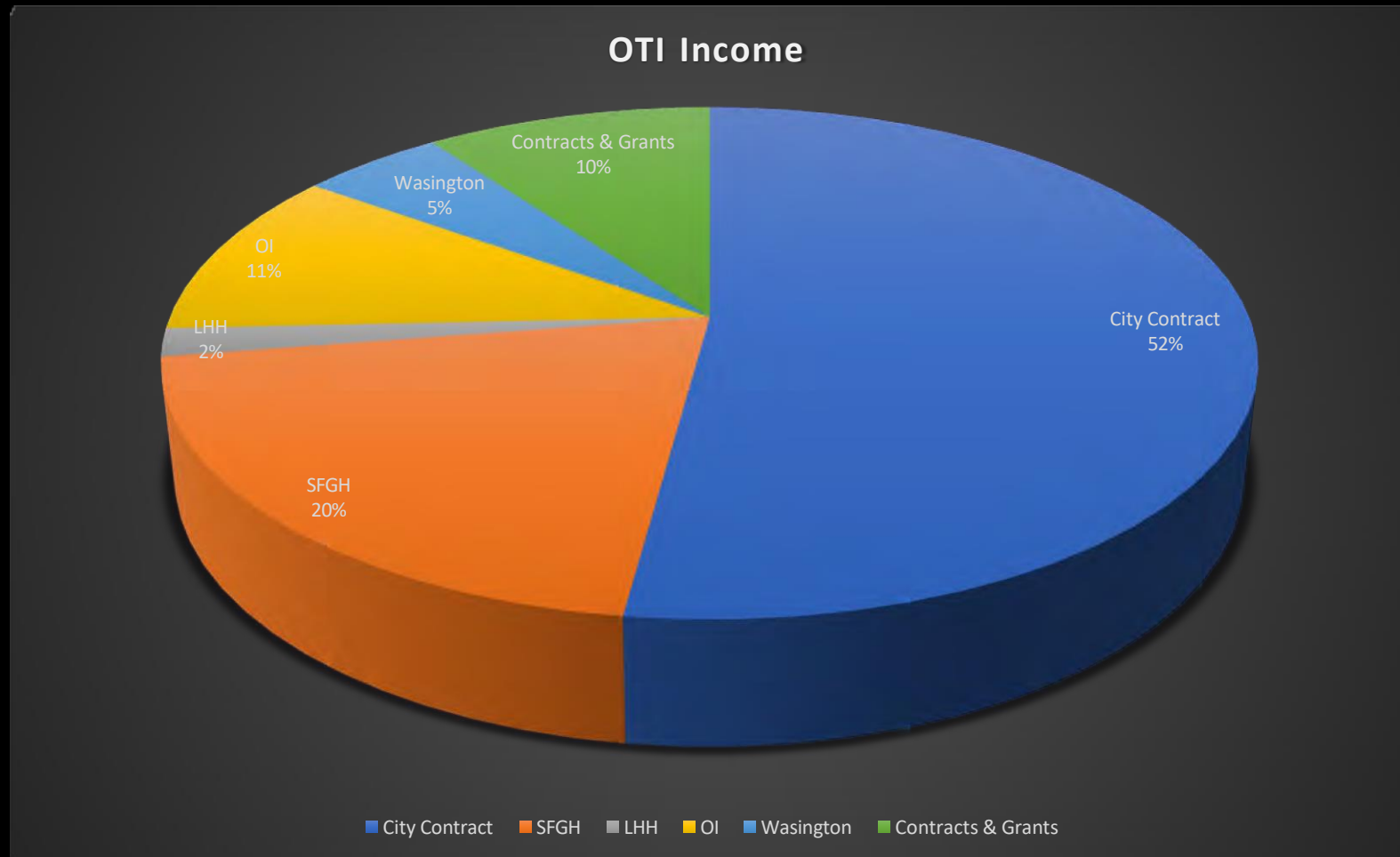
Associate Program Director; Chair, Education Committee, Dept. of
Orthopaedic Surgery

Finances

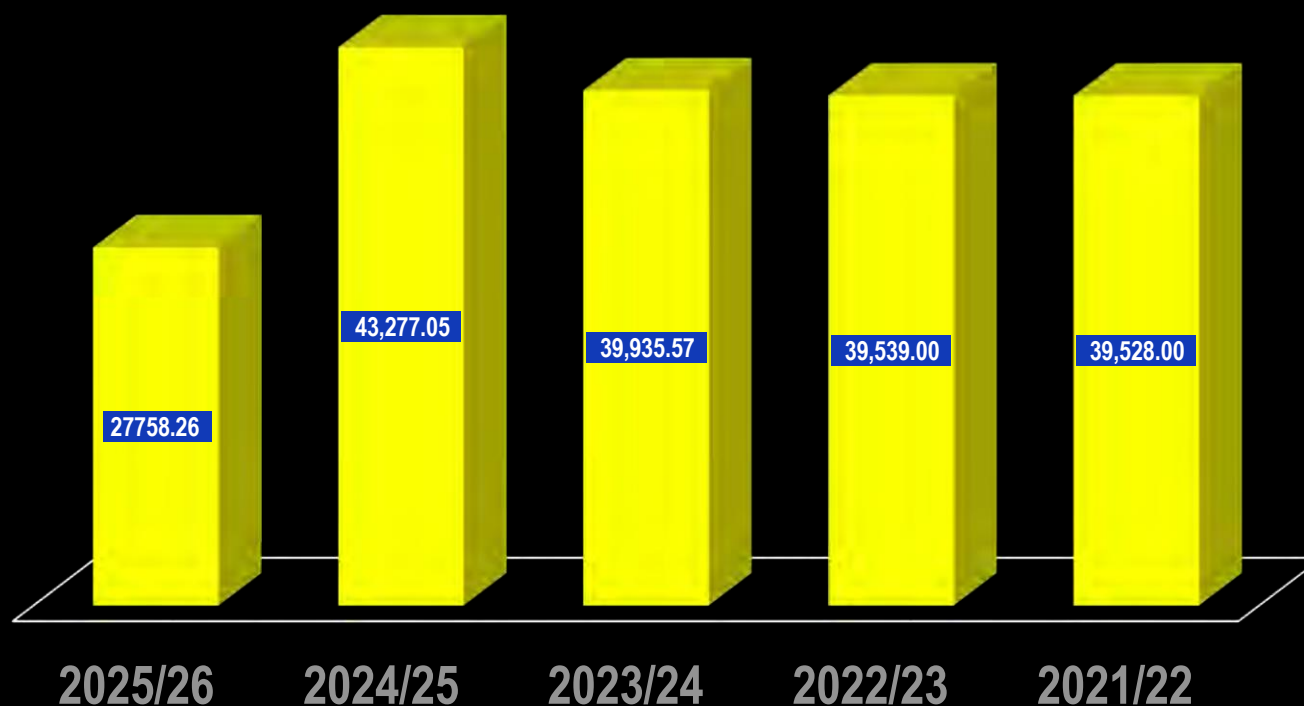
SFGH Ortho Payor Mix 25/26

Payor	Payer Mix -Percent Charges	Payer Mix -Percent Payments
Guarantor	2.15%	3.07%
Medicare	25.84%	21.04%
Medi-Cal	15.29%	5.84%
Insurance	12.56%	31.67%
3 rd Party	4.49%	2.38%
Managed Care	37.91%	31.55%
NB/MIA	4.8%	4.74%
Cal Pending	-3.04%	-0.28%

Orthopaedic Surgery: Income 2022-23



Ortho & Podiatry Service Work RVU Production



Ortho & Podiatry Service Total RVU Production



SFGH Ortho Payor Mix 25/26

Payor	Payer Mix -Percent Charges	Payer Mix -Percent Payments
Guarantor	-1.09%	1.43%
Medicare	14.17%	16.15%
Medi-Cal	3.82%	3.33%
Commercial Insurance	39.72%	51.84%
3 rd Party	8.32%	5.06%
Mcal Managed Care	33.88%	20.18%
NB/MIA	2.27%	2.01%
Cal Pending	-1.10%	0.01%

Ortho Collections (per RVU/Ratio)

- 25/26 \$38.20 (23.35%)
- 24/25 \$38.80 (23.98%)
- 23/24: \$36.86 (22.66%)
- 22/23: \$35.50 (21.85%)
- 21/22: \$37.59 (23.10%)
- 20/21: \$40.76 (25.18%)

Education

SFGH/OTI Orthopaedic Surgery: Education

- UCSF Residency program: “top 10” choice
- SFGH rotation: rated as housestaff favorite
- Medical student clerkship ratings: high (3rd and 4th year rotations); medical student casting course based at SFGH
- All anatomy/core curriculum sessions run at ZSFG

UCSF Resident Teaching Award: 7 of last 10 years (P. Toogood (2), Kandemir (2), T. Ding, D. Shearer, N. Schroeder, MD)

UCSF Compassionate Physician Award: 6 of last 11 years (N. Lee, A. El Naga, U. Kandemir (2), D. Shearer, P. Toogood, MD)

Department of Orthopaedic Surgery: Weekly Conferences

- Daily: Consult/trauma case on-call rounds
- Twice weekly: Interdisciplinary rounds, Blue (Mon)/Gold (Tues)
- Monday: Pre- and Post-operative indications conference (Blue)
- Tuesday: Pre- and Post-operative indications conference (Gold)
- Wednesday: UCSF Grand rounds/Basic science
- Thursday: Trauma conference – Blue; M&M (1x/8 weeks)
- Friday: Trauma conference – Gold; M&M (1x/8 weeks)

20th Annual Int'l San Francisco Orthopaedic Trauma Course

- National/International faculty (35)
- > 200 Attendees (17 of 50 States; 10 countries)
- Nursing Course
- Hands-on workshops
- Specimen-based labs/offsite

APRIL 24-26, 2025

19th ANNUAL INTERNATIONAL SAN FRANCISCO Orthopaedic Trauma Course

CHAIRS

Theodore Miclau, III, MD
Professor and Vice Chairman
UCSF Department of Orthopaedic Surgery

Amir Matityahu, MD
Professor
UCSF Department of Orthopaedic Surgery



Hands-On Workshops

(NEW afternoon specimen-based workshops. Limited to the first 100 participants.)

- Symposia and Case Discussions
- CME Credit

HIGHLIGHTS

Specimen-based laboratory course and limited to the first 100 participants. Learn new and evolving concepts in trauma and fracture management through didactic lectures, case presentations, and hands-on practice with the latest implants from international leaders in the field of orthopaedic traumatology. This course is of substantial value in the preparation for board and recertification examinations.



UCSF Surgical Training Facility

20th Annual International San Francisco Orthopaedic Trauma Conference

CHAIRS

Theodore Miclau, III, MD

Professor and Vice Chairman

UCSF Department of Orthopaedic Surgery

Amir Matityahu, MD

Professor

UCSF Department of Orthopaedic Surgery

HIGHLIGHTS

- 9 Hands-On Workshops (CME)
- Conference and Case Discussions
- 30 CME Credits
- Welcome Reception
- Off-Site Cadaver Hands-On Skills Lab
- NEW Optional OTI Spine Trauma Course with separate registration (CME)

Thursday - Saturday

April 16-18

InterContinental San Francisco

888 Howard Street

San Francisco, CA

2026

1st Int'l Spine Trauma Course

UCSF

University of California
San Francisco

OTI Spine Trauma Course

Optimizing Decision-making and Surgical Techniques

Simultaneous to the Annual Orthopaedic Trauma course.

Saturday
April 18, 2026

Course Chairs

Ashraf N. El Naga, MD
David Gendelberg, MD
Anthony DiGiorgio, DO

Speakers:

Ashraf N. El Naga, MD (UCSF)
David Gendelberg, MD (UCSF)
Anthony DiGiorgio, DO (UCSF)
Grace Xiong, MD (Stanford)

Wyatt Vander Voort, MD (UC Davis)
Hai Le, MD (UC Davis)
More to be announced...

Program Agenda:

7:00	Breakfast
8:50	Interactive didactic sessions, Lab Session 1 with hands-on and cadaveric instruction.
12:10	Lunch, exhibitors (50 min)
1:00pm	Interactive didactic sessions, Lab Session 2 with hands-on and cadaveric instruction.
4:00pm	Adjourn

Location: UCSF Pride Hall at ZSFG, San Francisco, CA

To be placed on a registration waiting list please contact Erin.simon@ucsf.edu

Education: Surgical Training Center Academic Courses

Depts.

UCSF/ZSFG OHNS

- Microvascular surgery training (anastomosis)
- Sialendoscopy
- Resident T-Bone
- FESS Surgery
- Facial Recon

UCSF/ZSFG Anesthesia

UCSF/ZSFG Emergency Medicine

UCSF/ZSFG O+P

UCSF Pain Management

UCSF/ZSFG Plastic Surgery

UCSF/ZSFG Urology

Ortho Courses.

- IGOT – SMART Summit Course
- Resident Anatomy
- Interns skill lab
- Core Surgical Curriculum
- Med School Ortho Rotations
- Advanced Fellowship Procedure Training



Education: Surgical Training Center



External Courses

- 2020-21: 100
- 2021-22: 103
- 2022-23: 97
- 2023-24: 32
- 2024-25: 63
- 25- Present: 59

Resident Courses

- 2020-21: 47
- 2021-22: 51
- 2022-23: 59
- 2023-24: 51
- 2024-25: 68
- 25- Present: 43

UCSF Orthopaedic Residency

Core Surgical Curriculum

Trauma:

- ORIF-midshaft and proximal humerus, ORIF BBF
- IM Nail Tibia and antegrade/retrograde Femur, Fasciotomies
- ORIF tibial plateau and supercondylar femur fracture

Spine:

- Anterior/Posterior Cervical Approach with anterior plating
- Anterior thoracolumbar approach with Cage
- Minimally invasive approaches, Laminectomy, Posterior TL approach, Pedicle instrumentation

Sports:

- Knee scope with meniscal debridement or repair, ACL Reconstruction
- Shoulder scope with SAD and Cuff Repair, and stabilization techniques

Foot & Ankle:

- Posterior tibial tendon reconstruction, Tripple Fusion, Bunion reconstruction
- Lisfranc's ORIF, Calc ORIF, and Talus ORIF

Arthroplasty:

- THA anterolateral and posterior, hip arthrocentesis, all hip approaches (anterior/ anterolat/ direct lateral/ posterolat); and extensile exposure as time permits (extended troch osteotomy)
- TKA, knee arthrocentesis

Hand:

- Carpal Tunnel Release, anterior and posterior approach to the wrist, ORIF DRF
- Trigger Finger Release, Tendon Repair, with approaches, Metacarpal Pinning
- Terrible Triad, elbow ligament repair, Olecranon fx repair, radial head fx repair/replace

Pediatrics:

- Supercondylar humerus fracture CRPP and ORIF, Monteggia Fx ORIF
- Casting, Flexible femoral Nailing, Club feet manipulation and casting
- Smith Pete approach (ped hip infection), SCFE assessment and pin

Oncology:

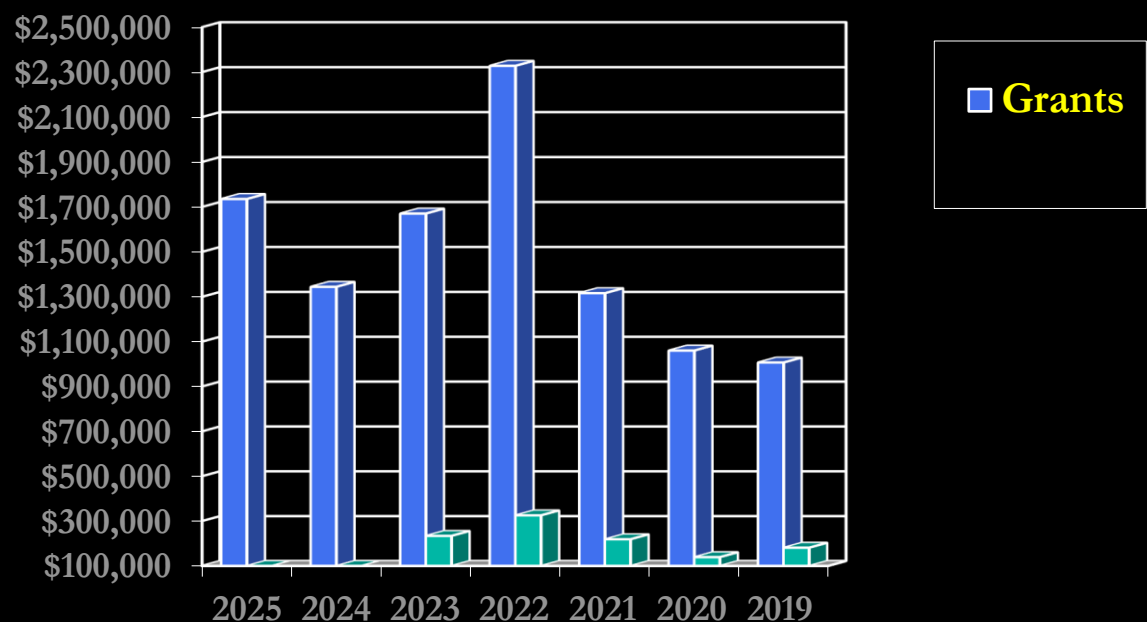
- Femoral resections and Reconstruction
- Retrograde and Antegrade humeral nails

Research

SFGH Orthopaedic Research Facilities

- Laboratory for Skeletal Regeneration
(Molecular Biology)
- Biomechanical Testing Facility
(Biomechanics)
- Clinical Research Center
- Surgical Training Facility
(Procedure Based Research)

Contracts and Grants (Direct Cost Only) 2025-26



	2025	2024	2023	2022	2021	2020	2019
Grants	1,735,280	1,344,446	1,670,464	2,327,825	1,316,219	1,060,316	1,006,923
Contracts	0	36,364	233,788	325,408	218,772	138,979	181,060

OTI Basic & Translational Science Labs

Focus Areas

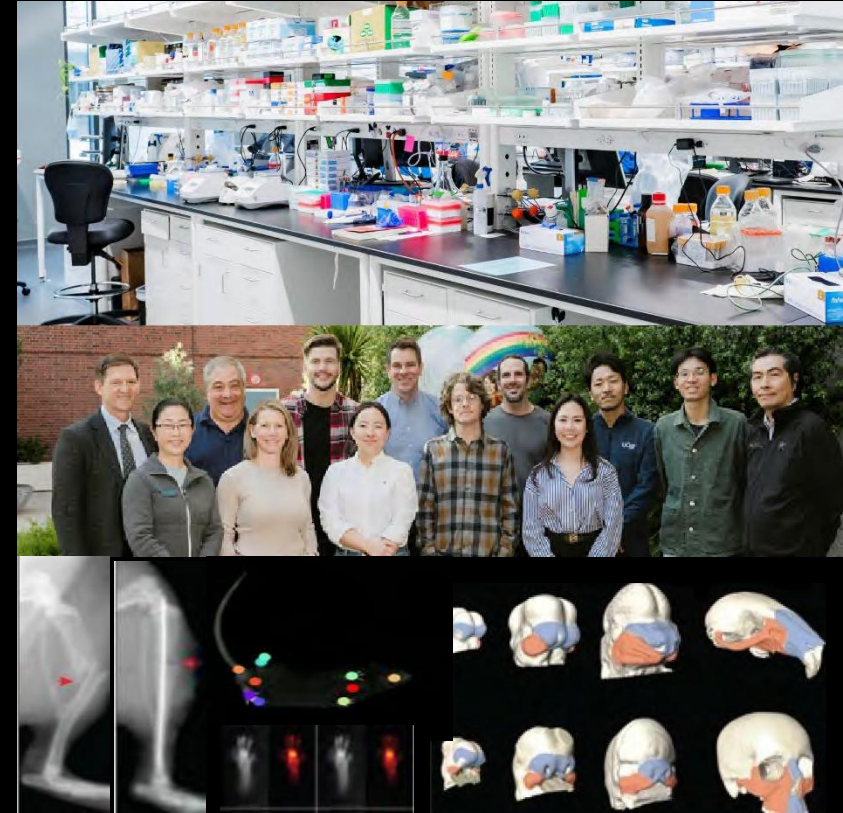
- Molecular & Cellular Biology of Fracture Repair
- Craniofacial Development
- Regenerative Therapeutics
- Fracture Related Infection

Lab PIs

- Director, Ralph Marcucio, PhD – Molecular & Cellular Biology Laboratory
- Ted Miclau, MD – Problematic Fractures
- Chelsea Bahney, PhD – Laboratory of Regenerative Therapeutics
- Nathan Young, PhD – Laboratory for Evolutionary Anatomy
- Kazu Morioka, MD, PhD – Pathological Fracture Healing

Grant Funding

- Federal: 3 R01 Prime, 2 R01SubAwards, 1 CIRM , 2 CFREF (CIHR) grants (Pending: 2 R01, 1 UG3/UH3, 1 F31)
- Foundation/Society Grants: 1 CIHR, 1 AO Foundation Grant, 1 Osteosynthesis & Trauma Care Fdn., OTA
- UCSF Awards: Damsky Award, 1 HIVE, 1 CTS, 1 RAP



OTI Biomechanical Testing Facility

Focus Areas

- Biomechanical evaluation of fracture fixation strategies
- Resident research training

Lab PIs

- Aaron Fields, PhD, Basic Science Director
- Habib Mohamed, PhD, Biomechanical Testing
- Meir Marmor, MD, Clinical Director
- Chelsea Bahney, PhD, Micromechanical Testing

Current Projects & Innovation

- Hand biomechanics (Dr. Lee)
- Fracture mechanics in rodent bones (Dr. Bahney)
- Fixation strategies for primary total hip replacement in geriatric acetabulum fractures (Dr. Marmor)
- Spino-pelvic fixation strategies (Dr. El Naga)
- Pelvic ring fixation with flexible implants (Dr. Xu)



Mechanical comparison of augmentation techniques for locking plate fixation of proximal humerus fractures

OTI Digital Science Laboratory

Focus Areas

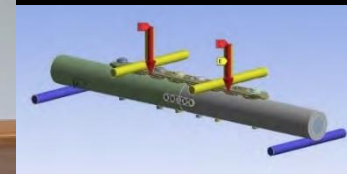
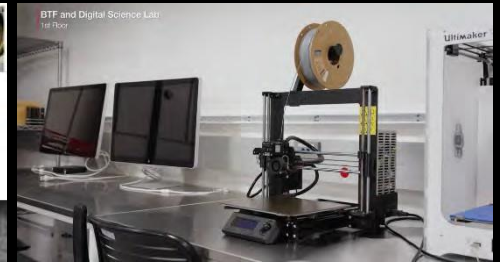
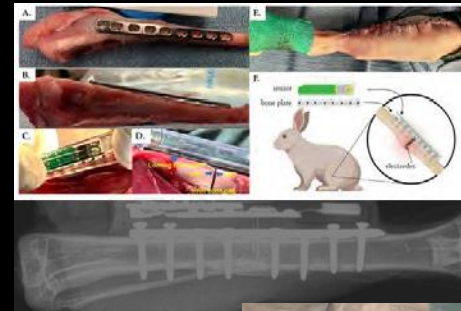
- Digital Health Solutions in Vulnerable Populations
 - Biosensors and wearable devices
 - Ultrasound and single camera gait image analysis
 - Computer modeling and simulation + 3D printing
 - Data Science and Artificial Intelligence

Lab PI

- Meir Marmor, MD, Clinical Director

Innovation Projects

- Development of a Handheld Ultrasound-Based System to Assist in Clinical Diagnosis of Acute Compartment Syndrome (DOD - USA Med Research ACQ Activity)
- Development of a Smart Fracture Fixation Implant to Wirelessly Monitor Fracture Healing (NSF Grant)
- FEA analysis of hip replacement in acetabulum fractures (AONA grant)
- Outcomes analysis using wearable devices after arthroplasty (UCSF Grants)



Mechanical influence of mini-fragment plates humeral shaft fracture fixation (FEA)



OTI Clinical Research Center Overview 2025-26

- **Director:** Saam Morshed, MD, PhD, MPH
- **Research Portfolio and Funding:** 18+ ongoing Orthopaedic Trauma and Spine health-related clinical trial projects funded by the government, non-profits, and industry. Five newly implemented projects.
- **Current Research Focus:** Geriatric fractures, pain management, digital health, evaluation of PROs, digital health, registries, and trends in NTDB.
- **International Partnerships:** The center manages a large NIH-funded international randomized trial and various small-scale multi-center observational studies in Sub-Saharan Africa.
- **Research Training Initiative:** Provides research training and Support to residents, trauma fellows, and medical students.
- **Collaborative Network:** The Center has an extensive collaborative footprint across the United States and Canada, coordinating with **METRC clinical sites** that include both **military and civilian** institutions
- **Key Investigators:** Theodore Miclau; Saam Morshed; Meir Marmor; David Shearer, David Gendelberg, Asraf El Naga, Nicholas Lee, and Utku Kandemir.



METRC Collaborators

International Outreach

International Accomplishments

Education

- Delivered 18 webinars since 2020
- Executed 36th SMART Course (SF, Tanzania, Mexico, Cuba, Nepal)
- 100+ Resident Global Electives (3 active international sites)
- 150+ International Observers from 40+ countries since 2010

Research

- 35 active research projects in 6 countries
- 4 prospective trials and 1 RCT
- Partnerships with countries across Sub-Saharan Africa and Latin America
- Funding from NIH, OREF, OTA, and others
- In 2025 : 20+ publications

Leadership

- Institute for Global Orthopaedics and Traumatology (IGOT)
- Asociación de Cirujanos Traumatólogos en las Americas (ACTUAR)
- Consortium of Orthopaedic Traumatologists (COACT)



Institute for Global Orthopaedics and Traumatology



MISSION: TO COLLABORATE WITH PARTNERS
AROUND THE WORLD TO PROMOTE EQUITY IN
ORTHOPAEDIC CARE



Program Development

Service Goals: 2025-2026

- Adapt to growing orthopaedic trauma demand
- Work on further integration with UCSF campus
- Address gaps in care, including wait times in several services (arthroplasty, sports, podiatry)

Thank You



Medical Executive Committee (MEC)
Summary of Changes

Document Name:	<i>ZSFG Clinical Service Rules and Regulations</i>
Clinical Service :	<i>Orthopaedic Surgery</i>
Date of last approval:	<i>2024</i>
Summary of R&R updates:	<i>The document was extensively reviewed for formatting and typographical errors corrected. Orthopaedic was spelled out. Capital letters were made more consistent. The workflow and guidelines for the ED, pediatric admissions, and medicine-orthopaedic surgery arrangements were updated to be consistent with existing inter-service agreements. The residents' responsibilities were updated. The required entries in the EMR were updated. The Chief of Service requirements were updated to bring the leadership position into compliance with the American College of Surgeons requirements for a trauma director and orthopaedic fellowship director.</i>
Update #1:	<i>Sections I through IX were reviewed for formatting, grammatical, and typographical errors were made.</i>
Update #1:	<i>Section V and VI: Updates on Departmental conferences and educational requirements and activities were made. Communication from junior to senior residents and faculty was emphasized/clarified.</i>
Update #2:	<i>Section VII: Updates for service consultation was made to be consistent with current medicine-orthopaedic and ED guidelines.</i>
Update #3:	<i>Attachment C: Chief of Service requirements were added to bring the position into compliance with a leadership positions (i.e., the Orthopaedic Trauma Liaison for the American College of Surgeons accreditation process (amended in 2022) and fellowship director position for the Orthopaedic Trauma Association). The current Chief of Service is compliant with these requirements.</i>

San Francisco General HospitalZuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

Formatted: Font: Not Bold

~~ORTHOPEDIC~~CORTHOPAEDIC SURGERY CLINICAL
SERVICE
RULES AND REGULATIONS
~~2008~~201320172026

Formatted: Font color: Auto

~~ORTHOPEDIC~~~~CORTHOPAEDIC~~ SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

I.	ORTHOPEDIC SURGERY CLINICAL SERVICE ORGANIZATION	775
I.	ORTHOPEDIC SURGERY CLINICAL SERVICE ORGANIZATION	4
A.	SCOPE OF SERVICE	775
A.	SCOPE OF SERVICE	4
B.	MEMBERSHIP REQUIREMENTS	775
B.	MEMBERSHIP REQUIREMENTS	4
C.	ORGANIZATION OF ORTHOPEDIC SURGERY CLINICAL SERVICE	775
C.	ORGANIZATION OF ORTHOPEDIC SURGERY CLINICAL SERVICE	4
II.	CREDENTIALING	I
I.	CREDENTIALING	5
A.	NEW APPOINTMENTS	886
A.	NEW APPOINTMENTS	5
B.	REAPPOINTMENTS	986
B.	REAPPOINTMENTS	5
C.	AFFILIATED PROFESSIONALS	997
C.	AFFILIATED PROFESSIONALS	6
D.	STAFF CATEGORIES	997
D.	STAFF CATEGORIES	6
III.	DELINEATION OF PRIVILEGES (REFER TO ATTACHMENT A)	II

I.....	DELINEATION OF PRIVILEGES (REFER TO ATTACHMENT A).....	6
A.....	DEVELOPMENT OF PRIVILEGE CRITERIA.....	1097
A.....	DEVELOPMENT OF PRIVILEGE CRITERIA.....	6
B.....	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM.....	1097
B.....	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM.....	6
C.....	CLINICAL PRIVILEGES.....	1097
C.....	CLINICAL PRIVILEGES.....	6
D.....	TEMPORARY PRIVILEGES.....	10107
D.....	TEMPORARY PRIVILEGES.....	6
IV.....	PROCTORING AND MONITORING.....	101081
V.....	PROCTORING AND MONITORING.....	7
A.....	MONITORING (PROCTORING) REQUIREMENTS.....	10108
A.....	MONITORING (PROCTORING) REQUIREMENTS.....	7
B.....	ADDITIONAL PRIVILEGES.....	10108
B.....	ADDITIONAL PRIVILEGES.....	7
C.....	REMOVAL OF PRIVILEGES.....	11108
C.....	REMOVAL OF PRIVILEGES.....	7
V.....	EDUCATION.....	11108
V.....	EDUCATION.....	7
VI.....	ORTHOPEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION.....	V
I.....	ORTHOPEDIC CORTHOPAEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION.....	7
A.....	SUPERVISION.....	11108
A.....	SUPERVISION.....	

	 SUPERVISIO	
N.....	.....	7
B. EDUCATIONAL ACTIVITIES	.....	11118
B.....	 EDUCATIONAL	
ACTIVITIES.....	.....	7
C. EDUCATIONAL GOALS	.....	12119
C.....	 EDUCATIONAL	
GOALS.....	.....	8
D. GUIDELINES	.....	12119
D.....	.....	
S.....	 GUIDELINE	8
E. DUTIES OF RESIDENTS (Specific Responsibilities):	.....	131210
E.....	 DUTIES OF RESIDENTS (Specific	
Responsibilities).....	.....	13129
VII. ORTHOPEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA	.....	151411VI
I.....	 ORTHOPEDICORTHOPAEDIC SURGERY CLINICAL SERVICE CONSULTATION	
CRITERIA.....	.....	151410
VIII. DISCIPLINARY ACTION	.....	151411VII
I.....	 DISCIPLINARY	
ACTION.....	.....	151410
IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT	.....	151412I
X.....	 PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION	
MANAGEMENT.....	.....	151411
A. RESPONSIBILITY	.....	151412
A.....	.....	
Y.....	 RESPONSIBILIT	151411
B. REPORTING	.....	161412
B.....	.....	
G.....	 REPORTIN	161411
C. CLINICAL INDICATORS	.....	171513
C.....	 CLINICAL	
INDICATORS.....	.....	171512
D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES	.....	171513
D.....	 CLINICAL SERVICE PRACTITIONERS PERFORMANCE	
PROFILES.....	.....	171512

E.	MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES	15
E	MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES	171513
E	MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES	171512
F.	MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE	171513
F	MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE	171512
X.	MEETING REQUIREMENTS	181513
X	MEETING REQUIREMENTS	181512
XI.	ADOPTION AND AMENDMENT	X
I	ADOPTION AND ADMENDMENT	181614X
I	ADOPTION AND ADMENDMENT	181613
ATTACHMENT A	ORTHOPEDICORTHOPAEDIC PRIVILEGE REQUEST FORM	1514
ATTACHMENT B	ORTHOPEDICORTHOPAEDIC SURGERY POLICIES AND PROCEDURES	1920

Formatted: Normal, Indent: Left: 0", First line: 0"

~~San Francisco General Hospital~~Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

ATTACHMENT C — CLINICAL SERVICE CHIEF OF ~~ORTHOPEDIC~~ORTHOPAEDIC SURGERY JOB
DESCRIPTIONDescription..... 3235

I. ORTHOPEDICORTHOPAEDIC SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The OrthopedieOrthopaedic Surgery Service at San Francisco General HospitalZuckerberg San Francisco General is organized along two axes: tertiary orthopedieorthopaedic trauma care and general orthopedieorthopaedics. The orthopedieorthopaedic trauma service involves the treatment of complex injuries, such as pelvic and acetabular fractures, spinal fractures and dislocations ~~(including spinal core injuries)~~, high-grade open fractures, and complex soft tissue injuries. The management of these complex injuries is comprehensive and greatly enhanced by the board-certified/board-eligible specialists and fellowship-trained subspecialists on the orthopaedic surgery service, including fellowship-trained orthopaedic-fellowship-trained subspecialists on the orthopaedic surgery service, including fellowship-trained orthopaedic surgeons in trauma, sports, spine, arthroplasty, foot and ankle, and hand, as well as board-certified/board-eligible surgeons in trauma, sports, spine, arthroplasty, foot and ankle, and hand, as well as specialists as in physical medicine and rehabilitation and podiatry. The general Orthopedieorthopaedic surgery services offered are comprehensive, covering ~~and of the highest quality. They cover all orthopedieorthopaedic sub-specialties except oncology and pediatrics for that which are covered by specialists from UCSF~~ subspecialties except oncology and pediatrics, which specialists from UCSF cover, helped by the contribution of board-certified physiatrists and a board-certified podiatrist, and the fact that all attendings are post-residency fellowship-trained in various orthopedic subspecialties.

As a member of the OrthopedieOrthopaedic Surgery Service, the board-certified physiatrist is also the Medical Director of the Rehabilitation Service for SFGHZSFG and Laguna Honda Hospital (LHH). The service also has a fully equipped orthotics and prosthetics ~~work group~~shop run by an experienced orthotist/prosthetist, with experts in prosthetics and orthotics, with experts in both.

~~The general Orthopedic surgery services offered are comprehensive and of the highest quality. They cover all orthopedic sub-specialties except oncology and hand for which an outside consultants are available.~~

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF ORTHOPEDICORTHOPAEDIC SURGERY CLINICAL SERVICE

Currently, the Clinical Service of Orthopedieorthopaedic sSurgery clinical service at San Francisco General HospitalZuckerberg San Francisco General largely is staffed by 8

orthopedicorthopaedic surgeons with 50% or more time effort (Drs. Coughlin, Kandemir, Matityahu, Mielau, McClellan, Pekmezci, Meinberg, and Morshed, Marmor,), two trauma fellows (who are Clinical Instructors and Active SFGH ZSFG Medical Staff Members), hand surgeons, two full-time podiatrists, and (Drs. Dr. MartinDini, Werner), 2 full-time physiatrists (Drs. Pascual and Nagao), and 1 part-time physiatrist (Dr. Tran). Hand coverage is supplemented by one full-time orthopaedic hand surgeon (Dr. Strauss) and 42 part-time volunteer hand surgeons (Drs. Richards and, Cardon, and Green, Gordon). Pediatric and oncology clinics are staffed by UCSF surgeons UCSF surgeons staff pediatric and oncology clinics, is staffed by 1 part-time staff member (Dr. Delgado). There are several volunteer surgeons who assist Several volunteer surgeons assist in the clinics and ORs in the above areas (Drs. Jergesen, Rosenblatt, Glick, and Fong). The attending physicians and podiatrists are responsible for daily attending rounds on both services, assuring quality patient care, resident education, and dictation of attending notes on all patients every day ensuring quality patient care, resident education, and the completion of attending notes. Ortho and ortho trauma call coverage are provided by the Call coverage is by the 8-9 ortho trauma attendings, the hand call is split with the plastic surgery service and provided by the hand surgeons, The orthopaedic trauma attendings provide orthopaedic and orthopaedic trauma primary and back-up call coverage; the hand call is split with the plastic surgery service and provided by the fellowship-trained hand surgeons; and the spine call is split with the neurosurgery service and provided by the fellowship-trained spine surgeons. (with the exception of Dr. Rosenblatt, who covers approximately 1 call per month).

The administrative tasks at SFGH ZSFG are solely covered by the core attending physicians. SFGH ZSFG is a major public hospital with the complex problems of indigent care as well as the more routine problems of hospital management. The core staff is responsible for running the outpatient clinics, orthopedicorthopaedic wards, and operating rooms, as well as addressing the utilization and service issues. In addition, there are multiple 13 hospital committees, which require orthopedicorthopaedic staff participation, all of which are the responsibility of the full-time staff.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

1. Board Certified or Eligible by the American Board of OrthopedicOrthopaedic Surgery, the American Board of Physical Medicine and Rehabilitation, or the American Board of Podiatric Surgery. Applicants not board-certified must document recent training and experience by providing a narrative of their clinical activities during the preceding two (2) years. They must also demonstrate current competence to the Chief of Service.
2. Current California Medical or Podiatric Licensure
3. Current DEA Certificate

4. Current X-Ray Certificate

B. REAPPOINTMENTS

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

1. ~~Practitioners-Practitioners'~~ Performance Profiles

Practitioner's performance profiles are determined and monitored in two ~~fashionsways~~. ~~Outpatient encounters are monitored by the hospital outpatient clinic services~~~~The hospital outpatient clinic services monitor outpatient encounters~~, and statistics are available ~~by ICD9 and via~~ CPT codes. Inpatient services, including emergency room consultations, are monitored and counted according to different categories. Complications of all ~~nature are also compiled on a monthly basis and are kept on file by the Service as well as types are also compiled monthly and kept on file by the Service and~~ in the Medical Staff Services Office.

2. Modification of Clinical Service

~~A request by a practitioner for a modification of clinical services is first reviewed by the Chief of Service~~~~The Chief of Service first reviews a practitioner's request for a modification of clinical services~~ in light of the generally accepted requirements (formal and practical) of the appropriate state and national associations/organizations. If the Chief of Service judges that the requested modification is reasonable, it is then discussed at a faculty meeting ~~as necessary~~. ~~If the general consensus of the faculty is favorable for such a modification, it is submitted by the Chief of the Clinical Service~~~~faculty's consensus is favorable to such a modification, the Chief of the Clinical Service submits it to the~~ ~~SFGHZSFG~~ Credentials Committee for review and recommendation.

3. Staff Status Change

The process for Staff Status Change for members of the ~~OrthopedieOrthopaedic~~ Surgery Services is in accordance with ~~SFGHZSFG~~ Bylaws, Rules and Regulations, and accompanying manuals.

4. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the ~~OrthopedieOrthopaedic~~ Surgery Clinical Services is in accordance with ~~SFGHZSFG~~ Bylaws, Rules and Regulations, and accompanying manuals.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals to ~~SFGHZSFG~~ through the ~~OrthopedieOrthopaedic~~ Surgery Clinical Service is in accordance with ~~SFGHZSFG~~ Bylaws, Rules and Regulations ~~and accompanying manuals, and accompanying manuals~~, as well as these Clinical Service Rules and Regulations.

D. STAFF CATEGORIES

The ~~OrthopedieOrthopaedic~~ Surgery Clinical Service ~~fall into the same staff categories which are described in Article III—Categories of the Medical Staff of the~~ ~~SFGHZSFG~~

Bylaws, Rules and Regulations falls into the same staff categories as described in Article III – Categories of the Medical Staff of the ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

III. DELINEATION OF PRIVILEGES (Refer to Attachment A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

~~Orthopedic~~Orthopaedic Surgery Clinical Service privileges is developed in accordance with SFGHZSFG Medical Staff Bylaws, Article V: Clinical Privileges, Rules and Regulations are developed in accordance with ZSFG Medical Staff Bylaws, Article V: Clinical Privileges, Rules and Regulations, and accompanying manuals.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The ~~Orthopedic~~Orthopaedic Surgery Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

~~Orthopedic~~Orthopaedic Surgery Clinical Service privileges shall be authorized in accordance with the SFGHZSFG Medical Staff Bylaws, Article V: Clinical Privileges, Rules and Regulations, and accompanying manuals.
All requests for clinical privileges will be evaluated and approved by the Chief of ~~Orthopedic~~Orthopaedic Surgery Clinical Service.

The process for ~~modification/change to the privileges for members of the Orthopedic Surgery Service is in accordance with the SFGHZSFG Medical Staff Bylaws, Rules and Regulations~~ modifying or changing the privileges of members of the Orthopaedic Surgery Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, and accompanying manuals.

D. TEMPORARY PRIVILEGES

Temporary Privileges shall be authorized in accordance with the SFGHZSFG Medical Staff Bylaws, Article V: Clinical Privileges.

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Proctoring requirements for physicians who perform surgery on the ~~Orthopedic~~Orthopaedic Surgery Clinical Service require that the Chief of Service, or designee, observe five (5) of the applicant's major surgical cases. Proctoring requirements for physicians who treat clinic outpatients require that the Chief of Service, ~~or designee, observes the practitioner in three (53) outpatient clinic settings, and or designee observe the practitioner in three (3) outpatient clinic settings and conduct retrospective reviews of~~ the care provided to fifteen (15) outpatients.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the ~~Orthopedic~~Orthopaedic Surgery Clinical Service shall be in accordance with SFGHZSFG Bylaws, Rules and Regulations, and accompanying manuals.

San Francisco General HospitalZuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the ~~Orthopedic~~Orthopaedic Surgery Clinical Service shall be in accordance with ~~SFGH~~ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

V. EDUCATION

The ~~Orthopedic~~Orthopaedic Surgery Service at ~~SFGH~~ZSFG offers ~~high-quality~~high-quality educational activities, including at the ~~post~~postgraduate and undergraduate levels. It is one of the main teaching sites for the UCSF ~~orthopedic~~orthopaedic surgery residency program. The trauma group, also known as the Orthopaedic Trauma Institute (OTI), headquartered at ZSFG, has two non-ACGME fellows who rotate through the site. The service is also an important teaching site for the Department of Emergency Medicine. Furthermore, residents from the ~~Department of Family Medicine, Internal Medicine, and the Department of~~Departments of Family Medicine, Internal Medicine, and Pediatrics occasionally rotate through the ~~orthopedic~~orthopaedic outpatient clinics.

At the graduate level, the service ~~is also~~serves as the main teaching site for third-year UCSF medical students. It also offers rotations for UCSF fourth-year medical students, which occur throughout the academic year. ~~During the academic year, between 5-10 UCSF medical students and about 5-10 non-UCSF fourth-year medical students rotate through the service. Visiting medical students from US Medical Schools and other observers also rotate on the service.~~

VI. ~~ORTHOPEDIC~~ORTHOPAEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM- AND SUPERVISION

A. SUPERVISION

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

B. EDUCATIONAL ACTIVITIES

Currently, there are eight ~~orthopedic~~orthopaedic residents on rotation at ~~SFGH~~ZSFG, two residents from every ~~Orthopaedic-Orthopaedic~~ year PGY-~~25~~ through ~~52~~ at all times. There ~~are~~ is also a varying number of interns (~~21-30-4~~) at any point in time. There are ~~two orthopaedic trauma-two~~ fellows on the ~~Orthopaedic-Orthopaedic~~ Surgery Service, with periodic clinical support from the UCSF Spine, Hand, and Vascular Surgery fellows. ~~These traineesy~~ are divided into ~~22~~ teams and are providing emergency room coverage.

Resident teaching at ~~SFGH~~ZSFG occurs in three ways:

- ~~I~~Interactive didactic sessions with faculty
- Clinical teaching in the operating room, inpatient ward, and clinics
- ~~H~~Hands-on teaching in ~~the operating room, clinic and rounds~~the surgical training facility located at ZSFG
- ~~resident~~Resident involvement in research projects.

Regular ~~d~~Weekly didactic sessions include~~are~~:

~~San Francisco General Hospital~~Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

- ~~D~~aily on-call case review
- ~~W~~weekly case conference ~~attending~~attended by the residents, the full and ~~part~~time~~part-time~~ staff, which includes ~~a~~ post-operative trauma case review
- ~~W~~weekly pre-operative case review
- ~~W~~weekly Grand Rounds at UCSF
- ~~W~~weekly specialty conference (foot and ankle, Morbidity and Mortality)
- ~~monthly~~ ~~W~~weekly trauma conference (didactic, journal club, bioskills exercises)

~~Monthly~~ Regular research meetings are held with the full-time attending physicians, the research personnel, and the involved residents and medical students.

Medical students currently rotate at ~~SFGH~~ZSFG through Surgical Specialties 110 (1 week) and ~~4-week~~4-week optional electives.

C. EDUCATIONAL GOALS

~~The r~~otation on the ~~Orthopedic~~Orthopaedic Surgery Service at ~~San Francisco General Hospital~~Zuckerberg San Francisco General is primarily designed to provide the ~~orthopedic~~orthopaedic resident ~~an in-depth experience in operative and non-operative management of orthopedic traumatology and general orthopaedics with an in-depth experience in operative and non-operative management of orthopaedic traumatology and general orthopaedic surgery.~~ Emphasis is placed on the treatment of polytrauma victims as well as those with isolated injuries. In addition, ~~a significant exposure to general and other subspecialty orthopaedic conditions based on outpatient clinical problems, including spine, sports, arthroplasty, foot and ankle, pediatrics, and hand surgery.~~ a significant exposure to general and other subspecialty orthopaedic conditions, based on outpatient clinical problems, including spine, sports, arthroplasty, foot and ankle, pediatrics, and hand surgery, is available. Thorough participation in ongoing clinics, programs, lectures, conferences, supervised patient care ~~and in-depth surgical experience provide, and in-depth surgical experience provides~~ orthopaedic residents with sufficient experience to manage a wide range of ~~diseases and afflictions of the musculoskeletal system~~musculoskeletal diseases and conditions.

D. GUIDELINES

All ~~orthopedic~~orthopaedic residents are responsible for the day-to-day management of patients admitted to the ~~Orthopedic~~Orthopaedic Service at ~~San Francisco General Hospital~~Zuckerberg San Francisco General. Although the staff physician carries ultimate responsibility for patient care, it is expected that the fellows ~~and all~~ residents will be intimately involved in patient care on an ongoing basis, making daily rounds and providing an ongoing continuum of care for inpatients. Decisions regarding admission and complications should be reported immediately to the staff physician. Residents will not operate independently unless ~~under unusual circumstances, i.e., emergency situations, and if so in unusual circumstances, e.g., emergencies, and only if~~ directed by the staff physician. History and physical examinations ~~on new patient admissions are expected to be carried out, generally by the junior resident, but they should be evaluated carefully for new patient admissions are expected to be performed, generally by the junior resident. Still, they should be carefully evaluated~~ and reviewed in detail by the ~~chief resident on the service~~service's chief resident. The chief resident, likewise, is responsible for examining the patient and taking a relevant history, and should be available to assist the junior resident in directing the appropriate work-up, writing of specific orders as

necessary, and requesting specific consults unless otherwise outlined by the staff physician.

It is stressed that the chief resident is ultimately responsible for the day-to-day care of patient management under the direction of the staff physicians. Should the first-year resident or the junior resident not be familiar with the plan of patient care or treatment protocols, it is the chief resident's responsibility to oversee these matters and to educate the junior resident as necessary. ~~It goes without saying that a smooth-functioning, competent surgical team is dependent upon the chief resident's interest, organizational skills, efficiency, knowledge, and ability to communicate.~~ smoothly functioning, competent surgical team depends on the chief resident's interest, organizational skills, efficiency, knowledge, and ability to communicate. The surgical teams will be assisted thorough the work of the nurse practitioners on the Orthopaedic Surgical Service. The nurse practitioners on the Orthopaedic Surgical Service will assist the surgical teams with patient care. The ~~orthopedic~~orthopaedic interns and residents are responsible for working closely with them to provide ~~care to the patients~~patient care on the service.

E. DUTIES OF RESIDENTS (Specific Responsibilities):

Also refer to the House Staff Competencies Link on the CHN Intranet Site

1. Patient Care Responsibilities

~~Orthopedic~~Orthopaedic residents are expected to make patient rounds at least once a day. It is anticipated ~~and expected that all residents on the service would make rounds in the early morning prior to going to that all residents on the service will make rounds in the early morning before attending~~ the morning conferences. All patients should be seen, charts should be reviewed, orders written, dressings changed, consultations requested, and x-rays reviewed as necessary. The nurses should be advised of any problems or orders, ~~which that need to be carried out expeditiously require expeditious action.~~ Rounds for problem patients should be ~~made again at the end of the day, postoperative checks should be made on all patients repeated at the end of the day; postoperative checks should be performed on all patients,~~ and postoperative notes should be ~~placed on the chart signed and completed in the medical record~~ before the residents ~~department depart~~ for the evening. -All postoperative x-rays should be reviewed, and ~~notations made in the chart of the appropriate findings~~relevant findings should be documented in service notes that are placed in the medical record. The status of the implants should be noted, or ~~in the case of total hip arthroplasty, for instance, a notation should be made that the x-rays reveal that the hip implant is in,~~ in the case of total hip arthroplasty, for instance, a notation should be made that the x-rays reveal the hip implant is in a satisfactory position and remains reduced. A neurological-vascular check should be a standard part of the postoperative evaluation ~~and a notation should be made in the chart documented that this has been examined, evaluated, and documenting that this has been examined, evaluated,~~ and is normal or not ~~should be included in the medical record.~~ -Any abnormalities should be reported to the staff physician immediately. - A note must be written in the ~~chart~~medical record each day. The chief resident or designee should write an initial evaluation note after the junior resident's history and physical exam. - All patients scheduled for operative procedures must have a preoperative note, ~~which includes the patient's diagnosis, alternatives of treatment and documents the patient's that includes the patient's diagnosis, treatment alternatives, and documentation of~~ informed consent. ~~Patient Discharge Planning~~

(PDP)It is expected that the orthopaedic team will complete any necessary patient discharge documentation the evening before the patient's anticipated dischargeAny necessary patient discharge documentation forms are toshould be completed the evening before the patient's anticipated discharge. -All discharge summaries must be completed within 24 hours of the patient's discharge and preferably done the day the patient is discharged while the chart is still on the station. All patients should receive discharge instructions or After Visit Summary documents.

5. Clinic Responsibilities

All residents are expected to be present on time for clinical sessions-sessions. Clinic staff will discuss with the resident how he wishes to run his or herthey wish to run their particular clinic.-In general, residents are expected to carry out thorough history and physical examinations directed towardperform thorough history and physical examinations focused on the patient's orthopedieorthopaedic problem.-The staff physician assigned to the clinic is available for consultation and instruction at all times while the clinic is operating for residents to present patients. -Particularly interesting or difficult problems are excellent material for presentation at the weekly conference. Residents will dictatechart on the clinic patients they see and be in compliance with the the clinic patients they see, and residents and attendings will comply with standard billing practices.

The emergency room resident is responsible for being present in their team's activities, and leaveduring their team's activities and for leaving for consults when paged. Coverage of the emergency room during these times is as assigned on the call schedule.

6. Surgical Responsibilities

Residents assigned to specific operative cases are expected to check that the required documentationpaperwork, including history and physical (including interval history and physical) and consent, and that proper site marking has occurred. If the patient has questions regarding the procedure and would like to confer with the attending staff, the resident will inform the attending staff member. The resident is expected to confer with the attending staff regarding details of the procedure, including specifics about the operation, appropriate implants, and positioning. The resident is expected to arrive in the operating suite promptly at the time the patient is brought into the room in order to assist the anesthesiologist as necessary and facilitate positioning of the patient, arranging x-rays, double checking instruments packs, time-outswhen the patient is brought into the room to assist the anesthesiologist as necessary, facilitate patient positioning, arrange x-rays, double-check instruments, and perform time-outs, among other functionsete. It is essential, that all they haveThey must have a thorough knowledge of anatomy along with the procedure plan for the specific operation, along with the procedure plan for the specific operation, and a knowledge of alternative forms along with alternative surgical techniques for the management of that specific problem. OrthopedieOrthopaedic residents not well-versedwell-versed in the relevant literature ore, the anatomy of the exposure to be performed or the planned procedure that has been planned are unlikely to be given active involvement in the surgical case and, at best, would have a compromised educational experience. The extent of a resident's involvement in a specific operative procedure is in a great part dependent not only on the resident's natural ability, surgical knowledge, in a great part, dependent not only on the resident's natural ability, surgical knowledge, and skill, but also on their interest, desire, and preparation.

7. Conference Responsibilities

As an important part of the educational curriculum, ~~conferences on specific topics are held daily~~ conferences on specific topics are held, along with grand rounds each Wednesday at UCSF, ~~F and one Saturday morning per quarter for City-Wide Grand Rounds.~~ These conferences are planned months in advance ~~and carefully thought out by staff and senior residents regarding their educational content in relation and they have been carefully thought out by staff and senior residents as to the educational content as it relates~~ to the overall educational curriculum. Residents are expected to attend these conferences and ~~to come prepared to discuss the subject matter and to provide~~ come prepared to discuss the subject matter and to engage in a healthy exchange of ideas and questions that would maximize ~~attendees'~~ everyone's educational experience. Case presentations at the weekly ~~orthopedic~~ orthopaedic conferences are essential for discussing and analyzing current treatment rationale. If the junior resident is presenting cases, ~~he/she/they~~ they should discuss the ~~presentation with the chief resident prior to the conference, review briefly the relevant literature and to have a working knowledge of the treatment, complications and results to be expected~~ presentation with the chief resident before the conference as necessary, briefly review the relevant literature, and have a working knowledge of the expected treatments, complications, and outcomes. The chief resident should have a more detailed knowledge of the material and problem, and be prepared to discuss ~~more extensively the current concepts of the problem being presented along with its current accepted treatment and complications of treatment~~ in greater detail the current concepts of the problem being presented, its accepted treatment, and its complications.

VII. ORTHOPEDICCORTHOPAEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

The ~~Orthopedic~~ Orthopaedic Surgery Service ~~receives consultations answers consultations~~ from many different ~~sources.~~ sources. For emergency room consultations, patients ~~are~~ should be seen in accordance with the Emergency Department Diversion Reduction Initiative, which outlines ~~that patients in the ED should be seen~~ seen with a goal to respond to pages within 15 minutes, initially assess the patients within 30 minutes of the initial page, and disposition from the ED within 2 hours, in one hour, and for inpatient consultation, patients are seen within 24 hours.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. RESPONSIBILITY

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

San Francisco General HospitalZuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

To ensure appropriate care and safety of all patients receiving care in the department, it is understood that this care is provided chiefly in the emergency room, the operating room, the inpatient nursing units, and the clinics.

To minimize morbidity and mortality ~~as well as to~~ avoid unnecessary days of inpatient care, ~~the Orthopedic~~Orthopaedics Clinical Service targets and contributes to the efficient delivery of patient services.

B. REPORTING

Performance Improvement/Patient Safety (PIPS) and Utilization Management activity records will be maintained by the ~~Orthopedic~~Orthopaedic Clinical Service. Further, minutes will be sent to the Medical Staff Service Department and will include PIPS and Utilization Management information.

C. CLINICAL INDICATORS

The following clinical indicators are among those closely followed:

- Open fractures
- ~~Injuries to the operating room for I&D time interval~~
- ~~Antibiotic~~Antibiotic therapy prophylaxis in patients ~~at risk~~
- Nosocomial infection rate by surgical categories (i.e., clean, contaminated, infected, and open fractures)
- Readmission rates following ORIF of fractures
- ~~Professional behavior (e.g.i.e., Unusual occurrenceSAFE reports).~~
- Deaths

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

The practitioner performance profiles are monitored by the outpatient clinic and inpatient statistics, as well as by the monthly M&M Review Board.

E. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

Monitoring and evaluating ~~on of the~~ appropriateness of patient care services ~~is done on a daily basisare conducted daily~~. Each morning at ~~7:00-6:45AM6:45am6:45 am~~, service attendings and all housestaff meet to discuss all emergency room consultations and admissions from the previous 24 hours, including their diagnostic evaluations, treatment plans (surgical and conservative), and discharge plans. ~~Following these conferences, pre-operative and post-operative cases will be reviewed on Mondays and Tuesdays. Twice a weekOnce a week with each service, all inpatients are formally reviewed with representatives from Physical Therapy, Social Services, and Rehabilitation Services.~~

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1. Physicians/Affiliated Professionals

~~All of the professional staff, except for the housestaff, are evaluated by the Chief of Service as well as by the and the Chairman of the Department on an annuallyprofessional staff, except the house staff, are evaluated annually by the Chief of Service and the Department Chairman-basis. The faculty are evaluated by the residents and fellows regularly during the academic year according to UCSF Department of Orthopaediregularly evaluated by residents and fellows during the academic year, according to UCSF Department of Orthopaedic Surgery policy.~~

2. Housestaff

Each resident is evaluated twice during their rotation. ~~Once, in the middle of his/her rotation, where constructive comments can beare made following a performance evaluation, and again at the end of the rotation.~~ - At these meetings, ~~suggestions can be made by the attending staff to give some direction to the resident for his/herattending staff can make suggestions to guide the resident in their self-improvement.~~ -At the end of the rotation, ~~a formal evaluation by the entire faculty is performed for each residenteach resident undergoes a formal evaluation by the entire faculty.~~ -The findings are summarized on the appropriate form and forwarded to the ~~Chairman of the DepartmentDepartment's Chairman.~~ These results are discussed ~~quarterly semi-annually~~ at the Department Chief of Service meeting.

X. MEETING REQUIREMENTS

In accordance with ~~SFGHZSFG~~ Medical Staff Bylaws, ~~a~~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~~good-faith participation in the governance and quality evaluation processes of the Medical Staff by attending at least 50% of all assigned committee meetings, as well as clinical service meetings, and the annual Medical Staff Meeting.

The ~~Orthopedie~~Orthopaedic Surgery faculty shall meet monthly. Discussions will include monitoring and ~~evaluation of the quality and appropriateness of the~~evaluating the quality and appropriateness of care and treatment provided to patients.

As defined in the ~~SFGHZSFG~~ 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~~AMENDMENT

The ~~Orthopedie~~Orthopaedic Surgery Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the ~~Orthopedie~~Orthopaedic Surgery faculty annually during a faculty meeting.

XII. PATIENT INFORMATION

~~All patient-related health information will be treated with the upmost confidentiality, in accordance with the Health Insurance Portability and Accountability Act (HIPPA~~utmost confidentiality, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) guidelines.

Formatted: Normal, Indent: Left: 0.5"

ATTACHMENT A- ORTHOPEDICORTHOPAEDIC SURGERY PRIVILEGES

Privileges for Zuckerberg San Francisco General

Requested Approved

Applicant: Please initial the privileges you are requesting in the Requested column.

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

OrthoSurg. ORTHOPAEDIC SURGERY 2010

(MEC 08/10)

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.

28.00. GENERAL PRIVILEGES

Core privileges directed at the treatment of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities, include the following treatments (other than those outlined for supplemental privileges):

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopedic Surgery.

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

REAPPOINTMENT: 20 operative procedures in the previous two years.

A. Amputation, traumatic and elective

B. Application of skeletal traction

C. Arthrodesis

D. Arthroscopic surgery

E. Arthrotomy

F. Back and neck pain; chronic and acute

G. Biopsy of the musculoskeletal system

H. Bone graft

I. Contusion, sprains, and strains

J. External fixation of fractures

K. Fractures and dislocations, open or closed

L. Infection (surgical and medical treatment)

M. Injections (Joint, Bursa, trigger point, tendon sheaths)

N. Internal fixation of fractures

O. Ligament reconstruction

P. Osteotomy

Q. Osteotomy

R. Repair of lacerations

S. Revision of total hip and knee surgeries

T. Skin grafts

U. Spinal surgery (other than supplemental privileges)

V. Sports medicine and related injuries

W. Tenotomy and myotomy

Formatted: Font: 11 pt, Not Bold, Font color: Auto

Formatted: Heading 7, Indent: Left: 0.5", Space Before: 0 pt, Widow/Orphan control, Adjust space between Latin and Asian text, Adjust space between Asian text and numbers, Tab stops: Not at 0.06" + 1.21"

Formatted

... [1]

Formatted

... [2]

Formatted

... [3]

Formatted

... [4]

Formatted

... [5]

Formatted

... [6]

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08"

Formatted

... [7]

Formatted

... [8]

Formatted

... [9]

Formatted

... [10]

Formatted

... [11]

Formatted

... [12]

Formatted

... [13]

Formatted

... [14]

Formatted

... [15]

Formatted

... [16]

Formatted

... [17]

Formatted

... [18]

Formatted

... [19]

Formatted

... [20]

Formatted

... [21]

Formatted

... [22]

Formatted

... [23]

Formatted

... [24]

Formatted

... [25]

Formatted

... [26]

Formatted

... [27]

Formatted

... [28]

Formatted

... [29]

Formatted

... [30]

Formatted

... [31]

Formatted

... [32]

Formatted: Font: Times New Roman, 10 pt

Printed 6/24/2013

Page 1

Privileges for Zuckerberg San Francisco General

Requested Approved

	☒ Total joint surgery
	☒ Tumor surgery
	☒ Wound debridement
	aa. Management of orthopedic/orthopaedic conditions for patients in SNF Units
	bb. Major tumor resection
28.05	OUTPATIENT PRIVILEGES
	Outpatient clinic privileges directed at the evaluation and diagnosis of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities
	PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopedic/Orthopaedic Surgery.
	PROCTORING: 5 observed visits and 15 retrospective reviews visits
	REAPPOINTMENT: 20 visits in the previous two years.
28.10	SPECIAL PRIVILEGES: SPINAL SURGERY
	PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery and has completed fellowship training in spinal surgery or possesses equivalent experience.
	PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Orthopaedic Surgery or designee.
	REAPPOINTMENT: 20 procedures in the previous two years.
	Patient management includes the areas specified below:
	A. Complex anterior and posterior cervical, thoracic, and lumbar spinal surgery
	B. Open reduction and internal fixation of spine fractures
	C. Intra-discal chemonucleolysis
	D. Percutaneous disk excision
28.20	SPECIAL PRIVILEGES: HAND AND MICROVASCULAR SURGERY
	PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microvascular surgery or possesses equivalent experience.
	PROCTORING: Review of 5 operative procedures and 15 retrospective reviews of procedures
	REAPPOINTMENT: 20 operative procedures in the previous two years.
	A. Microsurgery and replacement, replantation of limbs and parts, including adjacent and free tissue transfer.
	B. Complex Hand Surgery and Replantation of Limbs and Parts
	C. Use of operating microscope, repair blood vessel/nerve, digit replantation
	D. Free muscle/skin flap microvascular anastomosis
28.30	GENERAL PODIATRIC PRIVILEGES
	PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.
	PROCTORING: 5 observed cases and 15 retrospective reviews of procedures.
	REAPPOINTMENT: 20 cases in the previous two years.
	Simple outpatient procedures including:

Formatted

... [33]

Formatted: Font: 8 pt

Formatted

... [34]

Formatted

... [35]

Formatted

... [36]

Formatted

... [37]

Formatted

... [38]

Formatted

... [39]

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Indent: Left: 2.08"

Formatted: Font: 9 pt

Formatted

... [40]

Formatted

... [41]

Formatted

... [42]

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Indent: Left: 2.08"

Formatted

... [43]

Formatted

... [44]

Formatted

... [45]

Formatted

... [46]

Formatted

... [47]

Formatted

... [48]

Formatted

... [49]

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Indent: Left: 2.08"

Formatted

... [50]

Formatted: Indent: Left: 0", Hanging: 2.3"

Formatted

... [51]

Formatted

... [52]

Formatted

... [53]

Formatted

... [54]

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted

... [55]

Formatted

... [56]

Formatted

... [57]

Printed 6/24/2013

Page 2

Formatted

... [58]

Formatted: Font: Times New Roman, 10 pt

Privileges for Zuckerberg San Francisco General

Requested Approved

- A. Nail avulsion
- B. Chemical Martisectomies
- C. Biopsy and debridement of cutaneous lesions, and simple infection process relative to nails and skin.

28.40. SURGICAL PODIATRIC PRIVILEGES

28.41. Category I: Podiatric Surgery

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.

PROCTORING: 5 observed cases and 15 retrospective reviews of procedures (Category I).

REAPPOINTMENT: 20 cases in the previous two years.

- A. Treatment of cutaneous lesions
- B. Removal of foreign bodies
- C. Removal of superficial debridements

28.42. Category II: Podiatric Surgery

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.

PROCTORING: 5 observed procedures and 15 retrospective reviews of procedures (Category 2).

REAPPOINTMENT: 20 procedures in the previous two years (Category 2).

Deep procedures of the forefoot including:

- A. Excision of soft tissue lesions
- B. Intermetatarsal neuromas
- C. Bunionectomies
- D. Capsulotomies
- E. Tenotomies
- F. Removal of foreign bodies of the forefoot
- G. Amputation
- H. Osseous procedures of the forefoot including sesamoidectomy
- I. Fusion of interphalangeal joints
- J. Osteotomies

29.00. PHYSICAL MEDICINE & REHABILITATION

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation, with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Performs basic procedures within the usual and customary scope of physical medicine and rehabilitation, including but not limited to diagnosis, management, treatment, and preventive care for adult and pediatric patients.

Procedures include:

- A. Intra-articular joint injection
- B. Intra-articular joint aspiration

Printed 6/24/2013

Page 3

Formatted

... [59]

Formatted: Font: 8 pt

Formatted

... [60]

Formatted

... [61]

Formatted

... [62]

Formatted: Indent: Left: 0", Hanging: 2.3", Space Before: 0.6 pt, Tab stops: 0.06", Left + 0.56", Left + 2.23", Right

Formatted

... [63]

Formatted

... [64]

Formatted: Indent: Left: 2.3"

Formatted

... [65]

Formatted

... [66]

Formatted

... [67]

Formatted

... [68]

Formatted

... [69]

Formatted: Indent: Left: 2.3"

Formatted: Font: 9 pt

Formatted: Font: 9 pt

Formatted

... [70]

Formatted

... [71]

Formatted

... [72]

Formatted

... [73]

Formatted

... [74]

Formatted

... [75]

Formatted

... [76]

Formatted

... [77]

Formatted

... [78]

Formatted

... [79]

Formatted

... [80]

Formatted

... [81]

Formatted

... [82]

Formatted

... [83]

Formatted

... [84]

Formatted: Indent: Left: 2.08"

Formatted

... [85]

Formatted

... [86]

Formatted: Indent: Left: 2.08"

Formatted

... [87]

Formatted

... [88]

Formatted

... [89]

Formatted

... [90]

Formatted: Font: Times New Roman, 10 pt

Privileges for Zuckerberg San Francisco General

Requested _ Approved

- C. Joint bursa aspiration
- D. Joint bursa injection
- E. Tendon sheath injection
- F. Trigger/Tender point injection
- G. Ganglion aspiration
- H. Nerve block
- I. Chemical neurolysis
- J. Neuromuscular junction block
- K. Autologous blood tendon injection
- L. Lumbar puncture
- M. Intrathecal pump management

29.10 SPINAL INJECTION TECHNIQUES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

- A. Transforaminal epidural injection (selected nerve root block)
- B. Interlaminar epidural injection
- C. Facet joint injection
- D. Facet nerve block
- E. Discography
- F. Epidurolysis
- G. Sympathetic nerve block
- H. Sacroiliac joint injection
- I. Epidural blood patch
- J. Radiofrequency nerve ablation

29.20 SPINAL TECHNIQUES: SPECIAL PROCEDURES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

- A. Spinal cord stimulation
- B. Percutaneous vertebroplasty/kyphoplasty
- C. Implanted drug delivery for pain or spasticity
- D. Intradiscal electrothermal therapy

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08"

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Indent: Left: 2.08"

Formatted: Font: 9 pt

Privileges for Zuckerberg San Francisco General

Requested Approved

29.30 CLINICAL NEUROPHYSIOLOGY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

- A. Electromyography
- B. Nerve conduction study
- C. Somatosensory evoked potential assessment
- D. Electromyography/nerve conduction guided
- E. Guided nerve block
- F. Electromyography/nerve conduction guided junction nerve block

29.40 EVOKED POTENTIAL TESTING

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: Review of 5 procedures and 15 retrospective reviews of procedures

REAPPOINTMENT: 20 operative procedures in the previous two years

30.00 ACUTE TRAUMA SURGERY

SCOPE: On-call trauma coverage for the comprehensive orthopedic/orthopaedic management of the acutely injured trauma patient.

PREREQUISITES: Completion of ACGME-approved residency with Board certification/eligibility in Orthopedic/Orthopaedic Surgery. Availability, clinical

performance and

continuing medical education consistent with current standards for orthopedic/orthopaedic surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons. PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.

REAPPOINTMENT: 20 operative procedures in the previous two years

31.00 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of orthopedic/orthopaedic Surgery, Plastic Surgery, Podiatric Surgery, or the American Board of Physical Medicine & Rehabilitation, or a member of the Clinical Services prior to 10/17/00. A current x-Ray/Fluoroscopy Certificate is required.

PROCTORING: Presentation of valid California Fluoroscopy certificate

REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Indent: Left: 2.08"

Formatted: Font: 9 pt

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08"

Formatted: Font: 9 pt

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08", Space Before: 0.6 pt

Formatted: Font: 9 pt

~~San Francisco General Hospital~~Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

Privileges for Zuckerberg San Francisco General

Requested _____ Approved _____

32.00 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 Orthopedic Orthopaedics or a member of the Clinical Service prior to 10/17/00, 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 (completed training within the last 5 years)

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

I hereby request clinical privileges as indicated above.

Applicant _____

date _____

FOR DEPARTMENTAL USE:

Proctors have been assigned for the newly granted privileges.

Proctoring requirements have been satisfied.

Medications requiring DEA certification may be prescribed by this provider.

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

CPR certification is required.

CPR certification is not required.

APPROVED BY:

Division Chief _____

date _____

Service Chief _____

date _____

PRINTED 6/24/2013

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08"

Formatted: Font: 9 pt

Formatted: Indent: Left: 2.08"

Formatted: Indent: Left: 2.08"

Formatted: Indent: Left: 2.08"

ATTACHMENT A — ORTHOPEDIC PRIVILEGE REQUEST FORM

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

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

Requested—Approved

28 ORTHOPAEDIC SURGERY

28.00 — GENERAL PRIVILEGES

Core privileges include procedures directed at the treatment of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopedic Surgery.

PROCTORING: Review of 3 cases.

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.10 — DIAGNOSTIC RADIOLOGY; FLUOROSCOPY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopedic Surgery, Plastic Surgery, Podiatric Surgery, or the American Board of Physical Medicine & Rehabilitation. A current X-Ray/Fluoroscopy Certificate is required.

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.20 — PODIATRIC PRIVILEGES

Simple outpatient procedures, including nail avulsion, chemical, biopsy and debridement of cutaneous lesions, and simple infection process relative to nails and skin. Evaluation and non-invasive treatment of common podiatric medical pathology.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery.

PROCTORING: Review of 3 cases.

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.21 — Category I — Podiatric Surgery

Superficial procedures including the treatment of cutaneous lesions, removal of foreign bodies, and superficial debridements.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery.

PROCTORING: Review of 3 cases.

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.22 — Category II — Podiatric Surgery.

Deep procedures of the forefoot, including the excision of soft tissue lesions, intermetatarsal neuromas, bunionectomies, capsulotomies, tenotomies, removal of foreign bodies of the forefoot, and amputation. Osseous procedures of the forefoot including sesamoidectomy, fusion of interphalangeal joints, and osteotomies.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery.

PROCTORING: Review of 3 cases.

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

29.00 — PHYSICAL MEDICINE & REHABILITATION

Performs basic procedures within the usual and customary scope of physical medicine and rehabilitation, including but not limited to diagnosis, management, treatment, and preventive care

Formatted: Indent: Left: 0.5", First line: 0"

Formatted: Indent: Left: 0.5"

Formatted: Indent: Left: 0.5", First line: 0"

Formatted: Indent: Left: 0.5"

Privileges for San Francisco General Hospital/Zuckerberg San Francisco General

—
Requested — Approved

for adult and pediatric patients of all ages at the CHN facilities or in the patient's home.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation

PROCTORING: Review of 5 patient charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service

REAPPOINTMENT: Review of 5 patient charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service

29.02 SPINAL INJECTION TECHNIQUES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Physical Medicine and Rehabilitation. Additional training in spinal injection techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required. **PROCTORING:** Review of 5 direct observations and 5 charts to be reviewed by the Chief of Rehabilitation or designee with a recommendation to the Chief of the Orthopaedic Surgery Service. Direct observations and chart reviews may be on the same patient, or a combination thereof totaling 5 direct observations and 5 chart reviews.

REAPPOINTMENT: Review of 5 charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

29.03 CLINICAL NEUROPHYSIOLOGY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: Review of 5 direct observations and 5 charts to be reviewed by the Chief of Rehabilitation or designee with a recommendation to the Chief of the Orthopaedic Surgery Service. Direct observations and chart reviews may be on the same patient, or a combination thereof totaling 5 direct observations and 5 chart reviews.

REAPPOINTMENT: Review of 5 charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

PATIENT MANAGEMENT INCLUDES THE AREAS SPECIFIED BELOW:

29.031 EMG

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: Review of 5 direct observations and 5 charts to be reviewed by the Chief of Rehabilitation or designee with a recommendation to the Chief of the Orthopaedic Surgery Service. Direct observations and chart reviews may be on the same patient, or a combination thereof totaling 5 direct observations and 5 chart reviews.

REAPPOINTMENT: Review of 5 charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

29.032 EVOKED POTENTIAL TESTING

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

Requested—Approved

PROCTORING: Review of 5 direct observations and 5 charts to be reviewed by the Chief of Rehabilitation or designee with a recommendation to the Chief of the Orthopaedic Surgery Service. Direct observations and chart reviews may be on the same patient, or a combination thereof totaling 5 direct observations and 5 chart reviews.

REAPPOINTMENT: Review of five charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

30—ACUTE TRAUMA SURGERY

SCOPE: On-call trauma coverage for the comprehensive orthopedic management of the acutely injured trauma patient.

PREREQUISITES: Completion of ACGME approved residency with Board certification/eligibility in Orthopedic Surgery. Availability, clinical performance and continuing medical education consistent with current standards for orthopedic surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons.

PROCTORING: Review of 3 cases.

REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

31—SPECIAL PRIVILEGES

PATIENT MANAGEMENT INCLUDES THE AREAS SPECIFIED BELOW:

31.1 Microsurgery and replacement, replantation of limbs and parts, including adjacent and free tissue transfer.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microsurgery.

PROCTORING: Review of 5 cases if training is completed through an ACGME program and 10 cases if the individual completed training through a non-ACGME training program.

REAPPOINTMENT: Review of 2 cases.

31.2 Complex Hand Surgery, which includes comprehensive care from the wrist to the digits.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microsurgery.

PROCTORING: Review of 5 cases if training is completed through an ACGME program and 10 cases if the individual completed training through a non-ACGME training program.

REAPPOINTMENT: Review of 2 cases.

32—MODERATE SEDATION

The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 5 cases or completion of the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department.

I hereby request clinical privileges as indicated above.

Applicant date

Formatted: Indent: Left: 0.5", First line: 0"

Formatted: Indent: Left: 0.5"

Formatted: Indent: Left: 0.5", First line: 0"

Formatted: Indent: Left: 0.5"

San Francisco General HospitalZuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

FOR DEPARTMENTAL USE:

Proctors have been assigned for the newly granted privileges.
Proctoring requirements have been satisfied.
Medications requiring DEA certification may be prescribed by this provider.
Medications requiring DEA certification will not be prescribed by this provider.
CPR certification is required.
CPR certification is not required.

APPROVED BY:

Division Chief date

Service Chief date

Printed 10/19/2007

Page 4

Formatted: Indent: Left: 0.5", First line: 0"

ATTACHMENT B- ORTHOPEDIC ORTHOPAEDIC SURGERY POLICIES AND PROCEDURES

A. EMERGENCY ROOM COVERAGE

1. ~~Representative, usually house staff, should respond~~
immediately IMMEDIATELY for to ER consultation.
2. The Orthopaedic Surgery Service administration will cConfirm that:
 - a. ~~that~~ your names and contact information are beeper number are listed correctly on the call schedule
 - b. the contact information for those on call for resident (intern, junior, and senior), fellow, and faculty (general orthopaedic surgery/trauma, spine, and hand) is accurate (e.g., at your beeper, if applicable, and cell phone) on the call schedule. Secure Chat and any other methods of clinical communications are is working.
3. The residents assigned to the ER on days should be available from 7:00 a.m. until 7:00 a.m. the following day, depending on their call assignment.
4. The resident on call on holidays covers the ER during the day and night.
5. The attendings for general call will have call shifts that are for day coverage (attending of the day; AOD) and night coverage (attending of the night; AON), with shifts from 7:00 a.m. to 6:00 p.m and 6:00 p.m to 7:00 a.m., respectively.
5. PATIENT TREATMENT REGISTER:
 - a. All outpatients must be recorded on the electronic "Patient-~~Case Log~~Treatment Register" sheet by the OrthopedicOrthopaedic Emergency Room Resident. ~~Record name, MRB number, phone, address, diagnosis, treatment and clinic appointment date. Patients must have complete registry information placed on the registry information sheet.~~
 - b. All admissions with orthopedicorthopaedic problems (whether admitted to the Orthopaedic Surgery Service or other service) must also be recorded on the appropriate patient list, specifying assigned SFGHZSFG ward and admitting service if other than Ortho.
 - c. ~~The Ortho Service administrative staff and nurse practitioners will obtain the list each morning and use it for service records.~~
 - d. Acute conditions (e.g., fractures, dislocations, infections, etc.) shall be evaluated prior to given disposition discharge instructions from the ED. Orthopaedic Surgery residents should participate in the scheduling of outpatient follow-up scheduling of patients seen in the ED. not be given e-referral appointments.
6. EMERGENCY TREATMENT POLICIES:
 - a. Junior orthopaedic surgery residents on call should cConsult immediately with Chief Resident regarding any potential surgical case.
 - b. ~~Unless they are junior resident on call certain of diagnosis and treatment, consult should consult the~~ Chief Resident prior to making disposition plans in which they are unsure.
 - c. The on-call junior resident should notify the Chief Resident immediately of all admissions to their service. The Chief Resident should notify the attending on call of all admissions to their service or cases scheduled.
 - d. Save all your residents should save all records, particularly the yellow copies of the consult forms (originals are to be left on the chart) document their consultation note in the medical record and to review all patient cases

Formatted: Indent: Left: 1", Hanging: 0.5"

Formatted: Indent: Left: 0", Hanging: 1.5"

the following morning in fracture rounds with the attending who was on-call or the current AOD. All consultations (ER & inpatient) must be reviewed by an attending prior to the on-call resident leaving the hospital post-call (no later than noon-8 a.m. the following day~~11am the following day~~).

- e. When in doubt, the junior resident should ~~not hesitate to~~ ask the Chief Resident to personally see the patient and/or the imaging studies (e.g., compression fractures of the spine, patients unable to walk or care for themselves safely in casts, potential compartment syndromes, “disposition problems” whose diagnoses are ~~orthopedic~~orthopaedic, etc.).
- f. ER ~~RECORDS~~Records: An orthopaedic surgery~~ORTHO~~ consult note must be written and signed in the medical record for each patient seen using the standard template form. The records should include medications given and procedures done for patients admitted to the hospital or sent home with follow-up instructions (including clinic follow-up).—For admissions, the attending of record must review the consult ~~and see the patient within 24 hours of admission; see the patient within 24 hours of admission;~~ and complete an attending attestation ~~form~~ in the medical record.
- g. Orthopaedic Surgery residents are responsible for the consultations in the ER.
- h. ~~Orthopedic~~Orthopaedics & Neurosurgery should be called for consults by ~~ER~~ according to the spine call schedule.
- i. Orthopaedics & Plastics should be called for consults according to the hand call schedule.

7. Avoid “curbside” consultation—it is usually not optimal for the patient.

B. EMERGENCY ADMISSIONS

1. EMERGENCY ~~ORTHOPEDIC~~ORTHOPAEDIC ADMISSIONS

- a. Emergency admissions are assigned to the service on call for that day, with the following exceptions:
 - 1) Patients requiring emergency surgery will be cared for by the team performing the operation.
 - 2) Re-admissions for the same problem will return to their previous team.
 - 3) Patients seen from 6 p.m. to 7 a.m. the night prior will be reviewed by and admitted to the attending of the day (AOD), who will be covering the OR during the following day, unless otherwise arranged.
- b. Residents should c~~omplete~~ ER admission paperwork/documentation at the time of admission; including admission orders and a complete history and physical examination.
- c. Direct admissions/transfers from other hospitals are welcome and encouraged. They must be approved first by an attending ~~who will arrange the transfer with the SFGH/ZSFG eligibility/transfer coordinator (if inpatient to inpatient transfer) or the ED attending (if ED to ED transfer, who will arrange the transfer with the ZSFG eligibility/transfer coordinator (for inpatient-to-inpatient transfers) or the ED attending (for ED-to-ED transfers).~~ Make note of patient diagnosis, reason for transfer,

type of bed required (ICU, step-down, etc.) and the patient's diagnosis, the reason for transfer, the type of bed required (ICU, step-down, etc.), and the optimal timing for surgery. The attending of record should be consulted if patients are transferred out of the ED, including pediatric patients.

2. ADMISSIONS TO OTHER SERVICES

There must be:

- a. A note in the medical record clearly defining the patient's ~~orthopedic~~orthopaedic problems and treatment, provided or recommended, ~~and a legible signature with beeper number. Times and dates are required on all notes and orders.~~
- b. Clear ~~written~~ indication of which ~~orthopedic~~orthopaedic team is involved ~~with name of the chief resident and his/her beeper number.~~
- c. Verbal communication with the responsible senior or chief resident of the admitting service to ensure proper communication and discussion of medical plans.
- d. Patient admissions and transfers should adhere to the general guidelines established between the various services, ~~—(including trauma and medicine).~~
- e. While on another service, ~~such “consult the patients”~~ patients consulted on will be followed at least daily by the appropriate ~~orthopedic~~orthopaedic team, until the patient is stable for sign-off.
- f. Children with ~~orthopedic~~orthopaedic problems requiring hospitalization will be admitted to the ~~pPediatric ward~~Ward (6A) under the primary care of the Pediatric Service who must be notified immediately about any admission ~~and —(must see the patient in the ER in ER).~~ Orthopaedic Surgery Service —house staff may~~interns may~~ assist with the care of ~~thesesuch patients, but need not do work-ups and ward care as these are provided by the Pediatric house staff.~~

C. NIGHT AND WEEKEND COVERAGE

1. The assigned junior resident and intern must stay in the hospital.
2. When a new junior resident assumes night/weekend call, the chief resident mayust also remain in the hospital to provide immediate ~~back-up~~backup. —These requirementsis may be discontinued only by mutual agreement of the chief resident and service chief.
3. Before leaving for the day, interns will review sign out their patients with the intern and/or nurse practitioner on duty regarding pending problems, etc.
4. Night call is the responsibility of thatthe person on the call schedule. If you are illthe scheduled resident on call needs or need to be off for some other reason, it is your their responsibility to make sure thatany reason, it is their responsibility to ensure the time is covered by another house officerHO of the same level who agrees to coverwho agrees to cover for you. The chief residents must approve of a switch in night call. Other team members, orthopaedic surgery administrator, telephone operator and ER must be notified of any deviation from the printed scheduleorthopaedic surgery administrators, telephone operators, and the ER must be notified of any deviation from the Department's published schedule.-

5.

Do not "hassle" the administrative assistant about the call schedule.- Questions regarding the call schedule should be directed to the Chief of Service.

5.

D. VACATIONS

1. Resident vVacations should be scheduled 6 weeks in advance; and should be done through the protocol established through the UCSF Department of Orthopaedic Surgery Departmentresidency, which includes approval from the service's s-chief resident, chief of service, and residency coordinator. Vacations consist of 5 consecutive working days; and cannot exceed that time during the rotation. An additional 5 days of educational leave may be granted in addition to the vacation time. Leave should not exceed 10 working days, unless specifically cleared with the Chief of Service and the UCSF Department of Orthopaedic Surgery Residency Director.-
2. Residents can request vacation at ZSFG in accordance with the Department of Orthopaedic Residency requirements. Vacation will be granted and placed on the ealendar on a first-come-first-servedscheduled on a first-come, first-served basis. The rotations at ZSFG allow for only one resident to be gone at a time. Exceptions will be considered for very important educational events or personal issues, and must. They must be approved by both service chief residents and the faculty from the service that will be the service chief residents and the faculty from the service affected by the leave. If this exceptional leave is granted, the residents must be a senior and juniorseniors and juniors from different teams. Leave generally will not be granted for the first week of any rotation, during the Christmas Holiday or New Year's (when coverage teams are formed, allowing for every team member to have an equal number of designated, non-vacation days off), or the first/last weeks of the academic year.

No vacation should be taken during the first or last week of the rotation, or withing the two weeks before and after the beginning of the academic year.

Formatted: Normal, Justified, Indent: Left: 0", Hanging: 1.5", Tab stops: 0.5", Left + 1", Left + 1.5", Left + 2", Left + 2.5", Left + 3", Left

Formatted: Normal, Justified, Indent: Left: 0", Hanging: 1.5", Tab stops: 0.5", Left + 1", Left + 1.5", Left + 2", Left + 2.5", Left + 3", Left

Formatted: Normal, Justified, Indent: Left: 0", Hanging: 1.5", Tab stops: 0.5", Left + 1", Left + 1.5", Left + 2", Left + 2.5", Left + 3", Left

Formatted: Font: Times New Roman

Formatted: Font: Times New Roman

Formatted: Font: Times New Roman

Formatted: Font: Times New Roman

Formatted: Font: Times New Roman

Formatted: Font: Times New Roman

Formatted: Font: Times New Roman

- ~~4. Only one person can be gone from the SFGH/ZSFG service at any time. Any exception must be approved by the Chief of Service, the Service attendings (Gold or Blue) affected by the absence, and both Chief Residents.~~

E. **ORTHOPEDIC/ORTHOPAEDIC TEAM ROUNDS**

1. Each chief resident will round with ~~his/her~~their team on all ~~his or her~~their patients daily, ~~prior to before~~ fracture consult rounds (with the exception of except Wednesdays when the residents should attend Grand Rounds and the rounding is performed by the in-house residents on call, the inpatient service Nurse Practitioners, NPs, and with the fellows). Patient visits This must include an opportunity for the patient to discuss ~~his/her~~their care with team members. Patients should know their assigned team, the name of their chief resident, attending, and at least one other M.D. on the team.
2. A patient's perception of his physician as "insensitive" or "unprofessional" is a frequent precursor of patient complaints and medicolegal issues. a lawsuit! Always acknowledge the patient ~~prior to before~~ examination or bedside discussion of ~~his~~ problems. Service providers are urged to Listen to the patient and take an interest in their personal lives, concerns, and well-being whenever it is possible.
3. Rounds must begin early enough so the ~~chief residents~~ can see and assess each patient.
4. WEEKENDS AND HOLIDAYS, the service the residents will be responsible to make rounds on patients from both teams, do necessary ward work, write notes and report for making rounds on patients from both teams, doing necessary ward work, writing notes, and reporting problems to the team on duty. The residents will subsequently conduct rounds with the attending on call/on-call attending.
5. ATTENDING MULTIDISCIPLINARY WARD ROUNDS, followed by a review of all inpatient consults daily. x-rays, will be held weekly by each team, Blue on Monday at 8:00 a.m. and Gold on Tuesday at 8:00 a.m. Prior to Before these rounds, patients will have been seen on regular work rounds and wounds prepared for examination by the resident teams.

F. **WARD PROCEDURES**

1. MEDICAL RECORDS:
 - a. A history and physical will be written/documented for each patient on admission by the intern or junior housestaff, who will write/enter orders after consulting with a senior resident.
 - b. There must be a resident note for each patient confirming pertinent history, physical examination, lab and x-ray findings, and given clearly recorded diagnoses and plans completed and signed in the medical record.
 - c. Any procedure (e.g., case change, closed reduction, etc.) must be recorded in the patient's medical record along with other notable findings (e.g., physical findings, post-reduction x-rays, etc.) and a Operative notes can be completed directly in the electronic health record or dictated on Preventions as necessary.
 - d. Progress notes by the residents should be written/entered/completed daily on each patient, and dated and signed legibly. Electronic progress notes should be written by the fellow or an attending on the service daily.

- e. There should be an interval history/preoperative note written in the chart medical record less than 24 hours before any elective procedure. ~~This should include but not is not limited to the patient diagnosis, surgical indications, significant laboratory values, significant co-morbidities, and planned procedure.~~

2. ORDERS

- a. All orders will be written-entered completely, including time and date, and signed. All admission and postoperative orders must be written on the standing order forms.
- b. Verbal orders ~~phone orders~~ must be countersigned within 24 hours.
- c. ~~Narcotics, anticoagulants and IV fluid orders will be carried out for up to 72 hours when they will stop automatically unless renewed.~~
- cd. ~~GIVE ADEQUATE PAIN MEDICATION!~~ Provide adequate pain medication. Pre-medicate—pre-medicate before a painful procedure. Do not hesitate to consult the pPain mManagement sService.
- de. All medication orders must be renewed every 7 days reviewed regularly.
- ef. All orders must be re-established/reconciled ~~are automatically stopped at the time of surgery and on inter-service transfer. They therefore must be re-written in these cases.~~
- fg. X-rays and lab studies must be ordered in the medical chart record, as well as requested on appropriate forms. ~~(test 7 clinical information completed as requested on appropriate forms). Practitioners should~~ Do not order unnecessary (routine) blood work or x-rays.
- gh. All instructions for the cast technician or braces must be recorded in the medical record/chart, just as any other order.

3. DISCHARGE RECORDS

- a. The chief resident attending is responsible for the correctness of recorded discharge diagnoses.
- b. ~~Complete, specific, final orthopedic diagnoses must be on the Patient Discharge Form (pink right margin) and on dictated summary.~~
- c. A brief ~~(preferably one page only)~~ dictated discharge summary will be done for each patient. This must record at least the patient's diagnoses, including date of injury, operations performed with dates, problems encountered, if any, and plans for further care and follow-up. ~~(See section below on Laguna Honda transfers).~~
- c. If a patient is transferred to another hospital or physician, a telephone conversation must occur between the receiving orthopedist and a senior ~~orthopedic~~ orthopaedic team member to discuss the patient's diagnoses, condition, treatment undertaken and transfer arrangements. This conversation, including ~~name, address and phone number of receiving orthopedist~~ the name, address, and phone number of the receiving orthopedist, must be recorded in a progress note within the medical record. A ~~dictated-discharge~~ summary and pertinent x-rays or access to their medical record ~~their copies~~ should accompany transferred patients ~~patients so transferred~~.
- d. Discharge instructions and/or After Visit Summary and/or Interfacility Transfer Summary will be provided at the time of discharge and a copy of this will be recorded/kept in the patient's medical record.

Formatted: Indent: Left: 0", Hanging: 1.5"

Formatted: List Paragraph, Indent: Left: 1.5", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 3 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75"

G. DISCHARGE PLANNING

1. ~~P~~Anticipate your patient's needs for discharge planning at the time of admission ~~should be anticipated~~. If a patient is not certain to be discharged ambulatory and independent, consult the social worker and/or discharge ~~nurse coordinator~~ planner as soon as possible.
2. ~~G~~Remember to allow for needed gait training or other physical therapy before ~~the~~ planned time of ~~discharge~~ discharge ~~should be performed~~. ~~Schedule this in advance, not at the last minute~~.
3. ~~I~~nform your patients ~~Patients should be informed~~ as soon as possible about a planned discharge dates, and ~~keep him them informed~~ of any changes.!
4. Visiting nurse services may permit discharge home where visiting PT may also be arranged.
5. Laguna Honda Hospital (county facility) has a limited number of acute ~~and chronic~~ rehabilitation beds ~~(see below)~~. ~~They also have chronic care beds with a long waiting list~~.
6. Laguna Honda Hospital staff will screen all prospective patients for ~~their the~~ rehabilitation ward before ~~accepting them for admission~~ admitting them. Patients must need rehabilitation services, ~~must~~ be willing and able to participate, and ~~must~~ have an appropriate ~~plan for discharge~~ discharge plan from LHH.
7. The social worker will arrange ~~the~~ LHH rehabilitation evaluation for a patient upon request of the ~~Orthopedic~~ Orthopaedic team.
8. The ~~SFGH~~ ~~orthopedic~~ ~~Orthopedic~~ Orthopaedic Service has a weekly follow-up clinic at LHH ~~every at 1:00 p.m. on Tuesdays~~ ~~week ams~~ alternating between the two services. One attending ~~and the appropriate junior resident staffs~~ staff member ~~attends~~ these clinics.
9. ~~I~~f a patient is accepted for transfer to the LHH rehabilitation ward, a discharge summary must be ~~dictated the day before transfer~~ completed and signed in the ~~medical record prior to before~~ discharge. It must include the following:
 - a) ~~Which team (Blue or Gold) will follow the patient.~~ Follow-up.
 - b) Explicit physical therapy and activity orders, including ~~weight bearing~~ weight-bearing status.
 - c) Notation of any x-rays desired to be done ~~prior to before~~ the first ~~Tuesday~~ LHH ~~Orthopedic~~ Orthopaedics clinic, in which the patient will be seen.

H. COMPLETION OF MEDICAL RECORDS

1. A ~~dictated~~ discharge summary ~~and a written discharge front sheet~~ should be completed and signed in the medical record before the patient is discharged.
2. ~~Brief o~~Operative note ~~and or complete o~~Operative ~~n~~Notes must be completed and signed prior to a patient moving out of the ~~perioperative~~ Peri-Operative ~~c~~Care area. ~~If a Brief Operative note is completed immediately following a procedure, then the comprehensive Operative Note must be completed and signed into the medical record within the 24 hours following the procedure. Operative notes must be dictated entered within 24 hours of the surgical procedure and written by resident/NP/fellow must be attested signed by the attending~~ The attending must attest to the operative notes written by the resident/NP/fellow within 3 days. Any ~~undictated or unsigned delinquent notes greater than 5 days~~ will result in suspension of surgical privileges.
3. ~~Clinic visits should be seen with an attending when possible. Clinic notes should be dictated as follows: non-licensed residents must see the patients with the~~

~~attendings and dictate with the attendings name in the note; licensed residents should dictate under their name (with "Dr. Statistical" as attending if they do not see the patient with an attending and dictate in the attendings name if seen with an attending; and attendings should dictate their own name in the notes. Medical students' are not allow to write notes notes do not substitute for resident and faculty notes. All clinic notes should be signed within a week. Any unsigned note greater than 5 days after its dictation also will result in suspension of surgical privileges.~~

3. Hospital privileges may be suspended for any physician who fails to complete ~~required charts or~~ DICTATE documentation-operative reports ~~notes~~ within the designated time. ~~The undictated charts will be reviewed weekly and notes needing countersignature will be brought to the Department by Medical Records for signature.~~

I. INFECTION PREVENTION

1. All needle sticks and body fluid contamination must be reported as soon as feasible. ~~First, file incident report at time of contamination. Second, possible. R~~report to ~~CMOSH-OHS or ER forfor instructions on~~ appropriate testing and counseling. ~~Third, obtain appropriate patient blood/serologic testing.~~
2. ~~HANDWASHING-Handwashing~~ and good dressing techniques are the keys to preventing ~~the~~ transfer of pathogenic bacteria from patient to patient.
3. ~~The use of~~Use gloves is required for all wounds, all dressings, and when touching any ~~linen's, gowns~~linens, gowns, or clothing that may be soiled with blood or body fluids. ~~Wash your hands~~Hand washing is required after touching each patient, even if ~~gloves were worn. you were wearing gloves.~~ See "Infection Control documentation on the SFDPH website, and Body Substance Precaution orientation Booklet."
4. Patients with planned or recent clean surgical procedures must not be admitted to rooms that also house patients with infected, draining wounds.

J. PRESSURE SORES & CONTRACTURES

1. Immobilized patients may develop pressure sores, contractures, and other problems. Patients who cannot ~~relieve-relieve~~ focal pressure by moving in bed, or who have insensible skin, are most at risk. ~~For others,~~ mobility aids will increase morale.
2. Unless sitting, trunk flexion, or loading of arms, is contraindicated, ~~a~~An overhead frame and trapeze should routinely be provided.
3. ~~Pressures sores typically develop on the sacrum, lateral buttocks~~Pressure sores typically develop on the sacrum, lateral buttocks, and heels. Rolling the patient every ~~two hours, maintaining dry clean sheets and use of additional padding (e.g., foam egg-erate~~2 hours, maintaining dry, clean sheets, and using additional padding (e.g., a foam egg-crate mattress pad) over the firm hospital mattress are standard. Additionally, a pillow placed longitudinally under the calf (not under the knee) with the heel hanging over the end will prevent heel pressure sores.
4. Patients in traction usually can be turned 30 degrees side-to-side, but if they cannot be turned enough to unload their sacrum, prompt use of ~~a Clinatron (or similar)~~an air bed before pressures develop is effective. ~~Such beds are available after~~

~~approval by the Plastic Surgery Service. If none are in the hospital, they can be rented and delivered immediately.~~

K. PLASTER

- ~~Do not pull Plastic-covered~~plastic-covered pillows or any other plastic material should not be placed next to setting plaster. If the patient c/o burning, the cast or splint should be removed immediately. REMOVE cast or splint immediately.
- Circumferential casts and splints, and even splints, can cause excessive pressure on a limb, especially a recently injured one with increasing swelling. Make sure that enough Adequate padding is required is applied to allow the case to be split without skin trauma.
- Cast univalving or bivalving should be done the ~~full-length~~full length of the case, dividing padding as well as plaster. The ~~caste~~ must then be spread to loosen it.
- Interns should check with the resident before opening a cast~~it~~. Casts should not be opened Do not open a cast directly over a traumatic or operative wound.
- Casts should generally be sawed open ~~OUTSIDE the outside the OOR~~ to minimize airborne dust.
- Major cast work (spica, body jacket, etc.) should be planned and scheduled in accordance~~to~~ with the Chief Resident and ortho technician the preceding day.
- Inpatient cast work must not be done in the ER or the clinic. If prompt x-ray control or anesthesia is required, such plaster work is best done in the OR, as the floor cannot accommodate conscious sedation.
- Cast technician duties include :- Collect treatment equipment, set up traction, apply overhead frames, apply routine casts and splints, assistcollecting treatment equipment, setting up traction, applying overhead frames, applying routine casts and splints, and assisting with casts and cast braces.
- Maintain reasonable cleanliness in the Cast Room.
- Stamp and fill out cast room slips for all procedures done and equipment handed out (crutches, braces, etc.). Billing slips are required to obtain insurance payments for the hospital.
- Plastic cast material is available in limited amounts for patients with appropriate indications.
- Return all ~~orthopedic~~orthopaedic equipment to the area from which it is borrowed. If something is missing or broken, inform the cast technician.

L. TRACTION SUPPLIES

- Traction supplies (rope, splints, fleece slings, weight bags, overhead frames and pulleys, etc.) are stored on 3B. The 3B cast technician is responsible for keeping this material clean and orderly.
- Traction equipment should be removed from beds when no longer needed. The orthopaedic-technician makes regular rounds for this purpose. Overhead frames and trapezes remain on ortho beds, ~~however (Do not apply excessive tape to splints. It is difficult to remove!)~~.

M. ORTHOTICS AND PROSTHETICS

- All over-the-counter inpatient equipment (~~e.g., i.e.~~ braces, immobilizers, ~~etc.~~) should be ordered through the Orthotics and Prosthetics service. Care must be

taken to ensure that the brace is the right size and length to fit the brace is the correct size and length for the patient.

2. Proper orders or requisition forms must be completed in the record, including the patient's name, medical record number, diagnosis (including side of injury), and correct brace type.

N. SURGERY

Phone: 415-206-8134 or 8138:

Perioperative Nursing Supervisor: Patty Nichols
 R.N.

O. PREOPERATIVE PREPARATION

1. Consultation with the attending is required before any patient is scheduled for surgery.
2. Scheduling (Emergency and Elective)
 - a. All cases should be scheduled through by consultation with the appropriate senior chief resident. The attendings should be informed when scheduled any case is scheduled under their name.
 - b. Scheduling forms (ZSFG and Ortho) must be completed in the medical record for all cases.
 - c. Monday and Thursday generally are Gold OR days. Tuesday and Wednesday generally are Blue OR days. Friday is both an OR Gold and Blue day.
 - d. Elective operating schedules must be given to the OR head nurse by 48 entered prior to before general release times for the ORs, or 72 hours prior to before surgery for the elective room, 12:00 noon the day before for 9th Room Cases, and 6:00 am the day of surgery for 8th Room Cases.
 - e. Non-urgent cases "added on" after that time will be scheduled in sequence by the OR as space and personnel permit.
 - f. Emergency cases must be scheduled through in Emergency cases must be scheduled in collaboration with the attending or service chief resident.
 - g. The consent form must be obtained prior to before booking, and the booked case must match the booking form.
3. Resident-specific responsibilities:
 - a. Residents will perform pre-operative notes on the night prior to before surgery for inpatients.
 - b. A member of the resident team should be present at the 6:30 a.m. huddle in the OR. Residents will see all first cases prior to before morning conference (6:45 a.m.) and verify that all required paperwork is complete and the patient is site marked the morning conference (6:45 a.m.) and verify that all required paperwork is complete and that the patient is site-marked. The site marking must be done by a provider that is licensed, and will be available for the time-out, and is-licensed provider who will be available during the time-out and capable of starting the procedure. The responsible resident will also perform the site markings, and confirm the paperwork is complete for all subsequent cases.
 - c. Residents will check with the attending pre-operatively to ensure that the surgical plan, including necessary instrumentation and positioning,

Formatted: Indent: Left: 0", Hanging: 1.5"

Formatted: Indent: Left: 0", Hanging: 2"

Formatted: Indent: Left: 0", Hanging: 2"

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 5 + Alignment: Left + Aligned at: 1.5" + Tab after: 2" + Indent at: 2"

Formatted: List Paragraph, Indent: Left: 1", Hanging: 0.75", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Tab after: 1.25" + Indent at: 1.25", Tab stops: 1.75", List tab + Not at 1.25" + 2"

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Indent: Left: 1.5", Hanging: 0.5", No bullets or numbering

is understood. The resident will go to the OR prior to before induction to ensure that the proper instrumentation is available.

d. Chief resident will act as the contact person for the OR that day and identify themselves with the OR prior to 7am at the 6:35 am huddle on weekdays. When possible, they will write the names of the attendings, fellows, and residents who will be scrubbing in on the case each day.

d. The cChief rResident for each team (Gold/Blue) will assign resident teams to each case and list the assigned residents on the weekly case list presented at the weekly conference. The cases listed will also list have the responsible attendings for each elective case listed cases will also include the responsible attendings for each elective. Every effort will be made to maintain the identified teams. A copy of the case list will be provided electronically (via secured e-mail) to the OR front desk after conference.

4. Attending-specific responsibilities:

a. Attending surgeon will complete or co-sign the surgery booking form, or the case will not be scheduled by the operating room. These sheets will be accurate and legible, and include all required instrumentation and desired positioning should check the OR scheduling to ensure proper booking.

b. Attending surgeon should check the room prior to before induction to verify that the proper implants are available for elective cases. For emergency cases, the attending will provide verbal confirmation to the relevant teams.

c. The OR aAttending of the day (the on-call attending or his designee) will be available to cover any emergency or trauma cases in OR 8; and be available for board management or patient-related questions. The AOD will rounds around at the 6:305 a.m. huddle.

d. Attending surgeons will see the patient pre-operatively, and they or their designees will see the patient post-operatively if an inpatient (no later than POD #1). A member of the orthopaedic team who will be present at the start of the case will perform site monitoring and complete the paperwork pre-operatively if it has not already been. They will perform the site monitoring and complete the paperwork if it is not already done. The patient will not be placed in the room until the attending has seen the patient sees the patient for elective cases. The attending will be available to go to the room OR when paged by the circulator that the patient is in the room.

e. The aAttending surgeon will discuss the case of the patient with the patient's family post-operatively (if they are available).

3. Informed Consent

a. Disclosure:ISCLOSURE

Discussion of the procedure with the patient by the physician who will perform or supervise the procedure. Use a hospital translator if necessary. Disclosure must include:

- Nature and goal of procedure
- Likelihood of achieving the goal
- Reasonable alternatives, both medical and surgical
- Risks that are serious and/or common

After disclosure, whether or not the patient agrees, the physician must summarize the discussion in the medical record.

b. WRITTEN CONSENT FORMConsent form:

- Perform afterAFTER disclosure

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Font: 10.5 pt

Formatted: Indent: Left: 1.5"

Formatted: Indent: Hanging: 0.5", Tab stops: Not at 1.5" + 2.5"

- time)
- Complete all relevant information spaces (including date and
 - Signed by patient (or legally appointed conservator)
 - Signature witnessed by another M.D. or SFGH ZSFG employee
 - Translator The translator must sign
 - Special rules for minors (see Hospital Policy Manual)
4. INCOMPETENT PATIENT Patient not competent to sign consent:
 Check or family or legal guardian (conservator)
- a. Emergency ~~MERGENCY~~: If delay or non-treatment ~~post-significant risk to life, limb or serious deterioration of the patient's condition, note this and poses a significant risk to life, limb, or serious deterioration of the patient's condition, note this and the~~ patient's non-lucidity in the record as justification for proceeding.
 - b. Non-emergency ~~ON-EMERGENCY~~:
 1. Obtain probate court order (slow--call Risk Management, x5125 or pager 997-9660, to initiate).
 2. Alternative: ~~—~~ If treatment cannot reasonably be delayed, one member of the medical staff must document in the medical record:
 - a) nature of risk from the delay of treatment, and
 - b) advantages of the proposed procedure.
5. Preoperative evaluation and note which must include indications for surgery as well as a list of potential likely complications. ~~—~~ This will be written by the resident or attending most involved with the procedure whenever possible.
6. Appropriate a ~~Anesthesia~~ consultations should be obtained early enough to permit optimal patient preparation and to prevent ~~last-minute~~ last-minute cancellation by Anesthesia because of an "incompletely evaluated patient."
7. Early a ~~Anesthesia~~ consultations are routine for patients with complicated medical problems, including those with cardio-respiratory, hepatic, renal, or diabetic problems, as well as Jehovah's Witnesses.
8. All elective patients scheduled through the clinic should be referred to the anesthesia pre-operative clinic. ~~Preoperative medical evaluations can be obtained via the Medical Consult Service. For outpatients, they run a Preoperative Evaluation Clinic. Call x8492 to schedule appointment 2-4 weeks before anticipated date of surgery. However, if the patient already has a primary physician, that physician should do the evaluation.~~
9. Preoperative planning must consider requirements for equipment, especially implants. Elective cases scheduled in the clinic must have the equipment required signed or initialed by the attending surgeon. ~~Elective cases scheduled in the clinic must have the equipment required signed or initialed by the attending surgeon.~~
10. The operating resident will review the patient, including x-rays, with the OR attending so that both may be involved in preoperative planning. The operating resident must know the anatomy, the surgical approach, the operative procedure, the indications and surgical approach, operative procedure, indications, and alternative methods of treatment ~~treatment methods~~.
11. Pre-operative notes should be written on for inpatients the night prior to before surgery. ~~Pre-operative notes should be written on for inpatients the night prior to before surgery.~~
12. Routine lab studies ~~(CBS, UA, EKG, LFT's, Lytes, Creatinine, clotting studies, etc.) should be ordered~~ as indicated. Blood should usually be typed and held, or cross-matched if a transfusion is anticipated. X-rays must pulled up be in the OR before the case is begun ~~pulled up be in the OR before the case begins~~.

132. Essential instruments and implants must be selected and sterilized. ~~You must know where equipment is kept, as the night shift nurses are often unfamiliar with orthopedic equipment. Routine cases will be picked by OR nurse.~~

143. Cast materials must be ready and outside the operating room until wound closure.

154. Preparation:REPARATION

- a. Shave (in OR) only when and where hair will impede closure. ~~Clipping should be performed when possible.~~
- b. ~~If skin is intact, use iodophor~~Standard prep ~~should be used~~ (Prepadine, Betadine, Ioprep, etc.) ~~which can be painted directly on open wound. Skin must be completely dry if adhesive drape is~~The skin must be completely dry for the adhesive drape to stick reliably.
- c. Drape according to standard sterile draping techniques.

Formatted: Indent: Left: 0", Hanging: 2"

15. PROTECTION FOR SURGEONSProtection:

- a. All surgeons must wear goggles, glasses, or a face shield for every case.
- b. Double gloves must be worn for every case.
- c. For cases with significant blood loss, each surgeon ~~should~~must wear:
 - 1) Double shoe covers
 - 2) ~~Knee-high~~Knee-high disposable boots
 - 3) Gowns with reinforced sleeves and front panel
 - 4) Extra sleeves
- d. The pulse lavage must be used with its splash shield. If none is available, the pulse lavage is not to be used. Irrigate with a bulb syringe.
- e. ~~Stackhouse~~surgical helmet systems are available for use on all high-risk cases. When scheduling cases, ~~tell OR you~~communicate that you want to use the ~~Stackhouse~~ systems.
- f. b. When operating on high-risk patients, the members of the surgical team should ~~consider the use of~~wear Kevlar gloves.

Formatted: Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 2 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75"

176. Prophylactic antibiotics are used for all clean surgical procedures when implant materials ~~are~~ used ~~unless otherwise indicated:~~

- 1 gram Kefzol IV with induction of anesthesia
- 1 gram Kefzol IV in PAR

Check for allergy and consult with ~~the~~ chief resident if needed.

187. ~~Antibiotics for open fractures should be started in the ED per protocol.~~OPEN

FRACTURE ANTIBIOTIC ROUTINE

Grade III open fractures:

~~add gentamicin i.v. 1mg per kg q 8 urs if renal fuction is normal~~

If gross dirt contamination:

~~add penicillin 2,000,000 units q 6 hours~~

~~START IN ER, AS SOON AS POSSIBLE, 1 gram Kefzol IV Q 6 hours for 48 hours. Then STOP.~~

Formatted: Indent: Left: 0", First line: 0"

~~At time of DPC, use prophylactic routine (#16).~~

19. ~~A member of the surgical team should b~~Be in the OR by 7:30 a.m. If a member of the surgical team ~~is not in the room~~there, the procedure cannot ~~not~~ start.

Formatted: List Paragraph, Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 19 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

18.20. ~~The patient must be site-marked~~site-marked prior to before surgery by a licensed practitioner who is capable of starting the case and will be present at the beginning of the case. ~~The attending must call in to the Operating Room by 7:15 the morning of the surgery.~~

Formatted: No underline

- 19.21. All hair and street clothing must be covered. A self-laundered scrub-cap can be used if covered up by a clean, disposable cap. Use hood, not cap alone a hood, not a cap alone, to cover all hair if exposed (a. —A sweatband helps with sweat).
- 20.22. If you leave OR in greens, wear a long gown closed in the front. A short white jacket does not prevent contamination of the front of your greens. When in doubt, change your greens. When in doubt, greens should be changed before beginning another case, particularly for in those cases that have been on contaminated or infected wounds or if the greens were worn outside of the operating room area. Greens should never leave the hospital campus (can be worn between they can be worn between the hospital and Bother campus buildings). uilding 9).
23. The operating resident for the next case should stay in the assigned operating room between cases to expedite room turnover. Patients in the pre-operative area should be checked by the surgical team. The surgical team should check patients in the pre-operative area for completion of paperwork, site marking, and desire to have additional questions answered prior to surgery in order to ensure no delay for to confirm paperwork completion, site marking, and any additional questions to be answered before surgery, to ensure the start of the next case is not delayed the start of the next case. The surgical team in the OR in which the patient is expected to enter will be notified by the holding area staff for patients with incomplete requirements so that this can be dealt with in order to avoid delays in room turnover where the patient is expected to enter will be notified by the holding area staff of patients with incomplete requirements, so this can be addressed to avoid delays in room turnover.
- 22.23. Masks should be changed between every case.
23. Shoe covers must be worn in the OR at all times. If you leave the OR, remove your shoe covers and replace them upon return to the OR.

24.

Formatted: List Paragraph, Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 19 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

Formatted: Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 19 + Alignment: Left + Aligned at: 1" + Indent at: 1.25"

Formatted: Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 19 + Alignment: Left + Aligned at: 1" + Indent at: 1.25", Tab stops: Not at 1.5"

For general anesthesia, monitored anesthesia care (MAC), and local anesthesia with sedation.

San Francisco General HospitalZuckerberg San Francisco General
 1001 Potrero Ave
 San Francisco, CA 94110

Age	NO FOOD*	CLEAR LIQUIDS ONLY**
Less than 6 months	4 hours before ~~the~~ procedure	2 hours
7 months to age 12	After midnight	2 hours
Age 13 and adjust	After midnight	4 hours
Age	NO FOOD*	CLEAR LIQUIDS ONLY**
Any age	4 hours (recommended light meal only)	Ad lib
* No food includes dairy products, infant formula, any unclear liquid, gum		
** Clear liquids include water, filtered ~~apple~~ -apple juice, cranberry juice, ~~and~~ breast milk		

1. ~~1. Brief operative note A brief or full operative note must be completed and signed in the placed in the medical record prior to the patient moving out of the pPerio-Operative cCare aArea.~~
If a brief operative note is completed immediately after a procedure rather than a full oOperative note, then the full oOperative note Must-must be dictated-completed and signed within 24 hours of the intra-operative procedure. on the Provisions system
2. ~~2. All new fellows, residents, and interns who are unfamiliar with the system should be trained within the first week of prior to their starting on the service.~~
3. At the time of surgery, the surgical team should identify the resident responsible for the surgical ~~dictation~~documentation. The surgical resident responsible for the dictation should be identified on the operative note.
4. ~~4. Attendings should submit the yellow copies to the Orthopaedic Department for billing purposes and monitoring the dictations.~~
5. ~~5. Operative notes must be dictated within 24 hours of the surgical procedure. Any undictated note greater than 5 days will result in suspension of surgical privileges. Any unsigned note greater than 5 days after its dictation also will result in suspension of surgical privileges.~~

~~Dial 187, your UC 4-digit number of 1111, 1 (designates Discharge Summary), patients "B" number. Begin dictation.~~

- 1) ~~Reason~~Reason for admission - discharge diagnosis
- 2) Significant findings (only pertinent or positive)
 - a. Physical findings
 - b. Lab results
 - c. X-ray findings
 - d. Other test performed
- 3) Brief hospital course
 - a. Treatment rendered or procedures
 - b. Response to treatment
- 4) Final diagnosis
- 5) Disposition of patient (to home, etc.)
- 6) Condition on discharge (i.e., for patients admitted with fever, state "patient afebrile")
- 7) Discharge medications
- 8) Follow-up plans/tests pending
- 9) Any special diet
- 10) Special instructions for physical activity

~~STAT REPORTS: After you dial the patient's "B" number, dial "O" + "O" for operator. Talk with operator, then dial "2" and dictate.~~

Formatted: Font: Bold

Formatted: List Paragraph, Indent: Left: 1", No bullets or numbering

Formatted: List Paragraph, Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1" + Indent at: 1.5"

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0.5", Hanging: 1", Tab stops: 1.5", Left + 2.5", Left

Formatted: Indent: Left: 0", First line: 0"

TO: DIAL:

Listen	1
Dictate	2
Reverse	3
	w
	or
	ds
	)
Pause	4
Fast forward	7
Rewind	6
	to
	be
	gi
	nn
	in
	g
	of
	re
	pe
	rt
End of report	5
Call operator	0 + 0
Insert*	0 + 6

* TO INSERT: Listen (1) to the point where the dictation is correct. Paul (4) the recorded. Touch 0 + 6 to record the insert. Paul (4) when insertion is finished.

4. After dictating the operative note, sign and dictate the blue sheet and place in box on 3B adjacent to resident boxes.
5. If an intern is the surgeon on a case, the op note must be dictated by the most senior resident on the case.
5. Do not sign any operative notes.

O.P. X-RAYS AND FLUOROSCOPY POST OPERATIVE X-RAYS

1. If indicated, obtain films in ~~OR before breaking~~ the OR before breaking the sterile shield or discontinuing anesthesia.
- X-rays are not permitted in the PACU unless required for immediate monitoring.
2. Only those orthopaedic practitioners with a California fluoroscopy supervisors licenses may operate a fluoroscopy unit.
3. Prior to Before the use of fluoroscopy, the operator must announce that this equipment will be used and must ensure that those exposed to potential radiation are protected with shielding, including the operator, the patient, and ancillary personnel.

3. ———

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0", First line: 0"

Formatted: No bullets or numbering, Tab stops: 1.5", Left

Formatted: Indent: Left: 0"

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Indent: Left: 0", Hanging: 1.5", No bullets or numbering

Formatted: Indent: Left: 0"

P. Q. CLINIC RULES

1. Arrive when the clinic starts.
2. ~~Records: Orthopedic Clinic Progress Record forms produce an automatic copy. Use ball-point pen. Provide all pertinent information. Are we mentioning anything here about dictating e-referrals, or new patients?~~ All patient visits, including new patient visits, should be dictated recorded on the hospital system according to the posted dictation instructions (initial consultation, final visits/discharge notes, and follow-up visits).
3. All Orthopedic Clinic records must remain there. If you must have it, a copy can be made by the through the clinic Ortho office secretary (3A36).
4. If x-rays or cast removal is planned for the next visit, indicate it on the Clinic Progress in the note so Record so those nurses may this can be arranged this before you see the patient at the beginning of the visit.
5. Most routine x-rays are done in the orthopaedic Ortho Clinic. Try to order these early.
6. Clinic has priority. Do not leave for ward work, etc., unless on call.
7. If you must leave for an emergency, tell the chief resident and nurse that you are leaving and why.
8. Obtain written consent for appropriate procedures, such as hardware removal, etc.

Q. CLINIC PAPERWORK

1. Registration slip: (billing slip goes to Hospital Accounting)
 - a. Dr.'s name and patient's diagnosis (essential)
 - b. Return visit date
2. Prescription slip:
 - a. One drug per form
 - b. Sign and print name, use UCSF ID number.
4. Others: Nurse will orient you.

R. ADMISSIONS FROM CLINIC

1. The nurse will assist with ~~arrangements for admission~~ admission arrangements.
2. The cChief rResident and appropriate service attending should be notified of these admissions immediately.

S. EMERGENCY ADMISSIONS

1. Do not hold ~~patient in clinic for the patient in the clinic for a~~ work-up that can be done later on the ward.
2. Patient will be interviewed by eligibility workers and transported to the ward. aken to ward.

T. ELECTIVE (FUTURE) ADMISSIONS

1. Schedule through the chief resident and attending.-
2. ~~Diagnosis, reason for hospitalization, procedure with CPT number (Clinic nurse will help), estimated length of stay, date of admission, date of surgery, ward, admitting M.D., attending M.D. signature.~~

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

3. ~~The TAR must be completed as early as possible for pre admission financial approval if applicable. Complete the proper documentation and orders on the electronic medical record.~~
4. ~~The patient should be evaluated by for eligibility and may be appropriate for referral to the pre-operative clinic. Patient is then interviewed by eligibility worker.~~
3. ~~5. The patient should report to ICI immediately for pre admit approval. be sent to the pre-operative clinic.~~

Formatted: Indent: Left: 0", Hanging: 1.5", No bullets or numbering, Tab stops: 1.5", Left

Formatted: Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 2 + Alignment: Left + Aligned at: 1" + Tab after: 1.5" + Indent at: 1.5", Tab stops: 1.5", Left

U. ~~ELECTIVE ADMISSIONS FOR COME AND STAY SURGERY~~

Formatted: Indent: Left: -0.5"

1. ~~Same MediCal form as above. Note "Come and Stay."~~
2. ~~Patients return to clinic and day before their surgery for 1) pre op H&P, labs, disclosure and documentation, consent form and 2) preoperative instructions by nurse.~~

Formatted: Indent: Left: -0.5"

V. ~~COME -AND-GO SURGERY IN SURGICENTER~~

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

1. ~~TAR patients as soon as possible.~~
2. ~~M.D./R.N. should must schedule with the Surgi Center at least 3 days in advance advance.~~
23. ~~In general: Local anesthesia: Labs only if indicated. Need written H&P, disclosure, and consent.~~
4. ~~General anesthesia: Same work-up and documentation as for Come and Stay.~~

Formatted: Indent: Left: 0", First line: 0"

Formatted: Indent: Left: 0", Hanging: 1.5", No bullets or numbering, Tab stops: 1.5", Left

V. ~~CLINIC DISCHARGE CRITERIA~~

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

1. ~~The patient has a musculoskeletal condition that could be addressed with surgery, but after. Still, after oOrthopaedic sSurgical cConsultation, the patient is not a surgical candidate or the patient decides she/he does not want surgery.~~
2. ~~The patient has a musculoskeletal condition that does not need or no longer requires further follow-up with an oOrthopaedic sSurgeon.~~
3. ~~For patients who are discharged via this mechanism, a discharge note will be available in the LCR clearly completed and signed in the medical record explaining why the patient is currently not a good surgical candidate and when to reconsider referring the patient back for surgical evaluation. Additionally, recommendations will be made for appropriate non-surgical management for appropriate non-surgical management will be provided.~~

Formatted: Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 1 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75"

Formatted: Font color: Black

Formatted: Font color: Black

Formatted: Font color: Black

Formatted: Indent: Left: 1", No bullets or numbering

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

W. ~~INFECTIONS~~

~~Infections involving joints or bone should be admitted or admitted to be consulted by Orthopaedic surgery unless a significant medical or extensive surgical condition exists, in accordance with the medicine-orthopaedic bones should be admitted or referred to orthopaedic surgery, unless a significant medical or extensive surgical condition exists, in accordance with the medicine-orthopaedic surgical guidelines.~~

X. ~~ORTHOPEDIC ORTHOPAEDIC~~ PEDIATRIC ADMISSIONS

Formatted: Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 16 + Alignment: Left + Aligned at: 0.5" + Indent at: 0.75"

1. ~~The orthopedic orthopaedic intern and resident work up the patient. Pediatric consultation is required on patients less than age 4 who are going to the OR.~~
2. ~~The orthopedic resident and intern will write the orders; progress notes and follows the patient daily musculoskeletal the musculoskeletal exam of the patient.~~

Formatted: Indent: Left: 1", Hanging: 0.5", No bullets or numbering, Tab stops: 1.5", Left

Formatted: Indent: Left: 1", Hanging: 0.5"

2. Pediatric patients are admitted to the pediatric service with oOrthopaedics providing the consultation.
3. Orthopaedic surgery service sees the patients daily, leaving a note on the patient and addressing any musculoskeletal issues.
4. Specific Service Responsibilities: Elective Surgeries, Emergency Admissions, Emergency Surgeries, and Transfers

Pediatrics:

- a. Serve as the service of record with a Pediatric attending as the attending of record
- b. Perform admission H&P and discharge summary/H&P
- c. Handle all medical orders including, but not limited to:
 - i. Diet (special restrictions)
 - ii. Medications, including pain medication
 - iii. Nursing Checks (specific parameters if applicable, etc.)
- d. WriteEnter discharge orders and prescriptions
- e. Assist with placement, if necessary
- f. Communicate with PCP

OrthopedicOrthopaedics:

- a. Serve as the consulting service with an Orthopedicorthopaedic attending serving as the consultant attending
- b. WriteEnter initial consultation note, including specific recommendations for:
 - i. PT and level of activity
 - ii. Additional nursing care needed for the specific type of injury (i.e., neurovascular checks, -etc-)
 - iii. Specific orthopedicorthopaedic orders/requirements (i.e., limb elevation, icing, etc).
- c. Directly communicate the management plan and treatment recommendations to the pediatric service upon admission and on a daily basisdaily, at a minimum
- d. Obtain consent, explain surgical procedures, and describe anticipated outcomes
- e. Be available to answer questions from the pediatrics service on a 24/7 basis and to answer the family's questions on a daily basisdaily
- f. Round and write daily notes in the medical record, including new orthopedicorthopaedic recommendations.
- g. For elective cases, assureensure pre-op medical H&P has been performed prior tobefore admission.
- h. Collaborate with the discharge planning process, including appropriate discharge date, discharge management plans, and orthopedicorthopaedic clinic follow-up.

Y. ORTHOPEDICORTHOPAEDIC FAMEDICINEMILY—INPATIENT SERVICE ADMISSIONS

1. Orthopaedic patients with acute medical issues while on the in-patient orthopaedic Ortho-sService will first be staffed by inpatient Medical Consult Service. For any straight-forwardchronic medical problems, the Medical Consult Service will continue to provide management help with Ortho serving as the primary care team of record. However, if deemed appropriateif an acute management issue arises, the patient will be transferred, there will be a very low threshold for transfer to the 3rd FIS teamMedicine inpatient service team for any patients with complex medical needs.
2. Each morning, the FIS HospitalistMedicine inpatient service will receive any new overnight transfers from the overnight hospitalist or Medicine

Formatted: List Paragraph, Indent: Left: 1", Hanging: 0.5", Numbered + Level: 1 + Numbering Style: 1, 2, 3, ... + Start at: 2 + Alignment: Left + Aligned at: 1.5" + Indent at: 1.75", Tab stops: Not at 1.5"

Formatted: Font: 11 pt

Formatted: List Paragraph, Indent: Left: 1.5", First line: 0"

Formatted: Indent: Left: 1.5", No bullets or numbering

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: List Paragraph, Indent: Left: 1.25"

Formatted: List Paragraph

Formatted: Font: 11 pt

Formatted: Indent: Left: 1.25"

Formatted: Font: Italic, Underline

Formatted: Font: Italic, Underline

Formatted: Font: 11 pt, Italic, Underline

Formatted: Indent: Left: 1.25", No bullets or numbering

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: List Paragraph, Indent: Left: 1.25", Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 2" + Indent at: 2.25"

Formatted: Font: 11 pt

Formatted: Indent: Left: 2.63", Numbered + Level: 3 + Numbering Style: i, ii, iii, ... + Start at: 1 + Alignment: Right + Aligned at: 3.13" + Indent at: 3.25"

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: List Paragraph, Indent: Left: 1.25", Numbered + Level: 1 + Numbering Style: a, b, c, ... + Start at: 1 + Alignment: Left + Aligned at: 2" + Indent at: 2.25"

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: List Paragraph, Indent: Left: 1.5", No bullets or numbering

Formatted: Normal, Left, Indent: Left: 1", Hanging: 0.5", No bullets or numbering, Tab stops: Not at 0.5" + 1" + 2" + 2.5" + 3"

- teams. Later in the morning, the FIS Hospitalist will quickly round with the Ortho NPs and/or intern to set the plan of care for the Ortho-related problems for patients on the 3rd FIS team.
3. In accordance with the interservice agreements, for patients over 80 or with acute medical conditions warranting admission and management, the Medicine inpatient service will be the primary service with the OrthopaedicThe FIS HospitalistMedicine inpatient service will be the primary caregiver with Ortho Surgery Service-serving as a-elose-consulting service for patients on the Medicine inpatient service3rd FIS team. Orthopaedic NPs -NPs and interns will coordinate the disposition plan and follow-up for any oOrthopaedic-related medical issues. Otherwise, the hospitalistMedicine inpatient service will manage all other aspects of care and discharge.
4. For overnight and weekend issues, the overnight medicinea inpatient serviceFIS Overnight hHospitalist can be the first "go-to" person for any acute medical issues that arise on the oOrthopaedic sService in-patients.

Formatted: Indent: Left: 1", Hanging: 0.5"

*San Francisco General HospitalZuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110*

Y. PATIENTS WITH SPINE INJURIES

2. Patients with spine injuries are admitted to Orthopaedic Surgery and Neurosurgery according to the call schedule (approximately 50% each).

Formatted: Left, Indent: Left: 0", Hanging: 1.5", Tab stops: Not at 0.5" + 1" + 1.5" + 2" + 2.5" + 3"

Formatted: Normal

San Francisco General HospitalZuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110

ATTACHMENT C -- ~~CLINICAL SERVICE CHIEF OF~~ ORTHOPEDICCORTHOPAEDIC SURGERY
JOB ~~Description~~DESCRIPTION

~~CLINICAL SERVICE CHIEF OF ORTHOPEDIC SURGERY SERVICE~~
JOB DESCRIPTION
March 19, 2002

Formatted: Left

Formatted: Left, Indent: Left: 0", Hanging: 1.5"

Chief of ~~Orthopedie~~Orthopaedic Surgery Clinical Service

Position Summary:

The Chief of ~~Orthopedie~~Orthopaedic Surgery ~~Clinical Service~~ directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of ~~San Francisco General Hospital~~Zuckerberg San Francisco General (SFGHZSFG) and the Department of Public Health (DPH). The Chief also ~~insures~~ ensures 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 ~~Orthopedie~~Orthopaedic Surgery ~~Clinical Service~~ reports directly to the UCSF Associate Dean ~~at ZSFG~~ and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed ~~not less than at least~~ every ~~five~~four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the UCSF Associate Dean ~~at ZSFG~~, the UCSF Department Chair, and the SFGHZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these ~~individuals~~persons and groups ~~and, as well as~~ with other clinical departments.

Position Qualifications:

The Chief of ~~the Orthopedie~~Orthopaedic Surgery Service is board-certified ~~Surgery Clinical Service~~ is board-certified, has a University faculty appointment, and is a member of the Active Medical Staff at SFGHZSFG.

The Chief of Orthopaedic Surgery Service or their designee is the Co-Fellowship Trauma Director, in collaboration with the appointed UCSF Trauma Service Director, if the individuals are different. The Chief must be capable of leading the orthopaedic trauma program and be accredited for the position by the Orthopaedic Trauma Association (OTA) (i.e., have completed an OTA-accredited fellowship or completed a fellowship experience recognized by the OTA, including grandfathered fellowships).

~~Major~~Major Responsibilities:

The major responsibilities of the Chief of ~~the Orthopedie~~Orthopaedic Surgery ~~Clinical~~ Service include the following:

*San Francisco General HospitalZuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110*

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 SFGHZSFG and the DPH;

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

In collaboration with the Executive Administrator and other SFGHZSFG 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 SFGHZSFG Medical Staff Bylaws.

**ORTHOPAEDIC SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
2026**

**ORTHOPAEDIC SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS**

I.	ORTHOPAEDIC SURGERY CLINICAL SERVICE ORGANIZATION	4
A.	SCOPE OF SERVICE.....	4
B.	MEMBERSHIP REQUIREMENTS	4
C.	ORGANIZATION OF ORTHOPAEDIC SURGERY CLINICAL SERVICE	4
II.	CREDENTIALING.....	5
A.	NEW APPOINTMENTS	5
B.	REAPPOINTMENTS	5
C.	AFFILIATED PROFESSIONALS.....	6
D.	STAFF CATEGORIES	6
III.	DELINEATION OF PRIVILEGES (REFER TO ATTACHMENT A)	6
A.	DEVELOPMENT OF PRIVILEGE CRITERIA.....	6
B.	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM	6
C.	CLINICAL PRIVILEGES.....	6
D.	TEMPORARY PRIVILEGES.....	6
IV.	PROCTORING AND MONITORING	7
A.	MONITORING (PROCTORING) REQUIREMENTS.....	7
B.	ADDITIONAL PRIVILEGES	7
C.	REMOVAL OF PRIVILEGES	7
V.	EDUCATION.....	7
VI.	ORTHOPAEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION	7
A.	SUPERVISION	7
B.	EDUCATIONAL ACTIVITIES.....	7
C.	EDUCATIONAL GOALS	8
D.	GUIDELINES	8
E.	DUTIES OF RESIDENTS (Specific Responsibilities)	9
VII.	ORTHOPAEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA.....	10
VIII.	DISCIPLINARY ACTION	10
IX.	PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT	11
A.	RESPONSIBILITY	11
B.	REPORTING	11
C.	CLINICAL INDICATORS	12
D.	CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES	12
E.	MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES	15
F.	MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE	12
X.	MEETING REQUIREMENTS	12
XI.	ADOPTION AND AMENDMENT	16

ATTACHMENT A– ORTHOPAEDIC PRIVILEGE REQUEST
FORM 14

ATTACHMENT B– ORTHOPAEDIC SURGERY POLICIES AND
PROCEDURES 20

ATTACHMENT C– CLINICAL SERVICE CHIEF OF ORTHOPAEDIC SURGERY JOB
DESCRIPTION 35

I. ORTHOPAEDIC SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Orthopaedic Surgery Service at Zuckerberg San Francisco General is organized along two axes: tertiary orthopaedic trauma care and general orthopaedics. The orthopaedic trauma service involves the treatment of complex injuries, such as pelvic and acetabular fractures, spinal fractures and dislocations, high-grade open fractures, and complex soft tissue injuries. The management of these complex injuries is comprehensive and greatly enhanced by the board-certified/board-eligible specialists and fellowship-trained subspecialists on the orthopaedic surgery service, including fellowship-trained orthopaedic surgeons in trauma, sports, spine, arthroplasty, foot and ankle, and hand, as well as in physical medicine and rehabilitation and podiatry. The general orthopaedic surgery services offered are comprehensive, covering all orthopaedic subspecialties except oncology and pediatrics, which specialists from UCSF cover.

As a member of the Orthopaedic Surgery Service, the board-certified physiatrist is also the Medical Director of the Rehabilitation Service for ZSFG and Laguna Honda Hospital (LHH). The service also has a fully equipped orthotics and prosthetics group, with experts in both.

B. MEMBERSHIP REQUIREMENTS

Membership on the ZSFG Medical Staff is a privilege that shall be extended only to those practitioners who are professionally competent and who continually meet the qualifications, standards, and requirements outlined in the ZSFG Medical Staff Bylaws, Rules and Regulations, and accompanying manuals, as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION OF ORTHOPAEDIC SURGERY CLINICAL SERVICE

Currently, the orthopaedic surgery clinical service at Zuckerberg San Francisco General largely is staffed by orthopaedic surgeons with 50% or more time effort, trauma fellows (who are Active ZSFG Medical Staff Members), hand surgeons, podiatrists, and physiatrists. UCSF surgeons staff pediatric and oncology clinics. Several volunteer surgeons assist in the clinics and ORs in the above areas. The attending physicians and podiatrists are responsible for daily attending rounds on both services, ensuring quality patient care, resident education, and the completion of attending notes. The orthopaedic trauma attendings provide orthopaedic and orthopaedic trauma primary and back-up call coverage; the hand call is split with the plastic surgery service and provided by the fellowship-trained hand surgeons; and the spine call is split with the neurosurgery service and provided by the fellowship-trained spine surgeons.

The administrative tasks at ZSFG are solely covered by the core attending physicians. ZSFG is a major public hospital with the complex problems of indigent care as well as the more routine problems of hospital management. The core staff is responsible for running the outpatient clinics, orthopaedic wards, and operating rooms, as well as addressing the utilization and service issues. In addition, there are multiple hospital committees, which require orthopaedic staff participation, all of which are the responsibility of the full-time staff.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

1. Board Certified or Eligible by the American Board of Orthopaedic Surgery, the American Board of Physical Medicine and Rehabilitation, or the American Board of Podiatric Surgery. Applicants not board-certified must document recent training and experience by providing a narrative of their clinical activities during the preceding two (2) years. They must also demonstrate current competence to the Chief of Service.
2. Current California Medical or Podiatric Licensure
3. Current DEA Certificate
4. Current X-Ray Certificate

B. REAPPOINTMENTS

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

1. Practitioners' Performance Profiles

Practitioner's performance profiles are determined and monitored in two ways. The hospital outpatient clinic services monitor outpatient encounters, and statistics are available via CPT codes. Inpatient services, including emergency room consultations, are monitored and counted according to different categories. Complications of all types are also compiled monthly and kept on file by the Service and in the Medical Staff Services Office.

2. Modification of Clinical Service

The Chief of Service first reviews a practitioner's request for a modification of clinical services in light of the generally accepted requirements (formal and practical) of the appropriate state and national associations/organizations. If the Chief of Service judges that the requested modification is reasonable, it is then discussed at a faculty meeting as necessary. If the faculty's consensus is favorable to such a modification, the Chief of the Clinical Service submits it to the ZSFG Credentials Committee for review and recommendation.

3. Staff Status Change

The process for Staff Status Change for members of the Orthopaedic Surgery Service is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

4. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Orthopaedic Surgery Clinical Services is in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

The Orthopaedic Surgery Clinical Service falls into the same staff categories as described in Article III – Categories of the Medical Staff of the ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

III. DELINEATION OF PRIVILEGES (Refer to Attachment A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Orthopaedic Surgery Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V: Clinical Privileges, Rules and Regulations, and accompanying manuals.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Orthopaedic Surgery Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Orthopaedic Surgery Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations, and accompanying manuals.

All requests for clinical privileges will be evaluated and approved by the Chief of Orthopaedic Surgery Clinical Service.

The process for modifying or changing the privileges of members of the Orthopaedic Surgery Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, and accompanying manuals.

D. TEMPORARY PRIVILEGES

Temporary Privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V: Clinical Privileges.

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Proctoring requirements for physicians who perform surgery on the Orthopaedic Surgery Clinical Service require that the Chief of Service, or designee, observe five (5) of the applicant's major surgical cases. Proctoring requirements for physicians who treat clinic

outpatients require that the Chief of Service or designee observe the practitioner in three (3) outpatient clinic settings and conduct retrospective reviews of the care provided to fifteen (15) outpatients.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Orthopaedic Surgery Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

The Orthopaedic Surgery Service at ZSFG offers high-quality educational activities, including at the postgraduate and undergraduate levels. It is one of the main teaching sites for the UCSF orthopaedic surgery residency program. The trauma group, also known as the Orthopaedic Trauma Institute (OTI), headquartered at ZSFG, has two non-ACGME fellows who rotate through the site. The service is also an important teaching site for the Department of Emergency Medicine. Furthermore, residents from the Departments of Family Medicine, Internal Medicine, and Pediatrics occasionally rotate through the orthopaedic outpatient clinics.

At the graduate level, the service also serves as the main teaching site for third-year UCSF medical students. It also offers rotations for UCSF fourth-year medical students, which occur throughout the academic year. Visiting medical students from US Medical Schools and other observers also rotate on the service.

VI. ORTHOPAEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. SUPERVISION

Attending faculty shall supervise house staff so that they assume progressively increasing responsibility for patient care in accordance with their level of training, ability, and experience.

B. EDUCATIONAL ACTIVITIES

Currently, there are eight orthopaedic residents on rotation at ZSFG, two residents from every Orthopaedic year PGY-2 through -5 at all times. There is also a varying number of interns (2-3) at any point in time. There are two orthopaedic trauma fellows on the Orthopaedic Surgery Service, with periodic clinical support from the UCSF Spine, Hand, and Vascular Surgery fellows. These trainees are divided into 2 teams and are providing emergency room coverage.

Resident teaching at ZSFG occurs in three ways:

- Interactive didactic sessions with faculty
- Clinical teaching in the operating room, inpatient ward, and clinics
- Hands-on teaching in the surgical training facility located at ZSFG
- Resident involvement in research projects.

Regular didactic sessions include:

- Daily on-call case review
- Weekly case conference attended by the residents, the full and part-time staff, which includes a post-operative trauma case review
- Weekly pre-operative case review
- Weekly Grand Rounds at UCSF
- Weekly specialty conference (foot and ankle, Morbidity and Mortality)
- Weekly trauma conference (didactic, journal club, bioskills exercises)

Regular research meetings are held with the full-time attending physicians, the research personnel, and the involved residents and medical students.

Medical students currently rotate at ZSFG through Surgical Specialties 110 (1 week) and 4-week optional electives.

C. EDUCATIONAL GOALS

The rotation on the Orthopaedic Surgery Service at Zuckerberg San Francisco General is primarily designed to provide the orthopaedic resident with an in-depth experience in operative and non-operative management of orthopaedic traumatology and general orthopaedic surgery. Emphasis is placed on the treatment of polytrauma victims as well as those with isolated injuries. In addition, significant exposure to general and other subspecialty orthopaedic conditions, based on outpatient clinical problems, including spine, sports, arthroplasty, foot and ankle, pediatrics, and hand surgery, is available. Thorough participation in ongoing clinics, programs, lectures, conferences, supervised patient care, and in-depth surgical experience provides orthopaedic residents with sufficient experience to manage a wide range of musculoskeletal diseases and conditions.

D. GUIDELINES

All orthopaedic residents are responsible for the day-to-day management of patients admitted to the Orthopaedic Service at Zuckerberg San Francisco General. Although the staff physician carries ultimate responsibility for patient care, it is expected that the fellows and residents will be intimately involved in patient care on an ongoing basis, making daily rounds and providing an ongoing continuum of care for inpatients. Decisions regarding admission and complications should be reported immediately to the staff physician. Residents will not operate independently unless in unusual circumstances, e.g., emergencies, and only if directed by the staff physician. History and physical examinations for new patient admissions are expected to be performed, generally by the junior resident. Still, they should be carefully evaluated and reviewed in detail by the service's chief resident. The chief resident, likewise, is responsible for examining the patient and taking a relevant history and should be available to assist the junior resident in directing the appropriate work-up, writing of specific orders as necessary, and requesting specific consults unless otherwise outlined by the staff physician.

It is stressed that the chief resident is ultimately responsible for the day-to-day care of patient management under the direction of the staff physicians. Should the first-year resident or the junior resident not be familiar with the plan of patient care or treatment protocols, it is the chief resident's responsibility to oversee these matters and to educate the junior resident as necessary. A smoothly functioning, competent surgical team

depends on the chief resident's interest, organizational skills, efficiency, knowledge, and communication skills. The nurse practitioners on the Orthopaedic Surgical Service will assist the surgical teams with patient care. The orthopaedic interns and residents are responsible for working closely with them to provide patient care on the service.

E. DUTIES OF RESIDENTS (Specific Responsibilities):

Also refer to the House Staff Competencies Link on the CHN Intranet Site

1. Patient Care Responsibilities

Orthopaedic residents are expected to make patient rounds at least once a day. It is anticipated that all residents on the service will make rounds in the early morning before attending the morning conferences. All patients should be seen, charts should be reviewed, orders written, dressings changed, consultations requested, and x-rays reviewed as necessary. The nurses should be advised of any problems or orders that require expeditious action. Rounds for problem patients should be repeated at the end of the day; postoperative checks should be performed on all patients, and postoperative notes should be signed and completed in the medical record before the residents depart for the evening. All postoperative x-rays should be reviewed, and relevant findings should be documented in service notes that are placed in the medical record. The status of the implants should be noted, or, in the case of total hip arthroplasty, for instance, a notation should be made that the x-rays reveal the hip implant is in a satisfactory position and remains reduced. A neurological-vascular check should be a standard part of the postoperative evaluation, and documenting that this has been examined, evaluated, and is normal or not should be included in the medical record. Any abnormalities should be reported to the staff physician immediately. A note must be written in the medical record each day. The chief resident or designee should write an initial evaluation note after the junior resident's history and physical exam. All patients scheduled for operative procedures must have a preoperative note that includes the patient's diagnosis, treatment alternatives, and documentation of informed consent. It is expected that the orthopaedic team will complete any necessary patient discharge documentation the evening before the patient's anticipated discharge. All discharge summaries must be completed within 24 hours of the patient's discharge. All patients should receive discharge instructions or After Visit Summary documents.

5. Clinic Responsibilities

All residents are expected to be present on time for clinical sessions. Clinic staff will discuss with the resident how they wish to run their particular clinic. In general, residents are expected to perform thorough history and physical examinations focused on the patient's orthopaedic problem. The staff physician assigned to the clinic is available for consultation and instruction at all times while the clinic is operating for residents to present patients. Residents will chart the clinic patients they see, and residents and attendings will comply with standard billing practices.

The emergency room resident is responsible for being present during their team's activities and for leaving for consults when paged. Coverage of the emergency room during these times is as assigned on the call schedule.

6. Surgical Responsibilities

Residents assigned to specific operative cases are expected to check that the required documentation, including history and physical (including interval history and physical) and consent, and that proper site marking has occurred. If the patient has questions regarding the procedure and would like to confer with the attending staff, the resident will inform the attending staff member. The resident is expected to confer with the attending staff regarding details of the procedure, including specifics about the operation, appropriate implants, and positioning. The resident is expected to arrive in the operating suite promptly when the patient is brought into the room to assist the anesthesiologist as necessary, facilitate patient positioning, arrange x-rays, double-check instruments, and perform time-outs, among other functions. They must have a thorough knowledge of anatomy, along with the procedure plan for the specific operation, and a knowledge of alternative surgical techniques for the management of that specific problem. Orthopaedic residents not well-versed in the relevant literature or the anatomy of the exposure to be performed or the planned procedure are unlikely to be given active involvement in the surgical case and, at best, would have a compromised educational experience. The extent of a resident's involvement in a specific operative procedure is, in a great part, dependent not only on the resident's natural ability, surgical knowledge, and skill, but also on their interest, desire, and preparation.

7. Conference Responsibilities

As an important part of the educational curriculum, daily conferences on specific topics are held, along with grand rounds each Wednesday at UCSF. These conferences are planned months in advance and carefully thought out by staff and senior residents regarding their educational content in relation to the overall educational curriculum. Residents are expected to attend these conferences and come prepared to discuss the subject matter and to engage in a healthy exchange of ideas and questions that would maximize attendees' educational experience. Case presentations at the weekly orthopaedic conferences are essential for discussing and analyzing current treatment rationale. If the junior resident is presenting cases, they should discuss the presentations with the chief resident before the conference as necessary, briefly review the relevant literature, and have a working knowledge of the expected treatments, complications, and outcomes. The chief resident should have a more detailed knowledge of the material and problem and be prepared to discuss in greater detail the current concepts of the problem being presented, its accepted treatment, and its complications.

VII. ORTHOPAEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

The Orthopaedic Surgery Service receives consultations from many different sources. For emergency room consultations, patients should be seen in accordance with the Emergency Department Diversion Reduction Initiative, which outlines that patients in the ED should be seen with a goal to respond to pages within 15 minutes, initially assess the patients within 30 minutes of the initial page, and disposition from the ED within 2 hours.

VIII. DISCIPLINARY ACTION

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

**IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION
MANAGEMENT**

A. RESPONSIBILITY

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

To ensure appropriate care and safety of all patients receiving care in the department, it is understood that this care is provided chiefly in the emergency room, the operating room, the inpatient nursing units, and the clinics.

To minimize morbidity and mortality and avoid unnecessary days of inpatient care, the Orthopaedics Clinical Service targets and contributes to the efficient delivery of patient services.

B. REPORTING

Performance Improvement/Patient Safety (PIPS) and Utilization Management activity records will be maintained by the Orthopaedic Clinical Service. Further, minutes will be sent to the Medical Staff Service Department and will include PIPS and Utilization Management information.

C. CLINICAL INDICATORS

The following clinical indicators are among those closely followed:

- Open fractures
- Antibiotic prophylaxis in patients
- Nosocomial infection rate by surgical categories (i.e., clean, contaminated, infected, and open fractures)
- Readmission rates following ORIF of fractures
- Professional behavior (e.g., SAFE reports)
- Deaths

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

The practitioner performance profiles are monitored by the outpatient clinic and inpatient statistics, as well as by the monthly M&M Review Board.

E. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

Monitoring and evaluating the appropriateness of patient care services are conducted daily. Each morning at 6:45 am, service attendings and all housestaff meet to discuss all emergency room consultations and admissions from the previous 24 hours, including their diagnostic evaluations, treatment plans (surgical and conservative), and discharge plans. Following these conferences, pre-operative and post-operative cases will be reviewed on Mondays and Tuesdays.

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1. Physicians/Affiliated Professionals

All professional staff, except the house staff, are evaluated annually by the Chief of Service and the Department Chairman. The faculty are regularly evaluated by residents and fellows during the academic year, according to UCSF Department of Orthopaedic Surgery policy.

2. Housestaff

Each resident is evaluated twice during their rotation. Once, in the middle of his/her rotation, constructive comments can be made following a performance evaluation, and again at the end of the rotation. At these meetings, attending staff can make suggestions to guide the resident in their self-improvement. At the end of the rotation, each resident undergoes a formal evaluation by the entire faculty. The findings are summarized on the appropriate form and forwarded to the Department's Chairman. These results are discussed semi-annually at the Department Chief of Service meeting.

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 processes of the Medical Staff by attending at least 50% of all assigned committee meetings, as well as clinical service meetings and the annual Medical Staff Meeting.

The Orthopaedic Surgery faculty shall meet monthly. Discussions will include monitoring and evaluating the quality and appropriateness of 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 AMENDMENT

The Orthopaedic Surgery Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Orthopaedic Surgery faculty annually during a faculty meeting.

XII. PATIENT INFORMATION

All patient-related health information will be treated with the utmost confidentiality, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) guidelines.

ATTACHMENT A– ORTHOPAEDIC SURGERY PRIVILEGES

Privileges for Zuckerberg San Francisco General

Requested Approved

Applicant: Please initial the privileges you are requesting in the Requested column.

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

OrthoSurg ORTHOPAEDIC SURGERY 2010 (MEC 08/10)

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.

28.00 GENERAL PRIVILEGES

Core privileges directed at the treatment of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities include the following treatments (other than those outlined for supplemental privileges):

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopaedic Surgery.

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

REAPPOINTMENT: 20 operative procedures in the previous two years.

_____	_____	A. Amputation, traumatic and elective
_____	_____	B. Application of skeletal traction
_____	_____	C. Arthrodesis
_____	_____	D. Arthroscopic surgery
_____	_____	E. Arthrotomy
_____	_____	F. Back and neck pain; chronic and acute
_____	_____	G. Biopsy of the musculoskeletal system
_____	_____	H. Bone graft
_____	_____	I. Contusion, sprains, and strains
_____	_____	J. External fixation of fractures
_____	_____	K. Fractures and dislocations, open or closed
_____	_____	L. Infection (surgical and medical treatment)
_____	_____	M. Injections (Joint, Bursa, trigger point, tendon sheaths)
_____	_____	N. Internal fixation of fractures
_____	_____	O. Ligament reconstruction
_____	_____	P. Osteotomy
_____	_____	Q. Osteotomy
_____	_____	R. Repair of lacerations
_____	_____	S. Revision of total hip and knee surgeries
_____	_____	T. Skin grafts
_____	_____	U. Spinal surgery (other than supplemental privileges)
_____	_____	V. Sports medicine and related injuries
_____	_____	W. Tenotomy and myotomy

Privileges for Zuckerberg San Francisco General

Requested Approved

- GG. Total joint surgery
- HH. Tumor surgery
- Z. Wound debridement
- aa. Management of orthopaedic conditions for patients in SNF Units
- bb. Major tumor resection

28.05 OUTPATIENT PRIVILEGES

Outpatient clinic privileges directed at the evaluation and diagnosis of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopaedic Surgery.

PROCTORING: 5 observed visits and 15 retrospective reviews visits

REAPPOINTMENT: 20 visits in the previous two years.

28.10 SPECIAL PRIVILEGES: SPINAL SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery and has completed fellowship training in spinal surgery or possesses equivalent experience.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Orthopaedic Surgery or designee.

REAPPOINTMENT: 20 procedures in the previous two years.

Patient management includes the areas specified below:

A. Complex anterior and posterior cervical, thoracic, and lumbar spinal surgery

B. Open reduction and internal fixation of spine fractures

C. Intra-discal chemonucleolysis

D. Percutaneous disk excision

28.20 SPECIAL PRIVILEGES: HAND AND MICROVASCULAR SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microvascular surgery or possesses equivalent experience.

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

REAPPOINTMENT: 20 operative procedures in the previous two years.

A. Microsurgery and replacement, replantation of limbs and parts, including adjacent and free tissue transfer.

B. Complex Hand Surgery and Replantation of Limbs and Parts

C. Use of operating microscope, repair blood vessel/nerve, digit replantation

D. Free muscle/skin flap microvascular anastomosis

28.30 GENERAL PODIATRIC PRIVILEGES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.

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

REAPPOINTMENT: 20 cases in the previous two years.

Simple outpatient procedures including:

Privileges for Zuckerberg San Francisco General

Requested Approved

- A. Nail avulsion
- B. Chemical Martisectomies
- C. Biopsy and debridement of cutaneous lesions, and simple infection process relative to nails and skin.

28.40 SURGICAL PODIATRIC PRIVILEGES

28.41 Category I: Podiatric Surgery

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.

PROCTORING: 5 observed cases and 15 retrospective reviews of procedures (Category I).

REAPPOINTMENT: 20 cases in the previous two years.

- A. Treatment of cutaneous lesions
- B. Removal of foreign bodies
- C. Removal of superficial debridements

28.42 Category II: Podiatric Surgery

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.

PROCTORING: 5 observed procedures and 15 retrospective reviews of procedures (Category 2).

REAPPOINTMENT: 20 procedures in the previous two years (Category 2).

Deep procedures of the forefoot including:

- A. Excision of soft tissue lesions
- B. Intermetatarsal neuromas
- C. Bunionectomies
- D. Capsulotomies
- E. Tenotomies
- F. Removal of foreign bodies of the forefoot
- G. Amputation
- H. Osseous procedures of the forefoot including sesamoidectomy
- I. Fusion of interphalangeal joints
- J. Osteotomies

29.00 PHYSICAL MEDICINE & REHABILITATION

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by

American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation, with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Performs basic procedures within the usual and customary scope of physical medicine and rehabilitation, including but not limited to diagnosis, management, treatment, and preventive care for adult and pediatric patients.

Procedures include:

- A. Intra-articular joint injection
- B. Intra-articular joint aspiration

The

Privileges for Zuckerberg San Francisco General

Requested Approved

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- C. Joint bursa aspiration
- D. Joint bursa injection
- E. Tendon sheath injection
- F. Trigger/Tender point injection
- G. Ganglion aspiration
- H. Nerve block
- I. Chemical neurolysis
- J. Neuromuscular junction block
- K. Autologous blood tendon injection
- L. Lumbar puncture
- M. Intrathecal pump management

29.10 SPINAL INJECTION TECHNIQUES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- A. Transforaminal epidural injection (selected nerve root block)
- B. Interlaminar epidural injection
- C. Facet joint injection
- D. Facet nerve block
- E. Discography
- F. Epidurolysis
- G. Sympathetic nerve block
- H. Sacroiliac joint injection
- I. Epidural blood patch
- J. Radiofrequency nerve ablation

29.20 SPINAL TECHNIQUES: SPECIAL PROCEDURES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

_____	_____
_____	_____
_____	_____
_____	_____

- A. Spinal cord stimulation
- B. Percutaneous vertebroplasty/kyphoplasty
- C. Implanted drug delivery for pain or spasticity
- D. Intradiscal electrothermal therapy

Privileges for Zuckerberg San Francisco General

Requested Approved

29.30 CLINICAL NEUROPHYSIOLOGY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

- A. Electromyography
- B. Nerve conduction study
- C. Somatosensory evoked potential assessment
- D. Electromyography/nerve conduction guided
- E. Guided nerve block
- F. Electromyography/nerve conduction guided junction nerve block

29.40 EVOKED POTENTIAL TESTING

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required.

PROCTORING: Review of 5 procedures and 15 retrospective reviews of procedures

REAPPOINTMENT: 20 operative procedures in the previous two years

30.00 ACUTE TRAUMA SURGERY

SCOPE: On-call trauma coverage for the comprehensive orthopaedic management of the acutely injured trauma patient.

PREREQUISITES: Completion of ACGME-approved residency with Board certification/eligibility in Orthopaedic Surgery. Availability, clinical performance and continuing medical education consistent with current standards for orthopaedic surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons.

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

REAPPOINTMENT: 20 operative procedures in the previous two years

31.00 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of orthopaedic Surgery, Plastic Surgery, Podiatric Surgery, or the American Board of Physical Medicine & Rehabilitation, or a member of the Clinical Services prior to 10/17/00. A current x-Ray/Fluoroscopy Certificate is required.

PROCTORING: Presentation of valid California Fluoroscopy certificate

REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.

Privileges for Zuckerberg San Francisco General

Requested Approved

32.00 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 Orthopaedics or a member of the Clinical Service prior to 10/17/00, 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 (completed training within the last 5 years)

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

I hereby request clinical privileges as indicated above.

Applicant

date

FOR DEPARTMENTAL USE:

_____ Proctors have been assigned for the newly granted privileges.

_____ Proctoring requirements have been satisfied.

_____ Medications requiring DEA certification may be prescribed by this provider.

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

_____ CPR certification is required.

_____ CPR certification is not required.

APPROVED BY:

Division Chief

date

Service Chief

PRINTED 6/24/2013

date

**ZUCKERBERG SAN FRANCISCO GENERAL ZUCKERBERG SAN FRANCISCO GENERAL
ATTACHMENT B– ORTHOPAEDIC SURGERY POLICIES AND PROCEDURES**

A. EMERGENCY ROOM COVERAGE

1. Representative, usually house staff, should respond immediately to ER consultation.
2. The Orthopaedic Surgery Service administration will confirm that:
 - a. The names and contact information are listed correctly on the call schedule
 - b. the contact information for those on call for resident (intern, junior, and senior), fellow, and faculty (general orthopaedic surgery/trauma, spine, and hand) is accurate (e.g., beeper, if applicable, and cell phone) on the call schedule.
3. The residents assigned to the ER on days should be available from 7:00 a.m. until 7:00 a.m. the following day, depending on their call assignment.
4. The resident on call on holidays covers the ER during the day and night.
5. The attendings for general call will have call shifts that are for day coverage (attending of the day; AOD) and night coverage (attending of the night; AON), with shifts from 7:00 a.m. to 6:00 p.m and 6:00 p.m to 7:00 a.m., respectively.
5. PATIENT TREATMENT REGISTER:
 - a. All outpatients must be recorded on the electronic “Patient Log” by the Orthopaedic Emergency Room Resident.
 - b. All admissions with orthopaedic problems (whether admitted to the Orthopaedic Surgery Service or other service) must also be recorded on the appropriate patient list.
 - c. Acute conditions (e.g., fractures, dislocations, infections) shall be evaluated prior to given disposition discharge instructions from the ED. Orthopaedic Surgery residents should participate in the scheduling of outpatient follow-up scheduling of patients seen in the ED.
6. EMERGENCY TREATMENT POLICIES:
 - a. Junior orthopaedic surgery residents on call should consult immediately with Chief Resident regarding any potential surgical case.
 - b. The junior resident on call should consult the Chief Resident prior to making disposition plans in which they are unsure.
 - c. The on-call junior resident should notify the Chief Resident immediately of all admissions to their service. The Chief Resident should notify the attending on call of all admissions to their service or cases scheduled.
 - d. Residents should document their consultation note in the medical record and review all patient cases the following morning in fracture rounds with the attending who was on-call or the current AOD. All consultations (ER & inpatient) must be reviewed by an attending prior to the on-call resident leaving the hospital post-call (no later than 8 a.m. the following day).
 - e. When in doubt, the junior resident should ask the Chief Resident to personally see the patient and/or the imaging studies (e.g., compression fractures of the spine, patients unable to walk or care for themselves safely in casts, potential compartment syndromes, “disposition problems” whose diagnoses are orthopaedic).
 - f. ER Records: An orthopaedic surgery consult note must be written and signed in the medical record for each patient seen. The records should include medications given and procedures done for patients admitted to the hospital or sent home with follow-up instructions (including clinic

- follow-up). For admissions, the attending of record must review the consult, see the patient within 24 hours of admission, and complete an attending attestation in the medical record.
- g. Orthopaedic Surgery residents are responsible for the consultations in the ER.
 - h. Orthopaedics & Neurosurgery should be called for consults according to the spine call schedule.
 - i. Orthopaedics & Plastics should be called for consults according to the hand call schedule.
7. Avoid “curbside” consultation--it is usually not optimal for the patient.

B. EMERGENCY ADMISSIONS

1. EMERGENCY ORTHOPAEDIC ADMISSIONS

- a. Emergency admissions are assigned to the service on call for that day, with the following exceptions:
 - 1) Patients requiring emergency surgery will be cared for by the team performing the operation.
 - 2) Re-admissions for the same problem will return to their previous team.
 - 3) Patients seen from 6 p.m. to 7 a.m. the night prior will be reviewed by and admitted to the attending of the day (AOD), who will be covering the OR during the following day, unless otherwise arranged.
- b. Residents should complete ER admission documentation at the time of admission, including admission orders and a complete history and physical examination.
- c. Direct admissions/transfers from other hospitals are welcome and encouraged. They must be approved first by an attending, who will arrange the transfer with the ZSFG eligibility/transfer coordinator (for inpatient-to-inpatient transfers) or the ED attending (for ED-to-ED transfers). Make note of the patient's diagnosis, the reason for transfer, the type of bed required (ICU, step-down, etc.), and the optimal timing for surgery. The attending of record should be consulted if patients are transferred out of the ED, including pediatric patients.

2. ADMISSIONS TO OTHER SERVICES

There must be:

- a. A note in the medical record clearly defining the patient's orthopaedic problems and treatment, provided or recommended.
- b. Clear indication of which orthopaedic team is involved.
- c. Verbal communication with the responsible senior or chief resident of the admitting service to ensure proper communication and discussion of medical plans.
- d. Patient admissions and transfers should adhere to the general guidelines established between the various services, including trauma and medicine.
- e. While on another service, the patients consulted on will be followed at least daily by the appropriate orthopaedic team, until the patient is stable for sign-off.

- f. Children with orthopaedic problems requiring hospitalization will be admitted to the pediatric ward under the primary care of the Pediatric Service who must be notified immediately about any admission and must see the patient in the ER. Orthopaedic Surgery Service house staff may assist with the care of these patients.

C. NIGHT AND WEEKEND COVERAGE

1. The assigned junior resident and intern must stay in the hospital.
2. When a new junior resident assumes night/weekend call, the chief resident may also remain in the hospital to provide immediate backup. These requirements may be discontinued only by mutual agreement of the chief resident and service chief.
3. Before leaving for the day, interns will sign out their patients with the intern and/or nurse practitioner on duty.
4. Night call is the responsibility of the person on the call schedule. If the scheduled resident on call needs to be off for any reason, it is their responsibility to ensure the time is covered by another house officer of the same level who agrees to cover. The chief residents must approve of a switch in night call. Other team members, orthopaedic surgery administrators, telephone operators, and the ER must be notified of any deviation from the Department's published schedule.
5. Questions regarding the call schedule should be directed to the Chief of Service.

D. VACATIONS

1. Resident vacations should be scheduled 6 weeks in advance and should be done through the protocol established through the UCSF Department of Orthopaedic Surgery Department, which includes approval from the service's chief resident, chief of service, and residency coordinator. Vacations consist of 5 consecutive working days and cannot exceed that time during the rotation. An additional 5 days of educational leave may be granted in addition to the vacation time. Leave should not exceed 10 working days, unless specifically cleared with the Chief of Service and the UCSF Department of Orthopaedic Surgery Residency Director.
2. Residents can request vacation at ZSFG in accordance with the Department of Orthopaedic Residency requirements. Vacation will be granted and scheduled on a first-come, first-served basis. The rotations at ZSFG allow for only one resident to be gone at a time. Exceptions will be considered for very important educational events or personal issues. They must be approved by both the service chief residents and the faculty from the service affected by the leave. If this exceptional leave is granted, the residents must be seniors and juniors from different teams. Leave generally will not be granted for the first week of any rotation, during the Christmas Holiday or New Year's (when coverage teams are formed, allowing for every team member to have an equal number of designated, non-vacation days off), or the first/last weeks of the academic year.

E. ORTHOPAEDIC TEAM ROUNDS

1. Each chief resident will round with their team on all their patients daily, before consult rounds (except Wednesdays when the residents should attend Grand Rounds and the rounding is performed by the in-house residents on call, inpatient service Nurse Practitioners, and a fellow). Patient visits must include an opportunity for the patient to discuss their care with team members. Patients should know their assigned team, the name of their chief resident, attending, and at least one other M.D. on the team.
2. A patient's perception of his physician as "insensitive" or "unprofessional" is a frequent precursor of patient complaints and medicolegal issues. Acknowledge the patient before examination or bedside discussion of problems. Service providers

are urged to listen to patients and take an interest in their personal lives, concerns, and well-being whenever possible.

3. Rounds must begin early enough so the residents can see and assess each patient.
4. WEEKENDS AND HOLIDAYS, the service the residents will be responsible for making rounds on patients from both teams, doing necessary ward work, writing notes, and reporting problems to the team on duty. The residents will subsequently conduct rounds with the on-call attending.
5. ATTENDING MULTIDISCIPLINARY WARD ROUNDS, followed by a review of all consults daily. Before these rounds, patients will have been seen on regular work rounds by the resident teams.

F. WARD PROCEDURES

1. MEDICAL RECORDS:
 - a. A history and physical will be documented for each patient on admission by the intern or junior housestaff, who will enter orders after consulting with a senior resident.
 - b. There must be a resident note for each patient confirming pertinent history, physical examination, lab and x-ray findings, and given clearly recorded diagnoses and plans completed and signed in the medical record.
 - c. Any procedure (e.g., case change, closed reduction) must be recorded in the patient's medical record along with other notable findings (e.g., physical findings, post-reduction x-rays). Operative notes can be completed directly in the electronic health record or dictated as necessary.
 - d. Progress notes by the residents should be completed daily on each patient, and dated and signed.
 - e. There should be an interval history/preoperative note written in the medical record less than 24 hours before any elective procedure.
2. ORDERS
 - a. All orders will be entered completely.
 - b. Verbal orders must be countersigned within 24 hours.
 - c. Provide adequate pain medication—pre-medicate before a painful procedure. Do not hesitate to consult the pain management service.
 - d. All medication orders must be reviewed regularly.
 - e. All orders must be reconciled at the time of surgery and on inter-service transfer.
 - f. X-rays and lab studies must be ordered in the medical record. Practitioners should not order unnecessary (routine) blood work or x-rays.
 - g. All instructions for the cast technician or braces must be recorded in the medical record, just as any other order.
3. DISCHARGE RECORDS
 - a. The attending is responsible for the correctness of recorded discharge diagnoses.
 - b. A brief discharge summary will be done for each patient. This must record at least the patient's diagnoses, including date of injury, operations performed with dates, problems encountered, if any, and plans for further care and follow-up.
 - c. If a patient is transferred to another hospital or physician, a telephone conversation must occur between the receiving orthopedist and a senior

orthopaedic team member to discuss the patient's diagnoses, condition, treatment undertaken and transfer arrangements. This conversation, including the name, address, and phone number of the receiving orthopedist, must be recorded in a note within the medical record. A discharge summary and pertinent x-rays or access to their medical record should accompany transferred patients.

- d. Discharge instructions and/or After Visit Summary and/or Interfacility Transfer Summary will be provided at the time of discharge and will be recorded in the patient's medical record.

G. DISCHARGE PLANNING

1. Patient's needs for discharge planning at the time of admission should be anticipated. If a patient is not certain to be discharged ambulatory and independent, consult the social worker and/or discharge planner as soon as possible.
2. Gait training or other physical therapy before the planned time of discharge should be performed.
3. Patients should be informed as soon as possible about a planned discharge date and of any changes.
4. Visiting nurse services may permit discharge home where visiting PT may also be arranged.
5. Laguna Honda Hospital (county facility) has a limited number of acute and chronic rehabilitation beds. Laguna Honda Hospital staff will screen all prospective patients for the rehabilitation ward before admitting them. Patients must need rehabilitation services, be willing and able to participate, and have an appropriate discharge plan from LHH.
7. The social worker will arrange the LHH rehabilitation evaluation for a patient upon request of the Orthopaedic team.
8. The ZSFG Orthopaedic Service has a weekly follow-up clinic at LHH alternating between the two services. One attending staff member attends these clinics.
9. If a patient is accepted for transfer to the LHH rehabilitation ward, a discharge summary must be completed and signed in the medical record before discharge. It must include the following:
 - a) Follow-up.
 - b) Explicit physical therapy and activity orders, including weight-bearing status.
 - c) Notation of any x-rays desired to be done before the first LHH Orthopaedics clinic, in which the patient will be seen.

H. COMPLETION OF MEDICAL RECORDS

1. A discharge summary should be completed and signed in the medical record before the patient is discharged.
2. Brief operative and operative notes must be completed and signed prior to a patient moving out of the perioperative care area. If a Brief Operative note is completed immediately following a procedure, then the comprehensive Operative Note must be completed and signed into the medical record within 24 hours following the procedure. The attending must attest to the operative notes written by the resident/NP/fellow within 3 days. Any delinquent notes will result in suspension of surgical privileges.

3. Clinic visits should be seen with an attending when possible. Medical students' notes do not substitute for resident and faculty notes. All clinic notes should be signed within a week.
3. Hospital privileges may be suspended for any physician who fails to complete required documentation within the designated time.

I. INFECTION PREVENTION

1. All needle sticks and body fluid contamination must be reported as soon as possible. Report to OHS for instructions on appropriate testing and counseling.
2. Handwashing and good dressing techniques are the keys to preventing the transfer of pathogenic bacteria from patient to patient.
3. The use of gloves is required for all wounds, all dressings, and when touching any linens, gowns, or clothing that may be soiled with blood or body fluids. Hand washing is required after touching each patient, even if gloves were worn. See Infection Control documentation on the SFDPH website.
4. Patients with planned or recent clean surgical procedures must not be admitted to rooms that also house patients with infected, draining wounds.

J. PRESSURE SORES & CONTRACTURES

1. Immobilized patients may develop pressure sores, contractures, and other problems. Patients who cannot relieve focal pressure by moving in bed, or who have insensible skin, are most at risk. For others, mobility aids will increase morale.
2. Unless sitting, trunk flexion, or loading of arms, is contraindicated, an overhead frame and trapeze should routinely be provided.
3. Pressure sores typically develop on the sacrum, lateral buttocks, and heels. Rolling the patient every 2 hours, maintaining dry, clean sheets, and using additional padding (e.g., a foam egg-crate mattress pad) over the firm hospital mattress are standard. Additionally, a pillow placed longitudinally under the calf (not under the knee) with the heel hanging over the end will prevent heel pressure sores.
4. Patients in traction usually can be turned 30 degrees side-to-side, but if they cannot be turned enough to unload their sacrum, prompt use of an air bed before pressures develop is effective.

K. PLASTER

1. Plastic-covered pillows or any other plastic material should not be placed next to setting plaster. If the patient c/o burning, the cast or splint should be removed immediately.
2. Circumferential casts and splints can cause excessive pressure on a limb, especially a recently injured one with increasing swelling. Adequate padding is required to allow the case to be split without skin trauma.
3. Cast univalving or bivalving should be done the full length of the case, dividing padding as well as plaster. The cast must then be spread to loosen it.
4. Interns should check with the resident before opening a cast. Casts should not be opened directly over a traumatic or operative wound.
5. Casts should generally be sawed open outside the OR to minimize airborne dust.
6. Major cast work (spica, body jacket, etc.) should be planned and scheduled in accordance with the Chief Resident and ortho technician the preceding day.

7. Inpatient cast work must not be done in the ER or the clinic. If prompt x-ray control or anesthesia is required, such plaster work is best done in the OR, as the floor cannot accommodate conscious sedation.
8. Cast technician duties include collecting treatment equipment, setting up traction, applying overhead frames, applying routine casts and splints, and assisting with casts and cast braces.
9. Maintain reasonable cleanliness in the Cast Room.
10. Stamp and fill out cast room slips for all procedures done and equipment handed out (crutches, braces, etc.). Billing slips are required to obtain insurance payments for the hospital.
11. Plastic cast material is available in limited amounts for patients with appropriate indications.
12. Return all orthopaedic equipment to the area from which it is borrowed. If something is missing or broken, inform the cast technician.

L. TRACTION SUPPLIES

1. Traction supplies (rope, splints, fleece slings, weight bags, overhead frames and pulleys, etc.) are stored on 3B. The 3B cast technician is responsible for keeping this material clean and orderly.
2. Traction equipment should be removed from beds when no longer needed. The orthopaedic technician makes regular rounds for this purpose. Overhead frames and trapezes remain on ortho beds.

M. ORTHOTICS AND PROSTHETICS

1. All over-the-counter inpatient equipment (e.g., braces, immobilizers) should be ordered through the Orthotics and Prosthetics service. Care must be taken to ensure the brace is the correct size and length for the patient.
2. Proper orders must be completed in the record.

N. SURGERY

Phone: 415-206-8134

Perioperative Nursing Supervisor:

Patty Coggan, R.N.

O. PREOPERATIVE PREPARATION

1. Consultation with the attending is required before any patient is scheduled for surgery.
2. Scheduling (Emergency and Elective)
 - a. All cases should be scheduled through consultation with the appropriate senior resident. The attendings should be informed when any case is scheduled under their name.
 - b. Scheduling forms (ZSFG and Ortho) must be completed in the medical record for all cases.
 - c. Monday and Thursday generally are Gold OR days. Tuesday and Wednesday generally are Blue OR days. Friday is both an OR Gold and Blue day.

- d. Elective operating schedules must be entered before general release times for the ORs, or 72 hours before surgery for the elective room, and 6:00 am the day of surgery for 8th Room Cases.
 - e. Non-urgent cases “added on” after that time will be scheduled in sequence by the OR as space and personnel permit.
 - f. Emergency cases must be scheduled in collaboration with the attending or service chief resident.
 - g. The consent form must be obtained before booking, and the booked case must match the booking form.
3. Resident-specific responsibilities:
- a. Residents will perform pre-operative notes on the night before surgery for inpatients.
 - b. A member of the resident team should be present at the 6:30 a.m. huddle in the OR. Residents will see all first cases before the morning conference (6:45 a.m.) and verify that all required paperwork is complete and that the patient is site-marked. The site marking must be done by a licensed provider who will be available during the time-out and capable of starting the procedure. The responsible resident will also perform the site markings and confirm the paperwork is complete for all subsequent cases.
 - c. Residents will check with the attending pre-operatively to ensure that the surgical plan, including necessary instrumentation and positioning, is understood. The resident will go to the OR before induction to ensure that the proper instrumentation is available.
 - d. Chief resident will act as the contact person for the OR that day and identify themselves with the OR at the 6:35 am huddle on weekdays.
 - d. The chief resident for each team (Gold/Blue) will assign resident teams to each case and list the assigned residents on the weekly case list presented at the weekly conference. The listed cases will also include the responsible attendings for each elective.
4. Attending-specific responsibilities:
- a. Attending surgeon should check the OR scheduling to ensure proper booking.
 - b. Attending surgeon should check the room before induction to verify that the proper implants are available for elective cases. For emergency cases, the attending will provide verbal confirmation to the relevant teams.
 - c. The OR attending of the day (the on-call attending or his designee) will be available to cover any emergency or trauma cases in OR 8 and be available for board management or patient-related questions. The AOD will round at the 6:30 a.m. huddle.
 - d. Attending surgeons will see the patient pre-operatively, and they or their designees will see the patient post-operatively if an inpatient (no later than POD #1). A member of the orthopaedic team who will be present at the start of the case will perform site monitoring and complete the paperwork pre-operatively if it has not already been done. The patient will not be placed in the room until the attending has seen the patient for elective cases. The attending will be available to go to the room when paged by the circulator that the patient is in the room.
 - e. The attending surgeon will discuss the case of the patient with the patient’s family post-operatively (if they are available).
3. Informed Consent
- a. Disclosure:

Discussion of the procedure with the patient by the physician who will perform or supervise the procedure. Use a hospital translator if necessary. Disclosure must include:

- Nature and goal of procedure
- Likelihood of achieving the goal
- Reasonable alternatives, both medical and surgical
- Risks that are serious and/or common

After disclosure, whether or not the patient agrees, the physician must summarize the discussion in the medical record.

b. Consent form:

- Perform after disclosure
- Complete all relevant information (including date and time)
- Signed by patient (or legally appointed conservator)
- Signature witnessed by another M.D. or ZSFG employee
- The translator must sign
- Special rules for minors (see Hospital Policy Manual)

4. Patient not competent to sign consent:

Check or family or legal guardian (conservator)

a. Emergency: If delay or non-treatment poses a significant risk to life, limb, or serious deterioration of the patient's condition, note this and the patient's non-lucidity in the record as justification for proceeding.

b. Non-emergency:

1. Obtain probate court order (slow--call Risk Management, x5125 to initiate).
2. Alternative: If treatment cannot reasonably be delayed, one member of the medical staff must document in the medical record:
 - a) nature of risk from the delay of treatment, and
 - b) advantages of the proposed procedure.

5. Preoperative evaluation and note which must include indications for surgery as well as a list of potential complications. This will be written by the resident or attending most involved with the procedure whenever possible.

6. Appropriate anesthesia consultations should be obtained early enough to permit optimal patient preparation and to prevent last-minute cancellation by Anesthesia because of an "incompletely evaluated patient."

7. Early anesthesia consultations are routine for patients with complicated medical problems, including those with cardio-respiratory, hepatic, renal, or diabetic problems, as well as Jehovah's Witnesses.

8. All elective patients scheduled through the clinic should be referred to the anesthesia pre-operative clinic.

9. Preoperative planning must consider requirements for equipment, especially implants.

10. The operating resident will review the patient, including x-rays, with the OR attending so that both may be involved in preoperative planning. The operating resident must know the anatomy, surgical approach, operative procedure, indications, and alternative treatment methods.

11. Pre-operative notes should be written for inpatients the night before surgery.

12. Routine lab studies (CBS, UA, EKG, LFT's, Lytes, Creatinine, clotting studies, etc.) should be ordered as indicated. Blood should usually be typed and held, or

- cross-matched if a transfusion is anticipated. X-rays must be pulled up in the OR before the case begins.
13. Essential instruments and implants must be selected and sterilized.
 14. Cast materials must be ready and outside the operating room until wound closure.
 15. Preparation:
 - a. Shave (in OR) only when and where hair will impede closure. Clipping should be performed when possible.
 - b. Standard prep should be used (Prepadine, Betadine, Ioprep, etc.). The skin must be completely dry for the adhesive drape to stick reliably.
 - c. Drape according to standard sterile draping techniques.
 15. Protection:
 - a. All surgeons must wear goggles, glasses, or a face shield for every case.
 - b. Double gloves must be worn for every case.
 - c. For cases with significant blood loss, each surgeon should wear:
 - 1) Double shoe covers
 - 2) Knee-high disposable boots
 - 3) Gowns with reinforced sleeves and front panel
 - 4) Extra sleeves
 - d. The pulse lavage must be used with its splash shield. If none is available, the pulse lavage is not to be used. Irrigate with a bulb syringe.
 - e. Surgical helmet systems are available for use on all high-risk cases. When scheduling cases, communicate that you want to use the systems.
 - b. When operating on high-risk patients, the members of the surgical team should consider the use of Kevlar gloves.
 17. Prophylactic antibiotics are used for all clean surgical procedures when implant materials are used unless otherwise indicated:
 - 1 gram Kefzol IV with induction of anesthesia
 - 1 gram Kefzol IV in PARCheck for allergy and consult with the chief resident if needed.
 18. Antibiotics for open fractures should be started in the ED per protocol.
 19. A member of the surgical team should be in the OR by 7:30 a.m. If a member of the surgical team is not in the room, the procedure cannot start.
 20. The patient must be site-marked before surgery by a licensed practitioner who is capable of starting the case and will be present at the beginning of the case.
 21. All hair and street clothing must be covered. A self-laundered scrub cap can be used if covered up by a clean, disposable cap. Use a hood, not a cap alone, to cover all hair if exposed (a sweatband helps with sweat).
 22. When in doubt, greens should be changed before beginning another case, particularly for those cases that have been on contaminated or infected wounds or if the greens were worn outside of the operating room area. Greens should never leave the hospital campus (they can be worn between the hospital and other campus buildings).
 23. The operating resident for the next case should stay in the assigned operating room between cases to expedite room turnover. The surgical team should check patients in the pre-operative area to confirm paperwork completion, site marking, and any additional questions to be answered before surgery, to ensure the start of the next case is not delayed. The surgical team in the OR where the patient is expected to enter will be notified by the holding area staff of patients with incomplete requirements, so this can be addressed to avoid delays in room turnover.
 23. Masks should be changed between every case.

24. Shoe covers must be worn in the OR at all times. If you leave the OR, remove your shoe covers and replace them upon return to the OR

For general anesthesia, monitored anesthesia care (MAC), and local anesthesia with sedation.		
Age	NO FOOD*	CLEAR LIQUIDS ONLY**
Less than 6 months	4 hours before the procedure	2 hours
7 months to age 12	After midnight	2 hours
Age 13 and adjust	After midnight	4 hours
Age	NO FOOD*	CLEAR LIQUIDS ONLY**
Any age	4 hours (recommended light meal only)	Ad lib
* No food includes dairy products, infant formula, any unclear liquid, gum		
** Clear liquids include water, filtered apple juice, cranberry juice, and breast milk		

OPERATIVE REPORTS

1. A brief or full operative note must be completed and placed in the medical record prior to the patient moving out of the perioperative care area.
2. If a brief operative note is completed immediately after a procedure rather than a full operative note, then the full operative note must be completed and signed within 24 hours of the intra-operative procedure.
3. At the time of surgery, the surgical team should identify the resident responsible for the surgical documentation.

DISCHARGE SUMMARY (per the Electronic Medical Record and include):

- 1) Reason for admission - discharge diagnosis
- 2) Significant findings (only pertinent or positive)
 - a. Physical findings
 - b. Lab results
 - c. X-ray findings
 - d. Other test performed
- 3) Brief hospital course
 - a. Treatment rendered or procedures
 - b. Response to treatment
- 4) Final diagnosis
- 5) Disposition of patient (to home, etc.)
- 6) Condition on discharge (i.e., for patients admitted with fever, state "patient afebrile")
- 7) Discharge medications

- 8) Follow-up plans/tests pending
- 9) Any special diet
- 10) Special instructions for physical activity

P. X-RAYS AND FLUOROSCOPY POST OPERATIVE X-RAYS

1. If indicated, obtain films in the OR before breaking the sterile shield or discontinuing anesthesia. X-rays are not permitted in the PACU unless required for immediate monitoring.
2. Only those orthopaedic practitioners with a California fluoroscopy supervisors licenses may operate a fluoroscopy unit.
3. Before the use of fluoroscopy, the operator must announce that this equipment will be used and must ensure that those exposed to potential radiation are protected with shielding, including the operator, the patient, and ancillary personnel.

Q. CLINIC RULES

1. Arrive when the clinic starts.
2. All patient visits, including new patient visits, should be recorded on the hospital system.
4. If x-rays or cast removal is planned for the next visit, indicate it in the note so this can be arranged at the beginning of the visit.
5. Most routine x-rays are done in the orthopaedic Clinic. Try to order these early.
6. Clinic has priority. Do not leave for ward work, etc., unless on call.
7. If you must leave for an emergency, tell the chief resident and nurse that you are leaving and why.
8. Obtain written consent for appropriate procedures, such as hardware removal, etc.

R. ADMISSIONS FROM CLINIC

1. The nurse will assist with admission arrangements.
2. The chief resident and appropriate service attending should be notified of these admissions immediately.

S. EMERGENCY ADMISSIONS

1. Do not hold the patient in the clinic for a work-up that can be done later on the ward.
2. Patient will be interviewed by eligibility workers and transported to the ward.

T. ELECTIVE (FUTURE) ADMISSIONS

1. Schedule through the chief resident and attending.
2. Complete the proper documentation and orders on the electronic medical record.
3. The patient should be evaluated for eligibility and may be appropriate for referral to the pre-operative clinic.

U. COME –AND-GO SURGERY IN SURGICENTER

1. M.D./R.N. should schedule with the Surgi Center at least 3 days in advance

2. In general: Local anesthesia: Labs only if indicated. Need written H&P, disclosure, and consent. General anesthesia: Same work-up and documentation as for Come and Stay.

V. CLINIC DISCHARGE CRITERIA

1. The patient has a musculoskeletal condition that could be addressed with surgery. Still, after orthopaedic surgical consultation, the patient is not a surgical candidate *or* the patient decides she/he does not want surgery.
2. The patient has a musculoskeletal condition that does not need or no longer requires further follow-up with an orthopaedic surgeon.
3. For patients who are discharged via this mechanism, a discharge note will be completed and signed in the medical record explaining why the patient is currently not a good surgical candidate and when to reconsider referring the patient back for surgical evaluation. Additionally, recommendations for appropriate non-surgical management will be provided.

W. INFECTIONS

Infections involving joints or bones should be admitted or referred to orthopaedic surgery, unless a significant medical or extensive surgical condition exists, in accordance with the medicine-orthopaedic surgical guidelines.

X. ORTHOPAEDIC PEDIATRIC ADMISSIONS

1. The orthopaedic intern and resident work up the musculoskeletal exam of the patient.
2. Pediatric patients are admitted to the pediatric service with orthopaedics providing the consultation.
3. Orthopaedic surgery service sees the patients daily, leaving a note on the patient and addressing any musculoskeletal issues.
4. Specific Service Responsibilities: Elective Surgeries, Emergency Admissions, Emergency Surgeries, and Transfers

Pediatrics:

- a. Serve as the service of record with a Pediatric attending as the attending of record
- b. Perform admission H&P and discharge summary/H&P
- c. Handle all medical orders including, but not limited to:
 - i. Diet (special restrictions)
 - ii. Medications, including pain medication
 - iii. Nursing Checks (specific parameters if applicable, etc.)
- d. Enter discharge orders and prescriptions
- e. Assist with placement, if necessary
- f. Communicate with PCP

Orthopaedics:

- a. Serve as the consulting service with an orthopaedic attending serving as the consultant attending
- b. Enter initial consultation note, including specific recommendations for:
 - i. PT and level of activity
 - ii. Additional nursing care needed for the specific type of injury (i.e., neurovascular checks)

- iii. Specific orthopaedic orders/requirements (i.e., limb elevation, icing).
- c. Directly communicate the management plan and treatment recommendations to the pediatric service upon admission and daily, at a minimum
- d. Obtain consent, explain surgical procedures, and describe anticipated outcomes
- e. Be available to answer questions from the pediatrics service on a 24/7 basis and to answer the family's questions daily
- f. Round and write daily notes in the medical record, including new orthopaedic recommendations.
- g. For elective cases, ensure pre-op medical H&P has been performed before admission.
- h. Collaborate with the discharge planning process, including appropriate discharge date, discharge management plans, and orthopaedic clinic follow-up.

Y. ORTHOPAEDIC MEDICINE INPATIENT SERVICE ADMISSIONS

- 1. Orthopaedic patients with acute medical issues while on the in-patient orthopaedic service will first be staffed by inpatient Medical Consult Service. For any chronic medical problems, the Medical Consult Service will continue to provide management help with Ortho serving as the primary care team of record. However, if an acute management issue arises, the patient will be transferred to the Medicine inpatient service team for any patients with complex medical needs.
- 2. Each morning, the Medicine inpatient service will receive any new overnight transfers from the overnight hospitalist or Medicine teams.
- 3. In accordance with the interservice agreements, for patients over 80 or with acute medical conditions warranting admission and management, the Medicine inpatient service will be the primary service with the Orthopaedic Surgery Service serving as a consulting service for patients on the Medicine inpatient service team. Orthopaedic NPs and interns will coordinate the disposition plan and follow-up for any orthopaedic-related medical issues. Otherwise, the Medicine inpatient service will manage all other aspects of care and discharge.
- 4. For overnight and weekend issues, the overnight medicine inpatient service Overnight hospitalist can be the first "go-to" person for any acute medical issues that arise on the orthopaedic service inpatients.

ATTACHMENT C -- CLINICAL SERVICE CHIEF OF ORTHOPAEDIC SURGERY JOB DESCRIPTION

Chief of Orthopaedic Surgery Clinical Service

Position Summary:

The Chief of Orthopaedic Surgery 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 (ZSFG) and the Department of Public Health (DPH). The Chief also ensures 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 Orthopaedic Surgery reports directly to the UCSF Associate Dean at ZSFG and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed at least 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 UCSF Associate Dean at ZSFG, 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 individuals and groups, as well as with other clinical departments.

Position Qualifications:

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

The Chief of Orthopaedic Surgery Service or their designee is the Co-Fellowship Trauma Director, in collaboration with the appointed UCSF Trauma Service Director, if the individuals are different. The Chief must be capable of leading the orthopaedic trauma program and be accredited for the position by the Orthopaedic Trauma Association (OTA) (i.e., have completed an OTA-accredited fellowship or completed a fellowship experience recognized by the OTA, including grandfathered fellowships).

Major Responsibilities:

The major responsibilities of the Chief of the Orthopaedic Surgery 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

*Zuckerberg San Francisco General
1001 Potrero Ave
San Francisco, CA 94110*

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.



University of California
San Francisco



ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Otolaryngology-Head and Neck Surgery Service Report

Zuckerberg San Francisco General Hospital and
Trauma Center

Megan Durr, MD

Chief of Otolaryngology-Head and Neck Surgery, ZSFG

6/10/2024



Departmental Personnel and Structure



UCSF Departmental Structure

- Andrew Murr, MD, Chair

- Head and Neck Cancer and Skull Base Surgery (7)

- Patrick Ha, MD
- Ivan El-Sayed, MD
- William Ryan, MD
- Chase Heaton, MD
- Jonathon George, MD
- Katherine Wai, MD
- Mary Jue Xu, MD
- Michael Chow, MD
- Ilya Likhterov, MD
- Weston Niermeyer, MD (fellow)

- Otology/Neurotology (5)

- Charles Limb, MD
- Steven Cheung, MD
- Aaron Tward, MD
- Jeffrey Sharon, MD
- Song Cheng, BM, BCh
- Nicole Jiam, MD

- Laryngology and Voice Disorders (4)

- Clark Rosen, MD
- VyVy Young, MD
- Yue Ma, MD
- Tyler Crosby, MD
- Jennifer Silver, MD (fellow)

■ Facial Plastic and Reconstructive Surgery (3)

- Daniel Knott, MD
- Chase Heaton, MD
- Andrea Park, MD
- Autefeh Sajjadi, MD (fellow)

■ Pediatric Otolaryngology (10)

- Kristina Rosbe, MD
- Anna Meyer, MD
- Dylan Chan, MD
- Garani Nadaraja, MD
- Joanne Czechowicz, MD
- Jordan Virbalas, MD
- Jacqueline Weinstein, MD
- Kimberly Luu, MD
- Lia Jacobson, MD
- Kara Brodie, MD
- Scott Hirsch, MD
- Rajas Tipnis, MD (fellow)

■ Rhinology/Sinus Surgery and General Otolaryngology (9)

- Tokunbo Ayeni, MD
- Andrew N. Goldberg, MD
- Andrew H. Murr, MD
- Steven Pletcher, MD
- Jolie Chang, MD
- Megan Durr, MD
- Patricia Loftus, MD
- Jose Gurrola, MD
- Anna Butrymowicz, MD
- Caroline Schlocker, MD

ZSFG Otolaryngology

Our mission is to provide comprehensive and compassionate Otolaryngologic care to the diverse communities of San Francisco. We are dedicated to training the next generation of Otolaryngologists and ensuring that all patients have equitable access to the highest quality care

ZSFG Faculty and Residents



ZSFG OHNS Core Clinical Faculty



Megan Durr, MD (0.6 FTE)

- General Otolaryngology
- Sleep Apnea/Snoring Surgery
- Facial Trauma Surgery



Patricia Loftus, MD (0.49 FTE)

- Rhinology/Skull Base Surgery
- General Otolaryngology
- Facial Trauma Surgery



Mary Xu, MD (0.7 FTE)

- Head and Neck Oncologic Surgery
- Endocrine Surgery



Tokunbo Ayeni, MD (0.2 FTE)

- General Otolaryngology
- Facial Trauma Surgery

ZSFG OHNS Core Clinical Faculty



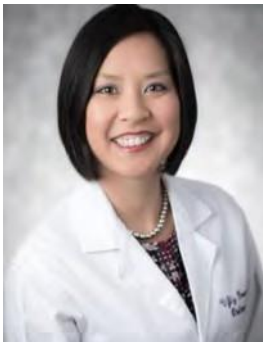
Song Cheng, MD (0.1 FTE)

- Otolaryngology/Neurotology



Anna Butrymowicz, MD (0.15 FTE)

- General Otolaryngology
- Facial Trauma Surgery



VyVy Young, MD (0.05 FTE)

- Laryngology



Andrew Goldberg, MD (0.05 FTE)

- General Otolaryngology
- Facial Trauma Surgery

ZSFG OHNS APPs



Shauna Brodie, NP (1.0 FTE,
10 years with OHNS)

- Director, Outpatient OHNS
- 4J Clinic Operations
- Cancer Care Coordination



Lori Ross, PA (1.0 FTE, started
6/25/24)

- Outpatient OHNS 4J Clinic

UCSF OHNS Fellows, 2025-2026

- Autefeh Sajjadi, MD

- Facial Plastic and Reconstructive Surgery



- Jennifer Silver, MD

- Laryngology



- Rajas Tipnis, MD

- Pediatric Otolaryngology



- Weston Niermeyer, MD

- Head and Neck Oncological Surgery



ZSFG Audiologists



Emily Kidwell, AuD



Alison Lacey, AuD



Lauren Hudec, AuD



Celia Tow, AuD

ZSFG OHNS Volunteer Faculty



Adrian House,
MD



Gerald
Kangelaris, MD



Andrea Yeung,
MD

ZSFG OHNS Clinical Faculty



- Andrew Murr, MD, FACS
 - Rhinology and Sinus Surgery
 - General Otolaryngology
 - Facial Trauma surgery

ZSFG Administrative Staff



Lorel Hiramoto
Business Manager



Josephine Hermoso
Billing and Operations Analyst
Trainee Administrator

UCSF OHNS Residents



ZSFG Resident Rotation

- 25 total residents, 15 rotate at ZSFG/year
- PGY-4 (5 residents)
- PGY-3 (5 residents)
- PGY-2 (5 residents)



ZSFG Resident Rotation

- Broad clinical experience
 - Operating Room
 - Outpatient clinic
 - Consultative service (inpatient, ED, urgent care)
 - Emergent and elective services
 - Trauma
- Resident-facilitated service
 - PGY-4 chief resident
 - Hands-on management of service
 - Manage OR schedule
 - Resident assignments

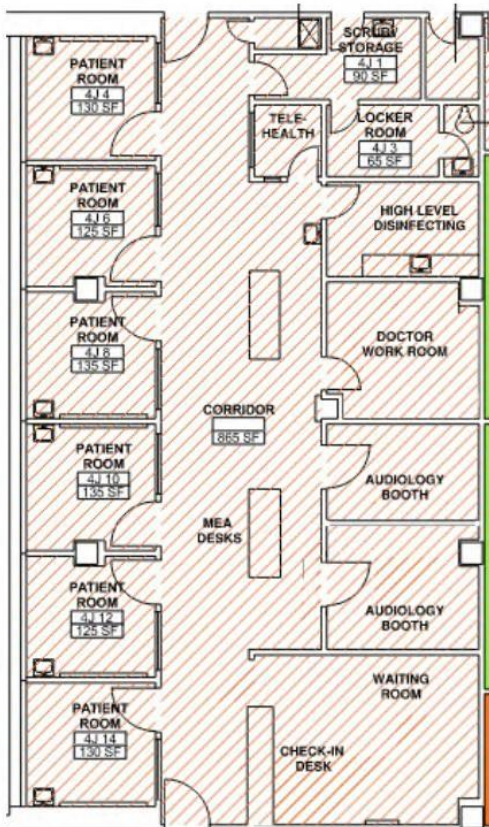


Clinical Service



4J Clinic

Floor plan of new 4J clinic includes 6 exam rooms with MEA desks in the middle space. Along the opposite wall are 2 audiology booths, a provider workroom, and a private provider room for telehealth visits.

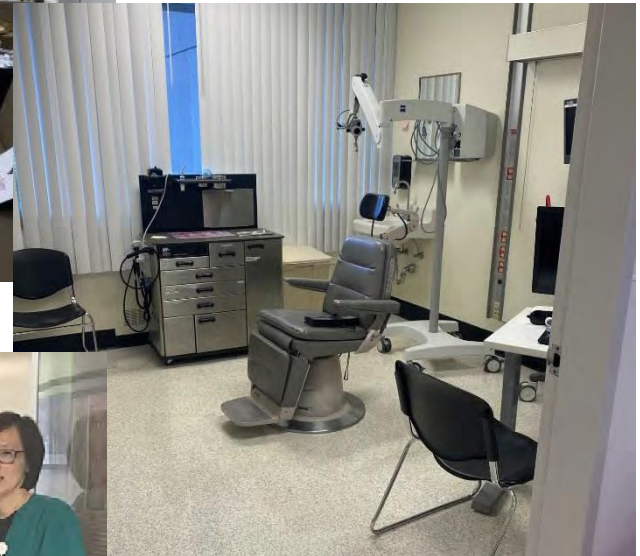


Center hallway of 4J (exam rooms along left)

Patient exam room in 4J



4J clinic staff



Clinical Scope of Service

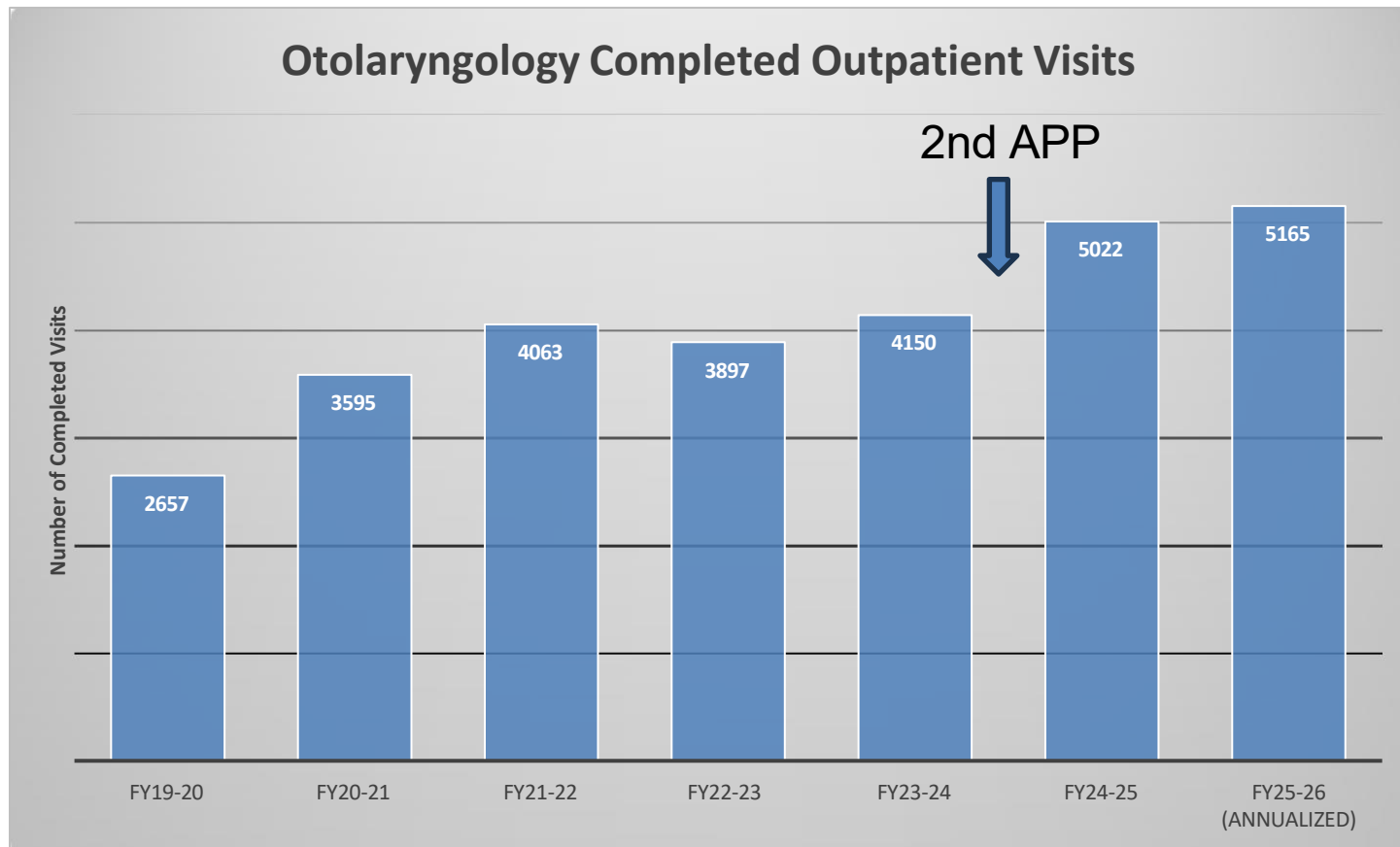
- Operating Room
- Inpatient service
- Outpatient clinic
- eConsult
- Inpatient consultation
- Emergency Department
- Urgent Care consultation
- Laguna Honda Hospital



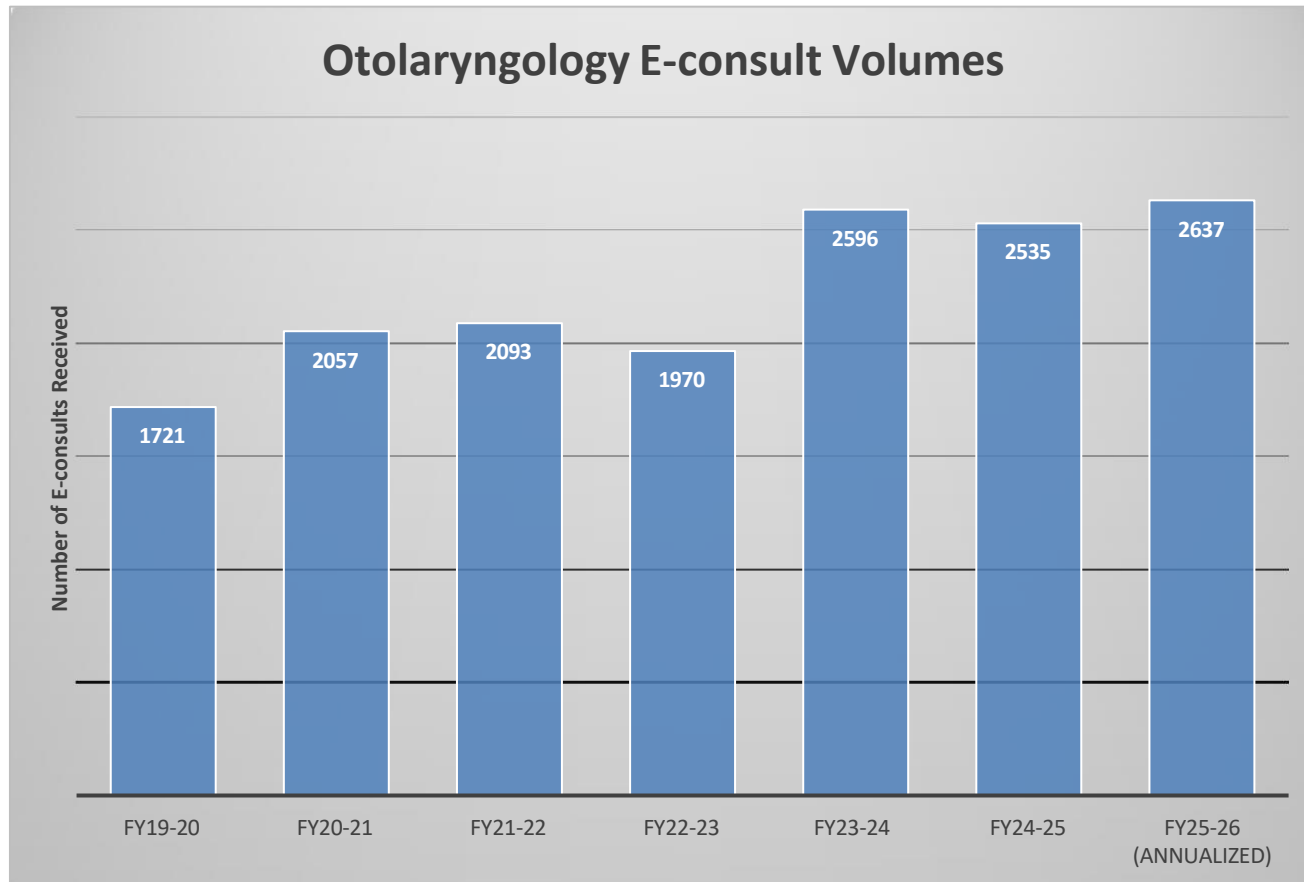
Clinical Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Clinic	OR	Clinic	OR/OR	OR/procedures
PM	Clinic	OR	Clinic	OR/OR	Clinic

Clinical Volume: Ambulatory Visits

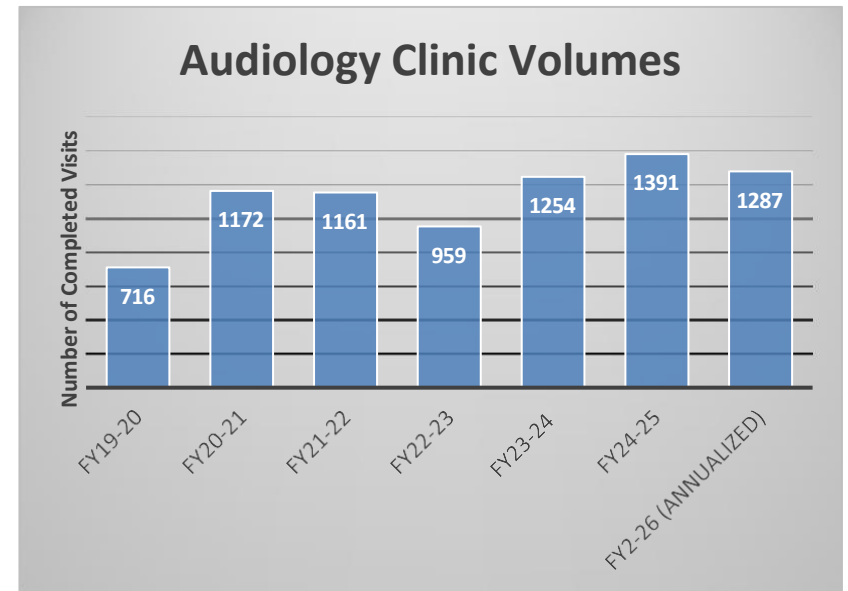
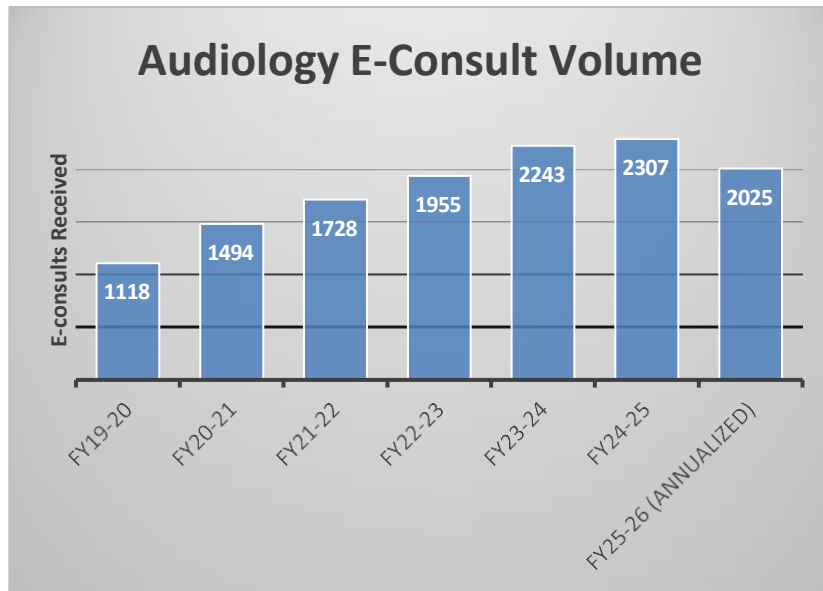


Clinical Volume: eConsult

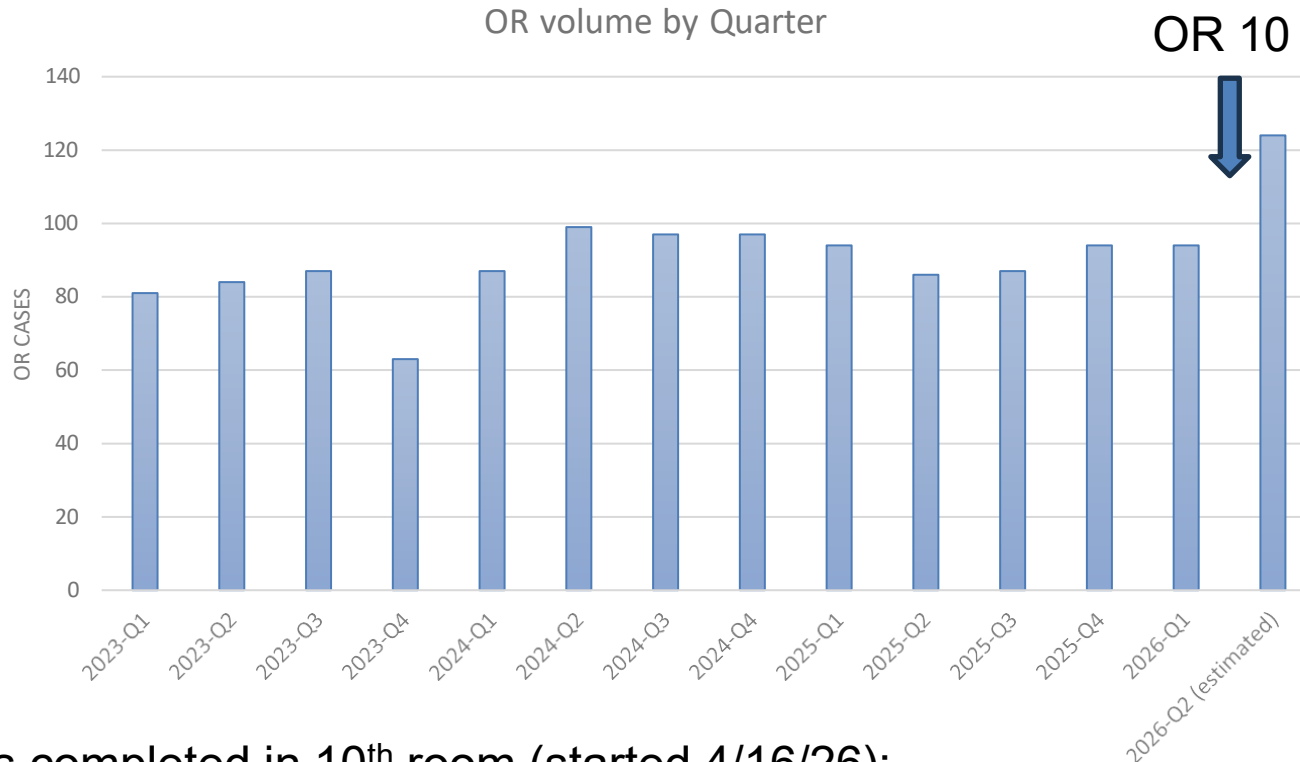


Audiology

- Contracted through UCSF Medical Center
- Management of the Audiology Department at ZSFG is under the direction of Payal Anand, AuD, Director.



OR Volume



Cases completed in 10th room (started 4/16/26):

- Thyroidectomy x 2
- Cancer resection x 3
- Trauma surgery x 3
- Tracheotomy x 3
- Neck mass excision x 2
- Tonsillectomy
- Ear foreign body removal

OR Case Distribution

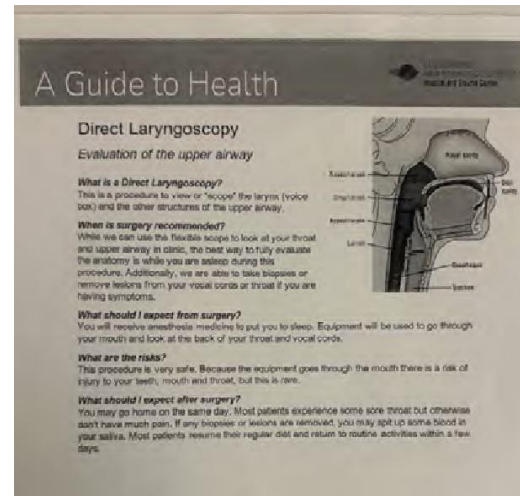
Surgery Type	Percent of Total Cases
FESS	15%
Cancer/neck mass	15%
Otology	15%
Rhinoplasty	12%
Trauma	10%
Tonsillectomy	8%
Endocrine Surgery	7%
Trach/revision/repair	7%
Laryngology	5%
Temporal artery biopsy	4%
Septoplasty	2%
Parotidectomy	2%

ZSFG Call

- Resident Call
 - Overnight home call shared by 3 residents
 - Junior resident call backed by senior resident
 - Facial Trauma call every 3rd night
- Faculty call
 - 24/7/365
 - All adult UCSF OHNS faculty participate



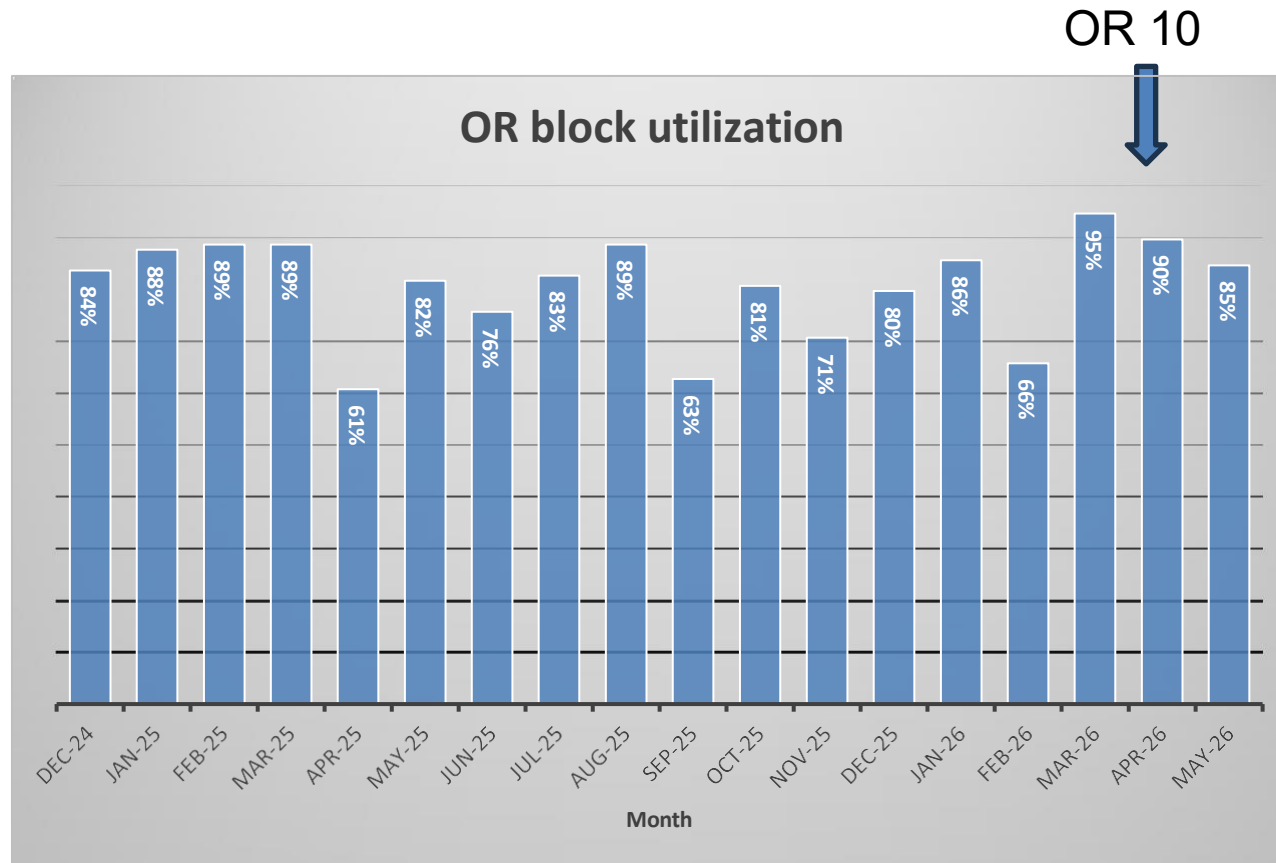
Performance Improvement and Patient Safety



Post-procedure Patient Handouts

- 78% received language concordant post-procedure handout ahead of surgery date
- 100% responded favorably on survey

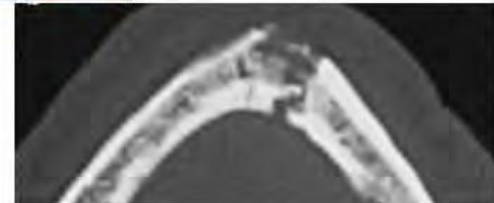
PIPS: OR Block Utilization



PIPS: Integrating Dental Preventative Care into OHNS cancer surveillance

Why does dental care for head and neck cancer patients matter?

- Radiation therapy →
 - 90% dry mouth
 - 50% dental decay
 - 15% osteoradionecrosis



PIPS: Integrating Dental Preventative Care into OHNS cancer surveillance



National
Comprehensive
Cancer
Network®

**NCCN Guidelines Version 4.2024
Head and Neck Cancers**

PRINCIPLES OF ORAL/DENTAL EVALUATION AND MANAGEMENT^{1,2}

- ◇ **High potency topical fluoride – continue long term after therapy**
 - **Daily 1.1% NaF gel or SNF₂ gel, brush on or in custom dental trays; or**
 - **Daily 1.1% NaF dentifrice; or**
 - **Fluoride varnish application, three times per year; or**
 - **Calcium phosphate artificial saliva rinse**
- ◇ **Regular frequent dental evaluations to detect dental disease**

GREATER BAY AREA

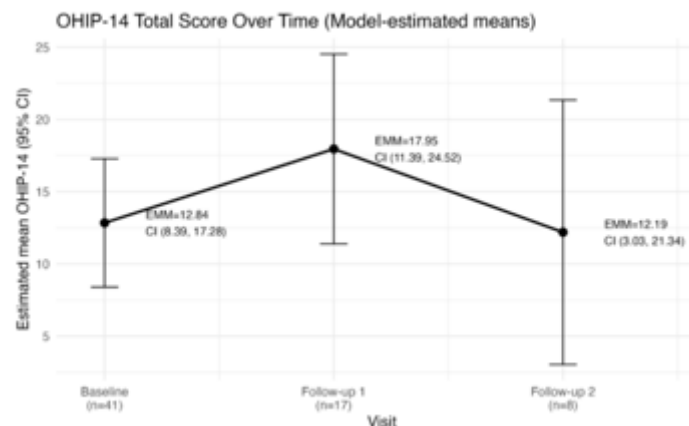
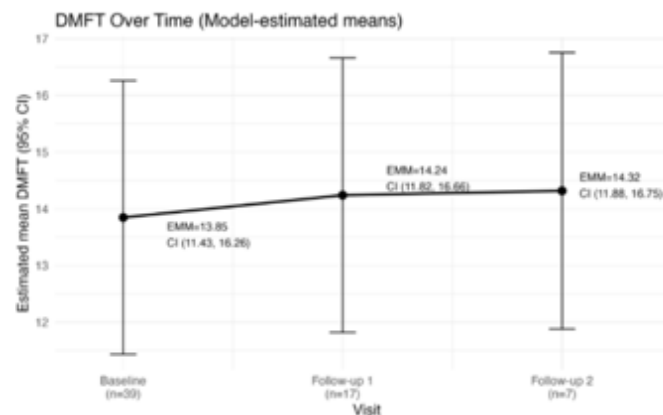
Dentists who see
Medi-Cal patients

3%

PIPS: Integrating Dental Preventative Care into OHNS cancer surveillance



Grant funding AAO Core Grant x 2 and
MZHF
Partner with Dental School to assess dental
outcomes



PIPS: Hearing Screening

New Hearing Loss: Where to Find Help

This booklet shares places to look for help paying for hearing tests, hearing aids, and other hearing care. It is general information, not medical or legal advice



Title: Patient Experiences with Accessing Hearing Care in an Urban Safety-Net Setting: A Qualitative Study

Authors: Armita Norouzi, BA^{1,2,4,*} and Kevin Avelar, BS^{3,*}; Emily Honzel, MD¹; Ana Marija Sola, MD¹; Kennedy Johnson, BS⁵; Nikhil Arora, MD¹; Emily Kidwell, AuD^{1,4}; Alison Lacey, AuD^{1,4}; Lauren Hudec, AuD^{1,4}; Ashley Carrington, AuD^{1,4}; Lori Ross, PA-C^{1,4}; Shauna Brodie, RN, MS, FNP^{1,4}; Su Li, RN⁴; Yew Song Cheng, BM BCh^{1,4}; Megan L. Durr, MD^{1,4}

Title: Hearing Care Access Among Patients with Hearing Loss in an Urban Safety-Net Clinic

Authors: Armita Norouzi, BA^{1,2,4}; Emily Honzel, MD¹; Kevin Avelar, BS³; Ana Marija Sola, MD¹; Kennedy Johnson, BS⁵; Nikhil Arora, MD¹; Emily Kidwell, AuD^{1,4}; Alison Lacey, AuD^{1,4}; Lauren Hudec, AuD^{1,4}; Ashley Carrington, AuD^{1,4}; Lori Ross, PA-C^{1,4}; Shauna Brodie, RN, MS, FNP^{1,4}; Su Li, RN⁴; Yew Song Cheng, BM BCh^{1,4}; Megan L. Durr, MD^{1,4}

Grant funding from SFGH
Foundation Equity and
Inclusion Grant and
Hearing Research, Inc

Performance Improvement: Administrative Service

- Megan Durr, MD
 - CPG Clinical Operations, Metrics and Performance (COMP) committee
 - Operating Room Committee
 - Block Time Committee
 - Ambulatory Care Committee
 - Medical Executive Committee
- Patricia Loftus MD and Andrew Goldberg, MD
 - Operating Room Committee
 - Block Time Committee
- Shauna Brodie, CRNP and Mary Ju Xue, MD (co-chair)
 - ZSFG Cancer Committee
- Andrew Murr, MD
 - UCSF Dean's Office, Chairs and Directors

Education



Education

- OHNS Residency Program
- 140.05 MS III elective in Otolaryngology
- 140.01C MS IV elective in Otolaryngology
- MS I OR Assist elective
- Anesthesia resident scope training
- Anesthesia PGY-1 month-long elective
- ZSFG Primary Care lecture series
- LHH staff education
- ZSFG Respiratory Care services outreach
- UCSF CME courses

ZSFG Resident Education

■ Educational Conferences

- Daily service rounds with attending at ZSFG
- Weekly resident-directed educational conference (UCSF)
- Weekly faculty-run didactic session (UCSF)
- Weekly head and neck tumor board (UCSF and ZSFG)
- Weekly departmental Grand Rounds (UCSF)
 - M&M
 - Invited guests



ZSFG Resident Education

■ Simulation

- Microvascular Free Flap Lab
- Ultrasound Training Course
- Rhinology/Skull Base Lab
- Temporal Bone Lab
- Temporal Bone Simulation
- Facial plating course



ZSFG Resident Education

■ Leadership Training Curriculum

Leadership Styles

Difficult Conversations

Public Speaking

Feedback



ORIGINAL REPORT

Enhancing Non-Technical Competencies in Otolaryngology Trainees With a Novel Leadership Curriculum

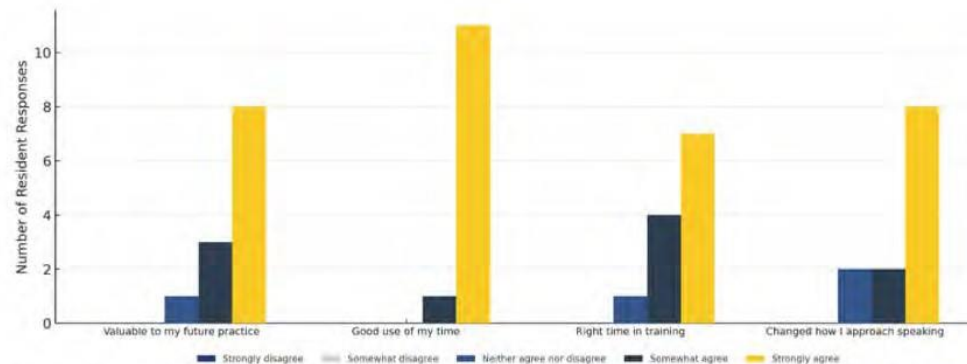


FIGURE 7 | Public speaking participant reactions. [Color figure can be viewed in the online issue, which is available at www.laryngoscope.com]

Resident Wellness



Faculty Wellness – Faculty Dinners



Department Wellness and Educational Events

- Quarterly 4J clinic lunches
- Education/collaborative discussions
- Recent Topics:
 - Website optimization
 - Hearing screening protocols
 - Fluoride implementation
 - Patient Education



About Us

Our team is composed of outstanding UCSF physicians, advanced practice providers, residents, audiologists, nurses, medical assistants, and administrators. UCSF Residents are an integral part of our service as they complete a 10 week rotation at ZSFG. During their time they conduct clinic visits, provide consultations for emergency room patients and patients staying in the hospital, and they carry out emergency and elective surgeries at the hospital.

Our Mission

To provide comprehensive and compassionate otolaryngologic care to the diverse communities of San Francisco. We are dedicated to training the next generation of otolaryngologists and ensuring that all patients have equitable access to the highest quality care.

Our Vision

To create a future where every San Franciscan has timely access to compassionate, innovative and world-class Otolaryngologic care, regardless of background or insurance-status.

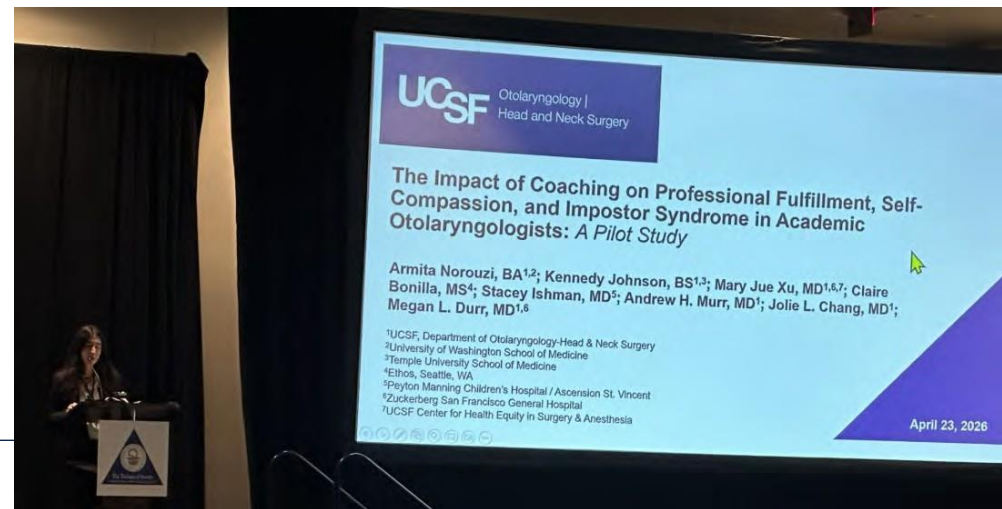
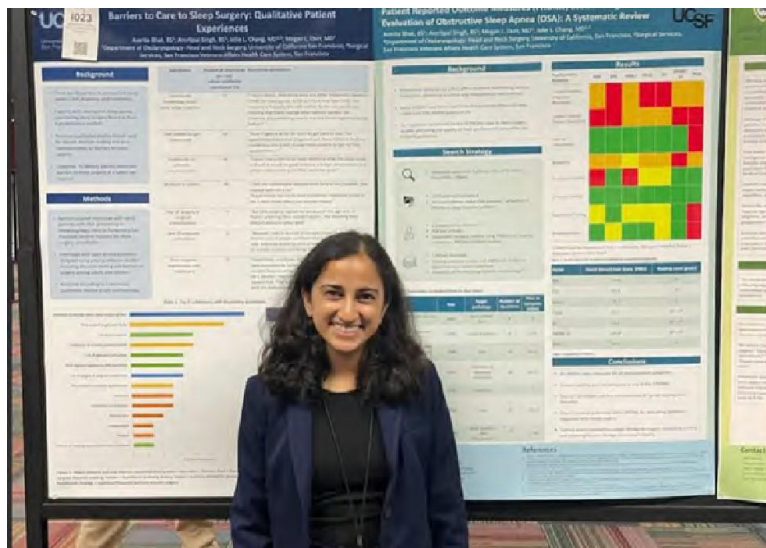
Preparing for Your Visit

Watch this short video to know what to expect at your upcoming appointment.



The ZSFG ENT Team

Research



Key Recent ZSFG OHNS Publications

Timely Matters: Predictors of Delay in Oral Cavity Cancer Patients Across the Care Continuum

Nicholas Correia¹ | Kennedy Johnson² | Megan Durr² | Barbara A. Grimes³ | Ann A. Lazar³ | Urmimala Sarkar⁴ | Patrick K. Ha² | Laura Chen¹ | Katherine C. Wai² | Ilya Likhterov² | Sue S. Yom⁵ | Jason W. Chan⁵ | Alain P. Algazi⁶ | Hyunseok Kang⁶ | William R. Ryan⁷ | Chase M. Heaton² | Ivan El-Sayed² | Jonathan George² | Mary Jue Xu^{2,3}

Adherence to Dental Care in Head and Neck Cancer Patients Post-Radiation Therapy: A Scoping Review

Yasmin Eltawil¹ | Kennedy Johnson² | Yousef Alqasbeer³ | Armita Norouzi² | Yilin Plao³ | Danielle Gillard⁴ | Alyssa Civasantos² | Kwang Kim³ | Jason Chan³ | Sue S. Yom⁵ | Megan L. Durr² | Shauna Brodie² | Sydnee Chavis⁶ | Michelle Chen¹ | Mary Jue Xu²

Original Research

Impact of Mild Traumatic Brain Injury on the Subjective Perception of Hearing and Balance

Alyssa M. Civasantos, MD, MS¹, Kennedy Johnson, BS¹, Sultan Al Azzawi, BS¹, Phiroz E. Tarapore, MD², Steven W. Cheung, MD^{1,3}, Jennifer H. Sabes, AuD¹, Jolie L. Chang, MD^{1,3}, and Megan L. Durr, MD¹

SCOPING REVIEW

Obstructive Sleep Apnea in Traumatic Brain Injury: A Scoping Review

Kennedy Johnson¹ | Nicholas Correia^{1,2} | Jolie L. Chang¹ | Megan L. Durr¹

¹Department of Otolaryngology-Head and Neck Surgery, University of California San Francisco, San Francisco, California, USA | ²School of Medicine, University of California San Francisco, San Francisco, California, USA

ORIGINAL ARTICLE

Social Determinants of Health in Patients Undergoing Osteocutaneous Free Flap Reconstruction for Malignant Disease of the Mandible

Robith M. Rethanabodhi¹ | Nina Patel¹ | Roya Behrani² | W. John Boscardin³ | Mary J. Xu³ | Chase Heaton³ | Katherine C. Wai¹ | Andrea M. Park¹ | P. Daniel Knott¹

¹Department of Otolaryngology-Head and Neck Surgery, University of California-San Francisco, San Francisco, California, USA | ²University of California-San Francisco School of Medicine, San Francisco, California, USA | ³Department of Medicine and Epidemiology and Biostatistics, University of California-San Francisco, San Francisco, California, USA

ORIGINAL REPORT

Predictors of No-Show in a Safety-Net Otolaryngology Clinic: A Repeated Measures Approach

Tiffany Husman¹ | Omeed Mirafteb-Salo¹ | Alonn Ilan² | Shauna Brodie^{2,3} | Alan Paciorek⁴ | Megan L. Durr^{2,3} | Jolie Chang¹ | Mary Jue Xu^{2,3}

ORIGINAL REPORT

Barriers to Care for Sleep Surgery at a Safety Net Hospital: Qualitative Patient Experiences

Armita N. Bhat¹ | Armita Singh¹ | Philip Kurien² | George Su³ | Jolie L. Chang^{1,4} | Megan L. Durr¹

¹Department of Otolaryngology-Head and Neck Surgery, University of California San Francisco, San Francisco, USA | ²Department of Anesthesia and Perioperative Care, University of California, San Francisco, San Francisco, USA | ³Department of Medicine, Division of Pulmonary, Critical Care, Allergy and Sleep Medicine at San Francisco General Hospital, University of California, San Francisco, San Francisco, USA | ⁴Surgery Service, Department of Veterans Affairs Medical Center, San Francisco, USA

Original Reports | Head and Neck Cancer

Prevalence of High-Risk Human Papillomavirus and Associated Risk Factors Among Individuals With Head and Neck Cancer in a National Referral Center in Tanzania

Aslam Nkya, MD, MMED¹; Mary Jue Xu, MD, MAS²; Godfrey Sama Philipo, MD, MPH, MGSC^{3,4}; Summaiya Haddadi, BMLS, MSc⁵; Dianna Ng, MD⁶; Beatrice Paul Mushi, MD, MPH⁴; Atuganile Edward Malango, MD, MMED⁶; Erick Philip Magorosa, BMLS, MSc⁶; Alan Paciorek, BS⁷; Li Zhang, PhD^{7,8}; Sikudhani Muya, MD, MMED⁹; Patrick Ha, MD²; Edwin Liyombo, MD, MMED¹; Erica Richard, MD, MMED¹⁰; Willybrood Massawe, MD, MMED¹; Joel M. Palefsky, MD¹¹; Sue S. Yom, MD, PhD¹²; Elia John Mmbaga, MD, PhD¹³; and Katherine Van Loon, MD, MPH¹⁴

DOI: <https://doi.org/10.1200/JGO-25-00596>

Journal of the Colleges of Medicine of South Africa

ISSN: (Online) 2960-110X, (Print) 3105-4331

AOSIS

Page 1 of 9 Original Research

Barriers to airway procurement processes in sub-Saharan Africa: An exploratory qualitative study

UCSF

Pride Hall



Community Outreach



- Chinatown
- Black Health Initiative in the Fillmore
- Local SROs

¹Otolaryngology-Head & Neck Surgery, UC San Francisco; ²Stanford Otolaryngology—Head & Neck Surgery; ³Co-first authors

Factor, years	Mean = 82.9 (SD = 23.7)
Gender	R/S Ratio
Male	24 (18.7%)
Female	61 (17.1%)
Race/Ethnicity	
White non-Hispanic	86 (19.2%)
Primary Language	
English	13 (12.6%)
Chinese	68 (78.7%)
Alaskan	4 (4.6%)
Unknown	1 (1.1%)
Marital Status	
Single	18 (20.4%)
Married	36 (20.2%)
Divorced	1 (1.4%)
Widowed	1 (1.4%)
Insurance Type	
Medicaid	36 (44.3%)
Medi-Cal/Managed	43 (40.4%)
Private	0 (0%)
Private/Partnership	4 (4.6%)
Other	38 (3.2%)
Cost Insurance	9 (11.7%)
Health Insurance	4 (4.6%)
Other dental or last year	53 (50.9%)
Has dental care provided	86 (82.2%)
Preventive, surgical, or radiation	79 (74.7%)
treatment to breast and neck cancer	3 (1.1%)
Activity for head and neck cancer	1 (1.1%)
Consent to be interviewed	1 (1.1%)
Unknown	1 (1.1%)
Primary Cancer	
Head and Neck	9 (9.3%)
Other	0 (0%)
Medical Use	
Prophylactic	1 (1.1%)
Chemotherapy	1 (1.1%)

Symptom	Percentage (%)
No Symptoms	62
Fatigue	48
Single-sided hearing loss	20
Nasal Obstruction	18
Pain in the Mouth	15
Sore in Mouth	12
Problems with Dentures	10
Nasal Bleeding	8
Single-sided Ear Pain	5
Weight loss	4
Single-Sided Ear Drainage	3
Difficulty Swallowing	2
Inconsonance	1
Red or White Patches in Mouth	1
Lump on Neck	1
Pain with Swallowing	1
Chills	1
Oral Bleeding	1
Coughing Blood	1
Fever	1

- **Feasibility:** This study was limited to find that the surveys were doable and we were unable to follow up with individuals to understand the impact of the screening and our recommendations. Though this was intentional as this was a pilot study, feasibility was assessed by 2% with a response rate for "yes," it would be feasible in future studies to include a follow-up component to assist with connecting participants with the correct resources.
- **Importance of medical interpretation:** In the setting of health care, appropriate interpretation is of critical importance in capturing participant engagement, assessing with survey questions, and explaining relevant clinical findings. We found that 3 interpreters, paired with 3 providers were necessary to keep pace with 87 participants over the course of 5 hours.
- **Future outreach:**
 - Nasal obstruction and hearing loss were most commonly reported, which may be future areas of focus for community outreach.
 - Though feasible, additional studies are needed to identify scope, and reach out to high-risk individuals.⁶

Community-based HMC screenings in St. Charles are feasible with appropriate personnel including interpreters and providers. While future targeted outreach may be more impactful for HMC prevention, further studies characterizing and implementing potential interventions for ethnic epidemiologic concerns may be meaningful for this population.

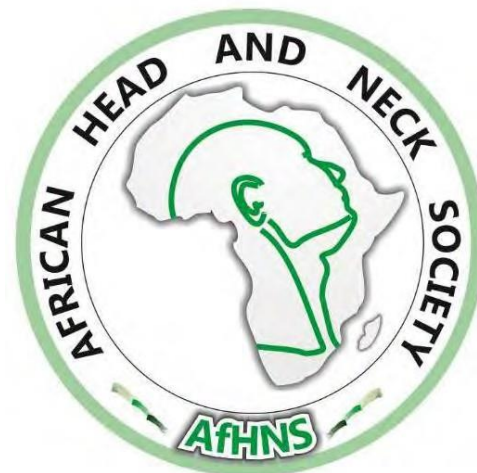
Center for
University of California, San Francisco
2400 Post Street, 5th Floor, San Francisco, CA 94115
corinne.jones@ucsf.edu

1. *For a comprehensive review of the literature on the effects of the environment on the development of the brain, see the book by R. M. Nelson and M. J. Zoccolillo (1991) 'The effects of the environment on the development of the brain', in R. M. Nelson and M. J. Zoccolillo (eds), 'The effects of the environment on the development of the brain', pp. 1-10. This book is a comprehensive review of the literature on the effects of the environment on the development of the brain, and is a valuable resource for researchers and clinicians alike.*

Community Outreach Events



Global Health



THE GLOBAL OHNS INITIATIVE

Towards universal access to high-quality, safe, timely, and affordable care for those with conditions of the head and neck

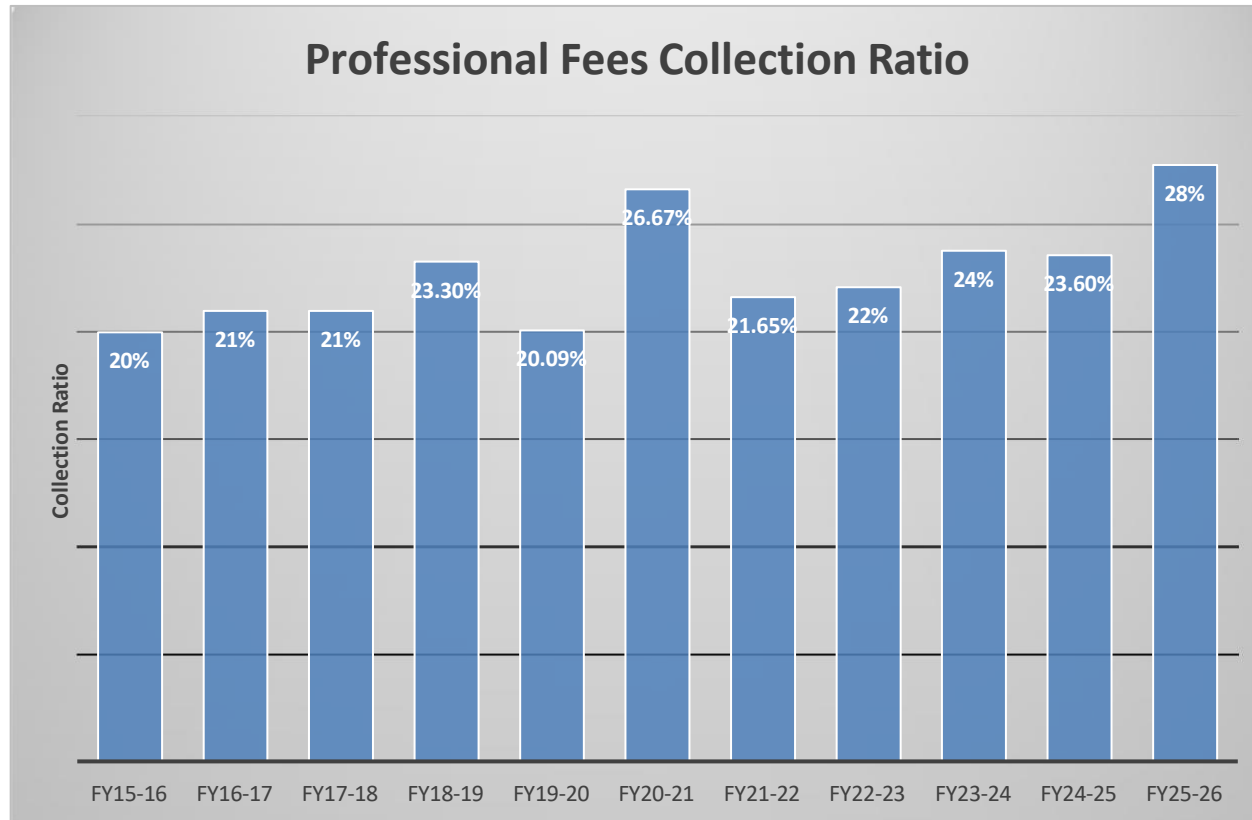


Finances

Professional Fee Collections

Year	Professional Fee Collection
2022-23	\$338,748
2023-24	\$398,911
2024-25	\$521,027
2025-26 (12mo estimate, up 16% prior year)	\$607,119

Professional Fee Collection Ratio



OHNS Revenue, FY 25-26

■ Laguna Honda Hospital Contract	\$29,001 (10mo)
■ Pro Fee Collections	\$505,934 (10mo)
■ Mng Care Capitated Payment	\$52,189 (mid-year only)
■ PQP incentives	\$27,393 (10mo)

Total (non-affiliation revenue)	\$614,517 (10mo)
■ Affiliation Agreement	\$1,481,666 (10mo)

Grand Total (with affiliation revenue) \$2,096,183 (10mo)

Affiliation Agreement

Clinical staffing

- Faculty: 2.1
- Staff 2.0



Strengths

- People
- Mission-driven service; committed to ZSFG True North Metrics
- Strong residency program with ample educational activities
- Growing clinical enterprise with expanded scheduling and updated equipment
- Recently added OR block time
- Growing research enterprise
- Financially lean operation and staffing model

Challenges

- Meeting clinic demand (especially Audiology) with growing work queue
- Outfitting and staffing the second audiology booth in new 4J clinic
- Faculty office space

Future

- Improve access, especially Audiology
- Permanent office space for faculty
- Continue to grow research enterprise
- Improve access to sub-specialists



Thank you!



City and County of San Francisco

Department of Public Health



Daniel Lurie
Mayor

Zuckerberg San Francisco General
Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	<i>ZSFG Clinical Service Rules and Regulations</i>
Clinical Service :	<i>Otolaryngology Head and Neck Surgery</i>
Date of last approval:	
Summary of R&R updates:	<i>Updated R&R to align with recent changes in the timing of the American Board of Otolaryngology oral examination, current resident evaluation practices, current document storage, and to align with office procedures listed in our SP update</i>
Update #1:	<i>I changed the timing in which board certification is required to align with the new board examination (that now happens during second year of practice vs previously occurred in first year of practice)</i>
Update #2:	<i>I changed the resident evaluation reporting to reflect current practice of reporting via evaluation form and discussion and clinical competency committee</i>
Update #3:	<i>Updated location of stored operative reports and meeting minutes to indicate that they are now stored electronically.</i>
Update #4:	<i>Updated the list of office procedures to perform to align with our current SP updates</i>
Update #5:	<i>Changed number of exam rooms with microscopes from 2 to “many” given we have obtained 2 additional microscopes with the hope to add more in the future and fill all 6 rooms.</i>

**OTOLARYNGOLOGY CLINICAL SERVICE
RULES AND REGULATIONS**

2024-2026

Formatted: Strikethrough

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

I.	OTOLARYNGOLOGY CLINICAL SERVICE ORGANIZATION.....	1
A.	SCOPE OF SERVICE.....	1
B.	MEMBERSHIP REQUIREMENTS.....	1
C.	ORGANIZATION OF OTOLARYNGOLOGY CLINICAL SERVICE.....	1
II.	CREDENTIALING.....	1
A.	NEW APPOINTMENTS.....	1
B.	REAPPOINTMENTS.....	2
C.	AFFILIATED PROFESSIONALS.....	2
D.	STAFF CATEGORIES.....	2
III.	DELINEATION OF PRIVILEGES.....	3
A.	DEVELOPMENT OF PRIVILEGE CRITERIA.....	3
B.	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM.....	3
C.	CLINICAL PRIVILEGES.....	3
D.	TEMPORARY PRIVILEGES.....	3
IV.	PROCTORING AND MONITORING.....	3
A.	MONITORING (PROCTORING) REQUIREMENTS.....	3
B.	ADDITIONAL PRIVILEGES.....	4
C.	REMOVAL OF PRIVILEGES.....	4
V.	EDUCATION.....	4
VI.	OTOLARYNGOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION (REFER TO SFCHN WEBSITE FOR HOUSESTAFF COMPETENCIES LINK).....	4
A.	RESIDENT EVALUATIONS.....	4
VII.	OTOLARYNGOLOGY CLINICAL SERVICE CONSULTATION CRITERIA.....	6
VIII.	DISCIPLINARY ACTION.....	6
IX.	PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT.....	6
A.	GOALS AND OBJECTIVES.....	6
B.	RESPONSIBILITY.....	6
C.	RESIDENT PARTICIPATION.....	6
D.	MONITORING COMPONENTS.....	7
E.	EVALUATION.....	7
F.	ONGOING CLINICAL MONITORS.....	7
G.	REPORTING.....	8
H.	PEER REVIEW.....	8
I.	EVALUATION.....	8
J.	REVIEW OF PATHOLOGY REPORTS.....	8
K.	CLINICAL INDICATORS.....	9
L.	CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES.....	9
M.	MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES.....	9

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

N.	MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE	9
X.	MEETING REQUIREMENTS	9
XI.	ADOPTION AND AMENDMENT	10
ATTACHMENT A: JOB DESCRIPTION.....		...
ATTACHMENT B: OTOLARYNGOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM		
APPENDIX : ORGANIZATION - OTOLARYNGOLOGY CLINICAL SERVICE		

I. OTOLARYNGOLOGY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Otolaryngology Head and Neck Surgery Clinical Service offers complete inpatient, outpatient and emergency care for all aspects of diseases that afflict the head and neck. The regular attending staff offers expertise in maxillofacial trauma, otology, laryngology, facial plastic surgery, [rhinology](#), head and neck surgery, sleep surgery, and general otolaryngologic procedures. The resident and attending staff work closely with the Audiology and Speech Therapy departments at ZSFG and offer complete audiologic, speech and swallowing evaluation for children and adults. All staff will comply with HIPAA guidelines as per the ZSFG Bylaws and Rules and Regulations.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General 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 OTOLARYNGOLOGY CLINICAL SERVICE

The Otolaryngology Clinical Service consists of the Audiology Service, and Otolaryngology Clinic. Please refer to Appendix for established guidelines.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

1. Guidelines for Appointment

- a. Certification by the American Board of Otolaryngology, or another specialty board appropriate to the privileges requested, within ~~three~~^{two} years of appointment, is required.

DEA certification is required for active and courtesy staff.

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

Reappointment to the medical staff requires an appraisal of the care given by the practitioner during his or her preceding appointment. This appraisal will be based upon direct observation of patient care when possible; review of the operative reports accrued in the preceding time period, review of the Morbidity and Mortality conference report files, and review of several randomly audited medical records.

2. Modification of Clinical Service

Modification of Clinical Services offered by the Otolaryngology –Head and Neck Surgery at ZSFG will only be made after discussion with the ZSFG Dean’s Office and a representative of the ZSFG administration with at least 30 days of written notification.

3. Staff Status Change

The process for Staff Status Change for members of the Otolaryngology Services is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

4. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Otolaryngology Services is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

5. On-Call Oversight

Faculty are expected to meet hospital, departmental, and ACGME requirements for on-call oversight. The call schedule is developed by the Department of [Otolaryngology-Head and Neck Surgery](#) at UCSF School of Medicine and requires 24 hour/day, 7 day/week, 365 days per year coverage of ZSFG.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment to the Affiliated Professionals of ZSFG through the Otolaryngology Clinical Service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

D. STAFF CATEGORIES

Otolaryngology Clinical Service staff fall into the same staff categories which are described in Article III of the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Otolaryngology Clinical Service Privilege Request Form shall be reviewed annually in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

C. CLINICAL PRIVILEGES

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Monitoring (proctoring) requirements for the Otolaryngology Clinical Service shall be the Responsibility of the Chief of the Service. (See II.B.1. & 2 above).

1. Goals and Objectives

The goals and objectives are to provide a one-year observation period following appointment to the medical staff to ensure that the privileges applied for are appropriate for the individual practitioner.

2. Participation

All new appointees to the medical staff during the first 6 months of their clinical appointment will be proctored.

3. Appraisal of Patient Care

Evaluation of patient care will be by:

- a. Observation of care provided during surgery.
- b. Assessment of the appropriateness of care delivered as observed on ward rounds.
- c. Review of minimum of 5 case files.
- d. Review of Morbidity and Mortality Reports relevant to the particular practitioner.

4. Individual Responsibilities

- a. Department Chief:
 1. Review the above information and make a recommendation either to continue or drop the physician from the medical staff.
 2. Make observations of patient care intraoperatively, on ward rounds and by assessment of patient complications or appointment of another physician to do the proctoring.
- b. Administrative Assistant:
 1. Review list of current hospital staff who require proctoring.
 2. Assemble relevant information for review by Chief on an annual basis so that pertinent recommendations can be made.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Otolaryngology Clinical Service shall be in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

The Otolaryngology-Head and Neck Surgery Clinical Service at the Zuckerberg San Francisco General is a cornerstone of the Otolaryngology-Head and Neck Surgery residency program at UCSF. Residents in their PGY-2, PGY-3, and PGY-4 years spend [approximately](#) two months at ZSFG, or the allotted time as determined by the number of residents in a given class. The majority of their trauma experience, outpatient care, and general otolaryngology-head and neck surgery cases are centered at this site. In addition, medical students regularly rotate on the service as either a mandatory third year clerkship (introduction to Otolaryngology) or as a fourth year sub-intern. Otolaryngology-Head and Neck Surgery faculty at the ZSFG are actively involved in the residency and medical student teaching program at UCSF on many levels. In addition, all members of the staff can attend UCSF department courses for CME credits.

VI. OTOLARYNGOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. RESIDENT EVALUATIONS

1. Individual Responsibilities

The Chief of Service and other attending staff are responsible for monitoring care provided by the resident staff. The Chief of Service provides the required reports. Attending faculty supervise house staff in such a way that the house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience.

- Role, responsibility, and patient care activities of the house staff: The house staff have primary responsibility for the clinical care of patients on the wards, in the clinic, and in the operating room under the supervision of attending staff. It is the goal of the program to have the residents develop a formal therapeutic relationship with the patients and to have patients identify the housestaff as the primary care provider. This includes initial history and physical exams, medical test decision making, procedures, and analysis of care options and therapeutic interventions. This educational environment is consistently monitored by the real-time presence of the attending staff who closely monitor and supervise house staff interactions and decision making. It should be remembered that the house staff are all eligible for California State Licensure to practice independently as physicians and surgeons in the state of California by having completed ACGME approved surgical internships.
- The attending staff and program director make decisions about the extent to which the resident can practice independently by analyzing a variety of factors including in-service scores, rotation evaluations, semi-annual formal performance evaluations, ABO surgical experience data, and also by direct, daily contact and observation.
- Resident Evaluation Process: the residents are evaluated in accordance with ACGME requirements for Otolaryngology/Head and Neck Surgery. The residents participate in Grand Rounds, Morbidity and Mortality conference, regularly scheduled didactic lectures, journal clubs, textbook chapter readings, the annual in-service examination, and individual rotation evaluations on the MedHub system in accordance with Graduate Medical Education Committee guidelines. American Board of Otolaryngology/Head and Neck Surgery surgical experience reports are examined semi-annually in formal reviews with the Program Director and Chair. Clinical comments and evaluations are made to the house staff on a daily basis by the attending staff and Chief of Service.
- Patient Care Orders: house staff may independently write patient care orders.

2. Activities Reviewed

Observations of resident performance include those made:

- Intraoperatively
- On ward rounds

- During review of patient charts
- Referrals by committee or other departments
- During Grand Rounds
- During conference presentations
- On review of Morbidity and Mortality Reports

3. Reporting

~~A report of each~~ Each resident's ZSFG performance is evaluated by faculty and discussed at the Departmental clinical competency committee meetings by a ZSFG representative. ~~completed and forwarded to the Chair and/or program Director, Department of Otolaryngology/Head and Neck Surgery UCSF immediately following completion of each resident's rotation at ZSFG.~~

VII. OTOLARYNGOLOGY CLINICAL SERVICE CONSULTATION CRITERIA

The Otolaryngology-Head and Neck Surgery Clinical Service consult service will evaluate all patients in consultation within 12 hours of being requested by a ZSFG physician. Urgent consultation (within one hour) and Emergent consultation (immediate) are also available as needed. The senior resident in Otolaryngology-Head and Neck Surgery (the ZSFG Chief Resident) is responsible for all consultation requests. An Otolaryngology-Head and Neck Surgery attending will evaluate all consults within 24 hours of any consultation request.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

1. To ensure that patients receive appropriate diagnoses and good care with proper medications, treatment and therapy.
2. To avoid unnecessary days of inpatient care.
3. To minimize morbidity.
4. To minimize nosocomial infections.
5. To enhance the value of the clinical service educational programs.

B. RESPONSIBILITY

Service Chief

The Service Chief has the overall responsibility for the PIPS program. Design, initiation, implementation and follow-up of patient care evaluation activities may be delegated to other members of the clinical service.

Administrative Assistant:

1. Maintain Performance Improvement & Patient Safety (PIPS) files
2. Search Otolaryngology Clinical Service PIPS database.
3. Assemble information as needed for PIPS review.

C. RESIDENT PARTICIPATION

Residents participate actively in the Morbidity and Mortality Conferences. Residents provide observations to the Service Chief regarding clinical attendings. Observations

regarding the Chief of Otolaryngology/Head and Neck Surgery are made directly to the Chair, Otolaryngology/Head and Neck Surgery, UCSF.

D. MONITORING COMPONENTS

Some or all of the following ongoing monitors are utilized to review and evaluate the quality and appropriateness of care provided by the department:

1. Mortality Report records
2. Morbidity and Mortality Conference records
3. Review of non-tissue case referrals
4. Clinical monitors
5. Attending evaluations of housestaff
6. Housestaff evaluations of attendings and rotations and programs
7. Referrals: Utilization Review, incident reports, malpractice cases, transfusion reactions, adverse drug reactions.

E. EVALUATION

1. As clinical service problems, patterns, and trends are identified, appropriate assessments methodologies to determine the cause and extent of the problem will be selected and may include:
 - a. Medical audit utilizing predetermined clinically valid criteria
 - b. Experimental design and research
 - c. Staff discussion
 - d. Outside consultation
2. Action: Remedial actions may include:
 - a. In-service education and training programs
 - b. New/revised policies and procedures
 - c. Staffing changes
 - d. Equipment changes
 - e. Counseling and proctoring
 - f. Referral to outside committee for follow-up when appropriate
3. Reevaluation:

Reevaluation and monitoring will be completed to ensure that certain problems have been eliminated or reduced insofar as possible.

F. PERFORMANCE IMPROVEMENT DRIVER METRICS

1. OR block utilization; monitored on a monthly basis
2. TNAA (third next available appointment), monitored on a monthly basis
3. Outpatient no-show rate, monitored on a monthly basis

G. REPORTING

Evidence of all Otolaryngology Clinical Service Performance Improvement and Patient Safety activity will be maintained and reported during the monthly Morbidity and Mortality meetings held in conjunction with the rest of the UCSF clinical service as part

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

of the CME-certified Grand Rounds Conference schedule. Summaries of the meetings will be maintained within the department on a monthly basis and are available to the PIPS committee upon request.

The Chief of the Service or designee will be responsible for ensuring the correction of clinical service patient care issues. Assistance from the Performance Improvement and Patient Safety [committee](#) will be requested when certain problems cross clinical service/committee boundaries and/or when the clinical service is unable to correct the problem.

A yearly formal report encompassing ongoing clinical monitors will be submitted to the PIPS committee for review.

H. PEER REVIEW

Appraisal of clinical service and individual patterns of care, as required by reviews and evaluations conducted by the clinical service (e.g., Performance Improvement & Patient Safety, Infection Control) will be completed. This information will be utilized by the Chief of the Service in the medical staff reappointment process and delineation of privileges.

Patterns of care will be discussed during the monthly Mortality and Morbidity Conference meetings.

I. EVALUATION

The clinical service Performance Improvement and Patient Safety Plan will be evaluated annually. Questions to be answered include:

1. Did the program achieve its stated objectives and goals? If not, what goals were not achieved and what changes are necessary to achieve the desired goals?
2. What evidence is there of improved patient care as a result of the clinical service's Performance Improvement and Patient Safety (PIPS) Program?
3. What is needed to make the PIPS program more effective?
4. What components of the plan require alteration or deletion?

J. REVIEW OF PATHOLOGY REPORTS

1. Objective

To ensure that all pathology specimens removed by the Otolaryngology - Head & Neck Clinical Service are followed-up when necessary and result in adequate treatment.

2. Responsibility

a. Service Chief:

The Service Chief or designee reviews all reports submitted to ensure that treatment has been appropriate and complete. Takes action to initiate complete treatment and correct treatment errors when necessary.

3. Operations

Reports of operations performed by the service are maintained in departmental electronic files, 1 file under each attending's name.

4. Action

Problems with follow-up that are encountered will be discussed with the responsible resident/attending.

K. CLINICAL INDICATORS

Refer to Section IX.D. E., & F. above

L. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Section IX.D., E., & F. above

M. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

Refer to Section IX, D., E., & F., above

N. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to Section IX, D., E., & F., above

X. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws 7.2.I, all Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

Otolaryngology 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. Staff meetings are often held in conjunction with the UCSF Departmental Faculty meetings which are held approximately monthly. Minutes of the departmental meetings are ~~kept on file in the departmental office.~~[stored electronically by the UCSF department.](#)

As defined in the ZSFG Medical Staff Bylaws, Article VII, 7.2.G., a quorum is constituted by at least three (3)-voting members of the Active Staff for the purpose of conducting business.

XI. ADOPTION AND AMENDMENT

The Otolaryngology Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all full-time Active members of the Otolaryngology Service as often as necessary but at least every three years.

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

ATTACHMENT A: JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF OTOLARYNGOLOGY SERVICE JOB DESCRIPTION

Chief of Otolaryngology Clinical Service

Position Summary:

The Chief of Otolaryngology 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 (ZSFG) and the Department of Public Health (DPH). The Chief also ensures 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 Otolaryngology Clinical Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the 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 Otolaryngology 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 Otolaryngology 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;

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

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.

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

**ATTACHMENT B: OTOLARYNGOLOGY CLINICAL SERVICE PRIVILEGE REQUEST
FORM**

APPENDIX: ORGANIZATION - OTOLARYNGOLOGY CLINICAL SERVICE

1. OTOLARYNGOLOGY PROCEDURE CLINIC

a. Goals and Objectives

To establish guidelines for the safe and effective completion of procedures in the Otolaryngology Clinic

b. Procedures

All cases done require prior clearance by an otolaryngology attending who will assume responsibility for the case.

Under the guidance of an attending surgeon any case which may be safely accomplished under local anesthesia may be done as long as the attending surgeon has privileges for that type of procedure. Sedation may not be given for these procedures

The following procedures may be performed under these guidelines:

- Removal of intranasal [polyps/lesions or crusting](#)
- Incisional and excisional biopsies of non-vascular [nasal-masses or lesions of the head and neck](#)
- Cauterization or radiofrequency ablation of nasal turbinates
- Incisional or excisional biopsies and removal of facial ulcerations, tumors, neck masses, skin, and skin anomalies.
- Repair of facial lacerations
- Myringotomy and insertion of pressure equalization tubes
- Irrigation of paranasal sinuses
- Removal of intermaxillary fixation, archbars and other oral appliances.
- Closed reduction of nasal fractures
- [Diagnostic ultrasound of the head and neck and ultrasound-guided needle placement](#)
- [Botox injection](#)
- [Repair of tympanic membrane perforation](#)
- [Nasal cautery](#)
- [Removal of ear canal lesions, foreign bodies or cerumen including otomicroscopy](#)
- [Incision and drainage of abscess](#)
- [Salivary duct cannulation and flushing or saline or medications](#)
- [Tracheotomy tube changes and trachea-esophageal puncture changes](#)
- [Nasopharyngoscopy](#)
-

c. Staffing

At least one physician and an attendant will be available for participation in all cases.

Formatted: Not Expanded by / Condensed by

Formatted: Not Expanded by / Condensed by

Formatted: Not Expanded by / Condensed by

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

Cases will be scheduled during designated clinic time or at other times only if it will not interfere with the normal functioning of the clinic, and that adequate nursing staffing can be available.

d. Equipment

Only those procedures for which equipment can be assembled preoperatively for the completion of the entire procedure will be undertaken in the clinic treatment room.

2. **AUDIOLOGY SERVICE**
 - a. **Objective**

To establish an audiology service to provide diagnostic evaluation, screening, testing and rehabilitation services for individuals with known or suspected hearing disorders with appropriate staff, space, equipment and supplies.
 - b. **General Requirements**

Policy & Procedure Manual:

Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with the Chief, Department of Otolaryngology-Head & Neck Surgery and a representative of the Director of Hospitals and Clinics, Zuckerberg San Francisco General.

 1. Policies and procedures shall be approved by the Chief, Department Otolaryngology - Head & Neck Surgery and the Director of Hospitals and Clinics, Zuckerberg San Francisco General.
 2. Policies and procedures shall be reviewed annually by the Chief, Otolaryngology - Head & Neck Surgery and Director of the Audiology Service and revised as necessary.
 - c. **Organization**

Director: A qualified audiologist will have overall responsibility for the audiology service.

A qualified audiologist must have at least a Master's Degree in Audiology, a Certificate of Clinical Competence (CCC) from the American Speech, Hearing and Language Association (ASHA) and a California State License in Audiology.

The audiologist who directs the section will be accountable to the Chief, Department of Otolaryngology - Head & Neck Surgery or his or her designee regarding patient care.

The audiologist who directs the section will be accountable to the Director of Hospital and Clinics regarding administrative matters.
 - d. **Responsibilities of the audiologist shall include:**
 1. Development and implementation of pertinent policies and procedures.
 2. Coordination of a system of scheduled inpatient and ambulatory care patient services.
 3. Recommendation of the type and number of staff needed to perform the required services.
 4. Recommendation of the type and amount of equipment and facilities needed to perform the required services.

5. Establishment of continuing educational opportunities for staff personnel.
6. Participation in the review and evaluation of the quality and appropriateness of patient care.
7. Preparation of all required reports.
8. Development of appropriate job description for additional staff personnel as they are available.
9. Insuring that routine maintenance and calibration of equipment is accomplished and properly documented.
10. Teaching audiometric techniques to medical students and housestaff.
11. Participation in multidisciplinary teaching conferences.

e. **Staffing**

Supervision:

All services will be provided by, or under the direction of, an audiologist who meets the qualifications specified above.

Under the direct supervision of a qualified audiologist, audiology services may be provided by an individual who has completed the academic requirements in audiology and is in the process of obtaining the required professional experience necessary for certification.

Audiologists will be provided from the UCSF Audiology Department per the University contract.

The Chief, Department of Otolaryngology - Head & Neck Surgery or his/her designee will be available during the hours which audiology services are provided to provide professional consultation as required by the audiologist.

f. **Equipment and Supplies**

At least the following equipment shall be provided:

Audiometers:

1. One clinical audiometer
2. Immittance audiometer

Additional Diagnostic Tests and Materials:

1. Appropriate toys for play audiometry
2. Loud speakers
3. An otoscope
4. Tape deck

Calibration:

All audiometers will be calibrated to ANSI standards two times a year by an outside contractor. A record of calibrations will be kept in the audiometric test suite.

g. **Physical Plant**

1. Audiologic evaluations will be conducted in an audiometric test suite, which meets ANSI standards for reduction of background noise.

2. The room will be large enough for sound field-testing and be equipped with two speakers.
3. The audiometric test suite will be accessible by wheelchair.
4. Counseling and treatment areas will be provided adjacent to the audiometric test suite by request to the clinic nurse.

h. **Services Provided**

Audiologic services will be provided for total age range population from children to geriatric patients. Specialty consultation for infants and special tests are available at UCSF. Audiologic evaluations appropriate to rule out, establish, or monitor the type and degree of auditory dysfunction in a wide variety of pathologies and conditions will be available. These will include but not be limited to:

1. Pathologies of the auditory system
2. Exposure to ototoxic drugs
3. Exposure to loud noise
4. Head trauma
5. Delayed language development
6. Vertigo of unknown etiology
7. Prenatal, perinatal and neonatal high risk factors

Comprehensive audiologic services will be administered to establish a patient's hearing threshold, to monitor a patient's hearing level, to assist in the identification of site of lesion of hearing loss, to assess communication abilities and disabilities, and to indicate potential benefit from surgery, use of a hearing aid and aural rehabilitation.

i. **Basic Audiometry:**

Baseline or monitoring audiologic evaluations must include but are not limited to the following:

1. Air conduction pure tone audiometry
2. Bone conduction pure tone audiometry

j. **Diagnostic Audiometry:**

Diagnostic audiology evaluations must include, but are not limited to the following:

1. Air and bone conduction pure tone audiometry.
2. Speech reception thresholds
3. Speech discrimination scores.

Site of lesion audiologic evaluations must include but are not limited to the following:

1. Air and bone conduction pure tone audiometry
2. Speech reception thresholds
3. Speech discrimination scores including PB roll-over testing.
4. Immittance audiometry including acoustic reflex decay when possible.

k. **Additional Tests:**

Other audiologic tests may be performed at UCSF at the discretion of the audiologist or physician performing or supervising the test procedure to include:

1. ABR
2. ENG
3. Otoacoustic emissions.

l. **Hearing Aid Evaluations:**

Hearing aid evaluations and counseling are not provided.

m. **Aural Rehabilitation Services:**

1. Aurally disabled patients shall be referred to any appropriate source for aural rehabilitation services including auditory training, speech reading and hearing aid evaluation.
2. Counseling for parents of aurally disabled children shall be provided.

n. **High Risk Infants**

Screening for high-risk neonatal patients or infants will be provided by referral to the University of California, San Francisco, Department of Otolaryngology, for ABR audiometry.

o. **Case Management**

1. Patients seen for audiologic services may be referred by a physician or outside referral agency.
3. Audiometric test results will be recorded in the patient's medical record.
4. Notation will be made as to the audiologist's impression of the test results and any pertinent audiologic recommendations regarding necessity for further testing, need for amplification and/or aural rehabilitation services.
5. In addition to chart notes, copies of audiometric test results and recommendations will be sent to all outside referring physicians and agencies.

p. **Case Responsibility:**

1. Following audiologic evaluation, the patient will be returned to the referring physician for follow-up and continued medical management.
2. The audiologist will assume primary responsibility for the patient only when the referring physician requests that the audiologist assumes responsibility for a patient whose primary need is amplification and/or aural rehabilitation.
3. Patients for whom the audiologist has assumed primary responsibility will be referred back to his physician for consultation if significant changes are noted in auditory or vestibular status.

3. **OTOLARYNGOLOGYCLINIC**

a. **Objectives**

To establish guidelines for the safe and effective diagnosis and outpatient treatment of otolaryngologic conditions.

b. **General Requirements**

The otolaryngology clinic will be organized and run in the 4J clinic area. ~~Rooms 1 and 6 are~~ Many rooms are equipped with an operating microscope to use for otologic clinic procedures. All rooms have adequate lighting to be used for diagnosis and otolaryngology procedures as itemized in the protocol for the otolaryngology treatment room.

c. **Personnel**

1. DEPARTMENTAL CHIEF: Responsible for the overall management of the physician staff of the otolaryngology clinic. Responsible for setting policy for management of the clinic in consultation with the Nurse Manager.
2. NURSE MANAGER, 4J CLINIC: Responsible for the overall supervision of the nursing staff of the otolaryngology clinic.
3. SENIOR RESIDENT: Responsible for the coordination of resident attendance and resident and medical student teaching in the otolaryngology clinic.
4. JUNIOR RESIDENT/MEDICAL STUDENT: Patient Care as directed by the senior resident.
5. NURSE PRACTITIONER(S) and/or PHYSICIAN ASSISTANT(S): Responsible for e-referral as needed and other clinical duties as approved by ZSFG Affiliated Professional Staff Standardized Procedures and Protocols.
6. CLINICAL NURSE: Responsible for effective operation of the clinic as indicated below.
7. LICENSED VOCATIONAL NURSE/MEA: Responsibilities as listed below.
8. CLERICAL PERSONNEL: Responsible for making appointments and registering patients into the clinic.

d. **Schedule**

The Otolaryngology Clinic will run on the following schedule:

Monday:	8:15a.m. -5:00 p.m.
Tuesday:	No formal clinic
Wednesday:	8:15a.m.- 5:00 p.m.
Thursday:	8:15-12:00p.m.
Friday:	1:00 - 5:00 p.m.

e. **Appointments**

Patients may be referred by the emergency room or by other clinic/hospital physicians. Patients may also be scheduled in response to e-referral.

f. **Patient Visits**

Patients will be classified into the following categories:

1. NEW PATIENTS: These patients will routinely be scheduled for appointment time slots as indicated by templates approved by the OHNS chief of service.
2. FOLLOW-UP PATIENTS: These patients will routinely be scheduled as above.

3. DROP-IN PATIENTS: These patients do not have previous appointments that have been cleared by the clinic nurse or physicians. These patients will be seen after scheduled patients unless earlier evaluation is required for their condition.
4. INPATIENT CONSULTATIONS: These patients will be scheduled as acuity dictates.
5. OTOLARYNGOLOGY INPATIENTS: These patients will be seen, as required, when treatment requires use of clinic facilities.
6. AFTER HOURS CONSULTATIONS: Clinic rooms will be available for resident and attending evaluation of patients who are seen after normal clinic hours. Only patients who require specific equipment and facilities of the otolaryngology clinic should be seen in these areas.

A. Patient Processing

1. REGISTRATION: All patients will register per the current hospital policy.
2. ORDER OF PATIENT TREATMENT: Patients will be seen in the order of their arrival and based upon appointment time. This may be altered in the event of conditions requiring urgent treatment.
3. LAB AND X-RAY DATA: Prior to the patient being seen, the nursing staff will review the patient's record from the previous visit and ensure that laboratory and x-ray data previously ordered are available for review by the physician. He/she will attempt to locate these results if they are not in the electronic medical record.
4. HEAD AND NECK EXAM: On initial evaluation, patients will have a complete otolaryngology exam. The completeness of the exam will be modified as indicated on subsequent visits.
5. CLINICAL RECORDS: Providers will complete the outpatient clinical record immediately after seeing the patient. All outpatient encounters will be documented medical record system.
The face sheet will be completed by the provider prior to patient departure and the MEA will schedule other appointments and return visits.
6. AUDIOMETRIC EXAMS: Audiometric exams will be scheduled as outlined in the chapter on Audiology in the Clinical Service's Policy and Procedure Manual.

**OTOLARYNGOLOGY CLINICAL SERVICE
RULES AND REGULATIONS
2026**

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

I.	OTOLARYNGOLOGY CLINICAL SERVICE ORGANIZATION	1
A.	SCOPE OF SERVICE	1
B.	MEMBERSHIP REQUIREMENTS	1
C.	ORGANIZATION OF OTOLARYNGOLOGY CLINICAL SERVICE	1
II.	CREDENTIALING.....	1
A.	NEW APPOINTMENTS.....	1
B.	REAPPOINTMENTS	2
C.	AFFILIATED PROFESSIONALS.....	2
D.	STAFF CATEGORIES	2
III.	DELINEATION OF PRIVILEGES.....	3
A.	DEVELOPMENT OF PRIVILEGE CRITERIA	3
B.	ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM.....	3
C.	CLINICAL PRIVILEGES.....	3
D.	TEMPORARY PRIVILEGES.....	3
IV.	PROCTORING AND MONITORING.....	3
A.	MONITORING (PROCTORING) REQUIREMENTS	3
B.	ADDITIONAL PRIVILEGES.....	4
C.	REMOVAL OF PRIVILEGES.....	4
V.	EDUCATION.....	4
VI.	OTOLARYNGOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION (REFER TO SFCHN WEBSITE FOR HOUSESTAFF COMPETENCIES LINK)	4
A.	RESIDENT EVALUATIONS.....	4
VII.	OTOLARYNGOLOGY CLINICAL SERVICE CONSULTATION CRITERIA	6
VIII.	DISCIPLINARY ACTION	6
IX.	PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT.....	6
A.	GOALS AND OBJECTIVES.....	6
B.	RESPONSIBILITY	6
C.	RESIDENT PARTICIPATION.....	6
D.	MONITORING COMPONENTS	7
E.	EVALUATION.....	7
F.	ONGOING CLINICAL MONITORS	7
G.	REPORTING	8
H.	PEER REVIEW	8
I.	EVALUATION.....	8
J.	REVIEW OF PATHOLOGY REPORTS.....	8
K.	CLINICAL INDICATORS	9
L.	CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES	9
M.	MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES	9

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

N.	MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE.....	9
X.	MEETING REQUIREMENTS	9
XI.	ADOPTION AND AMENDMENT	10
ATTACHMENT A: JOB DESCRIPTION.....		
ATTACHMENT B: OTOLARYNGOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM		
APPENDIX : ORGANIZATION - OTOLARYNGOLOGY CLINICAL SERVICE		

I. OTOLARYNGOLOGY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Otolaryngology Head and Neck Surgery Clinical Service offers complete inpatient, outpatient and emergency care for all aspects of diseases that afflict the head and neck. The regular attending staff offers expertise in maxillofacial trauma, otology, laryngology, facial plastic surgery, rhinology, head and neck surgery, sleep surgery, and general otolaryngologic procedures. The resident and attending staff work closely with the Audiology and Speech Therapy departments at ZSFG and offer complete audiologic, speech and swallowing evaluation for children and adults. All staff will comply with HIPAA guidelines as per the ZSFG Bylaws and Rules and Regulations.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General 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 OTOLARYNGOLOGY CLINICAL SERVICE

The Otolaryngology Clinical Service consists of the Audiology Service, and Otolaryngology Clinic. Please refer to Appendix for established guidelines.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

1. Guidelines for Appointment

- a. Certification by the American Board of Otolaryngology, or another specialty board appropriate to the privileges requested, within three years of appointment, is required.

DEA certification is required for active and courtesy staff.

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

Reappointment to the medical staff requires an appraisal of the care given by the practitioner during his or her preceding appointment. This appraisal will be based upon direct observation of patient care when possible; review of the operative reports accrued in the preceding time period, review of the Morbidity and Mortality conference report files, and review of several randomly audited medical records.

2. Modification of Clinical Service

Modification of Clinical Services offered by the Otolaryngology –Head and Neck Surgery at ZSFG will only be made after discussion with the ZSFG Dean’s Office and a representative of the ZSFG administration with at least 30 days of written notification.

3. Staff Status Change

The process for Staff Status Change for members of the Otolaryngology Services is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

4. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Otolaryngology Services is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

5. On-Call Oversight

Faculty are expected to meet hospital, departmental, and ACGME requirements for on-call oversight. The call schedule is developed by the Department of Otolaryngology-Head and Neck Surgery at UCSF School of Medicine and requires 24 hour/day, 7 day/week, 365 days per year coverage of ZSFG.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment to the Affiliated Professionals of ZSFG through the Otolaryngology Clinical Service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations.

D. STAFF CATEGORIES

Otolaryngology Clinical Service staff fall into the same staff categories which are described in Article III of the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Otolaryngology Clinical Service Privilege Request Form shall be reviewed annually in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

C. CLINICAL PRIVILEGES

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Monitoring (proctoring) requirements for the Otolaryngology Clinical Service shall be the Responsibility of the Chief of the Service. (See II.B.1. & 2 above).

1. Goals and Objectives

The goals and objectives are to provide a one-year observation period following appointment to the medical staff to ensure that the privileges applied for are appropriate for the individual practitioner.

2. Participation

All new appointees to the medical staff during the first 6 months of their clinical appointment will be proctored.

3. Appraisal of Patient Care

Evaluation of patient care will be by:

- a. Observation of care provided during surgery.
- b. Assessment of the appropriateness of care delivered as observed on ward rounds.
- c. Review of minimum of 5 case files.
- d. Review of Morbidity and Mortality Reports relevant to the particular practitioner.

4. Individual Responsibilities

- a. Department Chief:
 1. Review the above information and make a recommendation either to continue or drop the physician from the medical staff.
 2. Make observations of patient care intraoperatively, on ward rounds and by assessment of patient complications or appointment of another physician to do the proctoring.
- b. Administrative Assistant:
 1. Review list of current hospital staff who require proctoring.
 2. Assemble relevant information for review by Chief on an annual basis so that pertinent recommendations can be made.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Otolaryngology Clinical Service shall be in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

The Otolaryngology-Head and Neck Surgery Clinical Service at the Zuckerberg San Francisco General is a cornerstone of the Otolaryngology-Head and Neck Surgery residency program at UCSF. Residents in their PGY-2, PGY-3, and PGY-4 years spend approximately two months at ZSFG, or the allotted time as determined by the number of residents in a given class. The majority of their trauma experience, outpatient care, and general otolaryngology-head and neck surgery cases are centered at this site. In addition, medical students regularly rotate on the service as either a mandatory third year clerkship (introduction to Otolaryngology) or as a fourth year sub-intern. Otolaryngology-Head and Neck Surgery faculty at the ZSFG are actively involved in the residency and medical student teaching program at UCSF on many levels. In addition, all members of the staff can attend UCSF department courses for CME credits.

VI. OTOLARYNGOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. RESIDENT EVALUATIONS

1. Individual Responsibilities

The Chief of Service and other attending staff are responsible for monitoring care provided by the resident staff. The Chief of Service provides the required reports. Attending faculty supervise house staff in such a way that the house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience.

- Role, responsibility, and patient care activities of the house staff: The house staff have primary responsibility for the clinical care of patients on the wards, in the clinic, and in the operating room under the supervision of attending staff. It is the goal of the program to have the residents develop a formal therapeutic relationship with the patients and to have patients identify the housestaff as the primary care provider. This includes initial history and physical exams, medical test decision making, procedures, and analysis of care options and therapeutic interventions. This educational environment is consistently monitored by the real-time presence of the attending staff who closely monitor and supervise house staff interactions and decision making. It should be remembered that the house staff are all eligible for California State Licensure to practice independently as physicians and surgeons in the state of California by having completed ACGME approved surgical internships.
- The attending staff and program director make decisions about the extent to which the resident can practice independently by analyzing a variety of factors including in-service scores, rotation evaluations, semi-annual formal performance evaluations, ABO surgical experience data, and also by direct, daily contact and observation.
- Resident Evaluation Process: the residents are evaluated in accordance with ACGME requirements for Otolaryngology/Head and Neck Surgery. The residents participate in Grand Rounds, Morbidity and Mortality conference, regularly scheduled didactic lectures, journal clubs, textbook chapter readings, the annual in-service examination, and individual rotation evaluations on the MedHub system in accordance with Graduate Medical Education Committee guidelines. American Board of Otolaryngology/Head and Neck Surgery surgical experience reports are examined semi-annually in formal reviews with the Program Director and Chair. Clinical comments and evaluations are made to the house staff on a daily basis by the attending staff and Chief of Service.
- Patient Care Orders: house staff may independently write patient care orders.

2. Activities Reviewed

Observations of resident performance include those made:

- Intraoperatively
- On ward rounds

- During review of patient charts
- Referrals by committee or other departments
- During Grand Rounds
- During conference presentations
- On review of Morbidity and Mortality Reports

3. Reporting

Each resident's ZSFG performance is evaluated by faculty and discussed at the Departmental clinical competency committee meetings by a ZSFG representative.

VII. OTOLARYNGOLOGY CLINICAL SERVICE CONSULTATION CRITERIA

The Otolaryngology-Head and Neck Surgery Clinical Service consult service will evaluate all patients in consultation within 12 hours of being requested by a ZSFG physician. Urgent consultation (within one hour) and Emergent consultation (immediate) are also available as needed. The senior resident in Otolaryngology-Head and Neck Surgery (the ZSFG Chief Resident) is responsible for all consultation requests. An Otolaryngology-Head and Neck Surgery attending will evaluate all consults within 24 hours of any consultation request.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

1. To ensure that patients receive appropriate diagnoses and good care with proper medications, treatment and therapy.
2. To avoid unnecessary days of inpatient care.
3. To minimize morbidity.
4. To minimize nosocomial infections.
5. To enhance the value of the clinical service educational programs.

B. RESPONSIBILITY

Service Chief

The Service Chief has the overall responsibility for the PIPS program. Design, initiation, implementation and follow-up of patient care evaluation activities may be delegated to other members of the clinical service.

Administrative Assistant:

1. Maintain Performance Improvement & Patient Safety (PIPS) files
2. Search Otolaryngology Clinical Service PIPS database.
3. Assemble information as needed for PIPS review.

C. RESIDENT PARTICIPATION

Residents participate actively in the Morbidity and Mortality Conferences. Residents provide observations to the Service Chief regarding clinical attendings. Observations

regarding the Chief of Otolaryngology/Head and Neck Surgery are made directly to the Chair, Otolaryngology/Head and Neck Surgery, UCSF.

D. MONITORING COMPONENTS

Some or all of the following ongoing monitors are utilized to review and evaluate the quality and appropriateness of care provided by the department:

1. Mortality Report records
2. Morbidity and Mortality Conference records
3. Review of non-tissue case referrals
4. Clinical monitors
5. Attending evaluations of housestaff
6. Housestaff evaluations of attendings and rotations and programs
7. Referrals: Utilization Review, incident reports, malpractice cases, transfusion reactions, adverse drug reactions.

E. EVALUATION

1. As clinical service problems, patterns, and trends are identified, appropriate assessments methodologies to determine the cause and extent of the problem will be selected and may include:
 - a. Medical audit utilizing predetermined clinically valid criteria
 - b. Experimental design and research
 - c. Staff discussion
 - d. Outside consultation
2. Action: Remedial actions may include:
 - a. In-service education and training programs
 - b. New/revised policies and procedures
 - c. Staffing changes
 - d. Equipment changes
 - e. Counseling and proctoring
 - f. Referral to outside committee for follow-up when appropriate
3. Reevaluation:

Reevaluation and monitoring will be completed to ensure that certain problems have been eliminated or reduced insofar as possible.

F. PERFORMANCE IMPROVEMENT DRIVER METRICS

1. OR block utilization; monitored on a monthly basis
2. TNAA (third next available appointment), monitored on a monthly basis
3. Outpatient no-show rate, monitored on a monthly basis

G. REPORTING

Evidence of all Otolaryngology Clinical Service Performance Improvement and Patient Safety activity will be maintained and reported during the monthly Morbidity and Mortality meetings held in conjunction with the rest of the UCSF clinical service as part

of the CME-certified Grand Rounds Conference schedule. Summaries of the meetings will be maintained within the department on a monthly basis and are available to the PIPS committee upon request.

The Chief of the Service or designee will be responsible for ensuring the correction of clinical service patient care issues. Assistance from the Performance Improvement and Patient Safety committee will be requested when certain problems cross clinical service/committee boundaries and/or when the clinical service is unable to correct the problem.

A yearly formal report encompassing ongoing clinical monitors will be submitted to the PIPS committee for review.

H. PEER REVIEW

Appraisal of clinical service and individual patterns of care, as required by reviews and evaluations conducted by the clinical service (e.g., Performance Improvement & Patient Safety, Infection Control) will be completed. This information will be utilized by the Chief of the Service in the medical staff reappointment process and delineation of privileges.

Patterns of care will be discussed during the monthly Mortality and Morbidity Conference meetings.

I. EVALUATION

The clinical service Performance Improvement and Patient Safety Plan will be evaluated annually. Questions to be answered include:

1. Did the program achieve its stated objectives and goals? If not, what goals were not achieved and what changes are necessary to achieve the desired goals?
2. What evidence is there of improved patient care as a result of the clinical service's Performance Improvement and Patient Safety (PIPS) Program?
3. What is needed to make the PIPS program more effective?
4. What components of the plan require alteration or deletion?

J. REVIEW OF PATHOLOGY REPORTS

1. Objective

To ensure that all pathology specimens removed by the Otolaryngology - Head & Neck Clinical Service are followed-up when necessary and result in adequate treatment.

2. Responsibility

a. Service Chief:

The Service Chief or designee reviews all reports submitted to ensure that treatment has been appropriate and complete. Takes action to initiate complete treatment and correct treatment errors when necessary.

3. Operations

Reports of operations performed by the service are maintained in departmental electronic files ,

4. Action

Problems with follow-up that are encountered will be discussed with the responsible resident/attending.

K. CLINICAL INDICATORS

Refer to Section IX.D. E., & F. above

L. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Section IX.D., E., & F. above

M. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

Refer to Section IX, D., E., & F., above

N. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to Section IX, D., E., & F., above

X. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws 7.2.I, all Active Members are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings and the annual Medical Staff Meeting.

Otolaryngology 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. Staff meetings are often held in conjunction with the UCSF Departmental Faculty meetings which are held approximately monthly. Minutes of the departmental meetings are stored electronically by the UCSF department.

As defined in the ZSFG Medical Staff Bylaws, Article VII, 7.2.G., a quorum is constituted by at least three (3)-voting members of the Active Staff for the purpose of conducting business.

XI. ADOPTION AND AMENDMENT

The Otolaryngology Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all full-time Active members of the Otolaryngology Service as often as necessary but at least every three years.

ATTACHMENT A: JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF OTOLARYNGOLOGY SERVICE JOB DESCRIPTION

Chief of Otolaryngology Clinical Service

Position Summary:

The Chief of Otolaryngology 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 (ZSFG) and the Department of Public Health (DPH). The Chief also ensures 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 Otolaryngology Clinical Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associate Dean, the UCSF Department Chair, and the 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 Otolaryngology 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 Otolaryngology 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;

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

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.

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

**ATTACHMENT B: OTOLARYNGOLOGY CLINICAL SERVICE PRIVILEGE REQUEST
FORM**

APPENDIX: ORGANIZATION - OTOLARYNGOLOGY CLINICAL SERVICE

1. OTOLARYNGOLOGY PROCEDURE CLINIC

a. Goals and Objectives

To establish guidelines for the safe and effective completion of procedures in the Otolaryngology Clinic

b. Procedures

All cases done require prior clearance by an otolaryngology attending who will assume responsibility for the case.

Under the guidance of an attending surgeon any case which may be safely accomplished under local anesthesia may be done as long as the attending surgeon has privileges for that type of procedure. Sedation may not be given for these procedures

The following procedures may be performed under these guidelines:

- Removal of intranasal lesions or crusting
- Incisional and excisional biopsies of non-vascular masses or lesions of the head and neck
- Cauterization or radiofrequency ablation of nasal turbinates
- Incisional or excisional biopsies and removal of facial ulcerations, tumors, neck masses, skin, and skin anomalies.
- Repair of facial lacerations
- Myringotomy and insertion of pressure equalization tubes
- Irrigation of paranasal sinuses
- Removal of intermaxillary fixation, archbars and other oral appliances.
- Closed reduction of nasal fractures
- Diagnostic ultrasound of the head and neck and ultrasound-guided needle placement
- Botox injection
- Repair of tympanic membrane perforation
- Nasal cautery
- Removal of ear canal lesions, foreign bodies or cerumen including otomicroscopy
- Incision and drainage of abscess
- Salivary duct cannulation and flushing or saline or medications
- Tracheotomy tube changes and trachea-esophageal puncture changes
- Nasopharyngoscopy
-

c. Staffing

At least one physician and an attendant will be available for participation in all cases.

Cases will be scheduled during designated clinic time or at other times only if it will not interfere with the normal functioning of the clinic, and that adequate nursing staffing can be available.

d. Equipment

Only those procedures for which equipment can be assembled preoperatively for the completion of the entire procedure will be undertaken in the clinic treatment room.

2. AUDIOLOGY SERVICE

a. **Objective**

To establish an audiology service to provide diagnostic evaluation, screening, testing and rehabilitation services for individuals with known or suspected hearing disorders with appropriate staff, space, equipment and supplies.

b. **General Requirements**

Policy & Procedure Manual:

Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with the Chief, Department of Otolaryngology-Head & Neck Surgery and a representative of the Director of Hospitals and Clinics, Zuckerberg San Francisco General.

1. Policies and procedures shall be approved by the Chief, Department Otolaryngology - Head & Neck Surgery and the Director of Hospitals and Clinics, Zuckerberg San Francisco General.

2. Policies and procedures shall be reviewed annually by the Chief, Otolaryngology - Head & Neck Surgery and Director of the Audiology Service and revised as necessary.

c. **Organization**

Director: A qualified audiologist will have overall responsibility for the audiology service.

A qualified audiologist must have at least a Master's Degree in Audiology, a Certificate of Clinical Competence (CCC) from the American Speech, Hearing and Language Association (ASHA) and a California State License in Audiology.

The audiologist who directs the section will be accountable to the Chief, Department of Otolaryngology - Head & Neck Surgery or his or her designee regarding patient care.

The audiologist who directs the section will be accountable to the Director of Hospital and Clinics regarding administrative matters.

d. **Responsibilities of the audiologist shall include:**

1. Development and implementation of pertinent policies and procedures.

2. Coordination of a system of scheduled inpatient and ambulatory care patient services.

3. Recommendation of the type and number of staff needed to perform the required services.

4. Recommendation of the type and amount of equipment and facilities needed to perform the required services.

5. Establishment of continuing educational opportunities for staff personnel.
6. Participation in the review and evaluation of the quality and appropriateness of patient care.
7. Preparation of all required reports.
8. Development of appropriate job description for additional staff personnel as they are available.
9. Insuring that routine maintenance and calibration of equipment is accomplished and properly documented.
10. Teaching audiometric techniques to medical students and housestaff.
11. Participation in multidisciplinary teaching conferences.

e. **Staffing**

Supervision:

All services will be provided by, or under the direction of, an audiologist who meets the qualifications specified above.

Under the direct supervision of a qualified audiologist, audiology services may be provided by an individual who has completed the academic requirements in audiology and is in the process of obtaining the required professional experience necessary for certification.

Audiologists will be provided from the UCSF Audiology Department per the University contract.

The Chief, Department of Otolaryngology - Head & Neck Surgery or his/her designee will be available during the hours which audiology services are provided to provide professional consultation as required by the audiologist.

f. **Equipment and Supplies**

At least the following equipment shall be provided:

Audiometers:

1. One clinical audiometer
- 2 Immittance audiometer

Additional Diagnostic Tests and Materials:

1. Appropriate toys for play audiometry
2. Loud speakers
3. An otoscope
- 4 Tape deck

Calibration:

All audiometers will be calibrated to ANSI standards two times a year by an outside contractor. A record of calibrations will be kept in the audiometric test suite.

g. **Physical Plant**

1. Audiologic evaluations will be conducted in an audiometric test suite, which meets ANSI standards for reduction of background noise.

2. The room will be large enough for sound field-testing and be equipped with two speakers.
3. The audiometric test suite will be accessible by wheelchair.
4. Counseling and treatment areas will be provided adjacent to the audiometric test suite by request to the clinic nurse.

h. **Services Provided**

Audiologic services will be provided for total age range population from children to geriatric patients. Specialty consultation for infants and special tests are available at UCSF. Audiologic evaluations appropriate to rule out, establish, or monitor the type and degree of auditory dysfunction in a wide variety of pathologies and conditions will be available. These will include but not be limited to:

1. Pathologies of the auditory system
2. Exposure to ototoxic drugs
3. Exposure to loud noise
4. Head trauma
5. Delayed language development
6. Vertigo of unknown etiology
7. Prenatal, perinatal and neonatal high risk factors

Comprehensive audiologic services will be administered to establish a patient's hearing threshold, to monitor a patient's hearing level, to assist in the identification of site of lesion of hearing loss, to assess communication abilities and disabilities, and to indicate potential benefit from surgery, use of a hearing aid and aural rehabilitation.

i. **Basic Audiometry:**

Baseline or monitoring audiologic evaluations must include but are not limited to the following:

1. Air conduction pure tone audiometry
2. Bone conduction pure tone audiometry

j. **Diagnostic Audiometry:**

Diagnostic audiology evaluations must include, but are not limited to the following:

1. Air and bone conduction pure tone audiometry.
2. Speech reception thresholds
3. Speech discrimination scores.

Site of lesion audiologic evaluations must include but are not limited to the following:

1. Air and bone conduction pure tone audiometry
2. Speech reception thresholds
3. Speech discrimination scores including PB roll-over testing.
4. Immittance audiometry including acoustic reflex decay when possible.

k. **Additional Tests:**

Other audiologic tests may be performed at UCSF at the discretion of the audiologist or physician performing or supervising the test procedure to include:

1. ABR
2. ENG
3. Otoacoustic emissions.

l. **Hearing Aid Evaluations:**

Hearing aid evaluations and counseling are not provided.

m. **Aural Rehabilitation Services:**

1. Aurally disabled patients shall be referred to any appropriate source for aural rehabilitation services including auditory training, speech reading and hearing aid evaluation.
2. Counseling for parents of aurally disabled children shall be provided.

n. **High Risk Infants**

Screening for high-risk neonatal patients or infants will be provided by referral to the University of California, San Francisco, Department of Otolaryngology, for ABR audiometry.

o. **Case Management**

1. Patients seen for audiologic services may be referred by a physician or outside referral agency.
3. Audiometric test results will be recorded in the patient's medical record.
4. Notation will be made as to the audiologist's impression of the test results and any pertinent audiologic recommendations regarding necessity for further testing, need for amplification and/or aural rehabilitation services.
5. In addition to chart notes, copies of audiometric test results and recommendations will be sent to all outside referring physicians and agencies.

p. **Case Responsibility:**

1. Following audiologic evaluation, the patient will be returned to the referring physician for follow-up and continued medical management.
2. The audiologist will assume primary responsibility for the patient only when the referring physician requests that the audiologist assumes responsibility for a patient whose primary need is amplification and/or aural rehabilitation.
3. Patients for whom the audiologist has assumed primary responsibility will be referred back to his physician for consultation if significant changes are noted in auditory or vestibular status.

3. **OTOLARYNGOLOGY CLINIC**

a. **Objectives**

To establish guidelines for the safe and effective diagnosis and outpatient treatment of otolaryngologic conditions.

b. **General Requirements**

The otolaryngology clinic will be organized and run in the 4J clinic area. Many rooms are equipped with an operating microscope to use for otologic clinic procedures. All rooms have adequate lighting to be used for diagnosis and otolaryngology procedures as itemized in the protocol for the otolaryngology treatment room.

c. **Personnel**

1. DEPARTMENTAL CHIEF: Responsible for the overall management of the physician staff of the otolaryngology clinic. Responsible for setting policy for management of the clinic in consultation with the Nurse Manager.
2. NURSE MANAGER, 4J CLINIC: Responsible for the overall supervision of the nursing staff of the otolaryngology clinic.
3. SENIOR RESIDENT: Responsible for the coordination of resident attendance and resident and medical student teaching in the otolaryngology clinic.
4. JUNIOR RESIDENT/MEDICAL STUDENT: Patient Care as directed by the senior resident.
5. NURSE PRACTITIONER(S) and/or PHYSICIAN ASSISTANT(S): Responsible for e-referral as needed and other clinical duties as approved by ZSFG Affiliated Professional Staff Standardized Procedures and Protocols.
6. CLINICAL NURSE: Responsible for effective operation of the clinic as indicated below.
7. LICENSED VOCATIONAL NURSE/MEA: Responsibilities as listed below.
8. CLERICAL PERSONNEL: Responsible for making appointments and registering patients into the clinic.

d. **Schedule**

The Otolaryngology Clinic will run on the following schedule:

Monday:	8:15a.m. -5:00 p.m.
Tuesday:	No formal clinic
Wednesday:	8:15a.m.- 5:00 p.m.
Thursday:	8:15-12:00p.m.
Friday:	1:00 - 5:00 p.m.

e. **Appointments**

Patients may be referred by the emergency room or by other clinic/hospital physicians. Patients may also be scheduled in response to e-referral.

f. **Patient Visits**

Patients will be classified into the following categories:

1. NEW PATIENTS: These patients will routinely be scheduled for appointment time slots as indicated by templates approved by the OHNS chief of service.
2. FOLLOW-UP PATIENTS: These patients will routinely be scheduled as above.

3. DROP-IN PATIENTS: These patients do not have previous appointments that have been cleared by the clinic nurse or physicians. These patients will be seen after scheduled patients unless earlier evaluation is required for their condition.
4. INPATIENT CONSULTATIONS: These patients will be scheduled as acuity dictates.
5. OTOLARYNGOLOGY INPATIENTS: These patients will be seen, as required, when treatment requires use of clinic facilities.
6. AFTER HOURS CONSULTATIONS: Clinic rooms will be available for resident and attending evaluation of patients who are seen after normal clinic hours. Only patients who require specific equipment and facilities of the otolaryngology clinic should be seen in these areas.

G. Patient Processing

1. REGISTRATION: All patients will register per the current hospital policy.
2. ORDER OF PATIENT TREATMENT: Patients will be seen in the order of their arrival and based upon appointment time. This may be altered in the event of conditions requiring urgent treatment.
3. LAB AND X-RAY DATA: Prior to the patient being seen, the nursing staff will review the patient's record from the previous visit and ensure that laboratory and x-ray data previously ordered are available for review by the physician. He/she will attempt to locate these results if they are not in the electronic medical record.
4. HEAD AND NECK EXAM: On initial evaluation, patients will have a complete otolaryngology exam. The completeness of the exam will be modified as indicated on subsequent visits.
5. CLINICAL RECORDS: Providers will complete the outpatient clinical record immediately after seeing the patient. All outpatient encounters will be documented medical record system.
The face sheet will be completed by the provider prior to patient departure and the MEA will schedule other appointments and return visits.
6. AUDIOMETRIC EXAMS: Audiometric exams will be scheduled as outlined in the chapter on Audiology in the Clinical Service's Policy and Procedure Manual.



City of San Francisco
Department of Public Health

**Zuckerberg San Francisco General
Hospital and Trauma Center**

Daniel Lurie
Mayor

Mary Mercer, MD
Chief of Staff

**SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form**

Directions:

1. Summarize the content changes that were made to the SP/protocols or Privileges using the table in Section I
2. Complete Section II: Follow instructions outlined in table
3. Email the revised SP with track changes and this completed form to the Michelle Mai, ZSFG Medical Staff Analyst (michelle.mai@sfdph.org), the CIDP Coordinator (erika.kiefer@sfdph.org), Nursing Manager (Jennifer.Berke@sfdph.org), and CIDP Co-Chairs (vagn.petersen@sfdph.org) (Vanessa.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:	Anesthesia
Department:	
Dept Chief:	
SP Author(s):	
Update #1:	Added Protocol #9: Consent & Ordering Blood Products for Transfusion
Reason/Explanation for Revision:	Reflect current practice
Update #2:	
Reason/Explanation for Revision:	

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below.

Preamble	• The Preamble is the portion of the SP that precedes the Protocols, the first pages of the SP, outlined I-VII, includes sections “Policy Statement, Functions to be Performed,” etc. • The Preamble was updated in 2023 to include changes in legislation, regulations, and practice. (CIDP, 10/2023)
Equity	Ensure language within the SP is inclusive. Examples include but are not limited to: • Do not use race/ethnicity descriptors unless necessary • Do not use sex assigned at birth unless necessary • Use “their” rather than “him/her” (CIDP, 8/2022)
ZSFG	Change “San Francisco General Hospital” to “Zuckerberg San Francisco General Hospital” and SFGH to ZSFG (CIDP, 10/2016) • “Community Health Network” change to “San Francisco Health Network” • “CHN” change to “SFHN”
Qualified Provider	Insert the following after every use of words “qualified provider:” who has completed proctoring and subsequently maintained their eligibility for performing the procedure. <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)



2026

**Zuckerberg San Francisco General Hospital
Committee on Interdisciplinary Practice**

Standardized Procedures

Nurse Practitioner/Physician Assistants

Title: Department of Anesthesia

PREAMBLE

I. Policy Statement

- A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose 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 4J Preoperative and Pain Clinic, the Pre-Op Clinic Medical Director's Office and on file in the Medical Staff Office.

II. Functions to Be Performed

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

Formatted: Font: (Default) Arial, 18 pt, Bold

Formatted: Centered

Formatted: Right: 1.19"

specific conditions requiring the Nurse Practitioner to seek physician consultation.

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

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/issues drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

1. Location of practice is in the Anesthesia Pre-operative Clinic, the Anesthesia Pain Management Clinic, and any other part of the hospital where pre-operative assessment and optimization, or acute/chronic pain assessment and management are required.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to the respective Medical Directors of the Preoperative Clinic and Pain Clinic, as well as the Anesthesia attending assigned to supervise the Anesthesia Pre-Op Clinic, Anesthesia Pain Management Clinic, or Anesthesia Acute Pain Service.
2. A consulting physician (Anesthesia attending) 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

IV. Scope of Practice

Protocol #1: Health Care Management: Primary Care/Specialty Clinics/Inpatient Units
Protocol #2: Pre-Op Screening of Adults
Protocol #3: Pre-Op Screening of Children
Protocol #4: Furnishing Medications and Drug Orders
Protocol #5: Electronic Consult (eConsult) Review
Protocol #6: Management of Neuraxial/Nerve Catheters for Pain Control
Protocol #7: Trigger Point Injections
[Protocol #8: Botox Injections for Migraines](#)
Protocol #9: Consent & Ordering Blood Products for Transfusion

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Font: Not Bold

Formatted: List Bullet

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) that must be from an American Heart Association provider.
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.

B. Specialty Training

1. Degree needed for adults: Adult Nurse Practitioner (ANP), Family Nurse Practitioner (FNP) or Physician Assistant (PA)
2. Degree needed for children less than 18 years of age: FNP, PA or Pediatric Nurse Practitioner (PNP)

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 Directors and/or designated physician and other supervisors, as applicable, will assess the NP/PA's ability to practice.

a. Clinical Practice

1. Length of proctoring period will be three months which can be shortened or lengthened.
2. The evaluator will be the Medical Directors and/or designated supervising physician or peer reviewers as applicable.
3. The method of evaluation in clinical practice will be a minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures demonstrate clinical competence or as noted in each special protocol.
2. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Directors, and/or designated physician, at appropriate intervals.
3. 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.
4. Biennial Reappointment: Medical Directors, and/or designated physician must evaluate the NP/PA's clinical competence. For reappointment, 5 chart reviews every 2 years or as noted in each special protocol. Charts can include reviews completed for special procedure reviews.

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, 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: Health Care Management – Specialty Clinics/Inpatient Units (Core)

A. DEFINITION

This protocol covers the procedure for age appropriate health care management in specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses within outpatient clinics, Emergency Department, Inpatient units, ICU.

B. DATABASE

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 ZSFG 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.
- 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. Uncommon, unfamiliar, unstable and complex patient conditions.
 - e. Upon request of patient, NP, PA, or physician
 - 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. smoking cessation, 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).

Protocol #2: Pre-Op Screening of Adults (Core)

A. Definition

This protocol covers the assessment and management of adults prior to the administration of anesthesia. This will include a directed history and physical.

1. Proctoring

- a. Length of proctoring period will be three months which can be shortened or lengthened.
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. The method of evaluation in clinical practice will be presentation of 5 adult cases to either the Medical Director or designated physician during the proctoring period with a chart review of the same 5 cases

2. Reappointment:

- a. The period of review will be every 2 years
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. Evaluation will be the review of 3 adult medical record cases

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. Historical information relative to the presenting illness (past health history, family history, occupational history, personal/social history, review of systems;
- c. Status of relevant symptom(s), e.g. present or stable

2. Objective Data:

- a. Physical examination appropriate to the disease process
- b. Review of appropriate laboratory / diagnostic studies
- c. All Point of Care Testing (POCT) will be performed according to the ZSFG 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. Diagnostic Plan
 - a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification
 - b. Referral to specialty clinics and supportive services, as needed
2. Treatment Plan
 - a. Physical and/or occupational therapy and/or speech therapy, if appropriate
 - b. Diet and exercise prescription as indicated by the disease process and the patient condition
 - c. Management of medications as appropriate
3. Patient conditions requiring Attending Consultation
 - a. With emergent conditions requiring prompt medication attention
 - b. With acute decompensation of the patient situation
 - c. When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings
 - d. Upon request of the patient, NP, PA, or Physician
 - e. When ordering expensive and/or unusual diagnostic studies
 - f. When prescribing medications not within the clinical expertise of the NP/PA
 - g. Patient conditions that may require physician consultation in addition to the ones mentioned in the preamble including but not limited to:
 - Significant abnormal lab values
 - New carotid bruits
 - New cardiac murmurs or other cardiac symptoms
 - Current uncompensated heart failure
 - New ECG changes
 - Other acute or chronic conditions which will benefit from treatment and stabilization prior to surgery.
 - Patients evaluated for surgery who have unusual and/or unanticipated findings.

4. Patient / Family Education

In verbal and/or written format, the Nurse Practitioner explains to the pertinent party or parties involved the disease process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up.

5. Follow-up and Referral

Performed in accordance with the standard of practice and/or with the consulting physician's recommendation.

E. Record Keeping

Patient contacts and visits are to be documented in accordance with standard practice and institutional policy. All information relevant to patient care will be recorded in the medical record.

A. Clinical Definition

This protocol covers the assessment and management of children less than 18 years of age prior to the administration of anesthesia. This will include a directed history and physical.

1. Proctoring

- a. Length of proctoring period will be three months in length which can be shortened or lengthened.
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. The method of evaluation in clinical practice will be presentation of 5 pediatric cases to either the Medical Director or designated physician during the proctoring period with a chart review of the same 5 cases.

2. Reappointment:

- a. The period of review will be every 2 years
- b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
- c. Evaluation will be the review of 3 pediatric medical record cases.

B. Database

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. Historical information relative to the presenting illness (past health history, family history, occupational history, personal/social history, review of systems
- c. Status of relevant symptom(s), e.g. present or stable

2. Objective Data:

- a. Physical examination appropriate to the disease process
- b. Review of appropriate laboratory / diagnostic studies
- c. All Point of Care Testing (POCT) will be performed according to the ZSFG 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. Diagnostic Plan

- a. Age appropriate screening tests, and/or diagnostic tests for purposes of disease identification
- b. Referral to specialty clinics and supportive services, as needed

2. Treatment Plan

- a. Physical and/or occupational therapy and/or speech therapy, if appropriate
- b. Diet and exercise prescription as indicated by the disease process and the patient condition
- c. Management of medication as appropriate.

3. Patient conditions requiring Attending Consultation

- a. With emergent conditions requiring prompt medication attention
- b. With acute decompensation of the patient situation
- c. When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings
- d. Upon request of the patient, NP/PA, or Physician
- e. When ordering expensive and/or unusual diagnostic studies;
- f. When prescribing medications not within the clinical expertise of the NP/PA
- g. Patient conditions that may require physician consultation in addition to the ones mentioned in the preamble including but not limited to:
 - Significant abnormal lab values
 - Congenital heart disorders
 - Severe neuromuscular disease
 - Cranio-facial malformations
 - Other acute or chronic conditions which will benefit from treatment and stabilization prior to surgery
 - Patients evaluated for surgery who have unusual and/or unanticipated findings

- 4. Patient / Family Education
 - a. In verbal and/or written format, the NP/PA explains to the pertinent party or parties involved the disease process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up.
 - b. The NP/PA will provide age appropriate verbal and/or written information to prepare a child and/or their family for the operative experience.
- 5. Follow-up and Referral

Performed in accordance with the standard of practice and/or with the consulting physician's recommendation.
- E. Record Keeping
 - 1. Patient contacts and visits are to be documented in accordance with standard practice and institutional policy.
 - 2. All information relevant to patient care will be recorded in the medical record.

Protocol #4: Furnishing Medications/Drug Orders (Core)

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. 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. The practice site, Anesthesia Services, 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: ZSFG, 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).

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 appropriate to presenting symptoms.
- 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 ZSFG 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. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
- c. Nurse Practitioners/Physician Assistants 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 electronic health record, or in the Medication Administration Record (MAR). The protocol will include the following:
 1. location of practice
 2. diagnoses, illnesses, or conditions for which medication is ordered
 3. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
- d. To facilitate patient receiving medications from a pharmacist the following information must be provided:
 - 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.(NP only), and DEA no.
- e. Limitations
 1. A prescription for a Schedule II or III controlled substance shall be limited to the number of tablets needed until the next scheduled follow-up clinic appointment.
 2. No refills will be allowed for lost or stolen narcotic prescriptions.

2. Patient conditions requiring Attending Consultation

- a. Problem which is not resolved after reasonable trial of therapies.
- b. Unexplained historical, physical or laboratory findings.
- c. Upon request of patient, NP, PA, or physician.
- d. Failure to improve pain and symptom management.
- e. Acute, severe respiratory distress

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 electronic medical record\MAR as appropriate.

Protocol #5: Electronic Consult (eConsult) Review

A. DEFINITION

eConsult review is defined as the review of new outpatient consultation requests via the online electronic health record. A new outpatient is defined as a patient that has neither been consulted upon by the specialty service, admitted to the specialty service nor seen in the specialty clinic within the previous two years.

1. Prerequisites:

- a. Providers reviewing eConsults will have six months experience with patients in the specific specialty area provided at ZSFG or elsewhere before allowed to do electronic referrals independently.
- b. Providers reviewing eConsults will be licensed as stated in the Standardized Procedure NP/PA Preamble.
- c. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
- d. Providers reviewing eConsults will have expertise in the specialty practice for which they are reviewing.

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Medical Director which will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.

3. Proctoring: Concurrent review of the first 20 eConsult consultation decisions will be performed by the Medical Director or designee concurrently for the first three months.

4. Reappointment: A review of five eConsults every two years.

B. DATABASE

1. Subjective Data

- a. History: 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 relevant to the presenting disease process as provided by the referring provider on the electronic referral. eConsult review will be confined to data found in the submitted eConsult form. Data contained in the paper or electronic medical record, but not in the eConsult, is specifically excluded from the eConsult review. The reviewer

will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

- b. Pain history to include onset, location, intensity, aggravating and alleviating factors, current and previous treatments.

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient as provided by the referring provider.
- b. Laboratory and imaging evaluation as obtained by the referring provider relevant to history, physical exam, and current disease process will be reviewed. Further evaluation will be requested from the referring provider if indicated.

C. DIAGNOSIS

A diagnosis will not be determined at the time of eConsult review. Differential diagnosis will be provided at the time the patient is seen in clinic by the consulting provider. Assessment of the subjective and objective data as performed by the consulting provider in conjunction with identified risk factors will be evaluated in obtaining a diagnosis.

D. PLAN

1. Review of eConsult

- a. Algorithms or referral guidelines developed and approved by the Medical Director will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.
- b. All data provided via the eConsult request will be reviewed and assessed for thoroughness of history, adequacy of work up, and urgency of condition.
- c. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation in patient condition.
- b. Unexplained historical, physical or laboratory findings.
- c. Upon request of the referring NP, PA, or physician.
- d. Problem requiring hospital admission or potential hospital admission.
- e. When recommending complex imaging studies or procedures for the referring provider to order.
- f. Problem requiring emergent/urgent surgical intervention.
- g. As indicated per the algorithms developed by the Chief of Service.

3. Education
 - a. Provider education appropriate to the referring problem including disease process, additional diagnostic evaluation and data gathering, interim treatment modalities and lifestyle counseling (e.g. diet, exercise).
4. Scheduling of Appointments
 - a. Dependent upon the urgency of the referral, the eConsult will be forwarded to the scheduler for either next available clinic appointment scheduling or overbook appointment scheduling.
5. Patient Notification
 - a. Notification of the patient will be done by the referring provider if the appointment is scheduled as next available. If the appointment is scheduled as an over book within two weeks of the electronic referral, the consulting scheduler is responsible for notifying the patient.

E. RECORD KEEPING

All information contained within the eConsult including the initial referral and any electronic dialogue between providers will be recorded in the electronic medical record upon scheduling or after a period of six months.

During the proctoring period, the eConsult request will be printed and the provider recommendations will be written on the printout. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into the electronic medical record and forwarded to the scheduler.

A. Definition

Management of in situ neuraxial and peripheral nerve catheters for the purpose of optimizing pain control including assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter after use is no longer indicated.

1. Location of procedure may include Emergency Department, Inpatient Units, Perioperative Area, and Intensive Care Units

- a. Indications - Patients with in situ neuraxial or peripheral nerve catheters who require catheter management.
- b. Precautions/Contraindications that require physician consultation:
 - Patients who are acutely hypotensive or predisposed to hypotension such as elderly patients, patients with heart failure, or hypovolemic patients.
 - New focal neurologic findings or severe back pain.
 - Patients with signs of neuraxial or peripheral nerve catheter infection or risk factors for contamination of such catheters including fever or elevated white blood cell count; catheter site tenderness, erythema, swelling, discharge, or bleeding; non-intact catheter dressing or catheter disconnection.
 - Patients with documented allergy to medication or medication in same class as catheter infusion medication.
 - Patients with coagulopathy or taking antithrombotic medications not consistent with joint UCSF/ZSFG "Guidelines For The Use of Antithrombotic Agents In The Setting Of Neuraxial Procedures"¹.

B. Data Base

1. Subjective Data

- a. History and review of symptoms relevant to the presenting complaint, pain presentation, and catheter placement procedure
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-containing products, anticoagulants, anti-platelet agents,

¹ <https://anesthesia.ucsf.edu/clinical-resources/guidelines-use-antithrombotic-agents-setting-neuraxial-procedures-0>

and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents and opioids.

2. Objective Data

- a. Physical exam to include vital signs review, inspection and palpation of the catheter site, sensory level of the neuraxial or nerve block, extremity motor and sensory function as appropriate
- 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 gauge effectiveness of pain control and determine the presence of complications related to pain management therapies

D. Plan

1. Therapeutic Treatment Plan

- a. Explain to the patient, if possible, the availability, risks, and benefits of relevant pain treatment modalities.
- b. Determine, in consultation with the attending physician, the consulting team, and the patient, which pain treatment modalities will be initiated, adjusted or discontinued
- c. Set up catheter medication infusion pump, initiate/adjust infusion medication, or remove catheter as appropriate
- d. Initiate, adjust, or discontinue other pharmacologic and non-pharmacologic pain modalities as indicated

2. Patient conditions requiring attending physician consultation

- a. Acute hypotension, allergic reaction, and any decompensation of patient.
- b. New neurologic findings or severe back pain
- b. Unexplained physical or laboratory findings
- c. Catheter requires removal/replacement due to inadequate function, loss of sterility, or signs of infection

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

3. Education

Provide patient and provider education related to catheter purpose, signs of malfunction/complication, and the patient controlled analgesia function

4. Follow-up

While on service, NP/PA will perform daily subjective/objective evaluation as described in section B) Data Base while catheter is in situ.

E. Record Keeping

1. Patient contacts are to be documented in the medical record in accordance with standard practice and institutional policy.
2. All information relevant to patient care 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 onsite training by a qualified anesthesia provider.
Proctoring a. A minimum of 2 observations by a qualified anesthesia attending of each of the following: clinical assessment of patient in relation to pain management, assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter
Reappointment a. The evaluator will be the Medical Director of the Anesthesia Acute Pain Service b. Management of 2 cases and 1 chart review every 2 years.

Protocol #7: Procedure: Trigger Point Injection

- A. DEFINITION:
A trigger point is defined as a focal area of soft tissue hyperirritability that is painful on palpation and/or elicits a twitch response. Trigger point injection is the insertion of a needle into a

trigger point, with or without injection of solution (e.g. saline, steroids, and anesthetics) into the region of the trigger point.

1. Indications:

- Pain attributed to a trigger point or a taut area of skeletal muscle

2. Precautions/contradictions:

- Allergy to injectable medication
- Close proximity to vital organs (e.g. potential risk of pneumothorax)

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, injury event 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 POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes such as myofascial pain with trigger points.

D. PLAN

1. Therapeutic Treatment Plan

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

2. Patient conditions requiring Attending Consultation
 - a. Acute decompensation of patient situation.
 - b. Allergic reaction
 - c. Unexplained historical, physical or laboratory findings
 - d. Upon request of patient, NP/PA, or physician
 - e. Problem requiring hospital admission or potential hospital admission.
3. Education

Patient will be informed that pain relief may occur immediately if anesthetics or steroids are injected. Baseline pain may recur upon clearance (“wearing out”) of the medications from the area of injection. Patient will be instructed in signs and symptoms of infection or allergy and procedures to follow if they occur.
4. Follow-up

Patients will be seen in follow up within 4-6 weeks if clinically indicated.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be documented in electronic medical record.

F. Summary of Proctoring and Reappointment Competency

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

Training by 3 direct observations of a qualified anesthesia attending performing trigger point injections will occur.

Standardized Training will include NP/PA being able to demonstrate knowledge of the following for all noted injection sites:

1. Indications for procedure and treatment
2. Risks and benefits of procedure and medication
3. Related anatomy and physiology
4. Consent process
5. Wound infection and wound healing mechanisms
6. Use of required equipment
7. Steps in performing procedures
8. Ability to interpret results and formulate follow-up plans
9. Documentation and CPT and ICD-10 coding
10. Ability to recognize complication

Proctoring:

a. New practitioners to procedure will have a minimum of 2 successful observed demonstrations of the procedure b. Experienced practitioners to procedure (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 demonstrations of the procedure. c. Chart review of all observed cases.
Reappointment Competency a. Performance of at least 2 injections every 2 years. b. 1 chart review every 2 years.

Protocol #8: Botox injections

A. DEFINITION

Administration of Botox (Onabotulinum toxin A) for the treatment of chronic migraine.

1. Location to be performed: ~~Neurology Service~~Anesthesia Pain Clinic
2. Performance of Botox Administration
 - a. Indications
 1. Prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer)
 - b. Precautions
 1. Potency units of Botox are not interchangeable with other preparations of botulinum toxin products.
 2. Spread of toxin effects: swallowing and breathing difficulties can lead to death. Seek immediate medical attention if respiratory, speech, or swallowing difficulties occur.
 3. Concomitant neuromuscular disorders, including peripheral motor neuropathic diseases, amyotrophic lateral sclerosis, or neuromuscular junction disorders (e.g., myasthenia gravis or Lamber-Eaton syndrome) may exacerbate clinical effects of treatment. Patients with known or unrecognized neuromuscular or neuromuscular junction disorders should be monitored when given Botox. They may be at increased risk of clinically significant effects including generalized muscle weakness, diplopia, ptosis,

dysphonia, dysarthria, severe dysphagia, and respiratory compromise.

4. Use with cautions in patients with compromised respiratory function.
5. Bronchitis and upper respiratory infections may occur in patients treated for spasticity.
6. Patients receiving concomitant treatment of Botox and aminoglycosides or other agents interfering with neuromuscular transmission (e.g., curare-like agents), or muscle relaxants, should be observed closely because the effect of Botox may be potentiated.

c. Contraindications

1. Allergy or hypersensitivity to Botox or any other botulinum toxin preparation or to any components in the preparation.
2. Infection at proposed injection site.
3. 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 and motor/sensory deficits.
- b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aminoglycosides and other agents interfering with neuromuscular transmission, anticholinergic drugs, other botulinum neurotoxin products, and muscle relaxants, and allergies.

2. Objective Data

- a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination and integrity of the skin at the proposed injection site.
- b. The procedure is performed following standard medical technique according to the PREEMPT trial and Manual of Botulinum Toxin Therapy, Second Edition.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes. Differential diagnoses would include but not limited to tension type headache or other primary headache disorders, intracerebral hemorrhage, aneurysmal subarachnoid hemorrhage, meningitis, space occupying lesion, idiopathic intracranial hypertension, cerebral venous thrombosis, spontaneous internal carotid artery dissection, or giant cell arteritis.

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 might include blood work such as C-Reactive Protein (CRP) and Erythrocyte sedimentation rate (ESR); CT or MRI only if patient symptoms do not meet criteria for migraine.
 - 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 Anesthesiology or Neurology Consultation with attending input confirming the need for the procedure.
3. Education
 - a. Discharge instructions and patient education material will be provided.
4. Follow-up
 - As appropriate for procedure performed.
 - a. Assess for side effects including a sensation of tightness across the forehead, inability to frown, eyebrow asymmetry eyelid ptosis, shoulder weakness or pain. Side effects typically self-resolve within 1-3 months.
 - b. Assess for allergic reaction.

Commented [DJ(1)]: Neuro provides consultation for these patients as well.

E. COMPETENCY ASSESSMENT

1. Initial Competence

- a. The Nurse Practitioner or Physician Assistant will be instructed on the procedure, efficacy and the indication of this therapy and demonstrate understanding of such.
 - b. The Nurse Practitioner or Physician Assistant will receive training and demonstrate competency in the following:
 - i. Medical indications and contraindications of the procedure.
 - ii. Benefits and potential side effects of the procedure.
 - iii. Related anatomy and physiology.
 - iv. Consent process (if applicable).
 - v. Steps in performing the procedures.
 - vi. Documentation of the procedure.
 - c. An Allergan certificate of completion of the Professional Education and Injection Paradigm Simulation Training for Botox will be required to certify that training is completed.
 - d. The Nurse Practitioner or Physician Assistant will observe the supervising physician/designee perform each procedure three times. The Nurse Practitioner or Physician Assistant will then perform the procedure three times under direct supervision.
 - e. The supervising physician will document the Nurse Practitioner or Physician Assistant's competency prior to allowing that individual to perform the procedure without supervision.
 - f. The Nurse Practitioner or Physician Assistant will ensure the completion of competency sign off documents.
2. Continued Proficiency
- a. The Nurse Practitioner or Physician Assistant will demonstrate competency by successful completion of the initial competency.
 - b. Each candidate will be initially proctored and signed off by the supervising physician/designee. The Nurse Practitioner or Physician Assistant must perform this procedure at least three times every two years. In cases where this minimum is not met, the supervising physician or designee must again sign off the procedure for the Nurse Practitioner or Physician

Assistant. The Nurse Practitioner or Physician Assistant will be signed off after demonstrating 100% accuracy in completing the procedure.

3. RECORD KEEPING

- a. Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Prerequisites
Completion of standardized procedure training on site
Proctoring Period
a. Minimum of 3 successful observed demonstrations b. Minimum of 3 chart reviews
Reappointment Competency
a. Evaluation will be performed by Supervising Physician and/or his or her designee b. Ongoing competency evaluation. 1. Completion of three procedures every 2 years. 2. Three chart reviews needed every 2 years.

Protocol #9: Consent & Ordering Blood Products for Transfusion

A. DEFINITION

Ordering the administration of whole blood or blood components i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate.

1. Location to be performed: Emergency Department, Inpatient Units, and Outpatient Clinics.

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.

b. Precautions

1. Blood and blood components must be given according to ZSFG guidelines.
2. Emergency exchange transfusion orders are not covered by this standardized procedure – these must be countersigned by the responsible physician.
3. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.

c. Contraindications

1. Absolute: none
2. 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.
3. Patient Declination for blood products for transfusion after informed consent discussion.

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.

Formatted: Font: (Default) Arial, 12 pt, Font color: Auto

Formatted: Font: (Default) Arial, 12 pt

Formatted: Heading 1

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.38", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.38", Hanging: 0.38", Space After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.38", Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", First line: 0.25", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space After: 0 pt, Line spacing: single

Formatted: Font: (Default) Arial, 12 pt

Formatted: Left, Indent: Left: 1", Hanging: 0.31", Space After: 0 pt, Line spacing: single

Formatted: Font: (Default) Arial, 12 pt

Formatted: Indent: Left: 1", Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", First line: 0.25", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space After: 0 pt, Line spacing: single

-

2. Objective Data

- a. Physical exam relevant to the decision to transfuse.
- 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 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. (ZSFG 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
- e. Problem requiring hospital admission or potential hospital admission.

-

3. Education

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

-

4. Follow-up

As appropriate for patient 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 and other patient data bases, as appropriate.

-

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Indent: Left: 1", Space After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space After: 0 pt, Line spacing: single

Formatted: Indent: Left: 0.5", Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Space Before: 6 pt, After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single

F. Summary of Prerequisites, Proctoring and Reappointment Competency

-

Prerequisite:

- a. Successful completion of the Zuckerberg San Francisco General Hospital 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 Period:

- a. Read and Sign the ZSFG Administrative Policy and Procedure 2.3 "Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options".
- b. Read ZSFG Transfusion Guidelines in Laboratory manual.
- c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.

Reappointment Competency Documentation:

- a. Completion of the two education modules and completion of the two examinations with a passing score of 80%.
- b. Performance of 1 transfusion order per year and 1 medical record review per 2 years.
- c. Review of any report from the Transfusion Committee.
- d. Evaluator will be the medical director or other designated physician.

Formatted: Font: (Default) Arial, 12 pt

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Font: (Default) Arial, 12 pt

Formatted: Space After: 0 pt, Line spacing: single

References

Allergan (2018). *Allergan Botulinum Toxin package insert*. MBD108116_v3 05/18.

Medscape (2021). *Migraine Headache Differential Diagnoses*. <https://emedicine.medscape.com/article/1142556-differential>. Retrieved December 15, 2021.

Medscape (2019). *Botulinum Toxin in Pain Management*. <https://emedicine.medscape.com/article/325574-overview>. Retrieved December 15, 2021.

Truong, D., Dressler, D., Hallett, M., & Zachary, C. (Eds.). (2014). *Manual of Botulinum Toxin Therapy* (2nd ed.). Cambridge: Cambridge University Press. doi:10.1017/CBO9781139178068

ZSFG 2020 Anesthesia Service NP/PA Standardized Procedures

Medical Director or Division Chief Approval or Service Chief Approval
Marc Steurer, MD

Author Name: Arthur Wood, MD Anesthesia Service Standardized Procedures

CIDP Approval Date: 5/06/2020

Credentials Approval Date: 6/01/2020

MEC Approval Date: 6/08/2020

Gov. Body Approval Date: 6/23/2020

Formatted: Font: (Default) Arial, Bold

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Font: Bold

Formatted: Font: Bold

Formatted: Space After: 0 pt, Line spacing: single

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Font: (Default) Arial

Formatted: Space After: 0 pt

Formatted: Space Before: 0 pt, After: 0 pt, Line spacing: single

Formatted: Space After: 0 pt, Line spacing: single



Department of Public Health

MS.08.01.03: Summary of Changes

Current	Revision	Explanation for Revision
All references to credentialing and primary source verifications performed within 180 days	All references to credentialing and primary source verifications performed within 120 days	NCQA shortened the primary source verification window from 180 to 120 days (effective July 1, 2025) to ensure provider credentials are up-to-date at the time of credentialing
N/A	V. Procedure (page 3) In accordance with ZSFG Medical Staff Bylaws, the Credentials Committee includes an interdisciplinary group representation of peer-review-qualified practitioners and designated physicians who hold direct responsibility, expertise, and active involvement in credentialing decisions. The committee uses a peer-review process to thoroughly evaluate credentialing information and make informed recommendations. The Medical Staff Services Department supports the credentialing process by providing comprehensive information for both initial credentialing and recredentialing reviews. Credentialing criteria are formally reviewed and approved by the Credentials Committee, its Chair, or designated members. Cases that do not meet the established eligibility criteria are escalated to the Credentials Committee for decision-making.	NCQA requires that policies (1) define the criteria used to make credentialing decisions and (2) state that these criteria are reviewed and approved by the Credentialing Committee, Medical Director, or another designated peer review body.
N/A	H. Non-Discriminatory Credentialing and Recredentialing v. The San Francisco Department of Public Health (SFDPH), including the San Francisco Health Network (SFHN) and ZSFG, credentialing applications may	Health Plan requirement, in response to NCQA Health Plan Accreditation standard CR 3, Element C, factor 6 requires non-discrimination statement be included on both the application and policy. Questions on race,



Department of Public Health

	request demographic information such as race, ethnic or national identity, gender, age, sexual orientation, language, and other related details. Providing this information is entirely optional and not required for credentialing. Any demographic data voluntarily disclosed by an applicant will not be used in any discriminatory manner and will have no impact on the review, evaluation, or approval of credentialing applications. This information is collected solely for purposes such as compliance with reporting requirements, promoting diversity, and improving health equity initiatives.	ethnicity, and language capabilities are optional and will not be used in credentialing decisions.
N/A	H. Non-Discriminatory Credentialing and Recredentialing vi. The San Francisco Department of Public Health (SFDPH), including SFHN and ZSFG, is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or professional disciplinary action from another state when that action is based exclusively on the application of a law from that state that restricts or penalizes care that is lawful in California. (§1375.61, SB-487)	Health Plan requires that a written policy that delegates do not automatically deny or terminate a provider solely because of an out-of-state judgment/conviction/discipline when the reason for that out-of-state action is only tied to another state's law restricting care that is legal in California.
J. System Control Measures	J. Credentialing Information Integrity Appendix G: SFHN Credentialing Information Integrity Policy and Procedure.	System Control Measures have been updated to NCQA's 2025 Credentialing Information Integrity standard (CR-2), requiring organizations to implement policies and procedures that define the scope of credentialing data, responsible staff, documentation and audit processes.
Appendix B – Verification Methods License to Practice in California Includes information on licensure sanctions and expirables.	Appendix B – Verification Methods License to Practice in California Includes information on licensure sanctions and expirables that are monitored monthly.	Health Plan requirement on the occurrence to which expirables are monitored.

ZSFG HOSPITAL & TRAUMA CENTER

Medical Staff Organization Credentialing Manual

Office of Origin: Medical Staff Services, (628) 206-2342

I. PURPOSE:

Zuckerberg San Francisco General Hospital (ZSFG) and Clinics ensure that licensed health care providers meet the minimum credentials standards for Medical Staff or Affiliate Staff membership. This Credentialing Manual (with accompanying policies and procedures) and the Appendix, will be reviewed and approved each year by the ZSFG Credentials Committee and Medical Executive Committee.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- Joint Commission Medical Staff Standards
- NCQA Credentialing Standards
- CMS Conditions of Participation
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

III. DEFINITIONS:

Practitioner: Any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, unless otherwise expressly limited.

Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures or privileges: Advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, or CRNA – certified registered nurse anesthetist), PA – physician assistant, PharmD, Optometrists, Genetic Counselor, Acupuncturist and other categories as approved by the Governing Body.

Provider: For purposes of this document, provider means practitioners and affiliates.

Complete Application:

A complete application, at the point that verifications are finished, means the following:

- all information was verified and any missing information is explained or accounted for;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by ZSFG have been resolved.

IV. POLICY:

The Medical Staff Office conducts credentialing with confidentiality for all clinical venues within ZSFG and will only delegate credentialing to any outside entities if needed. Credentialing is performed prior to appointment and reappointment to the ZSFG Medical Staff.

- A. Each provider has a confidential credentials file, which contains verification documents. For Medical Staff members, the credentials file includes quality information as described in Appendix A. These files are re-verified at least every two (2) years. Expirable documents are updated on an ongoing basis. All required verifications must be no more than 120 days old at the time of Governing Body review.

B. Credential files are treated as confidential and are kept within file cabinets with access by Medical Staff Office personnel only. These files are protected from discovery pursuant to Evidence Code Section 1156, et seq. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Section 1156, et seq.

1. The credentials file may be reviewed by contracting health plan representatives (pursuant to delegated credentialing agreements), except that information determined to be confidential.

A provider has the right to review the items in their credentials file, except the following elements: National Practitioner Databank Reports and Letters of Reference. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the credentials file.

2. The quality information may be reviewed by contracting health plan representatives for the following elements: malpractice claims history, disciplinary actions by hospitals, managed care organizations or State Medical Boards and outcomes of those actions. Other quality items are subject to review pursuant to delegated quality agreements or the National Commission on Quality Assurance (NCQA) credentialing standards.

A provider has the right to review the items in their quality file, except letters of reference or documents related to peer review activities. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the quality file.

C. Provider Rights to obtain Status of Application

Upon request, providers will be notified of the status of their application during the credentialing process.

D. Provider Rights to Amend Application

The provider attests that all information submitted for the credentialing process is accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the provider will be asked (via phone, letter or email) to resolve this discrepancy. The provider will be given opportunity to resolve the discrepancies, with response to the Credentials Committee Chair. Any attempts to intentionally hide or misrepresent information are addressed during the Credentials Committee review.

E. Notification of Provider Rights: Pursuant to the Medical Staff Bylaws, providers are notified of their rights to:

- review information submitted to support their credentialing application;
- correct erroneous information; and
- be informed of the status of their application upon request.

F. Erroneous Information: The applicant for appointment, reappointment, and/or clinical privileges will be notified by credentialing staff of any conflicting information found in the provider's application and/or any supporting documentation.

Notice will occur by telephone or written request within 10 days of discovery, and will be documented in the provider's credentials file.

- The provider will have 30 days to reconcile and return the application and/or

supporting documentation to the credentialing staff

- Acceptable format will be the corrected and signed credentialing application and, as applicable, a written and signed explanation for any discrepancies in the original application
- The Credentials Committee or Credentials Committee Chair will receive a report of any corrected information submitted by the provider.
- The documentation provided by the applicant and any other related documents will be placed in the provider's credentials file along with notation as to the date received.

G. Upon delegation of credentialing activities, audits may be performed by health plan representatives and other payers, based upon the following guidelines:

1. Audits must be scheduled in advance at a time mutually agreed upon by ZSFG and the auditing entity.
2. Selected documents regarding peer review may not be subject to auditing.
3. Auditors may not photocopy or remove documents.

If credentialing is not delegated, the health plan/payer is responsible for credentialing providers for their health plan.

V. PROCEDURE

In accordance with ZSFG Medical Staff Bylaws, the Credentials Committee includes an interdisciplinary group representation of peer-review-qualified practitioners and designated physicians who hold direct responsibility, expertise, and active involvement in credentialing decisions. The committee uses a peer-review process to thoroughly evaluate credentialing information and make informed recommendations.

The Medical Staff Services Department supports the credentialing process by providing comprehensive information for both initial credentialing and recredentialing reviews. Credentialing criteria are formally reviewed and approved by the Credentials Committee, its Chair, or designated members. Cases that do not meet the established eligibility criteria are escalated to the Credentials Committee for decision-making.

A. Initial Appointments

1. The following information is required to begin the Initial Appointment process:
 - Request from Department
 - Applicant Name
 - Curriculum Vitae/Resume including all professional work history
 - Faculty Appointment (if applicable)
 - Requested Privileges/Protocols (Standardized Procedures), (when applicable)
 - Requested Start Date for Temporary Privileges/Credentials only
 - ID attestation per Joint Commission guidelines
2. Providers must complete the following items:
 - Application for Medical Staff or Affiliate Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges, or for Affiliate, Standardized Procedures.
 - Agreement to abide by the Medical Staff Bylaws, Rules and Regulations
 - Health Plan Attestation form (as applicable)
 - Environmental Safety form
3. In addition to returning the above documents, providers also must submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not

limited to:

- Copy of California License(s) (an on-line query is acceptable)
- Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
- Evidence of Current Malpractice Coverage, if applicable
- Fluoroscopy Certificate as appropriate
- Current Photo
- CPR, BLS/ACLS, PALS, NALS, if applicable
- Current Curriculum Vitae (CV)

4. The Medical Staff Office reviews the documents as follows:

- a. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
- b. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges. The applicant confirms the correctness and completeness of the application.
- c. Clinical venues are specified and appropriate.
- d. Complete addresses, phone and fax numbers as listed for:
 - Medical school, Internships, Residencies, Fellowships;
 - Hospitals and affiliations;
 - Peer references; and
 - Malpractice insurance company(ies)
- e. Privileging forms or Standardized Procedures are completed as appropriate.
- f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
- g. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

5. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

Verification of provider enrollment screening in the Medicaid Fee-For-Service program. Completion of the Medi-Cal related acknowledgements for health plan specific trainings are required to begin within 10 working days of a new provider becoming active, and may be completed up to 120 days prior to the new being activated/approved.

6. File Triaging:

Once all of the information is gathered, the applicant's file is triaged by the Medical Staff Office and flagged for potentially adverse information to be carefully evaluated during the Credentials Committee review.

7. Temporary Privileges for Initial Appointments:

For Initial Appointments involving clinical urgency, a Service Chief may request temporary privileges up to 120 days. Request for Temporary Privileges/Credentials must be approved by the

CEO (or authorized designee) on the recommendation of the Chief of Staff (or authorized designee).

Actions on temporary privileges/credentials are updated in the Medical Staff Office database upon approval and appropriate areas are notified. The Medical Staff Office database updates the applicant's status and privileges/protocols are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

8. Applicants must complete the credentialing process with privileges or standardized procedures (as appropriate) prior to the provision of patient care to ZSFG patients.

B. Reappointments

1. Reappointment Application Packet

At least five (5) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:

- Preprinted Reappointment Application
- Copy of current clinical privileges

2. The provider is required to return the application and supporting documents within thirty (30) days, and include the following:

- Copy of current DEA Certificate as appropriate
- Fluoroscopy Certificate as appropriate
- CPR, BLS/ACLS, PALS, NALS, if applicable
- Current CV

3. If the application is not returned within the designated time period, the provider and Department Chair will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment may be deemed to be a voluntary resignation from the Medical Staff, and the provider will be submitted as "resigned" to the Credentials Committee.

Practitioners/Affiliates who automatically resign shall be required to complete a reinstatement form to reapply for membership. Reinstatement shall be processed in a manner parallel to the reappointment process. Reinstatement application forms shall be accepted within one (1) month from the date the practitioner membership expires.

All Practitioners/Affiliates whose membership has expired more than one (1) month shall be required to complete the initial appointment process.

4. The Medical Staff Office reviews the documents as follows:

- a. All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
- b. Applicant's signature is present and dated on all forms. The applicant confirms the correctness and completeness of the application.
- c. Privileging forms and Standardized Procedures are completed as appropriate.
- d. Clinical venues are specified and appropriate.

- e. Completed addresses, phone and fax numbers as listed for:
 - Hospitals and affiliations
 - Peer references; and
 - Malpractice insurance company(ies)
 - f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
 - g. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy) are current.
5. Verification of Information
- Verification of information begins as soon as the application appears complete, and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.
- Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed. Verification of provider enrollment screening in the Medicaid Fee-For-Service program
6. Reappointment Performance Improvement
- The results of performance monitoring, evaluation, and identified opportunities to improve care and service are documented in this file. Data Summary sheets are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership.
7. Pre-Credentials Committee Meeting
- A meeting shall be convened prior to the Credentials Committee meeting date which shall be attended by the Chair of the Credentials Committee and the credentialing staff to discuss files of concern and the agenda.

C. Evaluation And Approval Process

1. Clinical Services Evaluation Process

If an issue is identified, the related documentation is flagged for the Service Chief to review. The complete file - including application, supportive documents, privileges request form, practitioner sanctions, complaints, and adverse events –is sent to the appropriate Service Chief for review and recommended to the Credentials Committee. For any flagged files, the Service Chief must document sufficient review to support their recommendation for appointment or reappointment.

If the Service Chief is disinclined to make a favorable recommendation due to:

- concerns indicating the potential for a provider's conduct to be detrimental to patient safety or care, or
- concerns related to professional competence or behavior that could adversely affect patient welfare;

the Service Chief drafts a report outlining these concerns for the Credentials Committee.

After the Service Chief's recommendation is completed, the file is prepared for discussion at the next monthly Credentials Committee meeting, and the applicant is placed on the Credentials Committee Summary Report.

2. Credentials Committee Evaluation Process

The Credentials Committee reviews the Summary Report and all applicable credentialing criteria—such as practitioner sanctions, complaints, and adverse events identified through ongoing monitoring—before approving credentialing decisions and issuing its formal recommendation for appointment or reappointment. Files are evaluated in accordance with the File Triaging categories (see Appendix C).

Applications categorized as ‘*green*’ do not require committee discussion and are approved on the consent agenda. Applications categorized as ‘*yellow*’ or ‘*red*’ are discussed in detail by the Credentials Committee.

Applications requiring additional information/clarification may be tabled until sufficient information is gathered to support a recommendation. Discussion is documented in the committee meeting minutes. The report with Credentials Committee recommendations is then sent to the Medical Executive Committee (MEC).

3. Medical Executive Committee and Governing Body Evaluation Process

The Credentials Committee Summary Report is reviewed by the Medical Executive Committee, then the Joint Conference Committee, and then referred to the Health Commission as the Governing Body.

Actions on credentialing and recredentialing are updated in the Medical Staff Office database within 10 days of Governing Body approval, and these updates are made available on designated intranet sites for inquiry by the applicant or authorized staff. Notification of the Governing Body’s decision is forwarded to the applicant within 30 days.

4. Provider Enrollment

Upon Governing Body approval, formal notification of the finalized Credentials Committee Summary Report is sent to the contracted Health Plans, to ensure timely notification of all credentialing and recredentialing decisions, including changes in provider status, approved privileges, or conditions placed on participation.

D. Visiting Privileges

1. In circumstances involving clinical necessity when clinical services require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, visiting privileges may be granted on a case-by-case basis.
2. The following information is required to begin the Visiting Privileges process:
 - Completed Application
 - Curriculum Vitae/Resume including all professional work history
 - Faculty Appointment (if applicable)
 - Service Chief Recommendation
 - Requested Privileges
 - Requested Start Date
3. Providers must complete the following items:
 - Visiting Application including Confidentiality Statement and Consent to Release Information and Privileges.
 - Review the Medical Staff Bylaws, Rules and Regulations
4. In addition to returning the above documents, providers must also submit any relevant

licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:

- Copy of California License(s) (an on-line query is acceptable)
- Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
- Evidence of Current Malpractice Coverage
- Fluoroscopy Certificate as appropriate
- CPR, BLS/ACLS, PALS, NALS, if applicable
- Current Curriculum Vitae (CV)

5. The Medical Staff Office reviews the documents as follows:

- All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
- Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges.
- Clinical urgency and venues are specified and appropriate.
- Complete addresses, phone and fax numbers as listed for:
 - Hospitals and affiliations;
 - Peer references; and
 - Malpractice insurance company(ies)
- Privileging forms are completed as appropriate.
- California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

6. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

7. The Chief of Staff and the Executive Administrator (or authorized designees) may grant Visiting privileges for a specified period of time after the above information has been evaluated by the applicable service chief and he/she has made an affirmative recommendation.

E. Expirables/Ongoing Monitoring

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods.

F. Resignations

The effective date of the resignation will be the last day of the month in which the provider states that he/she is resigning, or a date indicated by the Chief of Service, and can occur before the Governing Body date. Notice of resignation to the Medical Staff Office may be submitted by the resigning provider or by the Department Chief, or Chief's designee, provided that the resigning provider is copied on the notice.

H. Non-Discriminatory Credentialing and Recredentialing.

The Medical Staff Office monitors and prevents discriminatory credentialing through the following process:

- i. Tracking and trending of reasons for denial and / or termination.
- ii. Semi-annual audits of files in process for more than 120 days.
- iii. All Credentialing Committee members, staff, and guests are required to sign the Statement of Confidentiality annually, which includes a non-discrimination statement. Committee members must also sign a standing non-discrimination agreement that remains in effect for the duration of their service. By signing, members attest that all credentialing decisions—whether related to approval, denial, or termination—are based solely on objective applicant qualifications and established network participation criteria, and never on factors such as age, gender, sexual orientation, race, ethnic or national identity, specialization, or the type of services provided.
- iv. Credentials Committee agenda must include a non-discrimination statement. All documents and information presented for committee review must exclude any references to a practitioner’s race, ethnic or national identity, gender, age, sexual orientation, or to specific procedures or types of patients the practitioner serves. This ensures that credential decisions remain unbiased, equitable, and compliant with the organization’s non-discrimination standards.
- v. The San Francisco Department of Public Health (SFPDH), including the San Francisco Health Network (SFHN) and ZSFG, credentialing applications may request demographic information such as race, ethnic or national identity, gender, age, sexual orientation, language, and other related details. Providing this information is entirely optional and not required for credentialing. Any demographic data voluntarily disclosed by an applicant will not be used in any discriminatory manner and will have no impact on the review, evaluation, or approval of credentialing applications. This information is collected solely for purposes such as compliance with reporting requirements, promoting diversity, and improving health equity initiatives.
- vi. The San Francisco Department of Public Health (SFPDH), including SFHN and ZSFG, is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or professional disciplinary action from another state when that action is based exclusively on the application of a law from that state that restricts or penalizes care that is lawful in California.
(§1375.61, SB-487)

I. Primary Source Verification (within 120 days prior to decision) - ongoing monthly monitoring
(see Appendix B - Verification Methods)

- National Practitioner Data Bank (NPDB)
- State Medical Board licensure
- Medi-Cal and Medicaid Suspended and Ineligible List
- Medicare and Medicaid exclusions/sanctions
- Office of Inspector General (OIG) Exclusion List
- SAM.gov debarment checks
- Board Certification
- Work History
- Malpractice insurance coverage and professional liability claim history
- Attestation questions answered in the application

J. Credentialing Information Integrity - (see Appendix G: SFHN Credentialing Information Integrity Policy and Procedure)
The purpose of this section is to ensure compliance with CR 8, Element A, National Committee for Quality Assurance (NCQA) standards.

A. CREDENTIALS FILE

(available for provider review)

The following documents are kept current and maintained in the Credentials file (as applicable):

1. Application for membership.
2. Delineation of privileges, recommended by the Service Chief in the service which privileges are being requested.
3. Current California State Medical (or other professional) License
4. Valid DEA certification, as applicable
5. Current X-ray Supervisor and Operator Certificate, as applicable
6. Verification of graduation from medical (or other professional) school and completion of residencies and fellowships
7. Verification of previous affiliations prior to SFGH Medical Staff appointment
8. Curriculum Vitae that includes a comprehensive work history
9. Evidence of current, adequate malpractice insurance
10. Professional liability claims history
11. Verification of Board Status Certification or Candidacy, as applicable
12. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
13. California Medical Board Status check for validation of license and sanction activity
14. Continuing Medical Education Compliance
15. Consent to release relevant information
16. Copies of the Governing Body Approval letters confirming Medical Staff appointment and/or approved privileges
17. For Affiliate Staff only: CPR (BLS/ACLS) certification

B. QUALITY FILE

(not available for provider review)

The quality files contain the following historical and current documents (as applicable):

1. Any action taken as a result of a malpractice claim within the previous three (3) years.
2. Reports of disciplinary actions and the outcome of those actions.
3. Results of internal and health plan quality management review such as Peer Review, Surgical Case and Hospital Mortality Review, Transfusion Committee reviews, patient complaints, clinical activity reports, and other quality indicators.
4. State Medical Board reports on any state sanction activity (e.g. 805 reports).
5. Any supplemental information or documentation regarding quality of care including, but not limited to, letters of reference or service.
6. Letters of Reference that attests to clinical competence and ethical character of the applicant.

APPENDIX B – Verification Methods

	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING / TEMP. PRIVILEGE
1	License to Practice in California Includes information on licensure sanctions and expirables that are monitored monthly.	Website as available for the type of provider. If website that is considered primary source verification is not available, credentialer confirms in writing. Whenever a Member's license or other legal credential authorizing practice in this state is revoked, limited, suspended, or expires, the Member's Medical Staff membership and Privileges shall be automatically suspended as of the date such action or expiration becomes effective.	X	X	X	X	X
2	DEA Registration Provider attests if DEA is not applicable to scope of practice.	Obtain online verification. If website that is considered primary source verification is not available, credentialer confirms in writing.	X	X	X	X	X
3	Fluoroscopy Certificate Provider attests if certificate is not applicable to scope of practice.	Obtain online verification. If website that is considered primary source verification is not available, credentialer confirms in writing.	X	X	X	X	X
4	Medical School (Domestic Graduates) or Other Professional Schools (non-physician applicants)	May be obtained (in writing or orally) from the institution(s) where medical school/other professional school completed or the AMA or AOA profile service, as applicable.	X				
5	ECFMG (Foreign Graduates) For physicians who enter USA-based internship/ residency programs.	www.ecfm.org or in writing from ECFMG	X				
6	Internship /other professional training	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X				
7	Residency/other professional training	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X		X <i>If any new training during the previous appointment period</i>		
8	Fellowship/ other professional training	May be obtained (in writing or orally) from the institution(s) where training completed or	X		X <i>If any new</i>		

APPENDIX B – Verification Methods

	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING / TEMP. PRIVILEGE
		the AMA or AOA profile service, as applicable.			<i>training during the previous appointment period</i>		
9	Board Certification or other professional certification or registration	CertiFACTS, ABMS compendium, query of the ABMS database, AMA or AOA profile or confirmation (orally or in writing) directly from the certifying organization.	X	X	X	X	X
10	Healthcare Organization Affiliations	Confirm in writing or by telephone with affiliation. Confirm dates of affiliation, scope of privileges, restrictions and any disciplinary actions taken during the affiliation. If verification of an affiliation is not obtained after two requests (including a phone call to the facility), this will be noted in the file and the file may then move through the evaluation process without verification of the affiliation.	X <i>Verify all affiliations within the last five years after Medical/ Professional School</i>	X <i>Verify as necessary to obtain information related to competency</i>	X <i>Verify current affiliation(s)</i>		X <i>Verify current affiliation(s)</i>
11	Work History (Looking for gaps in training and work history)	Applicant provides information on application form or curriculum vitae. Additional investigation occurs for 3 months month gaps in work history. Gaps will be documented in the file.	X <i>Verify all affiliations within the last five years after Medical/ Professional School</i>				X <i>Temps: the last five years Visiting: current affiliation</i>
12	Professional Liability Insurance	Obtain information related to coverage and amounts of coverage directly with carrier. Minimum insurance: \$2/million per claim and \$6/million annual aggregate coverage.	X		X		X
13	Professional Liability Claims History:	Applicant provides information about current and past claims, settlements and judgments; AND write to current carrier; AND request NPDB report.	X	X	X		X
14	Continuing Medical Education	License attestation	X		X		
15	National Practitioner Data	Enrolled in Continuous Query. Notified of new disclosures as	X	X	X		X

APPENDIX B – Verification Methods

	CREDENTIALING ITEM	METHOD OF VERIFICATION	CREDENTIALING EVENT				
			INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINTMENT	UPDATE AS EXPIRES	VISITING / TEMP. PRIVILEGE
	Bank (NPDB)	reported, along with monthly report.					
16	Medicare Sanctions	OIG Sanction Report	X	X	X	Monthly	X
17	Peer/Professional References/ Recommendations Peer means an individual in the same professional discipline (same type of license) or MD for Affiliated Staff as appropriate.	Peer references must be from individuals who have recently worked with the applicant, have directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, ethical character, health status and ability to work with others. If the applicant has recently completed professional training (resident, fellowship, etc.), a reference from the program director must be requested and references from supervising Attending physicians, rather than co-residents, must be obtained.	X <i>Obtain 3 Peer References, with at least one from each professional position held in the last two years</i>	X <i>As necessary to obtain confirmation of clinical competency</i>	X <i>Obtain 2 Peer References; If Courtesy appt. with no data summary sheet, one reference must be from a Supervisor at external primary hospital</i>		X <i>One peer reference</i>
18	Social Security Death Master File verification Verification of the SSDMF from NTIS via MD- Staff is required for all initial applicants and then to be verified on an ongoing monthly basis for all actively credentialed providers	Verification of the SSDMF is conducted through the MD-Staff credentialing database and	X			Monthly	X
19	SAM (GSA/EPLS)	System for Award Management	X		X	Monthly	X
20	CA DHCS (S&I)	California Department of HealthCare Services; Sanctions and Ineligible List	X		X	Monthly	X

APPENDIX C – File Triaging Categories

TRIAGING CATEGORY	INITIAL APPOINTMENT	REAPPOINTMENT
Green	No issues have been identified with the provider's application, and the file meets the following criteria: • Satisfactory References • No record of malpractice payment or current pending claims • No disciplinary actions • No licensure restrictions • No unexplained time gaps in work history • Current licensure • No problems verifying information • No indication of investigations or potential problems Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified	No issues have been identified with the provider's reappointment, and the file meets the following criteria: • Satisfactory References • No record of malpractice payments since the last appointment or current pending claims • No disciplinary actions • No licensure restrictions • Current licenses • No problems verifying information • No indications of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified • Applicant is not requesting new privileges • Applicant is not requesting a status change • Applicant meets all criteria for privileges requested • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified
Yellow	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • Malpractice claims • Criteria for Privileges requested is not met. • International Medical Graduate	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • Malpractice claims in past 3 years • Health problem identified which will likely have impact on exercise of clinical privileges or standardized procedures. • Lack of clinical activity or difficulty in obtaining monitoring reports
Red	The provider's file shows potentially adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification	The provider's file shows potentially adverse information, including: • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA)

APPENDIX C – File Triaging Categories

	organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • Any existing information shows a quality of care or competency issue	• Clinical privileges revoked, diminished or altered by another Healthcare organization • New privileges requested outside of normal scope of specialty • Any existing information shows a quality of care or competency issue

When available, information from these sources is integrated into the credentialing process:

- 1. Patient Complaints and Grievances:** The Office of Patient Experience (OPEX) monitors all grievances and provides bi-annual reports to the Governing Body, by way of Performance Improvement & Patient Safety (PIPS) Committee and Medical Executive Committee (MEC). Bi-annual monitoring reports are sent to Medical Staff Services and added to the agenda for discussion at the next Credentials Committee meeting. Significant issues are forwarded to Quality Improvement and/or Risk Management for further analysis with communication to the Service Chief. If the Service Chief determines immediate action is required, the Chief of the Medical Staff is notified and initiates appropriate resolution.
- 2. Adverse Events:** Risk Management monitors all adverse events and provides bi-annual reports to the Governing Body, by way of Performance Improvement & Patient Safety (PIPS) Committee and Medical Executive Committee (MEC). The monthly monitoring reports are sent to Medical Staff Services and added to the agenda for discussion at the next Credentials Committee meeting. Significant issues are communicated to the Service Chief. If the Service Chief determines immediate action is required, the Chief of the Medical Staff is notified and initiates appropriate resolution.
- 3. Clinical Activity Reports:** For monthly reappointment cycles, physician volume statistics and comparative data are gathered by the Medical Staff Office. Providers with no clinical activity may provide supporting information for consideration by the Service Chief to ensure appropriate recommendation of membership/privileges.
- 4. Quality Measures:** Physician specific quality data identified for Credentials Committee review as appropriate.
- 5. Peer Review:** Individualized profiling information is assessed by the Service Chief.
- 6. Medical Record Delinquencies:** The Service Chief reviews and notates as appropriate.
- 7. Risk Management/Malpractice Claims:** Risk Management entities report UC Regents and San Francisco City and County claims history. Providers are obligated to disclose past and pending liability actions and provide further details regarding these actions, including specific discussion with the Service/Division Chief. Claims histories also are requested from external professional liability insurance companies, as applicable. Providers with one or more claims are flagged for review by the Service Chief and the Credentials Committee.
- 8. Suspensions/Sanctions:** Physicians may be suspended for non-compliance with policies as outlined in the Medical Staff Bylaws, and for infractions, such as a license revocation or other action by the Medical Board or Governing Body (please see the Medical Staff Bylaws for further information). These suspensions are monitored by the Medical Staff Office and identified for Service Chief and Credentials Committee review.

- 9. Reporting of Adverse Action to Authorities and Contracted Health Plans:** Adverse action that has been taken against a practitioner which falls under the reporting guidelines for state and federal agencies will be reported as appropriate to the National Practitioner Data Bank, the California Medical or Nursing Board, to the SFDPH Office of Managed Care and to contracted Health Plans. (refer to the ZSFG Medical Staff Bylaws for activities or professional conduct that constitutes a request for investigation).
- 10. Service Quality Indicators:** Each clinical service establishes and monitors quality indicators. The Service Chief considers applicable indicators when recommending appropriate membership/privileges and indicates any issues for Credentials Committee consideration.
- 11. Provider Directories:** All information required to be published in the practitioner directories of managed healthcare plans per the contractual agreement will be consistent with the information required for the credentialing process.

I. PURPOSE

Ongoing Professional Practice Evaluation (OPPE) is designed to support quality patient care activities and can identify outliers related to clinical performance at Zuckerberg San Francisco General Hospital (ZSFG). OPPE is intended to ensure consistency and to foster a more efficient evidence-based privilege renewal process. The OPPE process focuses on the collection of practitioner-specific, professional practice data related to clinical activities of Medical Staff and Affiliated Medical Staff practitioners at ZSFG. OPPE improves the delivery of quality patient care and is conducted regularly, in accordance with The Joint Commission Medical Staff Standard MS.08.01.03. ZSFG Chiefs (or their designees) are expected to review the data metrics and sign-off the data. When necessary, intervention by the organized medical staff may be required, including but not limited to development and implementation of a Focused Professional Practice Evaluation (FPPE) to address practice that is considered marginal or unacceptable.

II. PROCEDURE

The ZSFG Medical Staff Services Department is required to coordinate the collection, validation, and assessment of practitioner-specific, professional practice data that is relevant to the clinical practices approved by the ZSFG organized medical staff. Continuous monitoring of practitioner's clinical competence metrics will support the ZSFG organized medical staff in the provision of high-quality, safe patient care that is compassionate, appropriate, and effective.

Each practitioner's professional practice metrics will be reviewed by each service Chief or their designee(s) in keeping with the goal of providing high-quality and safe patient care and in accordance with The Joint Commission Standard MS.08.01.03. The practitioner's professional practice evaluation will be documented in the Professional Performance (OPPE) by the Medical Staff Services Department and the timeframe for review of the data cannot exceed 12 months. Management of OPPE is the responsibility of the Medical Staff Services Department. Practitioner's Ongoing professional practice data (OPPE) is privileged, facility specific information protected by California Evidence Codes 1156 and 1157.

Categories of metrics may include the following groups, in accordance with the Accreditation Council for Graduate Medical Education (ACGME) core competencies: Patient Care, Medical/Clinical Knowledge, Practice- Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems- Based Practice. Examples of individual metrics may specifically include data from:

- Administrative Activity
- Case Characteristics and Volume
- Core Competencies
- Inpatient Utilization
- Outpatient Utilization
- Patient Safety and Quality
- Patient Satisfaction
- Patient Relations
- Risk Management

A. DEFINITIONS

Chief of Service – Physician with the ultimate responsibility to review and sign-off on the professional practice information of each practitioner in his/her department. If needed, the Chief of Service may designate a faculty member to review and sign-off on records.

Credentials Committee – The ZSFG Medical Staff Committee is responsible for recommending appointments and reappointments to the Medical Staff, delineation of staff privileges, and application of corrective actions where indicated.

Designee – Physician leader identified by the Service Chief to review a set of practitioners.

OPPE – the Ongoing Professional Performance Evaluation system is designed to aggregate practitioner-specific data from a variety of sources and display this information on a secure password protected website. All the information is stored on the city's secure network under ZSFG IT Security Policy.

Practitioner – Member of the ZSFG Medical Staff or Affiliate Medical Staff

B. CONFIDENTIALITY

Professional practice evaluation information is privileged and confidential in accordance with ZSFG Medical Staff Bylaws and California state evidence codes (including 1157) pertaining to confidentiality and non-discoverability.

All staff, committee members, and other practitioners involved in review and evaluation of performance will hold information in strict confidence, make no voluntary disclosures of such information, and agree to complete a confidentiality acknowledgement related to their handling of Professional Practice Evaluation information under this procedure.

A confidentiality acknowledgment will be completed at initial participation and at least every two years thereafter.

Security practices must be maintained to protect the integrity and confidentiality of OPPE at ZSFG. As OPPE reports are facility-specific, the information contained within are considered proprietary and thus only intended to be viewed by those directly involved in the OPPE process at ZSFG.

OPPE data may be directly shared with other facilities outside of ZSFG (1) Upon special request to the current Chief of Staff, or (2) as requested by another facility under a current, executed Memorandum of Understanding or Peer Review Sharing Agreement.

C. CONFLICTS OF INTEREST

A medical staff member asked to perform professional practice evaluation may have a conflict of interest if they might not be able to render an unbiased evaluation due to:

- Involvement in the patient's care
- Relationship to patient or patient family
- Relationship with the involved practitioners as a partner or direct competitor

It is the responsibility of the reviewer to disclose potential conflicts.

It is the responsibility of the Credentials Committee to determine whether a conflict would prevent the individual from participating and the extent of that participation if allowed.

APPENDIX E – Ongoing Professional Practice Evaluation (OPPE) Procedure

Individuals determined to have a conflict may be present during group discussion (if approved by Credentials Committee) but are required to recuse themselves prior to final deliberation and vote.

III. PROCEDURE

The OPPE will be updated with the latest available data every 12 months focusing on collection of metrics between July 1 and June 30 each year. Departmental OPPE data is coordinated between each clinical service and the ZSFG Medical Staff Services Team as detailed within the timeline table in the section below. Internal (ZSFG defined) benchmark data will be provided by the clinical services for specified metrics with each clinical service. Each clinical service will be responsible to review and validate the OPPE data for providers within their service.

Submission of OPPE data related to the clinical practice of each service Chief shall be reviewed/validated by someone other than the service Chief such as a senior faculty member in the department with the same clinical privileges.

A. TIMING & RECURRING SCHEDULE

The calendar below outlines the timeframes that the various parts of OPPE are carried out each cycle:

MONTH	DESCRIPTION	RESPONSIBLE PARTIES
July	- On July 1st, run retrospective master roster of credentialed providers from the credentialing database which lists provider holding an appointment/privileges through the ZSFG Medical Staff during the previous July 1 thru June 30 OPPE cycle. - Run the Board Certification Issues Report & the Suspensions Report from MD-STAFF for the previous July 1 thru June 30 OPPE cycle. - Obtain copy of the Hydra ZSFG Compliance Report from Dean's Office - Sort/edit the roster to create department-specific list of providers. - Sort/edit the roster again to identify providers with privileges in the department but whose home department is elsewhere. These are referred to as the "add-on" providers for the department for purposes of OPPE. They are listed at the end of each department's OPPE spreadsheet. - Reconcile the provider count against the original master roster to assure quality with no names overlooked throughout the data sorting process. - Copy the finalized department-specific OPPE spreadsheets as templates from the previous OPPE cycle. This involves deleting the provider names/metric data/comments, add/delete/revise metrics as directed by notes from Chiefs/approved by Chair, Credentials Committee to create the OPPE spreadsheets for the current OPPE cycle. - Copy/paste the provider names, including the "add-on" providers, from the department sections of the final edited master roster to the department-specific spreadsheet templates. (Note: Totaled 47 spreadsheets for 30 OPPE departments last OPPE cycle.) - Update/revise the instructions for completing the OPPE spreadsheet. - Update the Chief/Credentials Committee annual OPPE email language directed to Chiefs & designees. Save a copy to Outlook drafts folder. - Obtain note closure report data from IT/OPPE workgroup. Add board certification, license, & note closure data to the OPPE spreadsheet templates	OPPE Coordinator/ MSSO Chief, Creds Committee with OPPE IT workgroup UCSF Deans Office

APPENDIX E – Ongoing Professional Practice Evaluation (OPPE) Procedure

August	1. Complete any remaining steps from July list. 2. Aim towards a mid-August target for issuing OPPE lists to Chiefs & designees. 3. Use the department-specific annual OPPE email language indicating the due-date deadline within 60 days. Attach a copy of the department-specific OPPE spreadsheets along with a copy of the instructions for completion. 4. Repeat step #3 for each department or clinical service specialty. 5. Create a <u>Tracking Log of Spreadsheets Returned by Due Date & Finalized</u> which lists the departments or clinical service specialties who have received the OPPE email outreach requests. Use this log to track the response and versions returned.	OPPE Coordinator/ MSSO
September	1. Complete outreach to any remaining departments regarding remaining steps from August. 2. Send out reminders as 6 weeks, 4 weeks, and 2 weeks to services that have not responded. 3. Review/return spreadsheets back to Chiefs/designees with replies/requests for clarification/comments /finalization with cc to Chair/Creds Committee & Manager/MSSO Update <u>Tracking Log of M&U OPPE Evals</u> as indicated by reviews	OPPE Coordinator /MSSO Chair/Creds Committee Manager/ MSSO
October - November	1. Update & issue the <u>Tracking Log of Spreadsheets Returned by Due Date & Finalized</u> biweekly to Chair/Credentials Committee for his updates to Creds Committee, MEC, etc. 2. Continue spreadsheet reviews/replies/requests for clarification/comments/ working towards finalization for all clinical services remaining. Continue updating <u>Tracking Log of M&U OPPE Evals</u> as indicated by reviews.	OPPE Coordinator /MSSO Chair/Creds Committee
December	1. Finalize any remaining reviews of departments or clinical service specialties OPPEs spreadsheets. 2. Finalize the <u>Tracking Log of M&U OPPE Evals</u> Finalize the <u>Tracking Log of Spreadsheets Returned by Due Date & Finalized</u>	OPPE Coordinator / MSSO
January	1. When all spreadsheet reviews are finalized, meet with Credentials Committee Chair to review all marginal & unacceptable OPPE ratings identified. 2. Ensure that each marginal & unacceptable has commentary and has been appropriately addressed.	OPPE Coordinator /MSSO
May - June	Prepare Prep file folders and structure on T Drive for the next cycle of OPPE	OPPE Coordinator/ MSSO

B. Marginal and Unacceptable OPPE Evals:

1. During the review of the annual department OPPE spreadsheets, the Medical Staff Services Coordinator updates the Tracking Log of Marginal & Unacceptable OPPE Evals by department/provider and advises the respective Service Chief regarding providers whose OPPE evals may trigger a Focused Professional Practice Evaluation (FPPE) based on the following frequency thresholds:
 - a. Two (2) consecutive Unacceptable (U) evals for the same OPPE metric, OR
 - b. Three (3) consecutive Marginal (M) evals for the same OPPE metric, OR
 - c. One (1) Unacceptable and two (2) Marginal evals consecutively for the same OPPE metric
2. Marginal and Unacceptable OPPE ratings require the Chief to enter a comment in the COMMENTS column of the department's OPPE spreadsheet for providers whose data for any OPPE metric falls within the Marginal or Unacceptable threshold range for the metric. The Service Chief will consult with the Chair/Credentials Committee regarding the need for a for-

cause FPPE plan.

3. The Chief or designee will discuss any Marginal or Unacceptable OPPE evals with the provider. The Medical Staff Services Coordinator will confirm and document through use of a DocuSign form signed by both the service chief and subject provider.
4. Following completion of the annual OPPE spreadsheet reviews and finalization, the OPPE Coordinator and the Chair of the Credentials Committee meet to review the Tracking Log of M&U OPPE Evals to ensure that all have been reported to/addressed by the Chief.

C. RESPONSIBILITIES

1. Service Chief's Responsibilities:
 - a. Review, validate each practitioner's OPPE data within 60 days of posting by the ZSFG Medical Staff Services Department.
 - b. Comment on performance metrics that have not met the established thresholds or address identified clinical practice irregularities.
 - c. Sign-off on the data provided for each practitioner within the department, per OPPE review period.
 - d. Forward identified concerns or clinical practice irregularities to the ZSFG Medical Staff Services Department immediately, for further review by the ZSFG Credentials Committee.
 - e. May opt to assign a designee with the primary responsibility to review practitioners within the department. The Chair must keep the Medical Staff Services Department advised of any changes or updates.
 - f. Arrange for appropriate coverage to review OPPE data performance metrics reports during periods of planned absences.
2. Practitioner
 - a. May request to review their OPPE data.
 - b. May add supplemental information/comments for the Service Chief or designee to review as part of periodic validation and sign-off of the OPPE metrics.
 - c. May communicate with Service Chief or designee regarding any concerns regarding the content of the OPPE data.

D. OVERSIGHT & DATA RETENTION

1. The Medical Staff Services Department will be notified by the Chief or designee upon completion of the annual review/sign-off of OPPE clinical practice metrics. The Medical Staff Services Department will retain electronic copies of the individual practitioner's data for inclusion in the credentials file to be reviewed by the Credentials Committee as part of each provider's credentialing reappointment.

E. PROCEDURE REVIEW AND REVISION

The Ongoing Practitioner Practice Evaluation Procedure will be reviewed on an annual basis. Compliance with The Joint Commission and functionality will be evaluated as well as the continued relevance of the indicators chosen.

Appropriate revisions will be recommended by the Medical Executive Committee and/or the Credentials Committee.

I. PURPOSE

Zuckerberg San Francisco General Hospital (ZSFG) provides members with access to qualified specialists for HIV care. This procedure defines the additional qualifications for designating practitioners with an HIV/AIDS specialty at ZSFG. All practitioners are credentialed, recertified, and enrolled according to the National Committee for Quality Assurance (NCQA) policy and procedure CR-06.

II. PROCEDURE

REQUIRED QUALIFICATIONS: Practitioners can be designated as an HIV specialist if both of the following requirements are met.

1. Valid unrevoked and unsuspended California state medical license
2. Meets one of the 3 qualifications below:
 - a. Credentialed as an “HIV Specialist” by the American Academy of HIV Medicine (AAHIVM)
 - b. Board certified in the field of Infectious Diseases by a member board of the American Board of Medical Specialties (ABMS)
 - c. Long-standing HIV provider (5 years or greater) with at least 25 ongoing patients with HIV under their care
3. For qualifications in (2) above, the following requirements should also be met:
 - a. In the immediately preceding 12 months has clinically managed care to a minimum of 25 HIV patients; and
 - b. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV patients, including a minimum of five (5) hours related to antiretroviral therapy per year.

III. AFFILIATED PROFESSIONALS (NP, PA)

Nurse practitioners and physician assistants may be designated with HIV/AIDS specialty if they are under the supervision of an HIV/AIDS physician specialist, are credentialed as an “HIV Specialist” by the American Academy of HIV Medicine (AAHIVM) or have provided ongoing care to at least 25 patients with HIV infection with the additional requirements in #3 above.

IV. CREDENTIALING PROCEDURE

1. Any practitioner who wants to serve as an HIV/AIDS specialist must request to be credentialed as one using the HIV/AIDS Specialist Designation form in the credentialing packet.
2. HIV/AIDS Specialist applicants will be subjected to the credentialing requirements and process described in policy and procedure CR-06 Initial Credentialing, Recertification, Screening, and Enrollment of Practitioners. (NCQA)
3. HIV/AIDS Specialist applicants attest that they meet licensure, board certification, and work experience requirements established in Section IIS of this policy.
4. Physician Advisory/Peer Review/Credentialing Committee (PAC) reviews and approves all HIV/AIDS Specialist credentialing applications as described in policy and procedure CR-06.
5. A list of HIV/AIDS Specialists is kept current in the provider directory according to policy PR-21 and is searchable based on the HIV specialist designation.

V. MONITORING

Monitoring: ZSFG Medical Staff Services ensures HIV/AIDS Specialists’ board certification or specialty certification are monitored for their qualifications as part of the recertification process every 24

months, at minimum. The ZSFG/UCSF Division of HIV, Infectious Diseases & Global Medicine is responsible for monitoring the minimum amount of hours is met, if applicable

Committee Review: The Credentials Committee review all cases for approval or denial and provide feedback or request additional information or corrections as needed at regularly scheduled Credentials Committee meetings.

VI. DEFINITIONS

Continuing Medical Education:

- 1) For physicians, continuing medical education courses recognized as qualifying for Category 1 credit by the Medical Board of California;
- 2) For nurse practitioners, continuing education contact hours recognized by the California Board of Registered Nursing;
- 3) For physician assistants, continuing education units approved by the American Association of Physician Assistants or those described in either subsection (1) or (2), above.

Credentialing: a process of reviewing and evaluating licenses, permits, training, and other qualifications of licensed practitioners and organizational providers.

Initial Credentialing: initial review of a practitioner or organizational provider credentials

Credentials Committee: (a) Review the credentials of Applicants and make recommendations for membership and delineation of Clinical Privileges in compliance with these Bylaws; (b) Make a report to the MEC on each Applicant for Medical Staff membership and privileges, which shall include recommendations from the appropriate Clinical Service Chief; (c) Review all information available regarding the competence of Medical Staff Members and as a result of such review makes recommendations for the granting of Privileges, reappointments, and the assignment of Applicants to the various Clinical Services as provided in these Bylaws.

Practitioner: a licensed or certified professional who provides medical or behavioral healthcare services (source NCQA).

Recredentialing: process of reevaluating Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical Staff and the continuation of Clinical Privileges.

I. PURPOSE

The San Francisco Health Network Medical Staff Services Department meets regulatory and accreditation agency standards by instituting policies and procedures that describe the type of information reviewed, responsibility of each Staff member, process for documenting updates, types of inappropriate documentation and how that information is protected, monitored, and reported. SFHN Medical Staff Services ensures that each Staff member is trained on safeguarding credentialing information by taking an annual Credentialing Information Integrity Training to protect credentialing information from inappropriate modifications.

The purpose of this policy is to provide guidance to the San Francisco Network Health Plan Medical Staff Services Department in fulfilling its delegated Managed Care Plans responsibilities for auditing of credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues. SFHN demonstrates its commitment to protecting the integrity of credentialing information used in the credentialing process. Credentialing information integrity refers to maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates.

II. REFERENCES

NCQA Credentialing Standards CR 8: Credentialing Information Integrity

III. POLICY

A. Scope of Credentialing Information

SFHN Medical Staff Services credentialing staff are responsible for protecting all credentialing-related information. The following categories of information shall be maintained in a secure manner at all times:

1. Practitioner Application Materials

All application and attestation documents submitted by the practitioner shall be securely stored within the ASM platforms MD App and MD Staff.

2. Primary Source Documentation

Any credentialing documents received directly from a primary source or authorized agent shall be maintained in one of the following secure formats:

- A locked, access restricted cabinet; or
- The password protected MD Staff electronic credentialing system.

These measures ensure prevention of unauthorized access, modification, or disclosure.

3. Credentialing Activity Records

The following documentation related to credentialing activities shall be maintained accurately and securely:

- Primary source verifications (PSV) verification dates and verifier identification, electronic or wet signature or initials
 - a. Email - Verifications received by email will be from an approved source and verify a provider's name, type of information being verified, and relevant start/end/expiration dates, if applicable.
 - b. Verbal - Verifications from verbal sources are recorded electronically and will note the source, date of verification, type of verification, name of the individual verifying the information, their position and any relevant dates (certification, licensure, training,

APPENDIX G – SFHN Medical Staff Services Credentialing Information Integrity Policy and Procedure

educations, etc.)

- Dates of required reports, including sanctions and adverse event logs
- Credentialing checklist

4. Committee Documentation

Ensure that all documentation related to Credentialing Committee actions is properly recorded, finalized, and maintained

- Credentialing decision and decision date
- Clean file approval documentation, when applicable
- Credentialing Committee minutes

B. Staff Responsibilities

1. SFHN Medical Staff Services Credentialing Coordinators, Specialists, Supervisors, Managers, and Directors are all responsible for documenting credentialing activities. The following staff may also have read access to the system on an as needed basis but do not have the ability to make any modifications or deletions: Network Managers, Contracting Specialists, as well as Directors and CQO directly involved in the credentialing process (Credentialing Staff). Credentialing Staff will have read/write ASM MD Staff user access as appropriate to their specific responsibilities.
2. Credentialing Staff are assigned user roles based on areas of responsibility as defined in their job description. Each user role is assigned specific read/write system access as needed to perform their duties which may include modifying or archiving information. Credentialing information within MD Staff should not be deleted without first consulting a manager.
3. Oversight of credentialing information integrity function is performed by SFHN Medical Staff Services during the annual audit to ensure that information meet established policies. Credentialing files are audited by the SFHN Medical Staff Services Manager and documented on the “Cred Info Integrity Audit Analysis Tool”. The credentialing information integrity results are presented to the SFHN Medical Staff Services Credentialing Committee for review, approval, and /Patient Safety & Performance Improvement Committee (PIPS) if corrective action is necessary.

4.

Role	Access Level	Permissions	Staff Positions
Administrator (<i>all facilities</i>)	Full System Access	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit logs.	SFHN CQO; SFHN Director; ZSFG Manager
Administrator (<i>respective facility</i>)	Full Access – individual facility	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit	SFHN CQO; SFHN Director; ZSFG Manager; ZSFG Medical Staff Analysts; HR Managers/ Senior Analysts

APPENDIX G – SFHN Medical Staff Services Credentialing Information Integrity Policy and Procedure

		logs.	
General Users (respective facility)	General Access	View and modify provider information; document credentialing activities; upload documents; no deletion rights.	ZSFG/LHH/BHS Medical Staff Specialists; HR Analysts/Clerks
Read-Only User	View Only	View provider profiles and non-sensitive documents; no rights to modify or delete	DPH IT; DPH Patient Financial Services; DPH provider Enrollment; CPG; OPPE Coordinator

IV. PROCEDURE

A. Documentation Standards and Recording of Credentialing Activities (CR1 Factor 13)

1. Documentation Requirements

- a) A signed (or initialed) and dated credentialing document completed by the verifier; or a printed verification document with the verifier's handwritten or electronic initials and the date verification was performed.
- b) A verification checklist may be used in lieu of signing each document. When a checklist is used, it must include:
 - The source used for each verification
 - The date the verification was completed
 - The signature or initials of the verifier
 - The report date, if applicable (e.g., NPDB, OIG, sanctions lists)
 - Typed initials are acceptable when the checklist is part of the organization's electronic system (e.g., MD Staff) and the system contains a unique electronic signature or identifier tied to the Credentialing Staff person who performed the verification.

2. Standards for Recording Activities in Credentialing Files

For each verification, Credentialing Staff must either upload a copy of the source document or enter a system note that includes the verification source, method (online, written, oral), completion date, verifier's initials, and any required follow up. All documentation is maintained in the provider's electronic file in MD Staff.

3. Documenting Credentialing Information Updates

a) Authorized Modifications

Credentialing information may be updated by Credentialing Staff whenever existing information changes, renews, or needs correction. Staff make updates using their secure, password protected MD Staff accounts, and all changes are automatically logged in the provider's electronic credentialing record.

b) Appropriate Modifications include, but not limited to:

- Updates to expired licensure or other documents
- Changes, updates, or renewals of education, training, insurance, or privileges
- Corrections of data entry errors
- Resolution of duplicate provider profiles
- Reassignment or correction of documents previously appended to the incorrect provider profile

4. Updates to Primary Source Verification (PSV) Documents
For updates to PSV information, Credentialing Staff document what was changed, why it was changed, and include their initials and the date. A brief supporting note or email is added to the credentialing file or recorded in the MD Staff comments or checklist.
5. System Tracking Requirements
Electronic system automatically logs the date of any change and the username of the Credentialing Staff member who made it. Staff must ensure each entry accurately reflects the update and that all supporting documentation is included.
6. Documentation of Modifications
Credentialing Staff document each modification in the provider's electronic file by noting the date of the change, what was modified, why it was modified, and who made the update.

B. Types of Inappropriate Documentation & Updates

Inappropriate modifications to credentialing include but are not limited to:

1. Falsifying any credentialing dates, including verification, approval, or ongoing monitoring dates
2. Creating documentation without conducting the required verification or activity
3. Fraudulently altering existing documents such as credentialing minutes, clean-file reports, or monitoring reports
4. Attributing verification or review to an individual who did not perform it
5. Altering or "whiting out" dates or signatures on hard-copy documents
6. Unauthorized or unsanctioned deletion of provider files or supporting documentation

C. Monitoring the Information Integrity Process

1. An annual audit of credentialing staff documentation and associated updates is conducted as part of the health plan delegate audit. Files are randomly selected for the audits and reviewed for any inappropriate documentation and updates on the "Cred Info Integrity Audit Analysis Tool" reporting assessment.
2. The Credentialing Information Integrity Audit Results and Analysis Tool will be used to collect and evaluate the audit results which are then presented at the next Credentialing Committee for review and approval and Patient Safety & Performance Improvement Committee (PIPS) for quality-focused process recommendations.
3. If any files are found to have inappropriate documentation and/or updates, the SFHN Medical Staff Services Director or SFHN Chief Quality Officer will document the errors and track subsequent corrections, as well as issue a notice of corrective action and training to the identified group and/or individual system user.
4. If fraud or misconduct are found, the SFHN Medical Staff Services Director or SFHN Chief Quality Officer will report the findings to facility-specific Compliance Officer as well as NCQA through email or the NCQA website. Examples of fraud or misconduct include, but are not limited to:
 - a) Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
 - b) Creating documents without performing the required activities.
 - c) Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
 - d) Attributing verification or review to an individual who did not perform the activity.

- e) Updates to information by unauthorized individuals.
- 5. Consequences for inappropriate documentation or updates may include but are not limited to the following, in accordance with union rules & disciplinary requirements:
 - a) Revocation of user account login credentials
 - b) Corrective action memo issued to the individual user
 - c) Disciplinary action, up to termination of staff member.

D. Follow-Up and Corrective Actions based on Non-Compliance

- 1. The Credentialing Director or Credentialing Manager will document any actions taken to address modifications that do not meet policy standards and issue a corrective action to the affiliated group or specific individual.
- 2. The Credentialing Director will review corrective actions 3-6 months after it was issued to assess the effectiveness of these actions and may continue to monitor corrective actions if deemed necessary.
- 3. Results will be reported to the Credentialing Committee review & approval and Patient Safety & Performance Improvement Committee (PIPS) for quality-focused process recommendations.

E. Auditing and Analysis of Modifications to Credentialing Information

- 1. SFHN Medical Staff Services will use the Credentialing Information Integrity Assessment Reporting Tool to evaluate overall performance against this policy. The Credentialing Information Integrity Audit Results and Analysis Tool will be the audit and analysis tool.
- 2. A random sampling of 5% or 50 files (whichever is less) will be reviewed. Files (25 initial and 25 recredentialing files) will be reviewed annually and documented in the above tools. The report will include files for the previous 12 months.
- 3. Any inappropriate documentation or updates are documented and will be evaluated using a qualitative analysis to determine the cause.

F. Improvement Actions

- 1. Any corrective action or subsequent training ordered by the SFHN Medical Staff Services Director or SFHN Chief Quality Officer will be documented and included with the Analysis Tool.
- 2. The effectiveness of corrective actions will be reviewed 3-6 months after it was issued using a random sample of credentialing files process within that time period.
- 3. A conclusion as to the effectiveness of the corrective action will be determined by a based on the results of the reevaluation.

G. Staff Training

- 1. All staff involved in the credentialing or practitioners that are part of the San Francisco Health Network and affiliated San Francisco Department of Public Health entities will complete annual training on this policy, focused on the protection of credentialing information from inappropriate documentation or modification.
- 2. Training will include:
 - the role of staff in protecting information,
 - the types of information requiring protection,
 - the process for appropriately documenting updates to credentialing information,
 - what constitutes inappropriate updates or modifications and the prevention of falsification and fraud.

APPENDIX G – SFHN Medical Staff Services Credentialing Information Integrity Policy and Procedure

3. Staff will also be educated on the auditing process and methodology used to audit credentialing files including the process for documenting inappropriate documentation and reporting instances of fraud and misconduct.

V. REVIEW & APPROVAL

JCC / Governing Body	
MEC	
Credentials Committee	

Added appendix G

Approved by Medical Executive Committee – May 11, 2026

Approved by Credentials Committee – May 4, 2026

Added appendix F

Approved by Medical Executive Committee – November 13, 2025

Approved by Credentials Committee – November 3, 2025

Added appendix F (changed to appendix E – 11/3/2025)

Approved by Medical Executive Committee – October 17, 2024

Approved by Credentials Committee – September 30, 2024

Added appendices C & D

Approved by Medical Executive Committee – February 15, 2024

Approved by Credentials Committee – February 5, 2024

Added appendices A & B

Approved by Medical Executive Committee – December 15, 2022

Approved by Credentials Committee - December 5, 2022

Approved by Medical Executive Committee – December 16, 2021

Approved by Credentials Committee – December 6, 2021

Approved by JCC – October 22, 2019

Approved by Medical Executive Committee – October 17, 2019

Approved by Credentials Committee – October 8, 2019

ZSFG HOSPITAL & TRAUMA CENTER

Medical Staff Organization Credentialing Manual

Office of Origin: Medical Staff Services, ~~Office~~-(628) 206-2342

I. PURPOSE:

Zuckerberg San Francisco General Hospital (ZSFG) and Clinics ensure that licensed health care providers meet the minimum credentials standards for Medical Staff or Affiliate Staff membership. This Credentialing Manual (with accompanying policies and procedures) and the Appendix, will be reviewed and approved each year by the ZSFG Credentials Committee and Medical Executive Committee.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- Joint Commission Medical Staff Standards
- NCQA Credentialing Standards
- CMS Conditions of Participation
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

III. DEFINITIONS:

Practitioner: Any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, unless otherwise expressly limited.

Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures or privileges: Advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, or CRNA – certified registered nurse anesthetist), PA – physician assistant, PharmD, Optometrists, Genetic Counselor, Acupuncturist and other categories as approved by the Governing Body.

Provider: For purposes of this document, provider means practitioners and affiliates.

Complete Application:

A complete application, at the point that verifications are finished, means the following:

- all information was verified and any missing information is explained or accounted for;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by ZSFG have been resolved.

IV. POLICY:

- A.** The Medical Staff Office conducts credentialing with confidentiality for all clinical venues within ZSFG and will only delegate credentialing to any outside entities if

Formatted: Font: 12 pt

Formatted: Font: 11 pt

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Font: (Default) +Body (Calibri), 11 pt, Not Bold

Formatted: Heading 1, Justified, Indent: Hanging: 0.5", Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0.1" + Indent at: 0.6", Tab stops: 0.6", Left + 0.6", Left

Formatted: Font: 11 pt

Formatted: Justified

Formatted: Justified

Formatted: Justified

Formatted: Font: (Default) +Body (Calibri), 11 pt, Not Bold

Formatted: Heading 1, Justified, Indent: Hanging: 0.5", Numbered + Level: 1 + Numbering Style: I, II, III, ... + Start at: 1 + Alignment: Left + Aligned at: 0.1" + Indent at: 0.6", Tab stops: 0.6", Left + 0.6", Left

Formatted: Font: 11 pt

Formatted: Justified

needed. Credentialing is performed prior to appointment and reappointment to the ZSFG Medical Staff.

B. A. Each provider has a confidential credentials file, which contains verification documents. For Medical Staff members, the credentials file includes quality information as described in Appendix A. These files are re-verified at least every two (2) years. Expirable documents are updated on an ongoing basis. All required verifications must be no more than ~~180~~ 120 days old at the time of Governing Body review.

C. B. Credential files are treated as confidential and are kept within file cabinets with access by Medical Staff Office personnel only. These files are protected from discovery pursuant to Evidence Code Section 1156, et seq. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Section 1156, et seq.

1. The credentials file may be reviewed by contracting health plan representatives (pursuant to delegated credentialing agreements), except that information determined to be confidential.

A provider has the right to review the items in their credentials file, except the following elements: National Practitioner Databank Reports and Letters of Reference. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the credentials file.

2. The quality information may be reviewed by contracting health plan representatives for the following elements: malpractice claims history, disciplinary actions by hospitals, managed care organizations or State Medical Boards and outcomes of those actions. Other quality items are subject to review pursuant to delegated quality agreements or the National Commission on Quality Assurance (NCQA) credentialing standards.

A provider has the right to review the items in their quality file, except letters of reference or documents related to peer review activities. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the quality file.

D. C. Provider Rights to obtain Status of Application

Upon request, providers will be notified of the status of their application during the credentialing process.

E. D. Provider Rights to Amend Application

The provider attests that all information submitted for the credentialing process is accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the provider will be asked (via phone, letter or email) to resolve this discrepancy. The provider will be given opportunity to resolve the discrepancies, with response to the Credentials Committee Chair. Any attempts to intentionally hide or misrepresent information are addressed during the Credentials Committee review.

F. E. Notification of Provider Rights: Pursuant to the Medical Staff Bylaws, providers are notified of their rights to:

- review information submitted to support their credentialing application;

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Justified, Indent: Left: 0.6"

Formatted: Justified, Indent: Left: 0.6", Right: 0.62", Space Before: 3 pt, Tab stops: 1.51", Left

Formatted: Justified

Formatted: Font: 11 pt

Formatted: Justified

Formatted: Justified

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Font color: Auto

Formatted: Font: Bold

- correct erroneous information; and
- be informed of the status of their application upon request.

G. F. Erroneous Information: The applicant for appointment, reappointment, and/or clinical privileges will be notified by credentialing staff of any conflicting information found in the provider's application and/or any supporting documentation. Notice will occur by telephone or written request within 10 days of discovery, and will be documented in the provider's credentials file.

- The provider will have 30 days to reconcile and return the application and/or supporting documentation to the credentialing staff
- Acceptable format will be the corrected and signed credentialing application and, as applicable, a written and signed explanation for any discrepancies in the original application
- The Credentials Committee or Credentials Committee Chair will receive a report of any corrected information submitted by the provider.
- The documentation provided by the applicant and any other related documents will be placed in the provider's credentials file along with notation as to the date received.

H. G. Upon delegation of credentialing activities, audits may be performed by health plan representatives and other payers, based upon the following guidelines:

1. Audits must be scheduled in advance at a time mutually agreed upon by ZSFG and the auditing entity.
2. Selected documents regarding peer review may not be subject to auditing.
3. Auditors may not photocopy or remove documents.

If credentialing is not delegated, the health plan/payer is responsible for credentialing providers for their health plan.

V. PROCEDURE

In accordance with ZSFG Medical Staff Bylaws, the Credentials Committee includes an interdisciplinary group representation of peer-review-qualified practitioners and designated physicians who hold direct responsibility, expertise, and active involvement in credentialing decisions. The committee uses a peer-review process to thoroughly evaluate credentialing information and make informed recommendations.

The Medical Staff Services Department supports the credentialing process by providing comprehensive information for both initial credentialing and recredentialing reviews. Credentialing criteria are formally reviewed and approved by the Credentials Committee, its Chair, or designated members. Cases that do not meet the established eligibility criteria are escalated to the Credentials Committee for decision-making.

A. Initial Appointments

1. The following information is required to begin the Initial Appointment process:
 - Request from Department
 - Applicant Name
 - Curriculum Vitae/Resume including all professional work history
 - Faculty Appointment (if applicable)
 - Requested Privileges/Protocols (Standardized Procedures), (when applicable)
 - Requested Start Date for Temporary Privileges/Credentials only
 - ID attestation per Joint Commission guidelines
2. Providers must complete the following items:

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Font: 11 pt, Not Expanded by / Condensed by

Formatted: Font: 11 pt, Not Bold

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Not Bold

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Not Bold

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Not Bold

Formatted: Justified, Indent: Left: 0.6", No bullets or numbering

Formatted: Font: 11 pt

Formatted: Justified

Formatted: Font color: Auto

Formatted: Font: Bold

- Application for Medical Staff or Affiliate Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges, or for Affiliate, Standardized Procedures.
- Agreement to abide by the Medical Staff Bylaws, Rules and Regulations
- Health Plan Attestation form (as applicable)
- Environmental Safety form

3. In addition to returning the above documents, providers also must submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
- Copy of California License(s) (an on-line query is acceptable)
 - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
 - Evidence of Current Malpractice Coverage, if applicable
 - Fluoroscopy Certificate as appropriate
 - Current Photo
 - CPR, BLS/ACLS, PALS, NALS, if applicable
 - Current Curriculum Vitae (CV)

4. The Medical Staff Office reviews the documents as follows:
- a. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
 - b. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges. The applicant confirms the correctness and completeness of the application.
 - c. Clinical venues are specified and appropriate.
 - d. Complete addresses, phone and fax numbers as listed for:
 - Medical school, Internships, Residencies, Fellowships;
 - Hospitals and affiliations;
 - Peer references; and
 - Malpractice insurance company(ies)
 - e. Privileging forms or Standardized Procedures are completed as appropriate.
 - f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
 - g. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

5. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

Verification of provider enrollment screening in the Medicaid Fee-For-Service program. Completion of the Medi-Cal related acknowledgements for health plan specific trainings are required to begin within 10 working days of a new provider becoming active, and may be completed up to ~~180~~ 120 days prior to the new being activated/approved.

Formatted: Justified

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Justified

Formatted: Font color: Auto

Formatted: Font: Bold

6. File Triaging:

Once all of the information is gathered, the applicant's file is triaged by the Medical Staff Office and flagged for potentially adverse information to be carefully evaluated during the Credentials Committee review.

7. Temporary Privileges for Initial Appointments:

For Initial Appointments involving clinical urgency, a Service Chief may request temporary privileges up to 120 days. Request for Temporary Privileges/Credentials must be approved by the CEO (or authorized designee) on the recommendation of the Chief of Staff (or authorized designee).

Actions on temporary privileges/credentials are updated in the Medical Staff Office database upon approval and appropriate areas are notified. The Medical Staff Office database updates the applicant's status and privileges/protocols are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

8. Applicants must complete the credentialing process with privileges or standardized procedures (as appropriate) prior to the provision of patient care to ZSFG patients.

B.—Reappointments

B.

1. Reappointment Application Packet

At least five (5) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:

- Preprinted Reappointment Application
- Copy of current clinical privileges

2. The provider is required to return the application and supporting documents within thirty (30) days, and include the following:

- Copy of current DEA Certificate as appropriate
- Fluoroscopy Certificate as appropriate
- CPR, BLS/ACLS, PALS, NALS, if applicable
- Current CV

3. If the application is not returned within the designated time period, the provider and Department Chair will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment may be deemed to be a voluntary resignation from the Medical Staff, and the provider will be submitted as "resigned" to the Credentials Committee.

Practitioners/Affiliates who automatically resign shall be required to complete a reinstatement form to reapply for membership. Reinstatement shall be processed in a manner parallel to the reappointment process. Reinstatement application forms shall be accepted within one (1) month from the date the practitioner membership expires.

All Practitioners/Affiliates whose membership has expired ~~longer-more~~ than one (1) month shall be required to complete the initial appointment process.

Formatted: Justified

Formatted: Justified

Formatted: Justified

Formatted: Font: 11 pt, Not Bold

Formatted: Heading 2, Justified, Indent: Left: 0.31", Hanging: 0.25", Space Before: 0 pt, Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.6" + Indent at: 0.85"

Formatted: Font: 11 pt

Formatted: Justified

Formatted: Justified, Indent: Hanging: 0.25"

Formatted: Justified

Formatted: Font: 11 pt

Formatted: Font color: Auto

Formatted: Font: Bold

4. The Medical Staff Office reviews the documents as follows:
 - a. All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
 - b. Applicant's signature is present and dated on all forms. The applicant confirms the correctness and completeness of the application.
 - c. Privileging forms and Standardized Procedures are completed as appropriate.
 - d. Clinical venues are specified and appropriate.
 - e. Completed addresses, phone and fax numbers as listed for:
 - Hospitals and affiliations
 - Peer references; and
 - Malpractice insurance company(ies)
 - f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
 - g. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy) are current.

5. Verification of Information

Verification of information begins as soon as the application appears complete, and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

Verification of provider enrollment screening in the Medicaid Fee-For-Service program

6. Reappointment Performance Improvement

The results of performance monitoring, evaluation, and identified opportunities to improve care and service are documented in this file. Data Summary sheets are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership.

7. Pre-Credentials Committee Meeting

A meeting shall be convened prior to the Credentials Committee meeting date which shall be attended by the Chair of the Credentials Committee and the credentialing staff ~~in order to~~ discuss files of concern and the agenda.

C. —Evaluation And Approval Process

C.

1. —Clinical Services Evaluation Process

1.

If an issue is identified, the related documentation is flagged for the Service Chief to review. The complete file ~~(- including application, supportive documents, and privileges request form, practitioner sanctions, complaints, and adverse events -)~~ is sent to the appropriate Service Chief for review ~~and~~ recommendation to the Credentials Committee. ~~If the applicant's file was~~ For any flagged files, the ~~Service Chief reviewer~~ must document sufficient review to support making

Formatted: Right: 0.61"

Formatted: Font: 11 pt, Not Bold

Formatted: Heading 2, Left, Indent: Left: 0.31", Hanging: 0.25", Space Before: 0 pt, Numbered + Level: 1 + Numbering Style: A, B, C, ... + Start at: 1 + Alignment: Left + Aligned at: 0.6" + Indent at: 0.85", Tab stops: 1.25", Left

Formatted: Font: 11 pt

Formatted: Font: 11 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: List Paragraph, Space Before: 4.5 pt, Tab stops: 0.85", Left

Formatted: Font color: Auto

Formatted: Font: Bold

~~at their~~ recommendation for appointment ~~or~~ /reappointment.

If the Service Chief is disinclined to make a favorable recommendation ~~based on~~ due to:

- ~~• concerns indicating the potential for a provider's conduct to be detrimental to patient safety or care, or~~
- ~~• concerns related to professional competence or behavior that could adversely affect patient welfare;~~

~~• the Service Chief drafts a report outlining these concerns for the Credentials Committee, a perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or~~

~~perceived conduct or professional competence which affects or could adversely affect the health or welfare of a patient or patients, the Service Chief drafts a report to the Credentials Committee indicating concerns with the appointment/reappointment.~~

~~After the Service Chief's recommendation is completed, the file is prepared for discussion at the next monthly Credentials Committee meeting, and the applicant is placed on the Credentials Committee Summary Report. After the Service Chief's recommendation, the file is prepared for the monthly Credentials Committee and the applicant is added to the next monthly Credentials Committee Summary Report.~~

2. Credentials Committee Evaluation Process

~~The Credentials Committee reviews the Summary Report and all applicable credentialing criteria—such as practitioner sanctions, complaints, and adverse events identified through ongoing monitoring—before approving credentialing decisions and issuing its formal recommendation for appointment or reappointment. The Credentials Committee reviews the Summary Report and Committee makes a recommendation for appointment/reappointment. Files are reviewed evaluated~~ in accordance with the File Triaging categories (see Appendix C).

~~Applications deemed categorized as 'green' do not require committee discussion and are approved on the consent agenda. do not require committee discussion and are approved on the consent agenda. Applications deemed categorized as 'yellow' or 'red' are discussed in detail by the Credentials Committee, for review and recommendation.~~

Applications requiring additional information/clarification may be tabled until sufficient information is gathered to support a recommendation. Discussion is documented in the committee meeting minutes. The report with Credentials Committee recommendations is then sent to the Medical Executive Committee (MEC).

3. Medical Executive Committee and Governing Body Evaluation Process

The Credentials Committee Summary Report is reviewed by the Medical Executive Committee, then the Joint Conference Committee, and then referred to the Health Commission as the Governing Body.

~~Actions on appointments/reappointments are updated in the Medical Staff Office database within 10 days of Governing Body approval. The Medical Staff Office database updates are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification of the Governing Body decision is forwarded to the applicant within 30 days. Actions on credentialing and recredentialing are updated in the Medical Staff Office database~~

Formatted: Font: (Default) +Body (Calibri)

Formatted: List Paragraph, Justified, Indent: Left: 0.85", Space Before: 4.5 pt, Tab stops: 0.85", Left

Formatted: Font: 11 pt

Formatted: Indent: Left: 1.19", Tab stops: 1.25", Left + Not at 1.1"

Formatted: Font: (Default) +Body (Calibri)

Formatted: Normal, No bullets or numbering, Tab stops: 0.85", Left + Not at 1.1"

Formatted: Font: 11 pt

Formatted: Normal, Indent: Left: 0.85", No bullets or numbering, Tab stops: 0.85", Left + Not at 1.1"

Formatted: Normal, Justified, Indent: Left: 0.85", Right: 0.61", Space Before: 0 pt, Tab stops: 0.85", Left

Formatted: Justified

Formatted: Font color: Auto

Formatted: Font: Bold

within 10 days of Governing Body approval, and these updates are made available on designated intranet sites for inquiry by the applicant or authorized staff. Notification of the Governing Body's decision is forwarded to the applicant within 30 days.

4. Provider Enrollment

Upon Governing Body approval, formal notification of the finalized Credentials Committee Summary Report is sent to the contracted Health Plans, to ensure timely notification of all credentialing and recredentialing decisions, including changes in provider status, approved privileges, or conditions placed on participation.-

D. Visiting Privileges

1. In circumstances involving clinical necessity when clinical services require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, visiting privileges may be granted on a ~~case-by-case~~ case-by-case basis.
2. The following information is required to begin the Visiting Privileges process:
 - Completed Application
 - Curriculum Vitae/Resume including all professional work history
 - Faculty Appointment (if applicable)
 - Service Chief Recommendation
 - Requested Privileges
 - Requested Start Date
3. Providers must complete the following items:
 - Visiting Application including Confidentiality Statement and Consent to Release Information and Privileges.
 - Review the Medical Staff Bylaws, Rules and Regulations
4. In addition to returning the above documents, providers must also submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
 - Copy of California License(s) (an on-line query is acceptable)
 - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
 - Evidence of Current Malpractice Coverage
 - Fluoroscopy Certificate as appropriate
 - CPR, BLS/ACLS, PALS, NALS, if applicable
 - Current Curriculum Vitae (CV)
5. The Medical Staff Office reviews the documents as follows:
 - All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
 - Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges.
 - Clinical urgency and venues are specified and appropriate.
 - Complete addresses, phone and fax numbers as listed for:
 - Hospitals and affiliations;
 - Peer references; and

Formatted: Font color: Auto

Formatted: Font: Bold

- Malpractice insurance company(ies)
- Privileging forms are completed as appropriate.
- California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

6. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

7. The Chief of Staff and the Executive Administrator (or authorized designees) may grant Visiting privileges for a specified period of time after the above information has been evaluated by the applicable service chief and he/she has made an affirmative recommendation.

E. Expirables/Ongoing Monitoring

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods.

F. Resignations

The effective date of the resignation will be the last day of the month in which the provider states that he/she is resigning, or a date indicated by the Chief of Service, and can occur before the Governing Body date. Notice of resignation to the Medical Staff Office may be submitted by the resigning provider or by the Department Chief, or Chief's designee, provided that the resigning provider is copied on the notice.

H. Non-Discriminatory Credentialing and Recredentialing.

The Medical Staff Office monitors and prevents discriminatory credentialing through the following process:

- i. Tracking and trending of reasons for denial and / or termination.
- ii. Semi-annual audits of files in process for more than ~~six (6) months~~ 120 days.
- iii. ~~The presence of a non-discrimination statement on the Statement of Confidentiality to be signed by members, staff and guests of the Credentials Committee on an annual basis. All Credentialing Committee members, staff, and guests are required to sign the Statement of Confidentiality annually, which includes a non-discrimination statement. Committee members must also sign a standing non-discrimination agreement that remains in effect for the duration of their service. By signing, members attest that all credentialing decisions—whether related to approval, denial, or termination—are based solely on objective applicant qualifications and established network participation criteria, and never on factors such as age, gender, sexual orientation, race, ethnic or national identity, specialization, or the type of services provided.~~
- iii.
- iv. ~~The presence of a non-discrimination statement on the Credentials Committee agenda. Credentials Committee agenda must include a non-discrimination statement. All documents and information presented for committee review must exclude any references to a practitioner's race, ethnic or national~~

Formatted: Indent: Left: 0.69", Right: 0.62", Space Before: 0 pt

Formatted: Font: (Default) +Body (Calibri), 11 pt

Formatted: Font: 11 pt

Formatted: Font: (Default) +Body (Calibri), 11 pt

Formatted: Font: 11 pt

Formatted: Font: (Default) +Body (Calibri), 11 pt

Formatted: Font: 11 pt

Formatted: Font color: Auto

Formatted: Font: Bold

identity, gender, age, sexual orientation, or to specific procedures or types of patients the practitioner serves. This ensures that credential decisions remain unbiased, equitable, and compliant with the organization's non-discrimination standards.

iv-v. The San Francisco Department of Public Health (SFPDH), including the San Francisco Health Network (SFHN) and ZSFG, credentialing applications may request demographic information such as race, ethnic or national identity, gender, age, sexual orientation, language, and other related details. Providing this information is entirely optional and not required for credentialing. Any demographic data voluntarily disclosed by an applicant will not be used in any discriminatory manner and will have no impact on the review, evaluation, or approval of credentialing applications. This information is collected solely for purposes such as compliance with reporting requirements, promoting diversity, and improving health equity initiatives.

v. Documents and / or information, submitted to the Credentials Committee for approval, denial or termination do not designate a practitioner's race, ethnic / national identity, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes. The Credentialing Committee members will sign a non-discrimination agreement that remains in effect during their term as a Committee member. The statement attests that all decisions made by the committee are based on the applicant's credentials and network participation criteria and not the applicant's age, gender, sexual orientation, race, ethnic/national identity, specialization or special services the applicant may provide.

vi. The San Francisco Department of Public Health (SFPDH), including SFHN and ZSFG, is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or professional disciplinary action from another state when that action is based exclusively on the application of a law from that state that restricts or penalizes care that is lawful in California. (§1375.61, SB-487)

The Medical Staff Office monitors complaints alleging discrimination. Results are reported to the Credentialing Committee bi-annually.

I. **Queries: Verification of the following within 180 days of the Governing Body decision date: Primary Source Verification (within 120 days prior to decision) - ongoing monthly monitoring. (see Appendix B - Verification Methods)**

- National Practitioner Data Bank (NPDB) (required for all applicants)
- The State Medical Board responsible for issuing the provider's license
- Medi-Cal and Medicaid Suspended and Ineligible List Provider Reports
- Medicare and Medicaid exclusions/sanctions
- Office of Inspector General (OIG) Exclusion List
- SAM.gov debarment checks
- Board Certification
- Work History
- Malpractice insurance coverage and professional liability claims history
- Attestation questions answered in the application

J. **System Control Measures (CR 1C & D) Credentialing Information Integrity - (see Appendix G: SFHN Credentialing Information Integrity Policy and Procedure)**

The purpose of this section is to ensure compliance with the CR 8, Element A, National Committee for Quality Assurance (NCQA) standards.

Part C—System Controls

1. How—

Credentialing applications are received via MD Staff credentialing database.

Formatted: Font: (Default) +Body (Calibri), 11 pt

Formatted: Font: 11 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Indent: Left: 0.85", Hanging: 0.09"

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Italic

Formatted: Font: 11 pt, Italic

Formatted: Font: 11 pt, Italic

Formatted: Font: (Default) +Body (Calibri)

Formatted: Indent: Left: 0.85", Hanging: 0.09",
Numbered + Level: 2 + Numbering Style: i, ii, iii, ... +
Start at: 1 + Alignment: Right + Aligned at: 0.6" +
Indent at: 0.85"

Formatted: Font: 11 pt

Formatted: Indent: Left: 0.31", Right: 1.04", Space
Before: 0 pt

Formatted: Font: 11 pt, Not Bold

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Not Bold, Italic

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Italic

Formatted: Font: 11 pt

Formatted: Font: (Default) +Body (Calibri), 11 pt

Formatted: Font: 11 pt

Formatted: Font: 11 pt, Not Bold, Italic

Formatted: Font: 11 pt

Formatted: Indent: Left: 0.38", Hanging: 0.25"

Formatted: Font: 11 pt, Not Bold, Italic

Formatted: Font: 11 pt, Not Bold, Italic, Condensed by
0.25 pt

Formatted: Font: 11 pt

Formatted: Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging:
0.03", Right: 0", Space Before: 0 pt, Tab stops: Not at
0.85" + 0.85"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging:
0.03", Right: 0", Space Before: 0 pt, Tab stops: Not at
0.85" + 0.85"

Formatted: Font color: Auto

Formatted: Font: Bold

primary source verification information is received, dated and stored.	Supporting documentation such as primary source verifications (PSVs) are either uploaded into the MD Staff credentialing database or queried directly through the database. All primary source verifications (PSVs) collected as part of the ZSFG credentialing process for initial and reappointment applications are reviewed by the ZSFG credentialing team. ▲ Primary source verifications (PSVs) include but are not limited to the following: State licensure, DEA, DEA X, OIG, SAM/GSA, NPDB, AMA, NPI, Certifacts. PSVs are received or obtained by primary source websites, email, or verbally (over the phone): a. ~~Primary Source Websites~~ — Verifications from primary source websites will show the name of the source, the provider(s) being verified, the type of verification (license, certificate, etc.), and expiration date if applicable. b. ~~Email~~ — Verifications received by email will be from an approved source and verify a provider's name, type of information being verified, and relevant start/end/expiration dates if applicable. c. ~~Verbal~~ — Verifications from verbal sources are recorded electronically and will note the source, date of verification, type of verification, name of the individual verifying the information, their position and any relevant dates (certification, licensure, training, educations, etc.) PSVs are dated automatically via the MD Staff credentialing database and the dates cannot be changed/modified. ▲ PSVs are stored in the MD Staff Credentialing database hosted by the vendor.				
2. How modified information is tracked and dated from its initial verification?	PSVs uploaded into the MD Staff Credentialing database cannot be modified. The ZSFG credentialing team is oriented not to attempt to modify any type of PSV prior to upload within MD Staff Credentialing database. If a verification contains discrepant information that requires additional clarification, the credentialing team may include additional information to supplement the original PSV. Supplemental information should include the credentialing team member's name and date additional information was obtained.				
3. Staff who are authorized to review, modify and delete information, and circumstances when modification	All users are authorized to review information. No users have ability to modify PSVs uploaded into MD Staff. Authorized users are instructed to use good judgement and even consult a team member whenever a question arises regarding a need to remove/delete information in MD Staff. Access to MD Staff is role based and granted based on job function within the Medical Staff Services department or ZSFG facility. Access is reviewed quarterly and adjusted as needed. <table><tr><td>Role</td><td>Access</td><td>Permissions</td><td>Staff</td></tr></table>	Role	Access	Permissions	Staff
Role	Access	Permissions	Staff		

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0"

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt, Tab stops: Not at 0.85" + 0.85"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt, Tab stops: Not at 0.85" + 0.85"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt, Tab stops: Not at 0.85" + 0.85"

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font color: Auto

Formatted: Font: Bold

on or deletion is appropriate:				
	~~Administrator (all facilities)~~	~~Full System Access~~	~~View, add, modify, and delete information; manage user roles; workflow; oversight of credentialing information integrity functions and audit logs.~~	~~SFHN Director; ZSFG Manager~~
	~~Administrator (respective facility)~~	~~Full Access~~	~~View, add, modify, and delete information; manage user roles; workflow; oversight of credentialing information integrity functions and audit logs.~~	~~SFHN Director; ZSFG Manager; ZSFG Medical Staff Analysts; HR Managers/Senior Analysts~~
	~~General Users (respective facility)~~	~~General Access~~	~~View and modify provider~~	~~ZSFG/LHH/BS Medical Staff~~

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Line spacing: single

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Line spacing: single

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Line spacing: single

Formatted: Font color: Auto

Formatted: Font: Bold

	~~e-facility)~~	~~ss~~	~~informati on; document credential ing activities; upload document s; no deletion rights.~~	~~Specialists; HR- Analysts/Cl erks~~
	~~Read-Only User~~	~~View- Only~~	~~View- provider profiles and non- sensitive document s; no rights to modify or delete.~~	~~DPH- Information Technology; DPH Patient Financial Services; DPH- Provider Enrollment; ZSFG OPPE Coordinator~~
	Data Deletion Protocols Authorized users are encouraged to check with their direct manager when a need to delete information presents itself. This includes instances when a PSV may need to be re-run for a provider's profile. Examples of appropriate modifications to credentialing information include but are not limited to: — Erroneous Data Entry: Updates to expired licensure or other documents (<i>updating the database data fields to reflect current/accurate information</i>) — Changes/updates to education, training, or privileges when supporting PSVs are obtained — Correcting/rectifying any data entry errors — Addressing/identifying duplicative provider profiles — Misfiled Documents: Documents uploaded to incorrectly (<i>e.g. wrong provider profile</i>) — Duplicate Provider Records: When duplicate profiles are identified, data is consolidated into the correct profile. Examples of inappropriate modifications to credentialing information include but are not limited to: — Altering credentialing approval dates unsanctioned by the Joint Conference Committee (JCC) or prior to temporarily approval by the ZSFG clinical leadership while awaiting JCC final approval — Altering dates on verifications cannot be performed — Whited out of dates or signatures on hard copy documents			

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Line spacing: single

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0"

Formatted: Font color: Auto

Formatted: Font: Bold

	~~Unauthorized/inappropriate deletion of provider files or supporting documentation~~
4. The security controls in place to protect the information from unauthorized modification are:	An excerpt from the City of San Francisco Employee Handbook is detailed below (pg 54 of the New Employee Handbook). Work Site Security To prevent and discourage unauthorized access to your work site, do not leave your office area unattended. Do not prop open doors or windows that are normally kept locked. Lock all office doors after business hours or when you leave. Prevent and discourage theft by securing your valuables. Work-site keys and passes may not be shared, may not be duplicated without permission and must be returned upon separation. ~~Access to credentialing information is limited to authorized users only. Only authorized users are granted access to the MD Staff credentialing database based on business need.~~ ~~Authorized users are required to complete Annual Compliance and Privacy Training (DPH) along with Cybersecurity Training to ensure safeguard of credentialing database information.~~ Authorized users should: ~~Use strong passphrases containing unique combinations of uppercase letters, lowercase letters, numerals and symbols~~ ~~Refrain from writing down passwords~~ ~~Only use a unique password for any of their accounts, and not use a password more than once~~ ~~Update/change their passwords periodically, including when appropriate such as when passwords may be compromised~~ ~~Authorized user's accounts are inactivated upon separation from the organization, and every 30 days from their last login. The MD Staff credentialing database is only accessible via hospital intranet or VPN access. When the organization inactivates the user's active directory account, the user will no longer have a mechanism/pathway to log in to MD Staff for access to credentialing information.~~
5. The policies and procedures describe the organization's audit process for identifying and assessing risks and	Monitoring of our processes must occur at least annually. The audits of our process will be performed by a director in conjunction with selected members of the medical staff office team. The audits may include but are not limited to the following: ~~1. A description of the system functionality that prevents or disallows modifications of credentialing information.~~ ~~2. If the CR system allows modifications only under specific circumstances, an annual process for identifying all changes to established policies within the past 12 months and then updating the system controls accordingly.~~ ~~3. A review of automatic system alerts or flags for modifications or events in real time and a separate process for annually testing the performance of the system's automatic alerts or flags.~~

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt, Tab stops: Not at 0.85" + 0.85"

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0"

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Line spacing: single

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Space Before: 0 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt, Tab stops: Not at 0.85" + 0.85"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt, No bullets or numbering, Tab stops: Not at 0.24"

Formatted: Font color: Auto

Formatted: Font: Bold

ensuring that specified policies and procedures are followed. At a minimum, the description includes: - the audit elements include: - methodology used; - including sampling; - individuals involved in the audit; and - audit frequency. ➤ Over sight of the departmen t responsibl e for the audit.	Primary source documentation uploaded into our MD Staff credentialing database cannot be modified. An annual review sampling 5% of active records or 50 files will be reviewed at random from our monthly health plan roster (provider universe) and conducted by department management/senior staff to ensure that the provider records are complete and possesses accurate information. When auditing is used as the method for monitoring, sampling using the “5% or 50 files” audit method, with a minimum of 10 credentialing files and 10 recredentialing files shall occur. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits will audit 100% of the credentialing and recredentialing files. Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements. Monthly, quarterly, semiannual, or annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system’s audit trail function reporting capability. Credentialing, privileging, and enrollment are paperless processes that have very limited paper documents due to requirements for wet signatures. For paper documents/files, leadership conducts periodic walk-throughs of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours — i.e., in locked drawers/filing cabinets, not left on workstations, etc. Incorporate review of data modifications/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process. Assess for accuracy, appropriateness, compliance with policies. Findings will be documented and stored in a network folder. Credentialing staff and anyone who has access to credentialing information is required to sign an annual confidentiality form. These forms will be stored in a Medical Staff Services folder.

Formatted: Font: 12 pt

Formatted: Font: 12 pt

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Space Before: 0 pt

Formatted: Indent: Left: 0.6", Hanging: 0.03", Right: 0", Space Before: 0 pt, No bullets or numbering, Tab stops: Not at 0.85" + 0.85"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Line spacing: single

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0"

Formatted: Font color: Auto

Formatted: Font: Bold

Part D—Oversight	
1. Identify all modifications to credentialing and recredentialing information that—	At a minimum, an annual monitoring report will be required to show compliance with our Credentialing System Controls policies; procedures shall be reported to the ZSFG MSO and AH Credentials Committee and Medical Executive Committee. The report will need to include:

~~did not meet the organizations policies/procedures for modifications as described in CR 1, Element C, Credentialing System Controls.~~	a. ~~— A review of all modifications that did not meet the policies and procedures~~ i. ~~Conduct a qualitative and quantitative analysis of all modifications that did not meet policies.~~ ii. ~~Actions taken to address any modifications that did not meet established policy.~~ iii. ~~Implement quarterly monitoring when there are elements that did not meet the policies and procedures and provide written documentation in a report of this review.~~ b. ~~— The report shall include the person/role/title of the person performing the monitoring.~~ c. ~~— The report shall include the person/role/title of the person who has oversight of the monitoring process if different from who performs monitoring.~~
~~2. Document and analyze all modifications that did not meet standards by doing a qualitative and quantitative analysis of all modifications.~~	i. ~~Credentialing System Controls Oversight Report~~ ~~this template will be included in the request for documents at the time of the annual oversight assessment.~~ ii. ~~Monitoring and Reporting of Inappropriate Modifications~~ ~~this template will be included in the request for documents at the time of the annual oversight assessment. ZSFG MSO would need to submit this report if inappropriate modifications were identified. MSS will continue to monitor the report until it demonstrates improvement for three consecutive quarters. If improvement isn't demonstrated for at least one finding, all quarterly reports will be submitted to the MSS Director.~~
~~3. Acting on all findings. (Not applicable if no findings above.)~~	~~Findings will be acted upon by the ZSFG MSO, if any are identified.~~

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", No bullets or numbering, Tab stops: Not at

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Right: 0", No bullets or numbering, Tab stops: Not at 0.21"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03", Tab stops: Not at 2.45"

Formatted: Font: (Default) +Body (Calibri)

Formatted: List Paragraph, Indent: Left: 0.6", Hanging: 0.03"

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font color: Auto

Formatted: Font: Bold

POLICY & PROCEDURE WITH ALL APPENDICIES (A, B, C, D, F, G)

Added appendix G

Approved by Medical Executive Committee – May 11, 2026

Approved by Credentials Committee – May 4, 2026

Added appendix F

Approved by Medical Executive Committee – November 13, 2025

Approved by Credentials Committee – November 3, 2025

Added appendix F (changed to appendix E – 11/3/2025)

Approved by Medical Executive Committee – October 17, 2024

Approved by Credentials Committee – September 30, 2024

Added appendices C & D

Approved by Medical Executive Committee – February 15, 2024

Approved by Credentials Committee – February 5, 2024

Added appendices A & B

Approved by Medical Executive Committee – December 15, 2022

Approved by Credentials Committee - December 5, 2022

Approved by Medical Executive Committee – December 16, 2021

Approved by Credentials Committee – December 6, 2021

Approved by JCC – October 22, 2019

Approved by Medical Executive Committee – October 17, 2019

Approved by Credentials Committee – October 8, 2019

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri), 12 pt, Not Bold, Not Italic

Formatted: Space Before: 0 pt, Line spacing: single

Formatted: Indent: Left: 0"

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri), 12 pt, Font color: Custom Color(RGB(237,0,0))

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font: (Default) +Body (Calibri)

Formatted: Font: (Default) +Body (Calibri), 12 pt

Formatted: Font color: Auto

Formatted: Font: Bold



Department of Public Health

Implementation of Provisional Status for Newly Appointed Medical Staff

3.3. Provisional Medical Staff

The Provisional Medical Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have yet to complete initial proctoring requirements. Provisional Medical Staff Members shall be appointed to a specific Clinical Service and may serve on Medical Staff Committees. Provisional Medical Staff Members shall not be eligible to hold Medical Staff Offices or to vote on amendments to these

Situation

Newly appointed practitioners at ZSFG are currently assigned directly to Active or Courtesy status, which obscures the need for timely FPPE (initial proctoring). This has led to inconsistent proctoring completion, delayed evaluations, and potential regulatory vulnerabilities.

Practitioners granted full privileges between 13-24 months — and in some cases acting as proctors themselves before completing their own FPPE — puts us at risk of a survey finding.

Background

The Medical Staff Bylaws state that new practitioners enter a *provisional appointment period* prior to advancement. Provisional status is intended to provide a structured, time-limited oversight framework for FPPE and early competency evaluation.

TJC requires organizations to define, track, and evaluate FPPE for all new practitioners—lack of structure puts the hospital at risk during surveys.

Assessment

The absence of a clear Provisional designation creates operational, quality, and compliance risks. The Medical Staff Office have identified potential contributing factors to not using Provisional status:

- Departments have varying practices and inconsistently follow through on proctoring.
- FPPE reminders to practitioners are not automated.
- Some providers and service Chiefs are unclear on expectations regarding FPPE.
- Currently, providers show as “Active (P)” or “Courtesy (P),” which does not clearly convey their provisional status or FPPE responsibilities.
- Outstanding proctoring cases span 6–24 months for more than 170 practitioners.
- Early performance issues may be missed when evaluation timelines drift past the 1-year mark.
- Providers may be called on to proctor before completing their own evaluations, conflicting with bylaws requiring proctors to have unrestricted privileges.
- Other hospitals routinely use Provisional status to ensure standardization of oversight and



Department of Public Health

competency evaluation. It is considered an industry best practice and supports both FPPE tracking and regulatory readiness.

Recommendation

1. **Adopt Provisional Status as the default initial appointment category** for new privileged practitioners, replacing Active (P)/Courtesy (P) status.
2. **Standardize Provisional advancement criteria**, requiring:
 - Completion of required proctoring cases
 - Identify proctor that reviewed cases
 - Satisfactory peer review and OPPE indicators
 - Department Chief attestation
3. **Use Provisional status as a formal accountability mechanism** to ensure FPPE is completed within expected timeframes and support early identification of performance concerns. Provisional status does not limit or restrict practice or the privileges granted.

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	Standardized procedure - Nurse Practitioner/Physician Assistant
Clinical Service:	CHN Primary Care
Date of last approval:	2023
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 Perinatal 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. Further updates included 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. • Proposed Further updated language in accordance with AB1196: <u>“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. The practice site, Surgical Services, scope of</u>

	<u>practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol.”</u>
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 Protocols Protocol #10 Contraceptive Implant Removal & #9 Contraceptive Insertion • Current: Initially proctoring period required minimum of 6 removals for new provider, updated to 3 • Proposed: update to a minimum of 2 procedures for new provider • Current: Reappointment requires performance of 4 removals and 1 chart reviews every 2 years. • Proposed: update to a minimum of 2 case reviews every 2 years for removals and 1 case review for insertions. (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

City and County of San Francisco



Daniel Lurie
Mayor

Zuckerberg San Francisco General
Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

Department of Public Health

	Protocol #18 Skin biopsy • Proposed ADD: Covers removal of a small portion of abnormal skin to be tested in a laboratory • Adapted from current FCM SP

Medical Staff Services Department
Zuckerberg San Francisco General Hospital and Trauma Center

1001 Potrero Avenue | Building 20 | 3rd Floor | Suite 2300 | San Francisco, CA 94110
Telephone (628) 206-2342 | Fax (628) 206-2360



San Francisco Health Network

Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER /PHYSICIAN ASSISTANT

These standardized procedures are for the following 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 San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose 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 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 individual clinical sites within the Community Primary Care Clinical Service 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.

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 midwifery 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, interconceptional periods, provides family planning, conducts deliveries and cares for the newborn and infant.

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

*for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every ten years. 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 **practice agreement**.*

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.

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.

IV. **Scope of Practice**

- Protocol #1 Health Care Management: Primary Care
- Protocol #2 Health Care Management: Acute and Urgent Care
- Protocol #3 Health Care Management: Prenatal Care
- Protocol #4 Furnishing Medications and Drug Orders
- Protocol #5 Procedure: Arthrocentesis and Intraarticular Injections
- Protocol #6 Procedure: Musculoskeletal Soft Tissue Injections/Aspirations
- Protocol #7 Procedure: Endometrial Biopsy
- Protocol #8 Procedure: Incision and Drainage of Skin Abscesses
- Protocol #9 Procedure: Insertion of Contraceptive Implant
- Protocol #10 Procedure: Removal of Contraceptive Implant
- Protocol #11 Procedure: Insertion of Intrauterine Device
- Protocol #12 Procedure: Surface Trauma and Wound Care
- Protocol #13 Procedure: Splinting
- Protocol #14 Procedure: Waived Testing
- Protocol #15 Procedure: Tattoo Removal
- Protocol #16: Procedure: Nail Debridement
- Protocol #17: Procedure: Nail Removal/Matrisectomy
- Protocol #18: Procedure: Skin Biopsy

V. **Requirements for the Nurse Practitioner /Certified Nurse Midwife/Physician Assistant**

A. **Basic Training and Education**

- 1. Active California Registered Nurse/Certified Nurse Midwife/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) that must be from an 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 and DEA Number if applicable.
 8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center s. 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.

2. 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.

VI. *Development and Approval of Standardized Procedure*

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.*

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.
- 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.

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.

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.

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, 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.
 - 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.

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 35 weeks gestational age.
- c. Every week after 35 weeks gestational age.

E. RECORD KEEPING

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

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. . 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 Practice Agreement 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. The practice site, Surgical Services, 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: 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 CHN policy on Furnishing Medications (policy no. 13.2), the writing of Drug Orders. (Policy no. 13.5) & California AB1196 (Chapter 748) .

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 electronic health record The protocol will include the following:
 - i. location of practice
 - ii. diagnosis, illness, or condition for which medication is ordered
 - iii. name of medications, dosage, frequency, route, and 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
 - 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. Problem which is not resolved after reasonable trial of therapies.
 - b. Initiation or change of medication other than those in the formulary.
 - c. Unexplained historical, physical or laboratory findings.
 - d. Upon request of patient, NP, PA, or physician.
 - e. Failure to improve pain and symptom management.
 - f. Acute, severe respiratory distress
 - g. An adverse response to respiratory treatment or lack of therapeutic response.
- 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.

Protocol #5: Arthrocentesis and Intraarticular Injections

A. DEFINITION

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. 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.

- 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, 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 clinic and supportive services, as needed.

2. Patient conditions requiring 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 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

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

F. Summary of Prerequisite, 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 (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
 - j. Ability to recognize complications
 - k. 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 procedure will be the evaluator
2. New provider to procedure, a minimum of 2 successful observed

demonstrations.

3. Experienced provider to procedure, a minimum of 1 successful observed demonstration.
4. Explanation needed for any exceptions to minimum requirements.
5. Chart review will be done on all observed procedures.
6. Documentation of completion of training must be sent to the Medical Staff office.

Reappointment Competency Documentation

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

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 healthcare 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
 - i. Close proximity to neurovascular (arterial) structures
 - c. Contraindications
 - i. Allergy to medication
 - ii. Severe dermatitis or soft tissue infection overlying the joint or 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 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 procedure will be the evaluator
2. New provider to procedure will have a minimum of 3 successful observed demonstrations.
3. Experienced provider to procedure will have a minimum of 1 successful observed demonstration.
4. Explanation needed for any exceptions to minimum requirements.
5. Chart review of all observed cases.
6. Documentation of completion of training must be sent to the Medical Staff office.

Reappointment Competency Documentation

1. The evaluator will be an Attending Physician
2. Perform a minimum of 2 procedures every two years.
3. One chart review every two years.

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.

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.
 - 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, 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

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 time.
Proctoring Period:
1. New provider to procedure, a minimum of 2 successful observed demonstrations 2. Experienced provider to procedure, a minimum of 1 successful observed demonstrations 3. Explanation needed for any exceptions to minimum requirements 4. Two chart reviews.

Reappointment Competency Documentation:

1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator
2. Perform a minimum of 1 procedure every 2 years.
3. 1 chart review every 2 years.

Protocol #8: Incision and drainage of skin abscesses

A. DEFINITION

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

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Documentation

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.
Reappointment Competency Documentation 1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator 2. Perform a minimum of 1 procedure every 2 years. 3. 1 chart review every 2 years.

Protocol #9: Procedure: Insertion of Contraceptive Implant

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.
 - ii. May have drug interactions with anti-HIV medications and some herbal products.
 - iii. See drug precautions/interactions in 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 implant insertion, including sexual history to rule out preexisting pregnancy.
 - 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, 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.
 - 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.
2. Patient conditions requiring attending consultation
 - a. Difficult insertions/removals.
 - b. Acute decompensation of patient situation.
 - c. Upon request of patient, NP, CNM, PA, or physician
3. Education

Discharge information and instructions for care of site, expectant side effects, precautions and urgent/emergent symptoms.
4. Follow-up

As appropriate for implant insertion/removal.

E. RECORD KEEPING

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

F. Summary of prerequisites, proctoring, and reappointment competency

Prerequisites:

Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Established Experience: Documentation of greater than five (5) cases in the past two (2) years.

Limited Experience: Documentation of less than five (5) cases in the past two (2) years

Proctoring period: 1. For a new provider to procedure, a minimum of 2 successful observed demonstrations of insertions by a qualified provider. 2. For an experienced provider to pro a minimum of 1 successful observed demonstration of an implant insertion.
Reappointment competency documentation: 1. Review of 1 case of insertion every two years.

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 CPC.
2. Performance of procedure:
 - a. Indications
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

- 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

Prerequisite:

Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Established Experience: Documentation of greater than five (5) cases in the past two (2) years. Limited Experience: Documentation of less than five (5) cases in the past two (2) years

Proctoring period:

- a. Performance of a minimum of 2 removals for a new provider and 1 removals for a provider who has prior experience with independent removal.
- b. 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 cases

Reappointment Competency Documentation:

Review of 2 cases every 2 years.

Protocol #1: 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 TM
 - 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.

- 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. 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.
- 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. 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.

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 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
 - 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.
 - Patients requiring conscious sedation.

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, tetanus prophylaxis history, current medications, allergies.

2. Objective Data

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

- a. Patient consent obtained consistent with hospital policy before procedure is performed.
- b. Time Out performed per hospital policy.
- 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.
- 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**

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

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.
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 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. 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.

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

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

All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)

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. 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.

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.

- 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.

- 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?

2. Test Results requiring Attending Consultation

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

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

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

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

Six to eight weeks following treatment or as needed to address any concerns or complications.

E. RECORD KEEPING

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

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. Completion of 5 procedures every 2 years.
- b. Completion of 5 chart reviews every 2 years.

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.
 - 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.

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;
 - 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:

1. Performance of 1 procedure and 1 chart review every 2 years.
2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

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.

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

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:

1. Performance of 1 procedure and 1 chart review every 2 years.
2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

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

- 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*.
- 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 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.

Approval Dates:

Committee on Interdisciplinary Practice (CIDP)	
Credentials Committee	
Medical Executive Committee	
ZSFG Joint Conference Committee (JCC)	

ZSFG Medical Staff Bylaws Revisions

Summary of Changes

California law requires a public acute care hospital to maintain an organized medical staff operating under written medical staff bylaws approved by the hospital's governing body. These requirements arise principally from California hospital licensing regulations, including 22 CCR §§ 70701 and 70703, as well as the federal Medicare Conditions of Participation in 42 CFR § 482.22.

The bylaws serve as the foundational governance document for the medical staff and must address matters including credentialing, appointment and reappointment procedures, delineation of clinical privileges, peer review, corrective action, fair hearing rights, committee structure, and quality oversight.

In addition to adopting bylaws, hospitals and medical staffs are generally required to maintain, review, and update them periodically to ensure continued compliance with applicable law, regulatory requirements, accreditation standards, and operational needs. Federal Medicare regulations likewise require the medical staff to operate under current bylaws approved by the governing body. Accreditation organizations such as The Joint Commission also require periodic review and updating of medical staff bylaws and related governance documents to ensure they accurately reflect current practices, leadership structures, credentialing processes, and quality oversight obligations.

Pursuant to the procedures in Article 16 of the Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) Medical Staff Bylaws, the Bylaws Committee submits updates to the Medical Executive Committee every two years. The last substantive update occurred in 2019.

The final submitted revisions were reviewed by the Bylaws Committee, comprised of Medical Staff members, Affiliated Professionals, and members of the SFHN Medical Staff Services Department. Additionally, as also outlined in Article 16, this version has undergone preliminary review and discussion with the Joint Conference Committee for ZSFG between April 27 and May 11, 2026, with formal responses and clarifications submitted to the Commissioners and relevant changes made to the text. It was reviewed and approved by MEC on May 21 and then submitted to the full medical staff for review on May 28. Finally, on Wednesday, June 10, a quorum of full members of the medical staff voted unanimously to approve these changes for formal

consideration by the JCC and Full Health Commission at the June 22 and July 6 meetings, respectively.

Summary of Notable Changes:

Preamble

- Updates to various definitions, including those for various roles and positions
- Adding needed definitions, including “Clean Application” and “Practitioner”

Article 1: Name and Purpose

- Adding more inclusive language regarding Affiliated Professionals

Article 2: Medical Staff

- Adding reference to American Osteopathic Association (for alignment of conduct guidelines)
- Highlighting basic standards of conduct and referencing respective areas in Article 6 and 7
- Defining indications and process for granting of Temporary and Permanent waiver of ABMS Certification to maintain privileges
- Updating professional liability insurance requirements
- Re-adopting 2-year reappointment window for members
- Clarifying nondiscrimination terms

Article 3: Categories of the Medical Staff

- No significant changes from 2023 edits
- Adding quality improvement requirements for Active, Courtesy and Provisional and Administrative medical staff
- Clarifying quality improvement requirements and voting privileges for inactive members

Article 4: Appointments and Reappointments

- Clarifying that Affiliated Professionals are subject to same appointment processes and standards of oversight as medical staff

- Clarifying process for applicant review and recommendation, including the roles of the Clinical Service, Medical Staff Office, Credentialing Committee, Medical Executive Committee, and Governing Body, and standards and procedures.

Article 5: Clinical Privileges

- Clarifying that Affiliated Professionals are subject to the same oversight regarding quality improvement as for Medical Staff with Privileges.
- Clarifying procedures for temporary appointment and emergency privileges and status of Emergency and Visiting Physicians
- Adding Affiliated Professionals and Affiliated Status throughout
- Describing basic proctoring processes following appointment or new privileges

Article 6: Monitoring and Corrective Action

- Describing the standards of and processes for routine and cause-related monitoring
- Clarifying that all medical staff and Affiliated Professionals are subject to same professional standards of behavior and same progressive discipline and/or corrective action steps
- Removing clause regarding Director of Health's authority to restrict access to the health record or campus
- Describing reporting requirements to state licensing board following certain occurrences

Article 7: Hearings and Appellate Review

- Clarifying process for Corrective Action involving Affiliated Professionals
- Clarifying hearing procedures

Article 8: Structure of the Medical Staff

- Listing Officers, describing election process, and updating terms of service for Chief of Staff

Article 9: Clinical Services

- Defining Clinical Services and describing roles and responsibilities of Chiefs of Service
- Clarifying role and procedures regarding Chief of Staff
- Clarifying role and procedures for Chiefs of Service
- Clarifying CPC vacancy and appointment process

Article 10:Physician leadership

- Minimal changes from 2023 or current
- Describing “physician leadership” and defining reporting structures
- Adding “Associate CMO” roles

Article 11: Committees of the Medical Staff

- Updating committees and their reporting frequency
- Clarifying Medical Executive Committee membership and voting
- Updating UM Committee

Article 12: Meetings of the Entire Medical Sta

- Updating procedures for special meetings
- Clarifying bi-annual participation expectation

Article 13: Confidentiality of Information; Immunity & Releases

- Broadening coverage definition
- Clarifying privacy protection for discussions and deliberations

Article 14: Conflicts between the Medical Staff and the Governing Body

- Updating and clarifying conflict resolution workflow

Article 15: Rules and Regulations

- Updating review and approval procedures

Article 16: Adoption and Amendment

- Clarifying revision and adoption procedures

Article 17: Miscellaneous Provisions

- Describing requirements for forms of contact

**THE PRISCILLA CHAN AND MARK ZUCKERBERG
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER**

April 2026

Draft

MEDICAL STAFF BYLAWS

ZSFG Medical Staff Bylaws

PREAMBLE

WHEREAS, The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG or Hospital) is a public hospital organized under the laws of the State of California and the Charter of the City and County of San Francisco; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, research, and undergraduate and postgraduate education in the health sciences; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Hospital Administration and the Governing Body are necessary to fulfill the Hospital's obligations to its patients.

THEREFORE, the physicians, dentists, clinical psychologists, and podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws and Rules and Regulations. These Bylaws and Rules and Regulations provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with Applicants to, and Members of, the Medical Staff as well as with Affiliated Professionals whose clinical care is subject to Medical Staff oversight.

DEFINITIONS

Affiliated Professional: Individuals who are credentialed through the Medical Staff, are subject to general Medical Staff oversight, and belong to a professional category not eligible for Medical Staff Membership. They are not Members of the Medical Staff and are not afforded the due process rights set forth in these Bylaws. and they may not vote on amendments to the Bylaws or Rules and Regulations.

Attending Faculty or Attending: Member of the Medical Staff who meets the Bylaws board certification or eligibility requirements within their specialty and who supervises (or may supervise) physicians in training (residents or fellows), medical students and affiliated professionals (if required by their licensure). Attending physicians may also be faculty or volunteer faculty at University of California School of Medicine.

Applicant: Physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership. To the extent applicable based on the context listed in these Bylaws, this term also applies in relation to people who are applying to be an Affiliated Professional.

Chief of Service: Each Member of the Active Medical Staff who is selected under Section 9.2 of these Bylaws to lead a Hospital clinical service and perform the duties listed in Section 9.3 of these Bylaws for that service. Each clinical service has a Chief of Service.

Chief of Staff: The Member of the Medical Staff who is elected as outlined by Article 8 of these Bylaws to serve as an officer of the Medical Staff and who serves as the head of the Medical Staff. The Chief of Staff has the powers and duties listed in Article 8 as well as elsewhere in these Bylaws.

City: The City and County of San Francisco.

Clean Application: An application for membership to the Medical Staff for which there is no missing information, all primary source verifications have been completed, and there are no

Deleted: clinical

Deleted: Service

ZSFG Medical Staff Bylaws

issues that raise concerns about the ethics, judgement, or quality of care of the application. The Chair of the Credentials Committee, in the Chair's sole discretion, will make the final determination as to whether the application is clean. Such applications may be approved by an email vote of the Credentials Committee and the Medical Executive Committee. Approval by the Governing Body must occur at a meeting of the Governing Body or a Committee of the Governing Body.

Deleted: shall

Clinical Service: A Hospital service group as listed in Article 9 of these Bylaws.

Date of Receipt: The date on which any Notice or other communication that was delivered personally or electronically, or three (3) days after it was postmarked.

Deleted: , Special Notice,

Department Chair: The Chair of the Department at the University of California, San Francisco. For the Community Primary Care Service (CPC), the Director of Primary Care or their designee will act as the "Department Chair".

Deleted: Days: Calendar days.

Director of Health: The Director of the San Francisco Department of Public Health. The Director of Health or their designee will ensure that information that is required to be communicated to the Governing Body by these Bylaws will be communicated, and such information may be communicated to the Director of Health without jeopardizing any peer review protections.

Deleted: who also serves as a member of the Joint Conference Committee for Quality Assurance for the Hospital...

Deleted: and the individual who serves as the Chief Executive Officer of the Governing Body and, as such, information ...

Director of the San Francisco Health Network: The individual responsible for managing the delivery system of the Department of Public Health and who supervises the Hospital's Chief Executive Officer. Information required to be communicated to the Hospital's Chief Executive Officer may be communicated to the Director of the San Francisco Health Network without jeopardizing any peer review protections.

DPH: The San Francisco Department of Public Health.

Governing Body: The San Francisco Health Commission subject to the responsibilities designated to the Director of Health by the San Francisco Charter and Municipal Code.

Hospital: The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

Hospital Administration: Executive Staff Committee members, including the Hospital Chief Executive Officer, Senior Associate Administrators, and Associate Administrators appointed by the Director of Health or Hospital Chief Executive Officer, who implement the day-to-day operations of the Hospital.

ZSFG Medical Staff Bylaws

House Staff: Trainees in [Accreditation Council for Graduate Medical Education or American Board of Medical Specialties](#) programs.

Deleted: ACGME

Deleted: ABMS

Joint Conference Committee for Quality Assurance (JCC): the committee where members of the Governing Body, Hospital Administration and Medical Staff review and discuss the Hospital's credentialing and quality assurance and performance improvement program.

Medical Staff: [The organization established by these Bylaws and consisting of the collective group of Members duly appointed under these Bylaws and that takes action on behalf of Members as outlined by these Bylaws.](#)

Medical Staff Services Department (MSSD): The hospital department that administratively supports medical staff activities.

Medical Staff Year: The period from July 1 through June 30.

Member: Physicians, dentists, clinical psychologists, and podiatrists whose applications have been approved by the Medical Executive Committee and the Governing Body for membership on the Medical Staff.

Practitioner: [A neutral term used to describe either a Member of the Medical Staff or an Affiliated Professional as defined elsewhere in these Bylaws whose Clinical Privileges and Credentialing are governed by the Medical Staff Bylaws and Rules and Regulations](#)

Notice: A written communication delivered personally, by email, electronically, or sent by United States mail regarding an appointment, reappointment, privileges, or Medical Staff status.

San Francisco Health Network (SFHN): The healthcare delivery system of the San Francisco Health Department. Hospital and community primary care are components of this delivery system that also includes skilled nursing care, mental health, substance abuse, and jail health services.

Staff: [All people who work at the Hospital, whether as paid employees or volunteers of the City or UCSF or as contractors, including people who perform clinical, administrative, facility maintenance, or other duties.](#)

University or UCSF: The University of California, San Francisco.

Deleted: Special Notice: Refers to a Notice regarding potential or pending corrective action regarding an appointment, reappointment, privileges, or Medical Staff status.⁴

Vice Chair of a Medical Staff Committee: An individual who is subordinate to the Committee Chair and need not be a Member of the Medical Staff. The Vice Chair may chair Committee meetings and may represent the Committee at Medical Executive Committee meetings in the absence of the Chair.

Vice Dean: The UCSF Vice Dean located at the Hospital.

Note 1-Designation of "Acting" Executives – The terms "Chief of Staff," "Chief of Service," "Chief Executive Officer," "Vice Dean," and "Director of Health" include any persons designated to act on [each person's behalf](#).

Deleted: Other

Deleted: :

Deleted: Clinical

Deleted: shall

Deleted: the Vice Dean's or Director of Health's

Deleted: [in either of their respective absences](#)

Note 2-Clarification of time-based definitions – [All references to days in these Bylaws are to calendar days \(not business days\).](#)

ZSFG Medical Staff Bylaws

ARTICLE 1. NAME AND PURPOSES

1.1. Name

The name of this organization is the Medical Staff of The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

Deleted: shall be

Deleted: (ZSFG or Hospital, as used herein)

1.2. Purposes and Responsibilities

The purpose of the Medical Staff is to work with, and alongside, Hospital Administration and Staff to achieve the Hospital's True North (see Appendix 1). Specifically, the Medical Staff's purposes and responsibilities are to:

Deleted: Leadership

Deleted: ,

Deleted: T

1.2.1. Collaborate

Collaborate with Hospital Administration to improve the services provided to patients;

1.2.2. Patient Care

Assure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital receive care at a level of quality and efficiency consistent with generally accepted standards and attainable within the Hospital's means and circumstances;

1.2.3. Professional Performance

Assure a high level of professional performance of all Applicants authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each Applicant may exercise in the Hospital and through a continuing review and evaluation of each Applicant's performance in the Hospital;

1.2.4. Educational Setting

Provide an appropriate educational setting for continuing education of the Medical Staff and Affiliated Professionals and for the education of both undergraduate and graduate students in the health sciences;

1.2.5. Community Health Education

Organize and support community health education and support services;

1.2.6. Self-Governance

Develop and maintain Bylaws for self-governance of the Medical Staff;

1.2.7. Communication

Provide a means whereby issues of mutual concerns to the Medical Staff and Hospital Administration may be discussed by the Medical Staff with the Governing Body, the Chief Executive Officer, and the Director of Health;

Deleted: ;

1.2.8. Performance Improvement and Patient Safety

Incorporate the principles of performance improvement and patient safety in the provision of clinical care; and

Deleted: .

1.2.9. Equity

Actively support the Hospital's commitment to equity in clinical, educational, and workplace relationships and systems.

Commented [LG(3): for committee discussion]

ZSFG Medical Staff Bylaws

ARTICLE 2. MEDICAL STAFF MEMBERSHIP

2.1. General Qualifications

Membership on the Medical Staff of the Hospital is a privilege that will be extended only to those Applicants who are professionally competent and continuously meet the qualifications, standards and requirements set forth in these Bylaws. Only those currently licensed physicians, dentists, clinical psychologists and podiatrists whose experience, training, ethics and demonstrated competence assure, in the judgment of the Medical Staff and the Governing Body, that any patient treated by them in the Hospital will receive quality medical care, may qualify for membership. Members of the Medical Staff must conduct themselves in the highest ethical tradition and in a manner consistent with the Code of Ethics of the American Medical Association, the American Dental Association, the American Psychological Association, the American Osteopathic Association, or the American Podiatric Medical Association. Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other Applicants for membership or privileges.

Deleted: which

Deleted: shall

Deleted: shall

2.2. Basic Qualifications for Consideration of Application For Active and Courtesy Medical Staff for Initial Appointment or Reappointment

To qualify for initial appointment or reappointment, an Applicant or Member or Affiliated Professional must demonstrate compliance with all the basic standards set forth in this Article 2 in order to have an application for Medical Staff membership accepted for review. The Applicant must meet the following standards:

Deleted: A

Deleted: Section

2.2.1. Licensure

Physicians must (1) be licensed to practice medicine by the Medical Board of California or Osteopathic Medical Board of California or (2) comply with all of the requirements of California Business and Professions Code Section 2113 or Section 2168 *et seq.*, including possession of a valid and current Certificate of Registration under those code sections and approval by the UCSF Dean, School of Medicine and the Vice Dean at the Hospital.

Dentists must be licensed to practice dentistry by the Dental Board of California.

Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine.

Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology.

Deleted: of the Medical Board of California

Deleted: Applicants must be certified, or be progressing towards certification by (1) boards which that are duly organized and recognized by an American Board of Medical Specialties (ABMS); or (2) a board or association with equivalent requirements approved by the Medical or Dental Board of California; or (23) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training that provides complete training in that specialty or subspecialty. Applicants/re-applicants must become board certified before their first reappointment. Where this is not possible due to board requirements, the Applicant must become board certified within two years of meeting board requirements and no later than six years after the initial granting of Medical Staff membership. Re-applicants who have let their board certification lapse must become board certified no later than the second reappointment after their certification lapsed.

2.2.2. Drug Enforcement Agency (DEA)

Applicants must possess by their start date a valid federal DEA number unless the Applicant will never prescribe, or supervise the prescribing of, medications.

2.2.3. Physician Board Certification

A. Applicants must be certified or be progressing towards certification by (1) boards that are duly organized and recognized by an American Board of Medical Specialties (ABMS) or (2) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training that provides

Formatted: Font: Not Bold

ZSFG Medical Staff Bylaws

complete training in that specialty or subspecialty. Applicants must become board certified before their first reappointment. In surgical specialties where case requirements must be met after training, exceptions may be made, but all applicants must achieve board certification no later than six years after the initial granting of Medical Staff membership. Re-applicants who have let their board certification lapse must become board certified no later than the second reappointment after their certification lapsed.

- B. A Chief of Service may submit a written request for waiver of the certification requirement or an extension of the six-year period to become board certified to the Medical Executive Committee (MEC) for persons who demonstrate that their education, training, experience, ability, judgment, and medical skills make them sufficiently qualified to serve as Medical Staff Members. The MEC and the Governing Body will consider each request and determine whether approval is in the best interest of the patients and of the Hospital.

Persons appointed with an approved waiver as described above must be categorized with one of the following statuses:

1) Temporary Waiver

Temporary waivers are valid for the duration of the appointment or reappointment period. The temporary waiver is intended for people with a path to ABMS certification that is compatible with expectations and scope of their academic role and clinical duties. The person with the waiver is progressing toward certification by a board duly organized and recognized by the ABMS, and must address their certification status at application for reappointment as outlined in this subsection 2.2.3.

2) Permanent Waiver

The waiver is permanent and automatically applies to future reappointments. The permanent waiver is intended for foreign trained practitioners that meet either of the below criteria:

- a. Have no reasonably-feasible path to ABMS certification (i.e., no path at all or a path to board certification that is either highly restrictive or would place undue burden on the individual and/or Clinical Service, significantly distracting from the Applicant's primary duties).
- b. Are practicing medicine with the approval of the Medical Board of California pursuant to Section 2168 of the California Business and Professions Code.

2.2.4. Professional Liability Insurance

Individuals (both Members and Affiliated Professionals) who are not Members of the faculty of the University or are not employed by the City and County of San Francisco must maintain professional liability insurance in an amount not less than \$2 million each occurrence, \$6 million aggregate with an insurance carrier acceptable to the City's Risk Manager. Each such Member or Affiliated Professional must upon acceptance of the Medical Staff and thereafter at

Formatted: Indent: Left: 0.25", Hanging: 0.25", No bullets or numbering

Deleted: Clinical Service Chief

Deleted: six year

Deleted:

Deleted: <#>The waiver is permanent and automatically applies to future reappointments until further action approved by the MEC and the Governing Body (a permanent waiver); or¶

Deleted: <#>American Board of Medical Specialties

Deleted: <#>Section

Deleted: <#> (a temporary waiver)

Deleted: providers

Deleted: For both initial temporary and permanent waivers In either case, and at each reappointment, the Chief of Service must document that the Applicant has completed activities commensurate the Member must show activities equivalent to those required by Maintenance of Certification requirements programs for their relevant specialty by the ABMSAmerican Board of Medical Specialties.¶

Deleted: The board certification requirement does not apply to the following:¶
Dentists, podiatrists, and clinical psychologists;¶
UCSF physicians practicing medicine with the approval of the Medical Board of California under California Business and Professions Code 2113 or 2168 (foreign trained physicians).¶

Deleted: M

Formatted: Not Highlight

Formatted: Not Highlight

Deleted: and

Deleted: ,

Deleted: shall

Deleted: shall

Formatted: Not Highlight

ZSFG Medical Staff Bylaws

any time requested by the Credentials Committee, provide the Credentials Committee with written evidence of conforming coverage. Each such individual must promptly report to the Credentials Committee any reduction, restriction, cancellation for termination of the required insurance coverage or, if applicable, change of insurance carrier. Insurance requirements set forth in these Bylaws are subject to review by the City's Risk Manager, and may be updated by the City's Risk Manager from time to time as conditions warrant. The insurance requirements of this section may be modified on a case-by-case basis for good cause by the Hospital's Chief Executive Officer in consultation with the City's Risk Manager and the Chief of Staff.

Deleted: An excess or umbrella policy for liability coverage that "follows form" can be used to meet this requirement.

Deleted: Member shall

Formatted: Not Highlight

Deleted: and approval

Formatted: Not Highlight

2.2.5. Participation in Medicare, Medicaid and Other Federal Health Care Programs

Applicants must:

- A. Be eligible to participate in the Medicare, Medi-Cal, and other federal health care programs;
- B. Obtain a National Provider Identifier (NPI); and
- C. Enroll in Medicare and/or Medi-Cal and receive an enrollment confirmation letter, excluding dentists and other practitioners whose professional services are not reimbursed by Medicare and/or Medi-Cal, respectively.

Deleted: Identification

Deleted: providers

Formatted: Not Highlight

2.3. Qualifications for Membership

In addition to meeting the basic qualifications, the Applicant must:

2.3.1. Experience, Education and Training

Document the Applicant's: (1) adequate experience, education, and training in the requested privileges; (2) current professional competence; (3) ability to perform the privileges requested; (4) good judgment; and (5) adequate physical and mental health to perform patient care activities, and demonstrate to the satisfaction of the Medical Staff that the Applicant is professionally and ethically competent to reliably provide the quality of care acceptable by the Medical Staff.

2.3.2. Ethics

Be determined: (1) to adhere to the lawful ethics of the Applicant's profession; (2) to work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and (3) to participate in and properly discharge Medical Staff responsibilities.

Deleted:

Deleted: shall be

Deleted: shall

Commented [LG(7): Note to be removed – We marked in blue areas where the two year term is changed to a three year term (or a question might arise about whether to change it). These are based on the Joint Commission/state regulators now allowing three year terms. Where highlighted in blue and still 2 years, that is intentional.

Deleted: that term that we will review by rules and regulations the term of the three year term issue. Insert link to statute regarding membership status.

Deleted: shall

Deleted: two three (3)

2.4. Condition and Duration of Appointment

2.4.1. Governing Body Action

Initial appointment and reappointment to the Medical Staff is made by the Governing Body. The Governing Body will act on appointments, reappointments, or revocation of appointments only after a recommendation from the Medical Staff as provided in these Bylaws.

2.4.2. Duration

Initial appointments and reappointments to the Medical Staff will each be for a period of not more than two (2) years.

ZSFG Medical Staff Bylaws

2.4.3. Clinical Privileges

Appointments to the Medical Staff confer on the appointee only such Clinical Privileges as have been granted by the Governing Body, in accordance with these Bylaws.

Deleted: shall

2.4.4. Provide Care

Every Member will provide care and supervision of the Member's patients, abide by the Medical Staff Bylaws, accept committee assignments and, when appropriate, provide emergency service care and accept consultation assignments.

Deleted: shall

2.4.5. Non-Discrimination

Members must not discriminate in the provision of care to patients based on race, religion, color, national origin, ancestry, age, disability, medical status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws.

Deleted: Shall

Deleted: t

Deleted:

Deleted: e

2.4.6. Division of Fees

The practice of division of fees under any guise whatsoever is prohibited and any such division of fees is cause for exclusion or expulsion from the Medical Staff.

Deleted: shall

Deleted: arbitrary

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Not Highlight

2.5. Harassment Prohibited

Harassment by a Member against any individual (e.g., against another Medical Staff Member, House Staff, Hospital personnel or patient) on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws will not be tolerated. All allegations of harassment will be investigated according to policies adopted by the City and/or University.

Deleted: shall be

Deleted: shall be

Deleted: employee

Deleted: shall

Formatted: Not Highlight

2.6. Nondiscrimination

No aspect of Medical Staff membership or Clinical Privileges and/or standardized procedures will be denied on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by local, state, or federal law. The credentialing and recredentialing processes will be conducted in a non-discriminatory manner and Members responsible for credentialing decisions will be required to sign an affirmative statement that they will make decisions in a non-discriminatory manner. Additionally, the Medical Staff must not discriminate with respect to staff privileges or the provision of professional services against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O., or D.P.M.

Deleted: shall

Formatted: Not Highlight

2.7. Effect of Other Affiliations

No person is entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the person holds a certain degree, is licensed to practice in this or any other state, is a Member of any professional organization, is certified by any Clinical Board, or because such person had, or presently has, staff Membership or privileges at another health care facility.

Deleted: shall be

2.8. Basic Responsibilities of the Medical Staff

Each Medical Staff Member, Affiliated Professional and each Applicant exercising temporary privileges, must continuously meet all of the following responsibilities:

Deleted: shall

ZSFG Medical Staff Bylaws

- A. Provide the Member's or Affiliated Professional's patients with care that is of a generally recognized professional level of quality and efficiency;
- B. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the Medical Staff and the Hospital;
- C. Abide by applicable laws and regulations of government agencies, standards of the Joint Commission, and the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation;
- D. Discharge such Medical Staff, Clinical Service, committee and service functions for which the Member, Affiliated Professional or Applicant exercising temporary privileges is responsible by appointment, election or otherwise; and
- E. Complete new hospital orientation prior to exercising privileges.
- F. Work cooperatively with Members, nurses, the Hospital Administration, and others so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care;
- G. Report to their Service Chief any illness, disability, or absence which could affect patient care; and cooperate, at the Member's expense, with any health evaluations as may be reasonably required by the Medical Executive Committee;
- H. Reporting to the Chief of Staff and their Service Chief within 7 days in the event of any formal action taken by government authorities to exclude the Member from participating in Medicare, Medicaid, or any other federal health care program;
- I. Report to the Chief of Staff and their Service Chief within 7 days of: (1) any reduction, suspension, revocation, or termination of their Clinical Privileges and/or membership, for medical disciplinary cause or reason, at another licensed health care facility or medical group; (2) any certifying or licensing agency's initiation of an investigation, accusation, action, or settlement, (3) any surrender of license or certification, or (4) any felony charge or conviction of a misdemeanor or felony;

Deleted: The

Deleted: on the Accreditation of Health Care Organizations

2.9. Non-Compliance With Basic Qualifications

An Applicant, Member or Affiliated Professional applying for reappointment who does not meet these basic qualifications is ineligible to apply for Medical Staff membership or reappointment and the application will not be accepted for review. If it is determined during the review process that an Applicant does not meet all of the basic qualifications, the review of the application will be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee.

Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant complies with the basic qualifications for Medical Staff membership.

Formatted: Indent: Left: 0.5", No bullets or numbering

Commented [LG(9): Global – see where it should be applicant and member.

Commented [MM9R2]: Change to "Professional" or more global term (for MS APs and Applicants etc.)

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall have

ARTICLE 3. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff is divided into Active, Courtesy, Provisional, Administrative, and Inactive Staff categories.

Deleted: shall be

3.1. Active Medical Staff

The Active Medical Staff consists of physicians, dentists, clinical psychologists and podiatrists qualified for Medical Staff membership who spend the majority of their clinical effort treating patients under the direction of a Clinical Service of the Medical Staff at the Hospital or DPH healthcare facilities. Members of the Active Medical Staff must be appointed to a specific Clinical Service and are eligible to vote, to hold Medical Staff offices, and to serve on Medical Staff committees. Active Medical Staff Members are required to participate in Clinical Service conferences, meetings, and continuous quality improvement.

Deleted: shall

Deleted: shall

Deleted: ,

Deleted: shall

Deleted: be

3.2. Courtesy Medical Staff

The Courtesy Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who do not spend the majority of their clinical effort, or who spend an average of less than 4 hours per week, treating patients under the direction of a Clinical Service of the Medical Staff. Courtesy Medical Staff Members must be appointed to a specific Clinical Service and may serve on Medical Staff committees. Courtesy Medical Staff Members are not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Courtesy Medical Staff Members are encouraged, but not required, to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of Service. Courtesy Medical Staff Members are required to participate in specific quality improvement activities that address their practice or involved them as a participant or witness.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Chief of the Clinical Service

3.3. Provisional Medical Staff

The Provisional Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have yet to complete initial proctoring requirements. Provisional Medical Staff Members must be appointed to a specific Clinical Service and may serve on Medical Staff Committees. Provisional Medical Staff Members are not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Provisional Medical Staff Members are required to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of Service. Provisional Medical Staff Members are required to participate in specific quality improvement activities that address their practice or involved them as a participant or witness.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Chief of the Clinical Service

3.4. Administrative Medical Staff

The Administrative Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have a significant administrative medical role, have been granted access to Medical Records, and consult with other Members of

Deleted: shall

the Medical Staff but who do not have Clinical Privileges or provide direct care to patients. Administrative Medical Staff Members need not be appointed to a specific Clinical Service and are eligible to vote, to hold Medical Staff offices, and to serve on Medical Staff committees. Administrative Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness.

Deleted: ,

Deleted: ,

Deleted: shall

Deleted: be

3.5. Inactive Medical Staff

The Inactive Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who are missing one or more requirements to begin or continue practicing privileges. These requirements may include, but are not limited to, initial and annual hospital orientation and Environmental Health & Safety (EH&S) requirements such as TB testing and N95 fit testing. Inactive Medical Staff Members, when they have inactive status, are not eligible to vote, to hold Medical Staff offices, or to serve on Medical Staff committees. Inactive Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness.

Deleted: shall

Deleted: MEDICAL STAFF BYLAWS

ARTICLE 4. APPOINTMENT AND REAPPOINTMENTS

4.1. General

4.1.1. Application Process

All applications for appointment and reappointment to the Medical Staff or as an Affiliated Professional of the Medical Staff must be in writing, signed by the Applicant, and submitted to the Medical Staff Services Department (MSSD) on a form approved by the Governing Body, upon recommendation of the Credentials Committee.

4.1.2. Application Content

Every Applicant for appointment or reappointment must furnish a fully completed application, and has the burden of producing accurate and adequate information for a proper evaluation of the Applicant's current clinical competence, character, and ethics. Information in applications must include:

Deleted: shall have

Deleted: shall

- A. Any previous denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment, whether voluntary or involuntary, to a professional license or DEA license;
- B. Voluntary or involuntary termination of Medical Staff membership or Affiliated Professional status, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or other health care organization;
- C. A factual synopsis of all pending and resolved professional liability actions, asserted or active within the previous five (5) years;
- D. For any resolved professional liability actions, a description of the judgment, arbitration award, settlement or other disposition; and
- E. Attestation responses regarding the following issues:
 - 1) Reason for an inability to perform essential functions of the position;
 - 2) Violations of any criminal law or statutes;
 - 3) Denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment of licensure; and
 - 4) Disciplinary activity or limitation of privileges and/or Medical Staff status.

Deleted: or standardized procedures

Deleted: made

Deleted: questions

Deleted: <#>History of chemical dependence or substance abuse;

4.1.3. Completion of Application

An application is "completed" when the Applicant has supplied all of the requested information and all necessary verifications have been obtained—including, but not limited to, current license, licensing board disciplinary records, specialty Board Certification status,

National Practitioner Data Bank (NPDB) information, DEA certificate, if appropriate, training and practice from professional school through the present, current malpractice liability insurance and history, and reference letters, as specified in [subsection 4.2.2 \(Completed Application\)](#), below.

Deleted: Section

4.1.4. Application Misrepresentation or Omission

Any significant misrepresentation or omission by an Applicant for appointment or reappointment [is](#) grounds for denial of the application or other appropriate corrective action, including revocation of Clinical Privileges and Medical Staff membership.

Deleted: may be

4.1.5. Effect of Application

By applying for appointment or reappointment to the Medical Staff, each Applicant:

- A. Signifies the Applicant's willingness to appear for interviews with the Medical Staff;
- B. Authorizes the Medical Staff to consult with Medical Staff Members, [administrators, or other personnel](#) of other health care facilities with which the Applicant has been associated and who may have information bearing on the Applicant's competence, character, ethical qualifications, relevant mental and physical health, and any claims history;
- C. Consents to the Medical Staff's inspection of all records and documents pertinent to the Applicant's current licensure, specific training, experience, current clinical competence and ability to perform the privileges requested and other matters that may be material to an evaluation of professional qualifications for Medical [or Affiliated](#) Staff membership;
- D. Releases from any liability the Hospital, the Medical Staff, the Governing Body, the City, and the University, for any acts performed in good faith and without malice in connection with evaluating the Applicant's credentials; and
- E. Certifies that the Applicant [will](#) promptly report to the MSSD any changes in the information submitted on the application which may subsequently occur.

Deleted: shall

4.1.6. Applicant's [Right to Be Informed](#)

Each Applicant has the right to be informed of the status of the Applicant's credentialing or recredentialing application upon request.

Deleted: r

Deleted: b

Deleted: i

4.2. Initial Appointment Process

4.2.1. Applicant's Receipt of Medical Staff Information

The Applicant [will](#) be provided with a copy of, or access to, the Medical Staff Bylaws and Rules and Regulations, and Clinical Service Rules and Regulations governing the Applicant's specialty.

Deleted: shall

4.2.2. Completed Application

The completed application for initial appointment [must](#) include: detailed information concerning the Applicant's professional qualifications, including, but not limited to, education, professional training, experience, licensure, relevant physical and mental health, disciplinary history, claims history, information regarding possible involvement in professional liability actions, biographical data, requests for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate

Deleted: shall

licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations, specialty board status, University faculty appointment status, and employment status; a signed agreement that the Applicant has read and will abide by the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; and a signed statement of commitment to the confidentiality of all Medical Staff proceedings. It is the duty of the MSSD to provide an up to date copy of the Medical Staff Bylaws and the duty of the Clinical Service to provide an up to date copy of the Rules and Regulations to the Applicant for which the Applicant must attest.

Deleted: ee

Deleted: shall

4.2.3. Applicant's Burden and Incomplete Application

The Applicant has the burden of submitting complete, accurate, and adequate information for a proper evaluation of the Applicant's qualifications, including all requirements specified in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and the Rules and Regulations of the department in relation to which that Applicant is seeking to work. This burden includes the burden of resolving any doubts about these matters and of providing any additional information requested by the Chief of Service, Chief of Staff, MSSD, or the Chair of the Credentials Committee. This burden also includes the Applicant paying any costs associated with verifications where the MSSD does not have access to the verification at issue. This burden may include submission to a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the MEC and, for City employees, as consistent with City rules. The Applicant's failure to sustain this burden or the provision of information containing any misrepresentations or omissions is grounds for denial of the application or subsequent termination, suspension, or limitation of Membership or Privileges under these Bylaws.

Deleted: Service Chief

An incomplete application may not be processed. If an Applicant fails to complete the application within sixty (60) days after the date of initial submission, it may be considered voluntarily withdrawn on the sixtieth day after initial submission. If, prior to such voluntary withdrawal, the MSSD discovers that an application is incomplete, it will provide notice to the Applicant and the Chief of Service (or their designee) of the incomplete application as soon as possible (and no later than thirty (30) days before the deadline). Such voluntary withdrawal does not entitle the Applicant to the rights set forth in these Bylaws. The Credentials Committee may, for a good cause, extend the time for completion of the application.

Deleted: will

Deleted: The Applicant will be notified of any missing items within thirty (30) days of the submission of the incomplete application. I

Deleted: will

Deleted: The Applicant will be notified of the missing items within thirty (30) days of withdrawal.

Deleted: shall

Deleted: and

Deleted: , and Standardized Procedures

Deleted: shall

Deleted: be

Deleted: ted

Deleted: Service Chief

Deleted: Service Chief

Deleted: 's

Deleted: shall then be forwarded

Deleted: shall

Deleted: the

Deleted: Service Chief

Deleted: s

4.2.4. Recommendation for Medical or Affiliated Staff Membership, and Clinical Privileges

When the MSSD has received all necessary verifications, the completed application, all supporting documentation, and other relevant information (collectively the "File"), it will submit the File to the Chief of Service for review and recommendations regarding membership and Privileges. The Chief of Service will then forward their written recommendations to the Credentials Committee. If the Applicant is seeking privileges in more than one Clinical Service, then the File will be submitted to all applicable Chiefs of Service for written recommendations once all verifications are received.

4.2.5. Credentials Committee Review and Action

The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

Deleted: shall

Deleted: Service Chief

Deleted: shall

4.2.6. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, through the Director of Health, that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges. When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

Deleted: shall

Deleted: or Standardized Procedures

Deleted: or Standardized Procedures

Deleted: shall

Deleted: shall

A. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body, through the Director of Health.

B. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.

C. When the recommendation of the MEC is adverse to the Applicant in respect to appointment or specific Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it.

Deleted: or or Clinical Privileges,

Deleted: shall

Deleted: Service Chief

Deleted: shall

Deleted: Special

Deleted: ,

Deleted: shall

Deleted: shall

D. An Applicant who has received an adverse recommendation from the MEC as part of their initial appointment for privileges is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee and MEC.

Deleted: until after the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights set forth in Articles 6 and 7 of these Bylaws.

E. Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant should receive a favorable recommendation for Medical or Affiliated Staff membership.

Deleted:

Formatted: Indent: Left: 0.5", No bullets or numbering

Deleted: shall

Deleted: or

Deleted: or

Deleted: , through the Director of Health

Deleted: ,

Deleted: shall

Deleted: Chief of the Clinical Service

Deleted: Special

Deleted: ,

Deleted: shall

4.2.7. Governing Body Review and Action

The Governing Body will act upon a favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights under Articles 6 and 7 of these

Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

Deleted: shall

- A. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.
- B. The final decision of the Governing Body must be made within forty-five (45) days of its receipt of the recommendation of the MEC. This final decision will be promptly forwarded to the MEC and the Applicant.
- C. The time periods set forth in this section are guidelines only, not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

Deleted: shall

Deleted: is

Deleted: shall

Deleted: initial consideration of a decision contrary to the...

Deleted: shall

Deleted: and are

Deleted: which

Deleted: shall

4.3. Reappointment Process

4.3.1. Frequency

The Medical Staff must reevaluate Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical or Affiliated Staff and the continuation of Clinical Privileges.

Deleted: shall

Deleted: two

Deleted: three

Deleted: 3

Deleted: 2

Deleted: shall

4.3.2. Reappointment Application Process

At least one hundred twenty (120) days before the expiration of a Member's appointment, the MSSD must email the Member a reappointment application. Within thirty (30) days of the date the application was emailed, the Member must return the completed application to the MSSD, along with all required information and materials.

4.3.3. Recommendation for Reappointment

Within thirty (30) days of the completed application for reappointment, the MSSD must email the completed application to the Chief(s) of the Service(s) in relation to which the Applicant is requesting Privileges. Each Chief of Service for a Service in relation to which the Member requests or has exercised Privileges must review the Member's completed File and forward the Chief of Service's written recommendations to the Credentials Committee. The recommendations will include a statement that the recommendations are based on the Clinical Service's performance improvement information for the Medical Staff Member or Affiliated Professional, any professional liability claims, the Member's clinical activity, education, and training, and any other pertinent information. The Chief of Service(s) must return the application with written recommendation no less than sixty (60) days before the expiration of the Member's appointment.

Deleted: calendar days

Deleted: shall

Deleted: or Standardized Procedures

Deleted: Service Chief

Deleted: or Standardized Procedures

Deleted: shall

Deleted: application and f

Deleted: Service Chief

Deleted: shall

Deleted: or Affiliated

Deleted: Service Chief

Deleted: shall

Deleted: calendar days

Deleted: or Standardized Procedures

Deleted: shall

Deleted: provider

In addition to the items listed in this subsection 4.3.3, each recommendation concerning reappointment of a Member and the Clinical Privileges to be granted upon reappointment must be based upon such Member's current professional performance including, but not limited to, ongoing Professional Practice Evaluation (OPPE) data, performance reviews, evidence of progression towards Board Certification or re-certification (if applicable), current competence, clinical or technical skills and judgment in the treatment of patients, ongoing practitioner specific continuous quality improvement evaluations, ethical conduct, attendance at Medical Staff

meetings and participation in Medical Staff affairs, compliance with these Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, results from the National Practitioner Data Bank inquiry, and mental or physical health that permits the Member to carry out the essential functions of the Member's Medical Staff category Privileges, or Standardized Procedures with or without reasonable accommodation,

4.3.4. Credentials Committee Review and Action

The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

4.3.5. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges. When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

- D. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body.
- E. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.
- F. When the recommendation of the MEC is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it until after the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights set forth in Articles 6 and 7 of these Bylaws.

4.3.6. Governing Body Review and Action

The Governing Body will act upon favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, through the Director of Health, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural

Deleted: or

Deleted: ¶

Credentials Committee Action¶

The Credentials Committee shall will review the completed reappointment application and File and the Clinical Service Chief/Chief of Service's final recommendations at the next regularly scheduled Credentials Committee Meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the applicationFile that require clarification in person. The Credentials Committee shall will then submit to the MEC its written report and recommendations as to reappointment and Privileges.¶

Medical Executive Committee Action¶

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC shall will review the Credentials Committee's report and recommendations, and will make recommendations to the Governing Body that the application be approved, denied, or deferred for further consideration.¶ When the recommendations include a denial of reappointment or a reduction in Clinical Privileges, the MEC shall must document the reasons for such recommendations in the minutes. Thereafter, the procedures set forth in Sectionsubsection 4.2.6 above shall will apply.

Deleted: , through the Director of Health

Deleted: or Standardized Procedures

Deleted: or Standardized Procedures

Deleted: , through the Director of Health

Deleted: ,

Deleted: or

Deleted: , or Standardized Procedures

rights under Articles 6 and 7 of these Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

G. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.

H. The final decision of the Governing Body must be made within forty-five (45) days after additional information is provided by MEC. This final decision will be promptly forwarded to the MEC and the Applicant.

I. The time periods set forth in this section are guidelines only, and are not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

Deleted: of its initial consideration of a decision contrary to the recommendation of the

4.3.7. Term of Reappointment

Reappointments to any Medical Staff category will be for a maximum of two (2) years.

4.3.8. Failure to Return a Completed Reappointment Application

If the Member has not returned a completed reappointment application to the MSSD within thirty (30) days of the email required under subsection 4.3.2, above, then the MSSD will email a final reminder allowing a fifteen (15) day extension from the date of the reminder email. Failure of a Medical Staff Member or Affiliated Professional to return a completed application for reappointment at least seventy-five (75) days prior to the expiration of the Member's current term may result in automatic resignation of the Member's Privileges, effective on the date the Member's current term expires. The respective Chief of Service will be notified in writing of the delinquent reappointment and pending termination. After the passing of the 15-day extension period and after the Chief of Service is notified, the MSSD will check with the Chief of Service regarding the status of the Member's Privileges, including regarding any discussion of submission of the reappointment application. If no progress has been made by the Member in addressing the reappointment application submission, the MSSD will forward information about the potential automatic resignation of the Member's Privileges to the Credentials Committee for review and a final decision regarding the automatic resignation. A Member who automatically resigns under this section will be processed as a reappointment if the Member submits a completed reappointment application within thirty (30) days from the date of termination.

Deleted: shall

Deleted: two

Deleted: three

Deleted: 3

Deleted: 2

Deleted: S

Deleted: or Affiliated

Deleted: can

Deleted: or Standardized Procedures

Deleted: Clinical Service Chief

Deleted: shall

Deleted: 15 day

Deleted: Clinical Service Chief

Deleted: Clinical Service

Deleted: or Standardized Procedures,

Deleted: or Standardized Procedures

4.3.9. Reapplication After Adverse Decision

An Applicant or Member who has received a final adverse decision regarding appointment, reappointment, membership, Privileges, or who has resigned after notice of an adverse recommendation or a final adverse decision, is not eligible to reapply to the Medical or Staff or for appointment as an Affiliated Professional for a period of two (2) years from the date of the final adverse decision or resignation. Thereafter, the Applicant may apply as a new

Deleted: or

Deleted: or Standardized Procedures

Deleted: shall not be

Deleted: Affiliated

Applicant and must submit information to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

4.4. Access to Own Credentials File

Each Member will be provided with access to information in the Member's own credentials file subject to the following provisions:

- A. The Member may receive a copy of only those documents provided by or addressed to the Member as well as all Ongoing Professional Practice Evaluation and/or Focused Professional Practice Evaluation reports (OPPE and FPPE reports, respectively); and
- B. A summary of peer review information, committee findings, letters of reference, proctoring reports, and complaints will be provided to the Member by the Chief of Staff within thirty (30) days of receipt of such a request. Summaries of peer review materials will disclose the substance, but not the source, of the information.

4.5. Right to Request Corrections/Additions

Members may exercise the right to request corrections or additions to their credentials file following the protocol set forth below:

- A. Members have the right to add to the Member's own credentials file a statement responding to any information contained in the file;
- B. A Member may submit a written request to the Chief of Staff for the correction or deletion of information in the credentials file. Such requests must include a statement of the basis for the action requested;
- C. The Chief of Staff will recommend to the MEC whether or not to make the requested correction or deletion;
- D. The MEC will approve or deny the Chief of Staff's recommendation by a majority vote; and
- E. The Member will be notified by the Chief of Staff of the decision of the MEC. The decision of the MEC is final.

4.6. House Staff

House Staff are not eligible for Medical Staff membership.

4.7. Affiliated Professionals

4.7.1. General

- A. Affiliated Professionals are individuals who:

- 1) Are employees of the City, or faculty or employees of the University, or functioning under an MOU approved by the MEC and Governing Body, and provide health services requiring them to exercise independent judgment within the area of the Affiliated Professional's professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State laws;
- 2) Do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists; and

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: .

Deleted: and may not vote on amendments to the Bylaws and Rules and Regulations

3) Belong to one of the following professional categories:

- Licensed Acupuncturists
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Nurse Practitioners
- Physician Assistants
- Clinical Pharmacists (PharmD)
- Optometrists
- Genetic Counselors.

- B. Although not eligible for Medical Staff membership, Affiliated Professionals are credentialed through the Medical Staff and are subject to general Medical Staff oversight.
- C. The clinical responsibilities of each Affiliated Professional must be set forth in privileges and standardized procedures developed by the Committee on Interdisciplinary Practice and approved by the Credentials Committee, MEC, and the Governing Body. Note that any reference in these Bylaws to privileges or standardized procedures for Affiliated Professionals includes both concepts as appropriate for the situation.

4.7.2. Role of Medical Staff

- A. Affiliated Professionals practice within the scope of the Affiliated Professional's licensure and as otherwise consistent with applicable Hospital and Medical Staff policies, procedures, or privileges. To the extent that state regulations require supervision of Affiliated Professionals beyond overall Medical Staff oversight, the additional supervisory relationship will occur as required by law.
- B. As employees of either the City or the University, Affiliated Professionals are recruited and hired through the usual personnel processes of each respective employing entity. Any clinical activity is contingent upon Medical Staff approval following the procedures set forth below.

4.7.3. Appointment

- A. Each Affiliated Professional who has been provisionally hired must submit an application to the MSSD for appointment to Affiliated Professional status. The Applicant must furnish all information required on the application form or reasonably requested by the Interdisciplinary Practice Committee, Credentials Committee, or the MEC. The Applicant has the burden of producing adequate information for a proper evaluation of competency, character, and ethics. An Applicant who fails to provide all requested information within thirty (30) days of the date of being notified of any deficiencies will be deemed to have withdrawn the application.
- B. An Applicant who is on the Office of Inspector General (OIG) Exclusion List is not eligible for appointment as an Affiliated Professional.
- C. An Applicant must possess a National Provider Identifier (NPI) or must have submitted an application for an NPI in order to be considered for appointment or reappointment as an Affiliated Professional.

Deleted: shall be

Deleted: shall be

Deleted: and to direction by Medical Staff Members

Deleted: shall

Deleted: or standardized procedures

Deleted: or standardized procedures

Formatted: Not Highlight

Formatted: Not Highlight

Deleted: <#>The work of each Affiliated Professional shall be conducted with oversight of a physician Member who shall be available either physically or electronically at any time the Affiliated Professional is acting pursuant to a standardized procedure. A Medical Staff Member can supervise the clinical activities of no more than four Affiliated Professionals at one time.

Deleted: <#>may

Deleted: <#>, as limited by any relevant

Deleted: <#>and

Deleted: <#>, or standardized procedures

Formatted: Not Highlight

Deleted: <#>be delineated and documented

Deleted: shall be

Deleted: shall be

Deleted: shall

Deleted: shall

Deleted: shall have

Deleted: shall

- D. An Applicant must possess a DEA certificate or have submitted the application for a DEA certificate unless the Applicant will be working in an area where no medications are prescribed (such as Radiology or Pathology) or whose licensure does not allow prescribing medications.
- E. An Applicant must have enrolled in Medicare and received an enrollment confirmation letter, excluding PharmDs whose professional services are not reimbursed by Medicare and Nurse Practitioners hired prior to April 2004 without a master's degree.
- F. Nurse Practitioners hired by the City or University after April 2004 must have a master's degree in nursing and be board-eligible.
- G. The MSSD will forward the completed application to the Chair of the Interdisciplinary Practice Subcommittee of the Credentials Committee. The Interdisciplinary Practice Subcommittee will review the application and will forward the application together with its recommendation to the Credentials Committee.
- H. The Credentials Committee will review the application and make a recommendation to the MEC.
- I. The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Governing Body.
- J. The Governing Body will review the recommendation of the MEC and will make a decision whether to approve the Affiliated Professional.
- K. If the Governing Body denies the Applicant's admission to Affiliated Professional status, the Applicant is limited to the remedies set forth in the Grievance Procedures in the applicable Memorandum of Understanding. The Applicant is not entitled to any of the procedural rights set forth in these Bylaws.
- L. Services that require a privilege or standardized procedure may not be performed until the Applicant's credentials and privileges or appointment have been approved by the Medical Staff.
- M. An Affiliated Professional who is admitted to Affiliated Professional status is subject to a period of proctoring/evaluation under rules and procedures established by the relevant clinical service.
- N. By applying for Affiliated Professional status, the Applicant must comply with and agrees to the same provisions that apply to Applicants for Medical Staff membership set forth in the following Sections and subsections of these Bylaws:
- a. Subsection 2.2.4 (Professional Liability Insurance);
 - b. Subsection 2.2.5 (Participation in Medicare, Medicaid and other Federal Health Care Programs);
 - c. Section 2.3 (Qualifications for Membership);
 - d. Section 2.5 (Harassment Prohibited);
 - e. Section 2.8 (Basic Responsibilities of the Medical Staff);
- O. Subsection 4.1.3 (Completion of Application);

Deleted:

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall be

Deleted: shall

Deleted: be

Formatted: Not Highlight

Deleted: or a standardized procedures

Deleted: shall be

Deleted: Sections 4.1.3, 4.1.4 and 4.1.5

Deleted: .

a. Subsection 4.1.4 (Application Misrepresentation or Omission); and

P. Subsection 4.1.5 (Effect of Application).

Q. Any material misrepresentation by an Applicant is grounds for denial of the application or for termination of Affiliated Professional status.

Deleted: may be

4.7.4. Reappointment

A. The initial appointment to Affiliated Professional status will last for a maximum period of two (2) years.

Deleted: shall

Deleted: two three (3)

B. Each subsequent reappointment will be for a maximum two (2) year period.

Deleted: shall

C. Prior to the end of each appointment or reappointment period, the MSSD will provide the Affiliated Professional with an application for reappointment, and the application for reappointment must be submitted and processed according to the same procedures as for the initial appointment and is subject to the same restrictions.

Deleted: two

Deleted: three (3)

Deleted: shall

Deleted: that shall

4.7.5. Corrective Action

A. Any corrective employment action against an Affiliated Professional must be done in accordance with the procedures set forth in the applicable City or University employment Memorandum of Understanding (MOU) or other applicable employment policies and rules. The Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.

Deleted: shall

Formatted: Font color: Text 1

Deleted: Applicant

Deleted: shall

B. In the event that immediate action is necessary to prevent imminent danger to the health or safety of any individual, the Affiliated Professional's right to perform some or all duties set forth in their Job Description may be suspended immediately, in accordance with the procedures set forth in the applicable MOU. In addition, any clinical privileges or standardized procedures exercised by an Affiliated Professional that is overseen by the Medical Staff may be addressed by the Medical Staff using concepts similar to those listed in Article 6 (Corrective Action) of these Bylaws at the discretion of the Chief of Staff or MEC without affording the Affiliated Professional any procedural rights listed in Article 6. Similarly, the Chief of Service may, in consultation with the Chief of Staff, address allegations of inappropriate behavior by Affiliated Professionals using the concepts listed in this subsection 6.2.2, although there are no specific requirements of using any specific concept or process listed in this section. An Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.

Formatted: Not Highlight

Deleted: The

Deleted: Applicant shall

ARTICLE 5. CLINICAL PRIVILEGES

Deleted: AND STANDARDIZED PROCEDURES

5.1. Clinical Privileges

5.1.1. Process

Members and Affiliated Professionals are entitled to exercise only those Clinical Privileges specifically granted to them by the Governing Body except as provided in Section 5.2 herein regarding temporary privileges, or to practice within Standardized Procedures. The granting of Privileges or Appointment with Standardized Procedures depends upon an individual's documented experience in categories of diagnostic and treatment areas and current competence as judged by ongoing continuous quality improvement reviews. The Rules and Regulations of each Clinical Service specify the Clinical Privileges for that Service.

Deleted: shall be

Deleted: and Standardized Procedures

Deleted: Member

Deleted: s

Deleted: and

Clinical Privileges or appointment with Standardized procedures are required for the provision of telehealth services. Specific privileges may cover the provision of both in-person and telehealth services. Privileges or standardized procedures for Members or Affiliated Professionals who provide only telehealth services are subject to the same requirements that apply to all privileges.

5.1.2. Education, Training and Experience

Every initial application for Medical Staff or Affiliated Professional appointment must contain a request for specific Clinical Privileges desired by the Applicant. The evaluation of such requests must be based upon the Applicant's documented education, training, experience and demonstrated competence, University faculty appointment (if applicable), references, and other relevant information, including a recommendation by the Chief of Service in which such Privileges are sought. The Applicant has the burden of demonstrating qualifications and competency in the requested Clinical Privileges or Appointment as an Affiliated Professional.

Deleted: shall

Deleted: Clinical Service Chief

Deleted: shall have

5.1.3. Evaluation

Ongoing monitoring of Clinical Privileges is based on a variety of modalities which can include but not be limited to direct observation of the care provided, review of medical records, and other peer review activities.

Deleted: shall

Deleted: be

5.2. Temporary Appointments with Clinical Privileges

Deleted: or Standardized Procedures

5.2.1. Pending Application for Permanent Medical or Affiliated Staff Membership

- A. In the event that there is a compelling patient care need which the Chief of Service could not have anticipated, the Chief of Staff in consultation with both the CEO (or designee) and the Chair of the Credentials Committee, may grant temporary appointment with Privileges to an Applicant who has a Clean Application, Credentials, and is pending the next meeting of the Governing Body for final approval.
- B. No person with Temporary Privileges or Affiliate status may vote or hold office.
- C. Temporary Privileges or Temporary Affiliate status may be granted for a period not to exceed sixty (60) days.

Deleted: Chief of the Clinical Service

Deleted: p

Deleted: or Standardized Procedures

Deleted: that has been approved by the

Deleted: Committee and the Medical Executive Committee...

Deleted: and

5.2.2. Application and Review

The Chief of Staff, with the concurrence of the Chief Executive Officer, may grant Temporary Privileges or Temporary Affiliate status after the following has been completed:

- A. The Chair of the Credentials Committee has determined that the Applicant has a "Clean Application" as defined in the Definition section of these Bylaws.
- B. The Chief of Service provides the Chief of Staff with a compelling patient care need that could not have been anticipated and that requires that the services of the Applicant begin before the application can be approved at the next meeting of the Governing Body.

Deleted: <#>The Applicant has been approved by a quorum of both the Credentials Committee and the MEC. Such approval may be obtained through a vote via email.

Deleted: <#>Chief of the Clinical Service

5.2.3. General Conditions

- A. There is no right to Temporary Privileges or Temporary Affiliate Status. They may be granted at the sole discretion of the Chief of Staff only after a Clean Application has been approved by the Chair of the Credentials Committee.

Deleted: and MEC

- B. A determination to grant Temporary Privileges or Temporary Affiliate Status ~~is~~ not binding or conclusive with respect to an Applicant's pending request for appointment to the Medical or Affiliated Staff.
- C. In exercising Temporary Privileges or Standardized Procedures, the Applicant ~~will~~ act under the supervision of the Chief of Service, or designee, to whom the Applicant is assigned and ~~will~~ be proctored and monitored in accordance with the Clinical Service Rules and Regulations and the proctoring provisions set forth in these Bylaws.
- D. Temporary Privileges or Temporary Affiliate Status ~~will~~ not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.
- E. Temporary Privileges or Temporary Affiliate Status ~~will~~ not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by the Bylaws.
- F. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate any or all of the Temporary Privileges or Standardized Procedures granted. In such an event, the Member Applicant ~~is~~ not entitled to the procedural rights set forth in Article 6 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.

5.3. Visiting Privileges

5.3.1. To Meet a Specific Need

- G. Visiting Privileges ~~may~~ be granted for a specified period of time, not exceeding ninety (90) days, on a case-by-case basis when a patient (or patients) of a Clinical Service requires the services of a physician, dentist, podiatrist, clinical psychologist or Affiliated Professional who is not a Member of the Medical or Affiliated Staff. If the individual with Visiting Privileges ~~desires~~ to join the Medical Staff, the individual ~~must~~ submit an application as a new appointment. No person with Visiting Privileges ~~may~~ vote or hold office. (Note: ZSFG Administrative Policy 22.06 refers to this position as "Consulting Clinical Physician".) The Chief of Staff, with the concurrence of the Chief Executive Officer, may authorize Visiting Privileges if:
- 1) The person has submitted a completed application for Visiting Privileges or Affiliated Professional Status;
 - 2) The Chief of Staff reasonably believes that the person has the qualifications, ability, and judgment required for Medical or Affiliated Staff membership;
 - 3) The Chief of Service requiring a person's services recommends the person; and
 - 4) The Chief of Service has provided, in writing, the clinical need for granting such Privileges.

5.3.2. General Conditions

- A. In exercising Visiting Privileges, the Applicant ~~must~~ act under the supervision of the Chief of Service, to which the Applicant is assigned.

Deleted: shall

Deleted: be

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: to

Deleted: S

Deleted: shall

Deleted: terms thereof

Deleted: shall

Deleted: be

Deleted:

Deleted: or

Deleted:

Deleted: shall

Deleted:

Deleted: shall

Deleted:

Deleted: The Chief of Staff, with the concurrence of the Chief Executive Officer, may authorize Visiting Privileges if t...

Deleted: Chief of the Clinical Service

Deleted: Chief of the Clinical Service

Deleted: p

Deleted: shall

- B. Visiting Privileges or Affiliate Status ~~must~~ not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.
- C. Visiting Privileges or Affiliate Status ~~will~~ not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by them.
- D. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate the Visiting Privileges or Affiliate Status. In such an event, the ~~practitioner~~ is not be entitled to the procedural rights set forth in Articles 6 and 7 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.
- E. ~~The Chief of Staff will present the candidate to the Governing Body for approval with a rationale regarding why~~ Visiting Privileges or Affiliate Status ~~should be granted~~.
- F. All requirements of ZSFG Administrative Policy 22.06 (including as it is amended in the future) must be met.

5.4. Emergency Situations and Privileges or Affiliate Status

5.4.1. Emergency Situations When More Qualified Healthcare Personnel Are Not Available

In the event of an emergency, any qualified Member ~~or~~ Affiliated Professional is allowed to do everything reasonable to save the life of a patient or to save a patient from serious harm. The Member or Affiliated Professional must promptly yield such care to more qualified healthcare personnel when available.

5.4.2. Emergency Situations Pertaining to a Single Patient or a Few Patients

In the event of an emergency or critical situation where no Member or Affiliated Professional possesses the expertise necessary to save the life of a patient or to save a patient from serious harm, the Chief of Staff may grant emergency Privileges or Affiliate Status to a licensed Practitioner, who has an academic appointment with the University and who possesses the requisite qualifications and expertise to treat the patient or a few patients, at the discretion of the Chief of Staff. In the event that no qualified Practitioner with an academic appointment at the University is available within the necessary clinical time frame, the Chief of Staff may grant emergency Privileges or Affiliate Status to a Practitioner with a license recognized by the state of California, who possesses the requisite qualifications and expertise to treat the patient(s). Care provided under emergency Privileges or Affiliate Status will be documented in the hospital medical record related to each patient treated by that Practitioner, and a record of the Practitioner's emergency Privileges or Affiliate Status will be maintained by the MSSD, including the Practitioner's name and license, the name and medical record number of any patients treated by that Practitioner, and the dates of service. MSSD will perform primary source verification of the medical license and verification of malpractice coverage as soon as possible.

5.4.3. General Emergency Situations

Deleted: shall

Deleted: S

Deleted: shall

Deleted: Practitioner

Deleted: provider

Deleted: shall

Deleted: The

Deleted: shall

Deleted: inform

Deleted: that

Deleted: were

Deleted: <#> for a patient care need that could not be met by a Member.

Deleted: Medical Staff Members and Affiliated Professionals...

Deleted: and

Deleted: shall be

Deleted: permitted

Deleted: shall

Deleted: a

Deleted: Member

Deleted: one becomes

Deleted: p

Deleted: physician

Deleted: provider

Deleted: with

Deleted: ,

Deleted: physician

Deleted: provider

Deleted: p

Deleted: provider

Deleted: licensed physician

Deleted: p

Deleted: provider

Deleted: provider's

Deleted: p

Deleted: provider's

Deleted: provider

General emergency situations may arise due to a disaster, such as an earthquake, weather emergency, or fire, due to an infectious disease, due to an extreme staffing shortage, or due to other circumstances. Any time such a general emergency situation arises, including but not limited to any time the Hospital activates its Emergency Management Plan, Members and Affiliated Professionals who are qualified based on training or experience may perform expanded roles outside the scope of their normal Privileges or Standardized Procedures at the discretion of the Chief of Staff in consultation with leadership from the affected clinical service areas without requiring that new Privileges be granted. The clinical services being supported by such qualified Members and Affiliated Professionals will provide any additional orientation or training that is necessary and ongoing supervision and oversight of the Practitioner during the emergency. Services provided in relation to such general emergency situations are subject to the following requirements based on the duration of the emergency:

A. Emergency Privileges or Affiliated Status for Service Less than One Month

- 1) In the event Practitioners present themselves to the Hospital during an emergency, including but not limited to when the Hospital activates its Emergency Management Plan, and the Hospital is unable to handle the immediate patient needs, Emergency Privileges or Affiliated Status may be granted by the Chief Executive Officer, the Chief of Staff, the Chief Executive Officer's designee(s), or the Chief of Staff's designee(s) to Practitioners for services less than one month in duration upon presentation of the following information, with a record to be kept by the MSSD when feasible:

- a. A valid government-issued photo identification card such as a driver's license or a passport, and
- b. At least one of the following:
 - i. A copy of a current license to practice;
 - ii. Primary source verification of licensure;
 - iii. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
 - iv. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in emergency circumstances; or
 - v. Confirmation by a Member or an Affiliated Professional with personal knowledge of the volunteer Practitioner's ability to act as a licensed independent Practitioner during an emergency.

- 2) During the emergency, the Medical Staff will oversee the performance of each Practitioner who has been granted emergency privileges or Affiliated Status. Based on its oversight of such Practitioner, the Medical Staff will determine within seventy-two (72) hours, and on an ongoing basis as needed after that, of the Practitioner's arrival if the emergency privilege should continue. Practitioners granted emergency Privileges or Affiliated Status must document the care they provide in a manner similar to Members of the Medical Staff when feasible.

Deleted: p

Deleted: p

Deleted:

Deleted: provider

Deleted:

Deleted: providers

Deleted: providers

Deleted: provider's

Deleted: provider

Deleted: provider

Deleted: providers

Deleted: provider's

Deleted: Providers

Deleted: p

- 3) Primary source verification of licensure and confirmation of malpractice coverage must occur as soon as the emergency is under control or within seventy-two (72) hours from the time the **Practitioner** presented to the Hospital, whichever comes first. If verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances, the following must be documented and maintained by the MSSD:

- The reason(s) verification could not be performed within seventy-two (72) hours;
- Evidence of the **Practitioner's** demonstrated ability to continue to provide adequate care, treatment, and services; and
- Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

Primary source verification of licensure is not required if the **Practitioner** has not provided care, treatment, or services under the emergency **Privileges or Standardized Procedures**.

- 4) When additional assistance is required by a clinical service due to an extreme staffing shortage and an outside **Practitioner** is identified who can capably perform the required duties, the Chief of Staff may grant emergency **Privileges or Affiliate Status** to be overseen by the clinical service and Chief of Service or the Chief of Service's designee. The MSSD will keep a record confirming the Chief of Service's or designee's agreement to the appointment and attestation that the **Practitioner** can adequately perform the necessary clinical care. The MSSD will determine the source of the **Practitioner's** malpractice coverage, the **Practitioner** will be granted access to the Hospital's medical record system, and the **Practitioner** will be given Hospital identification.

B. Emergency Privileges or Affiliate Status for Service More than One Month

The Medical Staff or Affiliated Professionals will use **Emergency Privileges or Standardized Procedures** using the procedures described above for emergency service less than one month. Once Hospital Leadership or the Chief of Staff determine that emergency service will be needed for more than one month, the Medical Staff will, within one month of emergency **Privileges or Affiliate Status** being granted to the **practitioner**, request that the **practitioner** apply for regular Hospital **Privileges or Affiliate Status**. If the **practitioner** declines to apply for regular **Privileges or Affiliate Status**, the Chief of Staff or designee may extend **Emergency Privileges or Affiliate Status** for a maximum of three additional months, for a total of no longer than four months of emergency privileges for that **practitioner** in most situations. The Chief of Staff may extend emergency privileges to cover the time period while the application for regular Hospital privileges is in process, which should not generally exceed three months from the time the **practitioner** submits the application. For **Emergency Privileges or Affiliate Status** longer than one month, the Chief of Staff will update the Governing Body of such Emergency Privilege or Affiliate Status s.

5.5. Visiting Physicians and other Categories of Practitioners

ZSFG Administrative Policy 22.06 "Visiting Physicians" (see Appendix 2) defines "Consulting Clinical Physician", "Consulting Academic Physician", "Physician Observer", and "Visiting Research Physician". Physicians in these roles and **Practitioners who would fall within**

Deleted: provider

Deleted: provider's

Deleted: provider

Deleted: p

Deleted: provider

Deleted: p

Deleted:

Deleted: provider

Deleted: provider's

Deleted: provider

Deleted: provider

Deleted: c

Deleted: p

Deleted: p

Deleted: provider

Deleted: provider

Deleted: p

Deleted: provider

Deleted: p

Deleted: c

Deleted: p

Deleted:

Deleted: provider

Deleted: provider

Deleted: <#>Disaster Privileges¶

Emergency Management Plan Activated¶

In the event that the Emergency Management Plan has been activated and the Hospital is unable to handle the immediate patient needs, Disaster Privileges may be granted by the Chief Executive Officer, the Chief of Staff, the Chief Executive Officer's designee(s), or the Chief of Staff's designee(s) upon presentation of the following:¶

A valid government issued photo identification card such as a driver's license or a passport, and at least one of the following:¶

A copy of a current license to practice medicine;¶

Primary source verification of licensure;¶

Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps. (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state of [r]

Deleted: <#>Affiliated Professionals and

Deleted: <#>Physicians

Deleted: ,

Deleted: professionals

the category of Affiliated Staff do not have Privileges or Standardized Procedures unless specifically granted under Section 5.3, above, may not direct patient care, do not have access to medical records, and must follow all requirements of ZSFG Administrative Policy 22.06.

for their specific category regarding:

- A. Their role in interacting with the patient and Members.
- B. Maintenance of professional liability coverage must be either through their primary institution or own insurance company.
- C. Sponsorship by the Chief of the sponsoring Clinical Service, or for Visiting Research Physicians, the Principal Investigator with the consent of the Chief of Service.
- D. Immunizations—if in patient care settings, must meet same requirements as clinical staff.
- E. Orientation as applicable for the specific category.
- F. Identification badges if in patient care areas.
- G. Required patient consent if interacting with or observing patients.

Deleted: R

Deleted: Clinical Service Chief

Deleted: ,

5.6. Proctoring

5.6.1. General

All new appointees to the Medical and Affiliated Staff and existing Members requesting additional Privileges or Standardized Procedures, regardless of specialty or category of membership, will be assigned a Proctor by the Chief of Service and complete a period of proctoring, as defined in subsection 5.6.4, below.

Deleted: p

Deleted: shall

Deleted: Clinical Service Chief

Deleted: 7

Deleted: "Proctoring Duration"

Deleted: p

Deleted: Clinical Service Chief

The Proctor must have unrestricted Privileges or Standardized Procedures to perform the evaluation(s) that the Proctor will conduct. The Chief of Service will submit a form to the Credentials Committee attesting to the satisfactory completion of proctoring. Documentation of the proctoring will reside in the Clinical Service Office.

5.6.2. Function and Responsibility of the Proctor

- H. The Proctor is responsible for evaluating the practitioner's clinical competence for the requested privileges or standardized procedures.
- I. The Proctor's primary responsibility is to evaluate the Proctoree's performance. However, if the Proctor believes intervention is warranted in order to avert harm to a patient, the Proctor may take any action the Proctor finds reasonably necessary to protect the patient.

Deleted: shall be

Deleted: practitioner

Deleted: provider's

5.6.3. Responsibility of the Proctoree

The Proctoree is responsible for notifying one of the assigned Proctors for each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the Proctoree is responsible for arranging the time of the procedure with the Proctor.

Deleted: shall be

Deleted: shall be

5.6.4. Proctoring Duration

Proctoring will be deemed successfully completed when the Proctoree completes the proctoring as described in the Clinical Service Rules and Regulations. Proctors may begin proctoring upon initial granting of Privileges or Affiliate Status with the goal of completing

Deleted: shall

Deleted: determined

Deleted: p

proctoring within the first six months after the initial grant, but in any case must complete proctoring within the first twelve (12) months of initial granting of new Privileges or Affiliate Status.

For Privileges or Standardized Procedures that are infrequently performed by the Member, the Chief of Service may submit a written request to the Credentials Committee to expand the proctoring period. Alternatively, the Chief of Service may request that proctoring occur at another accredited hospital. These Privileges or Standardized Procedures must be voluntarily relinquished or withdrawn if proctoring is not completed within twenty-four (24) months of the initial granting of the infrequently performed Privileges or Standardized Procedures unless the MEC and the Governing Body approve an extension.

5.6.5. Reciprocal Proctoring

Reciprocal proctoring is proctoring that is performed by non-Hospital Members at sites other than the Hospital. Reciprocal proctoring may be accepted when no Hospital Members who possess the necessary expertise are available to proctor a specific skill or procedure. Only such specific skills or procedures may be reciprocally proctored; all other elements of the Applicant's practice must be proctored by a Medical or Affiliated Staff Member of the Hospital. Requirements for reciprocal proctoring are as follows:

- J. The reciprocal Proctor is an active member of the medical or affiliated staff at another accredited hospital;
- K. The reciprocal Proctor possesses unrestricted Privileges to perform the procedure for which the proctoring is being performed; and
- L. The Chief of Service has approved the reciprocal proctoring arrangement and the reciprocal Proctor.

For each case that is reciprocally proctored, the reciprocal Proctor must complete a Hospital proctoring form and submit it to the Clinical Service. The Clinical Service will submit an evaluation summary to the Credentials Committee.

Deleted: p

Deleted: Proctoring should commence upon granting of medical privileges, be completed within the first six months of initial granting of new privileges and must be completed within the first twelve (12) months of initial granting of new privileges

Deleted: p

Deleted: Clinical Service Chief

Deleted: Clinical Service Chief

Deleted: p

Deleted: shall

Deleted: p

Deleted: an extension is approved by

Deleted: shall

Deleted: M

Deleted: M

Deleted: S

Deleted: p

Deleted:

Deleted: have been approved by the Chief of the Clinical Service

Deleted: shall

Deleted: shall

Deleted: ¶

... [2]

MEDICAL STAFF BYLAWS

ARTICLE 6. MONITORING AND CORRECTIVE ACTION

6.1. Routine and Issue-Related Monitoring

6.1.1. Routine Monitoring and Education, Including Verbal and Written Counseling

Responsibilities of the Chiefs of the Clinical Services include:

- A. Ensuring the quality of patient care rendered by their service and maintaining professional standards of behavior among Members and Affiliated Professionals (Practitioners) of their service. Academic performance or University employment are University matters and City employment is a City matter, and those matters are not addressed in these Bylaws.
- B. Quality of Patient Care - Education, Monitoring and Investigation and Response to Concerns Identified.
- C. Carrying out peer review and quality improvement functions for their service. The Chief of Service may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner will be given an opportunity to respond in writing and to discuss the matter with the Chief of Service. The Chief of Service will maintain documentation of any informal actions, monitoring, or counseling.

6.1.2. Focused Professional Practice Evaluation

- A. The Focused Professional Practice Evaluation (FPPE) is a process required by the Joint Commission for evaluation by the Medical Staff of the privilege-specific competence of the Practitioner who does not have documented evidence of competently performing the requested privilege(s) at the Hospital, whether at the time of application or on reappointment. Per the Joint Commission, this process may also be used when a question arises of a currently-privileged Practitioner's ability to provide safe, high quality patient care. The FPPE occurs for a limited time period during which the Medical Staff evaluates the Practitioner's professional performance. There are two types of FPPE: Proctoring FPPE and Secondary FPPE.

Deleted: The Chiefs of the Clinical Services are responsible for e...

Deleted: The Chiefs of Clinical Services are responsible for c...

Deleted: Chief of the Clinical Service

Deleted: Member

Deleted: Member

Deleted: shall

Deleted: Chief of the Clinical Service

Deleted: D

Deleted: shall be maintained by the Chief of the Clinical Service

Deleted: practitioner

Deleted: provider

Deleted: practitioner

Deleted: provider's

Deleted: practitioner

Deleted: provider's

Deleted: , described in the following subsections

Deleted: Add Affiliated Professionals to Proctoring FPPE?]

B. Proctoring, which is outlined in Section 5.6 above, is Initial FPPE. Proctoring FPPE is required for all new privileges and standardized procedures. This includes privileges and standardized procedures requested by new applicants and all newly-requested privileges and standardized procedures for existing Practitioners. There is no exemption based on board certification, documented experience, or reputation. A Provisional Medical Staff Member or Affiliated Professional who is undergoing Proctoring FPPE will remain in provisional status until the Proctoring FPPE is completed successfully.

Deleted: 7

Deleted: the first type of

Deleted: practitioner

Deleted: providers

C. Secondary FPPE, the second type of FPPE, is required when an issue regarding patient care or any other clinical or practice concern by a Practitioner is identified and requires more than a verbal warning but does not rise to the level of a corrective action investigation.

Deleted: Member

D. The outcome of each type of FPPE must be documented as outlined in subsection 5.6.1 above.

Deleted: 7

E. In addition, Secondary FPPE will always include a written summary submitted to the Credentials Committee at the time the issue is identified and the Secondary FPPE period begins. This written summary will include: the issue identified; a description of the counseling and/or training used; the method of monitoring; a target date for closure; and a final outcome/metric to be achieved for successful completion of the Secondary FPPE. At the target date for closure the assigned Proctor will submit a report to the Credentials Committee to determine closure or the need for continued monitoring. The Credentials Committee has sole power to determine whether the Secondary FPPE has been successfully completed, to extend the Secondary FPPE, or to recommend other appropriate action. Other Corrective Action may be initiated as otherwise outlined in this Article 6.

F. Although Initial and Secondary FPPE are focused on education and improvement, any issues addressed during either type of FPPE, including but not limited to recurring issues and the failure to successfully complete Secondary FPPE, can be considered progressive steps in the Medical Staff's efforts to address performance, clinical quality, professionalism, and other issues. Information obtained from the FPPE process may also be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information. Such information may also be shared with UCSF (for UCSF employees) or City Human Resources (for City employees), as appropriate, when a problem warrants a separate investigation for potential discipline.

Deleted: <#>A Provisional Medical Staff Member who is undergoing Proctoring FPPE will remain in provisional status until the Proctoring FPPE is completed successfully.

Deleted: <#>Proctoring

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Not Highlight

Formatted: Not Highlight

6.1.3. Ongoing Professional Practice Evaluation (Maintaining Privileges)

A. The Ongoing Professional Practice Evaluation (OPPE) is a process required by the Joint Commission regarding maintaining privileges of the Medical Staff at the Hospital and serves as an ongoing monitoring system for competence and professionalism of individual Medical Staff Members and Affiliated Professionals (Practitioners). Each Practitioner will be reviewed in their respective department on a periodic basis. Per the Joint Commission, this process involves identification of professional practice trends that impact quality of care and patient safety, and such identification may require intervention

Deleted: Members

Deleted: Member

Deleted: on

by the Medical Staff. The Joint Commission standard lists criteria that may be considered during the OPPE and possible sources of information.

- B. The OPPE process occurs on the schedule maintained by the Credentials Committee in coordination with the MSSD. The OPPE process will always include a written summary submitted by the department to the Credentials Committee to include: the OPPE plan for the department; a description of the metrics selected by the department for the review; the method of monitoring; and a final outcome/metric to be achieved for successful completion of the OPPE. At the target date for closure the department will submit a report to the Credentials Committee regarding the outcome of the review. The Credentials Committee has sole power to determine whether the OPPE has been successfully completed, to extend the OPPE, or to recommend other appropriate action regarding any Practitioner who fails to show appropriate competencies. Moreover, two consecutive unsatisfactory or three consecutive marginal ratings in any metric will always require the department to initiate an FPPE.
- C. Information obtained from the OPPE process may be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information.
- D. If there is uncertainty regarding the Practitioner's professional performance, the Medical Staff should refer the issue for further evaluation of the Practitioner under these Bylaws.

6.2. Professional Standards of Behavior

6.2.1. Professional Conduct

The Chiefs of Clinical Services are responsible for monitoring the professional behavior of Practitioners of their service and addressing inappropriate behaviors as described in the Hospital institution-wide Code of Professional Conduct Policy.

Expected behaviors of Members of the Medical Staff and Affiliated Professionals:

- A. All Members and Affiliated Professionals are expected to practice with professionalism and respect towards patients, colleagues, and others, including ensuring a high quality of services rendered and that care meets professional expectations. All Practitioners are expected to maintain professional communication and confidentiality, and to promptly address improvement expectations communicated through Medical Staff, human resources, or other avenues.
- B. Examples of inappropriate behaviors include, but are not limited to, the following:
- 1) Shouting or using vituperative language;
 - 2) Use of profanity directed at an individual;
 - 3) Slamming or throwing objects;
 - 4) Physical or verbal intimidation, harassment and/or violence;
 - 5) Hostile, condemning, or demeaning communications;
 - 6) Derisive, insulting, or demeaning criticism of performance;

Deleted: . On an ongoing basis, the Medical Staff will be adding Affiliated Professionals to the OPPE process, and each such group of Affiliated Professionals added by the Medical Staff will be covered by the same rules listed in this Section 6.1.3.

Deleted: D

Deleted: Member

Deleted: Such information may also be shared with UCSF or City Human Resources, as appropriate, when a problem warrants a separate investigation for potential discipline.

Deleted: practitioner

Deleted: provider's

Deleted: practitioner

Deleted: provider

Deleted: Members

Deleted: B

Deleted: as well as

Deleted: All Members and Affiliated Professionals are expected to treat patients and their families, as well as other providers, nurses, and ancillary staff, in a courteous, dignified, and respectful manner.

Deleted: also

Formatted: Not Highlight

Deleted: ensuring

Deleted: (in terms of clinical and professional standards), maintaining

Deleted: , maintaining

Deleted: ing

Deleted: ongoing

Deleted: Inappropriate Behavior

- 7) Deliberate failure to abide by Hospital, Medical Staff, departmental or committee bylaws, policies and procedures, or directives, including but not limited to, refusal to comply with required duties;
- 8) Behavior inappropriate to the delivery of quality patient care; and
- 9) Retaliation against any person who addresses or reports incidents of unacceptable behavior.

Expressing contrary opinions is not disruptive conduct, nor is expressing concern regarding constructive criticism of existing policies or procedures or questioning potentially unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any individual.

6.2.2. Investigation in Response to Alleged Inappropriate Behavior

- A. Alleged violations of [these Bylaws, other relevant policies, or](#) the Code of Professional Conduct may be reported by any Hospital personnel using the confidential and Evidence Code §1157-protected [Safety And Feedback Events \(SAFE\)](#), reporting form [maintained by the Quality Management Department and](#) designed for this purpose, or reported in writing to a direct supervisor, the [Chief of Service](#), or the Chief of Staff. Confidentiality will be maintained throughout the investigation of the alleged behavior and for any counseling, warning, disciplinary action, [appeal, or hearing](#) resulting from the investigation. The [Chief of Service or designee will inform the](#) person allegedly demonstrating inappropriate behavior of the report, and that person will have the opportunity to respond to or refute the allegations. If the investigation finds that the allegation does not meet the level of inappropriate behavior in violation of [these Bylaws, applicable policies, or the Code of Professional Conduct](#), the report will be closed and dismissed. Dismissed reports will not be considered in determinations of recurrent inappropriate behaviors.
- B. The [Chief of Service will](#) conduct an initial investigation within one (1) week of becoming aware of the issue. When the [Chief of Service](#) is the subject of the alleged behavior, the Chief of Staff will conduct the investigation. The [Chief of Service](#) may discuss the event with the affected [Member or Affiliated Professional](#). The Chief of Service or Chief of Staff [will](#) take appropriate action based on the following guidelines:
 - 1) Dismissed/No Action: The alleged behavior does not meet the level of inappropriate behavior in violation of [these Bylaws, applicable policies, or the Code of Professional Conduct](#). The Chief of Service will report this outcome to Risk Management, including a brief explanation of why the alleged behavior did not meet the level of inappropriate behavior. The UO report will be recorded as “dismissed.” No further action [will](#) be taken.

Deleted: <#> Maybe add the items below about professional/communication issues.¶

Deleted: All Members and Affiliated Professionals are also expected to practice with professionalism and respect towards patients, colleagues, and others, including quality of services rendered and ensuring that care meets professional expectations (in terms of clinical and professional standards), maintaining professional communication, maintaining confidentiality, and addressing ongoing improvement expectations communicated through Medical Staff, human resources, or other avenues. [How does this relate to FPPEs?]

Deleted:
Per Gabe – At what point do you loop in the Chief of Staff with regard to progressive steps/counseling?

Deleted: The Director of Health, or the Director of Health's designee, may restrict a Member's access to Hospital infrastructure, facilities, or systems in instances involving... [1]

Formatted: Not Highlight

Deleted: Unusual Occurrence (UO)

Deleted: Chief of the Clinical Service

Deleted: or

Deleted: I

Deleted: B

Deleted: will be informed

Deleted: by the Chief of the Clinical Service Staff of... [2]

Deleted: I

Deleted: B

Deleted: as defined by this

Deleted: Code

Deleted: I

Deleted: B

Deleted: Some examples of inappropriate behavior (a.r.,c[3])

Deleted: Chief of the Clinical Service

Deleted: shall

Formatted ... [4]

Deleted: Chief of the Clinical Service

Deleted: Chief of the Clinical Service

Deleted: Member

Deleted: shall

Deleted: I

Deleted: B

Deleted: as defined in these Bylaws

Deleted: as defined by these Bylaws

Deleted: shall

2) Meeting for Resolution: The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the involved parties. The Chief of Service may convene and facilitate a face-to-face meeting for resolution between the Member or Affiliated Professional (Practitioner) and the affected party. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chief of Service will notify Risk Management of the outcome of the Meeting for Resolution.

Deleted: Member

3) Verbal Counseling: The behavior had the potential to adversely affect patient care and is a first confirmed inappropriate behavior event for the Practitioner. The Chief of Service will verbally counsel the Practitioner when an instance of inappropriate behavior warrants such counseling. The verbal counseling will emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the Corrective Action procedures or as allowed by these Bylaws. The Chief of Service will create a written record of the verbal counseling, including the expectations, action plan, and consequences of repeat behavior of a similar nature (which will include written counseling) communicated to the Practitioner. A Practitioner also may be directed by the Chief of Service to issue an apology to the involved party or parties. The Chief of Service will maintain documentation of the counseling and notify Risk Management of this outcome.

Deleted: I

Deleted: Member

Deleted: shall

Deleted: Member

Deleted: I

Deleted: Member

Deleted: Chief of the Clinical Service

4) Written Counseling: The behavior had the potential to adversely affect patient care and is sufficiently serious to make verbal counseling insufficient or inappropriate, or it represents recurrent inappropriate behavior that previously was addressed with verbal counseling. The Chief of Service will meet with the Practitioner and write a formal letter that sets forth the serious nature of the inappropriate behavior, reiterates any previous verbal counseling in relation to similar inappropriate behavior exhibited by the Practitioner, emphasizes the responsibility of Practitioners to treat all persons at the Hospital courteously, respectfully, and with dignity, and informs the Practitioner that future similar conduct may result in referral of the matter to the MEC for possible Corrective Action. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature. The Chief of Service may also direct the Practitioner to issue an apology to the involved party or parties. The Chief of Service will send a copy of the written counseling to the Chief of Staff, the Vice Dean, and the MSSD for inclusion in the Practitioner's peer review (credentials) file. The Practitioner may submit a letter of rebuttal that will be placed in the Practitioner's peer review file. The Chief of Service will report this outcome to Hospital and UCSF ZSFG Risk Management.

Deleted: Verbal Counseling

Deleted: Member

Deleted: Inappropriate Behavior

Deleted: Member

Deleted: Member also

Deleted: Member

Deleted: by the Chief of Service

Deleted: Member

5) Action Plans may include remedial education, referral for psychological evaluation and treatment, referral for anger management counseling, or other professional assistance programs. The Chief of Service is encouraged to consult with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer in determining the appropriate plan of action. The Chief of Service, in consultation with the Chief of Staff, Vice Dean, Chief Medical Officer and/or

Deleted: level of action may be revised by the

Chief Executive Officer as appropriate, may revise the level of action after further information is obtained in the course of investigation and counseling.

6) Reporting: The Chief of Staff will report aggregate data on Code of Professional Conduct issues to the MEC no less than annually. The identity of individual Practitioners will not be disclosed in these reports.

7) Progressive Discipline: While, in general, progressive corrective action interventions are appropriate, there is no prescribed number or order of corrective interventions to address remediation. The choice of corrective action intervention is left to the determination of the Chief of Service or Chief of Staff.

Deleted: Member

Formatted: Not Highlight

Deleted: Add language about progressive steps, not having to go through each step, etc.? Maybe separate one section for progressive steps, the other for reporting and guidance around progressive steps, including when to notify Chief of Staff. Also look at hospital policy on Professionalism. Reference use of info from OPPE/FPPE as well as from HR processes.

Formatted: Indent: Left: 1", No bullets or numbering

Deleted: the Clinical

Deleted: s

Deleted: 1

Deleted: herein

Deleted: Member

Deleted: Member

6.2.3. Medical Executive Committee Approval is not Required and Procedural Rights are not Triggered

The approval of the MEC is not required for actions taken by the Chiefs of Service as set forth in Section 6.2 of these Bylaws, nor do such actions give rise to procedural rights for the Practitioner as set forth in Article 7 herein.

6.3. Corrective Action Investigations

6.3.1. Criteria for Initiation of Corrective Action

A corrective action investigation may be initiated whenever reliable information indicates that a Practitioner may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that are reasonably likely to be any of the following:

- C. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;
- D. Unethical;
- E. Contrary to these Bylaws and or the Medical Staff Rules and Regulations;
- F. Below applicable professional standards;
- G. Detrimental to Medical Staff or Hospital operations; and/or

Deleted: the Medical Staff

- H. Inappropriate behavior of sufficient seriousness or a documented pattern of inappropriate behavior as defined as more than two (2) incidents warranting verbal or written counseling within a two (2) year period or more than two (2) incidents.

Deleted: Disruptive

Deleted: of

Deleted: or the delivery of quality patient care

Deleted: <#>

Deleted: A

Deleted: Inappropriate Behavior

Formatted: Not Highlight

Deleted: V

Deleted: Written Counseling

Deleted: Clinical Service Chief

Deleted: Clinical Service Chief

Deleted: Section

Deleted: 2

6.3.2. Initiation of Corrective Action

- A. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer.
- B. If the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer determines that Corrective Action may be warranted under this Article 6 of these Bylaws, that person or entity may request the initiation of a formal Corrective Action Investigation or may recommend particular Corrective Action. Such requests must be conveyed to the MEC in writing. The MEC

may conduct an informal review of the matter to determine whether an investigation is warranted.

- C. The Chief of Staff will notify the Chief Executive Officer and the MEC and will continue to keep them fully informed of all action taken. In addition, the Chief of Staff will promptly forward all necessary information to the committee or person that will conduct any Investigation, as that term is defined in subsection 6.3.3.

6.3.3. Formal Investigation

- A. If the MEC concludes that a formal investigation (an "Investigation") is warranted, it will direct an Investigation to be undertaken. The MEC may conduct the Investigation itself, may assign the Investigation to an officer of the Medical Staff or a standing committee of the Medical Staff, or may appoint an ad hoc committee to conduct the Investigation. The person or group conducting the Investigation is referred to as the "Investigator."
- B. The affected Practitioner will be given an opportunity for an interview during the course of the Investigation to discuss or refute the charges or, in the discretion of the Investigator, to otherwise provide input regarding the Investigation. Such an interview does not constitute a "hearing" as the term is used in Article 7 of these Bylaws, and none of the procedural rights under Article 7 of these Bylaws will apply to the interview or the Investigation.
- C. The Investigation will proceed in a prompt manner, and the Investigator must maintain a written record of its proceedings.
- D. The Investigator must determine whether the Practitioner has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Practitioners.
- E. The Investigator must forward a written report of the Investigation to the MEC within fifteen (15) days of completion of the Investigation. The report must include findings of fact and recommendations for appropriate corrective action, if any. The deadline for submission of the written report may be extended by the MEC for good cause.
- F. If the MEC concludes action is indicated, but no further Investigation is necessary, it must proceed to take action.

6.4. Corrective Action

6.4.1. Medical Executive Committee Action

Within fifteen (15) days of receipt of the written report of the Investigation, the MEC will take action that may include, without limitation:

- A. Determining that additional information is needed, in which case MEC will direct how that information will be obtained for consideration by the Investigator or MEC.
- B. Determining no corrective action be taken, If the MEC determines there was no credible evidence for the complaint, any adverse information included in the complaint must be removed from the Practitioner's credentials file.
- C. Deferring action for a reasonable time when circumstances warrant.

Deleted: shall

Deleted:

Deleted: shall

Deleted: shall

Deleted: immediately

Deleted: F

Deleted: I

Deleted: shall

Deleted: m

Deleted: s

Deleted: m

Deleted: s

Deleted: Member

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: investigatory body shall

Deleted: investigatory body shall

Deleted: Member

Deleted: Member

Deleted: A

Deleted: shall be forwarded

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: or that additional information is needed

Deleted: shall

Deleted: Member

D. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein precludes department or committee chairs from issuing informal written or oral warnings outside of the mechanism for Corrective Action. In the event such letters are issued, the affected Practitioner may provide a written response that will be placed in the Practitioner's file.

Deleted: shall be deemed to

E. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff Practitionership or exercise of Clinical Privileges or Standardized Procedures, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring. *

Deleted: Member

Deleted: make

Deleted: shall

Deleted: Member

Deleted: member

F. Recommending reduction, modification, suspension or revocation of Clinical Privileges or Affiliate Status. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended must be stated. *

Deleted: shall

G. Recommending suspension, revocation or probation of Medical Staff membership or affiliation (i.e. revocation of Clinical Privileges or Affiliate Status, or limiting Standardized Procedures). If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended must be stated. *

Deleted: shall

Deleted: *

H. Taking other actions deemed appropriate under the circumstances.

* Actions reported to the Practitioner's professional licensing organization (such as the Medical Board of California) and entered into the National Provider Data Bank.

Deleted: Member

Deleted: b

The date for taking action may be extended by the MEC for good cause.

6.4.2. Procedural Rights

A. When No Corrective Action is Required or a Letter is Issued or Non-Reportable Action is Taken

If the MEC determines that no corrective action is required, that only a letter of warning, admonition, reprimand, or censure should be issued, or that other action is to be taken that is not reportable to the Member or Affiliated Professional's professional licensing organization, the decision will be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body must give great weight to the MEC's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC, and the MEC still has not acted. The decision becomes final if the Governing Body affirms it or takes no action on it within seventy (70) days after receiving the Notice of Decision.

Deleted: or

Deleted: ember

Deleted: shall

Deleted: shall

Deleted: shall

B. When Corrective Action Requiring a Hearing is Recommended

If the MEC recommends an action that is a ground for a hearing under Section 7.2 of these Bylaws, the Chief of Staff will give the Practitioner Notice of the adverse recommendations and of the right to request a hearing in accordance with Section 7.3 of these Bylaws. In the case of Members of the Medical Staff, the Governing Body may be informed of the recommendation, but will take no action until the Member has either waived the Member's right to a hearing or completed the hearing. Affiliated Professionals do not have the right to request a hearing per these Bylaws Section 4.7.5

Deleted: shall

Deleted: Member

Deleted: Special

Deleted: The

Deleted: shall

6.4.3. Initiation of Governing Body Action

If the MEC fails to investigate or take corrective action, contrary to the weight of the evidence, the Governing Body may direct the MEC to initiate investigation or corrective action for any Member or Affiliated Professional, but only after written notice to the MEC. If the MEC fails to take action in response to the Governing Body's direction, the Governing Body may initiate investigation and corrective action, but this corrective action must comply with these Bylaws. The Governing Body must inform the MEC in writing of such action.

Deleted: shall

6.4.4. Other Action

Nothing in this Article 6 or elsewhere in these Bylaws is intended to limit the University's or City's ability to take appropriate action with respect to employment. The University and the City have their own processes for employee discipline or other issues that are separate and distinct from processes under these Bylaws. To the extent that the University or City take action against their own employees through their respective processes, such processes include appropriate due process protections.

Deleted: a

6.5. Summary Action

6.5.1. Criteria for Initiation

- A. Whenever the Member's or Affiliated Professional's conduct is such that a failure to take action may result in imminent danger to the health or safety of any individual, the Chief of Staff, the MEC, or the Chief of Service in which the Practitioner holds Privileges may summarily restrict or suspend the Medical Staff membership, Clinical Privileges, or Affiliate Status, of such Practitioner.
- B. Unless otherwise stated, such summary restriction or suspension ("Summary Action") becomes effective immediately upon imposition, and the person or body responsible will promptly give written notice generally describing the reasons for the action to the Practitioner, and notice to the MEC, the Chief Executive Officer, and the Governing Body.
- C. The Summary Action may be limited in duration and will remain in effect for the stated period or until resolved as set forth in these Bylaws. Unless otherwise indicated by the terms of the summary action, the Chief of the involved Clinical Service, will make the necessary arrangements to provide alternate coverage for proper and necessary patient care during the period of restriction or suspension.
- D. The notice of the Summary Action given to the MEC constitutes a request to initiate corrective action, and the procedures set forth in Article 6 of these Bylaws must be followed.

Deleted: Chief of the Clinical Service

Deleted: Member

Deleted: or

Deleted:

Deleted: Member

Deleted: shall

Deleted: shall

Deleted: Special

Deleted: N

Deleted: Member

Deleted: N

Deleted: shall

Deleted: herein

Deleted: shall

Deleted: shall

Deleted: shall

6.5.2. Medical Executive Committee Action

The affected Member may request an interview with the MEC. The interview must be convened as soon as reasonably practicable under the circumstances but in no event less than seven (7) days after the Summary Action was taken. The interview does not constitute a hearing, as that term is used in these Bylaws, and none of the procedural rights under Article 7 of these Bylaws apply to Summary Actions. The MEC may thereafter continue, modify, or terminate the terms of the Summary Action. It will give the Member written Notice of its decision, which

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Special

must include the information specified in Section 7.3 of these Bylaws if the action constitutes grounds for a hearing.

Deleted: shall

Deleted: ,

6.5.3. Procedural Rights

Unless the MEC terminates the Summary Action, it remains in effect during the completion of the corrective action and hearing and appellate review process. When a Summary Action is continued, the affected Member is entitled to the procedural rights set forth in Article 7 these Bylaws, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within forty (40) days after the hearing on the Summary Action was requested.

Deleted: s

Deleted: a

Deleted: shall

Deleted: shall be

6.5.4. Initiation of Corrective Action by the Governing Body

- A. If no one authorized under Section 6.5 of these Bylaws is available to take a Summary Action to summarily restrict or suspend a Member's or Affiliated Professional's membership, Privileges, or Affiliate Status, the Governing Body (or its designee) may immediately suspend or restrict a Practitioner's Privileges if failure to do so may result in imminent danger to the health or safety of any individual, provided that the Governing Body (or its designee) has made reasonable attempts to contact the Chief of Staff, the MEC, and the Chief of the Service to which the Member is assigned before acting.
- B. Such Summary Action imposed under this subsection 6.5.4 is subject to ratification by the MEC. If the MEC does not ratify such Summary Action within two (2) working days of its imposition, excluding weekends and holidays, the Summary Action will terminate automatically.

Deleted: or

Deleted: Member's

Deleted: and

Deleted: shall

6.5.5. Reporting

When Summary Action involves summary suspension of privileges, membership, or affiliate status, the Summary Action must be reported under Section 805 of the Business and Professions Code if such Summary Action remains in effect for a period in excess of fourteen (14) days.

Deleted: or

6.6. Administrative Suspension of Privileges

6.6.1. Basis for Administrative Suspensions

The Chief of Staff may administratively suspend a Practitioner's Privileges or Affiliate Status for failing to complete training mandated by the hospital for regulatory purposes, failing to complete medical record documentation on a timely basis, failing to complete administrative responsibilities as required by the Chief of Service or Chief Executive Officer, and failure to obtain required health screening. Such administrative suspensions do not give rise to the due process rights of these Bylaws unless the suspension is in place for more than fourteen (14) days consecutively or thirty (30) days in a year and therefore becomes reportable to the Practitioner's professional licensing organization (such as the Medical Board).

Deleted: Member's

Deleted: p

Deleted: Chief of the Clinical Service

Deleted: shall

Deleted: Member's

6.6.2. Licensure

Automatic suspension or termination of Privileges or membership, or affiliate status, may occur as described:

Deleted: s

- A. Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked, limited, suspended, or expires, the Practitioner's Medical Staff

Deleted: Member's

Deleted: Member's

membership, Privileges, or Affiliate Status are automatically suspended as of the date such action or expiration becomes effective. Renewal of a Practitioner's license or other legal credential authorizing practice is the sole responsibility of the Practitioner. Any notices of upcoming license renewal deadlines provided by the Hospital are a courtesy, and the failure of a Practitioner to receive or review such notices does not excuse a lapsed license or legal credential.

Deleted: and

Deleted: shall

Deleted: Member's

B. Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Privileges or Affiliate Status that are within the scope of such limitation or restriction are automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

Deleted: Member's

Deleted: which

C. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, the Practitioner's membership status and Privileges or Affiliate Status automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

Deleted: Member

Deleted: shall

D. Whenever a Practitioner's professional liability insurance required by subsection 2.2.4 lapses, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended as of the date such lapse becomes effective shall remain suspended until adequate evidence of insurance is provided. If the Practitioner fails to provide adequate evidence of insurance within six (6) months, it is deemed as a voluntary resignation from the Medical Staff.

Deleted: Member

Deleted: shall be

Deleted: Member

Deleted: shall be

E. If the employment of a Practitioner who is a City employee is terminated or suspended by the City or the employee resigns, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically terminated or suspended, respectively, on the date such employment action becomes effective. If the employment or contractual relationship of a Practitioner who is a UCSF employee or contractor is terminated or suspended by UCSF or the contractor or the employee or contractor resigns, the Practitioner's Medical Staff membership and Privileges are automatically terminated or suspended, respectively, on the date such relationship change becomes effective. And if the employment or contractual relationship of a Practitioner who is a UCSF employee is transferred to another UCSF location or the Practitioner is removed by UCSF from providing patient care at the Hospital, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended on the date such relationship change or reassignment becomes effective. This subsection E does not impose automatic suspension or termination on someone who either (i) moves employment between the City and UCSF if they are still assigned to provide patient care at the Hospital or (ii) shifts from being employed by the City or UCSF to being a volunteer at the Hospital. In either instance, the Practitioner's Medical Staff membership and Privileges or Affiliate Status may continue as allowed by these Bylaws so long as (a) the Practitioner is in good standing, (b) the Practitioner has professional liability insurance as required by subsection 2.2.4 above, and (c) the Chief of Staff approves the continuance.

Deleted: Member

Deleted: shall be

Deleted: Member

Deleted: shall be

Deleted: Member

Deleted: shall be

Deleted: Member

Deleted: S

F. A Practitioner's Privileges or Affiliate Status automatically suspended under this subsection 6.6.2 may be reinstated during the then-current term only upon written notice from the Chief of Staff or the Chief of Staff's designee and with consent of the Hospital

Deleted: Member

Chief Executive Officer. Such reinstatement may include restrictions if imposed in accordance with Section 6.3. If the Practitioner provided patient care at the Hospital, or any City-affiliated institution while the Practitioner's license or credential was revoked, suspended, expired, limited, or restricted or while the Practitioner was on probation, reinstatement may not be granted until all instances of the Practitioner's patient care and billing during that time are reviewed to ensure that appropriate care was rendered, and to prevent improper billing.

6.6.3. DEA Certificate

- A. Whenever a Practitioner's DEA certificate is revoked, limited, suspended, or expires, the Practitioner is automatically and correspondingly divested of the right to prescribe or supervise prescription of medications covered by the certificate as of the date such action becomes effective throughout its term. The Practitioner must immediately notify the MSSD of any such revocation, limitation, suspension, or expiration.
- B. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medications is automatically subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

6.6.4. Medical Records

Practitioners are required to complete medical records within the time prescribed by the MEC. Failure to timely complete medical records results in an automatic suspension after notice is given. Such suspension applies to the Practitioner's right to admit, treat, or provide services to patients in the inpatient or outpatient settings. The suspension will continue until the Practitioner completes the records at issue and any related concerns are resolved.

6.6.5. Procedural Rights

Members whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned the Members's Medical Staff membership are entitled to the procedural rights set forth in Article 7 of these Bylaws only if the suspension or resignation is reported pursuant to California Business and Professions Code Section 805.

6.6.6. Notice of Administrative Suspension and Transfer of Patients

Notice of an automatic suspension must be given to the Practitioner and to the appropriate Chief of Service, and patients affected by an automatic suspension will be assigned to another Practitioner of the Clinical Service.

6.6.7. Automatic Termination

If a Practitioner is administratively suspended for more than three (3) months, the Practitioner's membership or Affiliate Status is automatically terminated. Thereafter, reinstatement to the Medical Staff requires application and compliance with the appointment applicable to new Applicants.

Deleted: s

Deleted: Member

Deleted: Member

Deleted: Member

Deleted: Member

Deleted: Member

Deleted: Member

Deleted: shall

Deleted: be

Deleted: Member

Deleted: Member

Deleted: Member

Deleted: shall

Deleted: become

Deleted: Member

Deleted: shall

Deleted: shall

Deleted: y

Deleted: Member

Deleted: shall

Deleted: Member

Deleted: Member

Deleted: Practitioners

Deleted: Member

Deleted: Practitioner's

Deleted: shall be

Deleted: shall

Deleted: Member

Deleted: ,

Deleted: shall

Deleted: Member

Deleted: Member

Deleted: Member

Deleted: shall be

Deleted: shall

Deleted: procedures

ARTICLE 7. HEARINGS AND APPELLATE REVIEWS

7.1. General Provisions

Except as otherwise provided in these Bylaws, the following definitions and rules apply under this Article.

- A. “Respondent” refers to the MEC in all cases when the MEC or authorized Medical Staff officers, Members, or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors, or committees took the action or rendered the decision which resulted in a hearing being requested.
- B. “Party” and “Parties” refer to the Petitioner and Respondent, individually (Party) or collectively (Parties).
- C. “Petitioner” refers to the Member who requested a hearing pursuant to subsection 7.3.2 of these Bylaws.
- D. Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws are not grounds for invalidating the action taken.
- E. If an adverse action described in subsection 7.2.1 of these Bylaws is taken or recommended, the Petitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.2. Hearings

7.2.1. Grounds for Hearings

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions regarding a Member of the Medical Staff is deemed an actual or potential adverse action and constitutes grounds for a hearing:

- A. Denial of Medical Staff appointment, reappointment, or Privileges;
- B. Revocation, suspension, restriction, or involuntary reduction of Medical Staff membership and/or Privileges;
- C. Involuntary imposition of significant consultation or proctoring outside of the FPPE process; or
- D. Any other corrective action or recommendation that must be reported to the Member’s professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

7.2.2. Termination from Medical Staff

Removal from a position as Chief of a Clinical Services or as an Officer of the Medical Staff, termination from the Medical Staff following two (2) years of inactive status, or termination from the Medical Staff following a resignation or lay off from employment with the University or the City, does not constitute grounds for a hearing.

7.2.3. Actions Taken Against Affiliated Professionals

Affiliated Professionals are subject to corrective action processes pursuant to their employer’s policies and procedures or through other contractual arrangements. Notwithstanding

Deleted: shall

Deleted: Body Whose Decision Prompted the Hearing

Deleted: ,

Deleted: has

Deleted: S

Deleted: shall

Deleted: be

Deleted: S

Deleted: shall be

Deleted: a

Deleted: ;

Deleted: <#>Actions Taken by Director of Health¶

The Medical Staff has authority, as outlined by these Bylaws, to consider whether to revoke, suspend, or restrict Privileges conferred by these Bylaws based on the conduct of a Member or Affiliated Professional. Actions, either direct or indirect, taken by the Director of Health, or the Director of Health’s designee, pursuant to the Director’s administrative authority, DPH policies, or Hospital policies Section 6.2.1.C, are not subject to hearing under these Bylaws only for the purpose of determining whether to revoke, suspend, or restrict Privileges conferred by these Bylaws.¶

As described in the DPH policy titled “Limiting Access to DPH Systems and Facilities,” the Director of Health, or the Director of Health’s designee, may restrict a Member’s access to Hospital infrastructure, facilities, or systems in instances involving violations of federal, state, or local laws, or Hospital rules, regulations, or policies that are not primarily related to quality of patient care, including but not limited to any violation of patient confidentiality laws, regulations, or policies. The Director of Health or the Director of Health’s designee may restrict, suspend, or permanently revoke access to patient health records kept or maintained by the City and/or to physical locations (the Hospital, clinics, or other buildings owned or operated by the City) in this manner. The approval of the MEC is not required for such actions.¶

Deleted: shall

the foregoing, clinical privileges or standardized procedures exercised by Affiliated Professionals are subject to oversight by the Medical Staff. Any performance concerns or problems with clinical care related to Affiliated Professionals that are addressed by the Medical Staff, which will occur in consultation with the City Attorney's Office serving as counsel to the Medical Staff, may result in clinical privilege or Affiliate Status restriction, suspension, or termination by the Medical Staff, including pursuant to the following:

- A. The Chief of Staff or the Chief of Staff's designee will determine how the issue is investigated. The Chief of Staff may appoint an *ad hoc committee* to investigate or advise the Chief of Staff and MEC. Any investigation should include an interview of the Affiliated Professional. Prior to the Medical Staff's restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Chief of Staff or the Chief of Staff's designee. The Chief of Staff or the Chief of Staff's designee in consultation with the MEC is authorized to make a recommendation on behalf of the Medical Staff and will do so in consultation with the City Attorney's Office. Notice of the decision will be given to the Affiliated Professional.
- B. The Chief of Staff or Chief of Staff's designee will inform the Governing Body of any recommendation that involves the restriction or suspension of Clinical Privileges or Affiliate Status of an Affiliated Professional for a cumulative total of thirty (30) days or more in any twelve (12)-month period or termination of such privileges. Prior to informing the Governing Body of the recommended restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Governing Body. The subsequent decision of the Governing Body is final.
- C. This subsection 7.2.3 does not afford an Affiliated Professional a right to a hearing under Sections 7.3 and 7.4 of these Bylaws.

7.3. Requests for Hearing

7.3.1. Notice of Proposed Action

The Medical Staff Member Petitioner must be notified in writing (by "Notice") of any recommendations that would constitute grounds for a hearing. The Notice must inform the Petitioner of the following:

- A. What action has been proposed against the Petitioner;
- B. Whether the action, if finally adopted, will be reported to the Member's professional licensing organization (such as the Medical Board) under California Business and Professions Code Section 805 and to the National Practitioner Data Bank;
- C. The reasons for the proposed action;
- D. That the Petitioner may request a hearing;
- E. That a hearing must be requested within twenty (20) days; and
- F. That the Petitioner has the hearing rights described in the Medical Staff Bylaws.

Deleted: standardized procedure

Deleted: subject

Deleted: and

Deleted: or

Deleted: c

Deleted: p

Deleted: standardized procedures

Deleted: present

Deleted: decision

Deleted: decision

Deleted: c

Deleted: p

Deleted: standardized procedures

Deleted: will be forwarded to the Governing Body

Formatted: Not Highlight

Deleted: 4

Deleted: Action for

Deleted: shall

Deleted: by Special Notice

Deleted: or action which

Deleted: shall

Deleted: action or

7.3.2. Request for Hearing; Waiver and Consideration of Waived Hearing by the Governing Body

The Petitioner has twenty (20) days following receipt of Notice of such recommendation to request a hearing. The hearing request must be in writing, must be communicated at minimum by electronic mail, and must be addressed to the Chief of Staff with a copy to the Chief Executive Officer. The Petitioner must state, in writing, the Petitioner's intentions with respect to attorney representation during the hearing process at the time the Petitioner sends the request for a hearing.

If the Petitioner does not request a hearing within the time and in the manner described, the Petitioner will be deemed to have waived any right to a hearing and accepted the recommendation involved. Such final recommendation, based on a waiver of the right to hearing, will be considered by the Governing Body for ratification within seventy (70) days. The Governing Body must consider such final recommendation, but the recommendation, is not binding on the Governing Body, which will exercise its independent authority to render a final decision on the matter.

7.3.3. Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the President of the Governing Body or the President's designee will fulfill the functions assigned in this Section to the Chief of Staff. In such instances, the term "recommendation" used in this Section 7.3 includes any action by the Governing Body.

7.3.4. Time and Place for Hearing

Upon receipt of a timely request for a hearing made by the Petitioner, the Chief of Staff will notify the Chief Executive Officer and the MEC, appoint a Judicial Review Committee, and schedule a hearing before the Judicial Review Committee. The Chief of Staff will give notice of the hearing within twenty (20) days after receipt of the request. The notice must state the time, place, and date of the hearing. The date of the commencement of the hearing will be within twenty (20) to forty (40) days from the date the Chief of Staff received the hearing request. The date of commencement for the hearing may be extended by the Chief of Staff for good cause in the Chief's sole discretion.

7.3.5. Notice of Charges

As part of, or together with, the notice of place, time, and date of the hearing, the Chief of Staff must state in writing the reasons for the recommendation, the acts or omissions with which the Petitioner is charged, and a list of the medical records in question, when applicable. The Petitioner must be provided with a summary of the rights to which the Petitioner is entitled at the hearing. A supplemental notice of charges may be issued at any time, provided the Petitioner is given sufficient time (at least seven days) to prepare.

7.3.6. Judicial Review Committee

The Chief of Staff will appoint a Judicial Review Committee composed of not fewer than three (3) Members of the Active Medical Staff (Active Members) who will gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision-maker, or otherwise actively participated in the consideration of the matter

Deleted: shall have

Deleted: action or proposed action

Deleted: shall

Deleted: ,

Deleted: shall

Deleted: files

Deleted: shall be

Deleted: or action

Deleted: OR ACTION

Deleted: shall

Deleted: and shall be given great weight by the Governing Body, although it

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Special Notice

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: final proposed action taken or recommended

Deleted: shall

Deleted: N

Deleted: shall

Deleted: shall

leading up to the recommendation. The Judicial Review Committee may have any number of members or alternates as determined by the Chief of Staff. The Chief of Staff will appoint one of these Active Members to serve as Chair. Knowledge of the matter involved does not preclude a Member from serving as a member of the Judicial Review Committee. In the event it is not possible to appoint all Judicial Review Committee members from the Active Medical Staff, the Chief of Staff may appoint any Member of the Medical Staff or other appropriate representatives affiliated with DPH. When feasible, the Judicial Review Committee will include at least one (1) Member who practices in the same specialty as a Petitioner and will include at least one (1) Member who is a UCSF employee and one (1) Member who is an SDPH employee. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable. Voir dire is expressly allowed, and it is to be conducted via written questions for the JRC members and the Hearing Officer. The parties will submit questions to the Hearing Officer, who will make a decision on which questions to allow. The Hearing Officer may include their own questions. The written answers to the voir dire questions will be submitted to both sides and to the Hearing Officer, and the Hearing Officer makes any final decision on challenges to participation

Deleted: or action

Deleted: shall

Deleted: Member

Deleted: Members

Deleted: or a non-Member-

Deleted: people

Deleted: shall

Deleted: , when feasible,

Deleted: Member

The proceedings and/or deliberations of the hearing will continue so long as three members of the Judicial Review Committee are present.

7.4. The Hearing Procedure

7.4.1. The Hearing Officer

The Chief of Staff will appoint a Hearing Officer to preside at the hearing. The Hearing Officer must be an attorney-at-law qualified to preside over a quasi-judicial hearing; however, an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities is not eligible to serve as Hearing Officer. The Hearing Officer must not be biased for or against any Party, must not gain any direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer must endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard, to assure that all participants present relevant oral and documentary evidence in an efficient and expeditious manner, and to maintain proper decorum. The Hearing Officer will determine the order of, or procedure for, presenting evidence and arguments during the hearing and has authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Judicial Review Committee Members or the Hearing Officer serving as the Hearing Officer. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as may be warranted by the circumstances. The Hearing Officer will participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer does not have a vote on the Judicial Review Committee.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: be

Deleted: shall

Deleted: p

Deleted: shall

Deleted: no

Deleted: shall

Deleted: that

Deleted: is maintained

Deleted: shall be

Deleted: entitled to

Deleted: shall have

Deleted: which

Deleted: seems

Deleted: shall

Deleted: shall not be entitled to

Deleted: Representatio

Deleted: n

Formatted: No bullets or numbering

7.4.2. The Chairperson of the Judicial Review Committee.

The Chief of Staff will appoint the chairperson for the Judicial Review Committee. The chairperson will serve as a liaison between the Hearing Officer and the Judicial Review

Committee. The chairperson will take votes on issues to be decided by the JRC. The vote can be done in person, via telephone, via email, or through other methods. Any decision by the JRC shall be reported to the parties in terms of the numbers voting for and against each decision or outcome

Formatted: Font: Not Bold

7.4.3. Hearing Logistics

The hearing may take place in person, by videoconference, or in hybrid format, at the discretion of the Judicial Review Committee in consultation with the Hearing Officer.

Formatted: Indent: First line: 0.5", No bullets or numbering

The Judicial Review Committee will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

If any members of the Judicial Review Committee cannot attend a session, the Judicial Review Committee will decide whether to allow the session to be recorded by video and to have the absent Committee members then watch the video after the session.

The JRC will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

Formatted: Indent: First line: 0.5", No bullets or numbering

If any members of the JRC cannot attend a session, the JRC will decide whether to allow the session to be recorded by video and to have the absent JRC members then watch the video after the session.

The JRC itself, and not the Hearing Officer, will decide how much time to allot to the hearing, providing each side at least five hours to present its case. It is solely within the JRC's discretion to allow for additional time. The JRC may place reasonable limits on the amount of testimony or argument it wants to allow, bearing in mind the fact that written evidence in most situations is deemed admitted.

Formatted: Indent: First line: 0.5", No bullets or numbering

The JRC should review all non-repetitive written evidence submitted prior to making its decision.

The JRC members may ask questions of witnesses directly, preferably saving their questions for a natural pause or break in the testimony.

For most witnesses, each side must examine the witness on all relevant topics when that witness is first called to testify (extending from session to session as appropriate). This is to minimize disruption to the witnesses called to testify. Only in extreme situations and for good cause will the Hearing Officer allow a witness to be recalled to testify after each side has had a chance to examine the witness.

The JRC has authority to limit or exclude testimony of any witness based on argument by a party that the testimony is not relevant or is unnecessary. Any JRC member may make such a motion on their own, and the JRC may vote on that motion as with any other argument.

The JRC is to meet alone with the Hearing Officer after it receives the written evidence, statement of the applicable legal standard, and written summaries of the case and before the hearing commences. During that meeting the JRC may discuss any questions or has or ideas about structuring or limiting the scope or structure of the hearing. This meeting is not to be transcribed, but the JRC, working with the Hearing Officer, will provide each side with the rules

it has adopted about how the matter will proceed and a written statement of any other limits it puts on the hearing process.

7.4.4. Representation

- A. The Petitioner is entitled, at the Petitioner's own expense, to be represented at the hearing by an attorney at law or by a physician licensed to practice in the State of California. If the Petitioner is represented by legal counsel, the MEC may also be represented by legal counsel. The MEC may not be represented by legal counsel if the Petitioner is not so represented. If the Petitioner elects not to be represented by an attorney at the hearing, the MEC will appoint a representative from the Active Medical Staff to present the recommendation and supporting evidence, and to examine witnesses. Notwithstanding the foregoing and regardless of whether the Petitioner elects to have attorney representation at the hearing, the Parties have the right to consult with legal counsel to prepare for a hearing or an appellate review.
- B. When Petitioner is represented by legal counsel, the Judicial Review Committee will determine the role of legal counsel at the hearing. The Judicial Review Committee may eject any legal counsel whose activities at the hearing are, in the judgment of the Judicial Review Committee, disruptive to the proper conduct of the hearing proceedings.
- C. The Hearing Officer has discretion to limit the role of attorneys to advising the attorney's clients, rather than presenting the case.

7.4.5. Postponements and Extensions

Postponements and extensions of the time limits beyond those listed in these Bylaws may be requested by anyone, may be granted by the Hearing Officer on a showing of good cause, and will be granted upon mutual agreement of the Parties and the Judicial Review Committee.

7.4.6. Failure to Appear or Proceed

Failure without good cause of the Petitioner to personally attend and proceed at a hearing in an efficient and orderly manner constitutes voluntary acceptance of the recommendations involved, and such recommendations will be forwarded to the Governing Body immediately for adoption in that event.

7.4.7. Discovery

A. Pre-hearing Documentation Review Expectation

The Judicial Review Committee will be provided a summative report of the investigatory and disciplinary actions taken to date on the matter being considered. Specifically, these should include at a minimum, the following documents: the investigatory committee report including findings and recommendations that were submitted to MEC, the motion and final MEC recommendation to the Governing Body, and any statements submitted by the Medical Staff member /Petitioner in participation of the investigatory committee process or in response to MEC action.

Formatted: No bullets or numbering

Deleted: shall be

Deleted:

Deleted:

Deleted: shall

Deleted: shall

Deleted: a

Deleted: in support thereof

Deleted: p

Deleted: shall

Deleted: T

Deleted: shall

Deleted: when attorneys are allowed to attend

Deleted: Any time attorneys are allowed to represent the parties at a hearing, t

Deleted: shall have

Deleted: the

Deleted: attorneys'

Deleted: ,

Deleted: expressly permitted

Deleted: but shall

Deleted: p

Deleted: or by the Hearing Officer on a showing of good cause...

Deleted: shall be deemed to

Deleted: or actions

Deleted: actions shall

Deleted: taken

Formatted: Indent: Left: 0.25", First line: 0.25"

The parties may submit a written summary of the case not to exceed 5 single-spaced pages 15 days prior to the hearing to the Hearing Officer and the JRC members. The written summary may reference information that party plans to show through evidence and testimony. But not more than 5 pages may be submitted (e.g., no exhibits or attachments).

Formatted: Indent: Left: 0.25", First line: 0.25", No bullets or numbering

No less than 15 days before the start of the hearing, the JRC is to be given the recommendation of MEC in its entirety. The JRC is to be advised that the MEC recommendation is just a recommendation and that the JRC is charged with making a final decision on the issue. If the Member submitted any written rebuttal or response to the MEC recommendation prior to requesting a hearing, that written rebuttal or response is also to be provided to the JRC in the same timeframe.

Written evidence (the exhibits for each side) is to be exchanged between the parties and submitted to the Hearing Officer and the JRC 15 days prior to the start of the hearing. Exhibits must be marked sequentially with letters for the Member requesting the hearing and numbers for MEC. Each page of the written evidence should be marked with sequential numbering (Bates numbering) with a different prefix identifying which side originally provide the record.

All documents that are kept in the ordinary course of business—including but not limited to medical records, policies, emails, reports, Medical Staff Office files, a person's Medical Staff credentialing and privileges file, OPPEs/FPPEs, any written reports or summaries of the investigation leading to the hearing, and human resources files—are automatically admitted into evidence for consideration by the JRC. If a party has an objection to consideration of such written evidence, the objection must be made in writing, must be specific to any document listing the reasons for the objection, and must be provided to the Hearing Officer at least 5 days prior to the hearing. The Hearing Officer will rule on any objections, bearing in mind that the rules of evidence do not apply to the hearing and that in most situations the proper way to challenge evidence is for a party to argue about the weight, if any, the JRC should assign to the evidence. Only extreme cases—such as submission of privileged, attorney-client protected information or submission of evidence that is demonstrably false from an assessment of the context—support a decision by the Hearing Officer sustaining an objection. If an objection to a document is upheld by the Hearing Officer, the document or the aspect of the document that was objected to, is not to be considered by the JRC. Each side has the right during the hearing to comment on whether exhibits are reliable and what weight to give each exhibit. For sake of clarity, time during the hearing should not be spent arguing objections based on the rules of evidence because the rules of evidence do not apply and because the JRC is sophisticated and can be reminded of its duty to make a judgement about what weight to give evidence.

B. Legal Standard

A proposed statement of the legal standard applicable to the hearing is to be submitted to the Hearing Officer 15 days prior to the start of the hearing. The Hearing Officer will then decide what statement of the legal standard applicable to the hearing will be provided to the JRC. The Hearing Officer may adopt any portion of the proposed written statements and/or may draft their own language. The statement of the legal standard must be provided to the JRC at least 5 days prior to the start of the hearing.

Formatted: Indent: Left: 0.5", No bullets or numbering

C. Rights of Inspection and Copying

The Petitioner may inspect and copy (at the Petitioner's own expense) any documentary information relevant to the charges that the [Respondent](#) has in its possession or under its control. The [Respondent](#) may inspect and copy (at its expense) any documentary information relevant to the charges that the Petitioner has in the Petitioner's possession or under the Petitioner's control. The request for discovery must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least twenty (20) days prior to the hearing is good cause for a continuance of the hearing. The Petitioner may not retain or possess unredacted medical records that contain any protected health information, and any unredacted records must be kept securely during the Hearing process. Petitioner must consult with the City Attorney's Office before accessing any patient medical record for purposes of preparing for the Hearing in order to ensure compliance with state and federal privacy rules.

Deleted: Body Whose Decision Prompted the Hearing

Deleted: Body Whose Decision Prompted the Hearing

Deleted: shall

Deleted: shall be

D. Limits on Discovery

The Hearing Officer will rule on discovery disputes the [Parties](#) cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either [Party](#) does not extend to confidential information referring solely to individually identifiable Members other than the Petitioner, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information. Protected health information of any patient is generally not to be disclosed during discovery and may only be produced in redacted form. If the volume of materials makes redaction unfeasible, then the Judicial Review Committee must impose reasonable restrictions, in consultation with the City Attorney's Office, to ensure that protected health information is not removed from the Hospital or disclosed.

Deleted: shall

Deleted: p

Deleted: p

E. Ruling on Discovery Disputes

In ruling on discovery disputes, factors that [the Hearing Officer](#) may consider include, but are not limited to, the following:

Deleted: be

Deleted: ed

- 1) Whether the information sought may be introduced to support or defend the charges;
- 2) Whether the information is "exculpatory" or "inculpatory" in nature;
- 3) The burden on the [Party](#) in possession of producing the requested information; and
- 4) What other discovery requests the [Party](#) has previously submitted resisted.

Deleted: p

Deleted: p

7.4.8. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The [Respondent](#) may object to the introduction of evidence that was not provided during the appointment or reappointment process or investigation of other matter at issue in the hearing. The information will be barred from the hearing by the Hearing Officer unless the Petitioner can prove the Petitioner previously acted diligently with respect to providing evidence and could not have submitted the information at issue.

Deleted: Body Whose Decision Prompted the Hearing

7.4.9. Pre-Hearing Document Exchange

At the request of either Party, the Parties must exchange copies of all documents that will be introduced at the hearing. The documents must be exchanged at least seven (7) days before commencement of the hearing. A failure to do so is good cause for a continuance.

7.4.10. Witness Lists

At the request of either Party, each Party must furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that Party at the hearing.

Nothing in the foregoing sentence precludes the testimony of additional witnesses whose possible participation was not reasonably anticipated. The Parties must notify each other as soon as a Party becomes aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least seven (7) days prior to the hearing date at which the witness is to appear constitutes good cause for a continuance.

7.4.11. Procedural Disputes

- A. The Parties have a duty to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
- B. The Parties are entitled to file motions as deemed necessary to give full effect to the rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the Judicial Review Committee. Such motions must be in writing and must specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving Party must deliver a copy of the motion to the opposing Party, who will have seven (7) days to submit a written response to the Hearing Officer, with a copy to the moving Party. The Hearing Officer will determine whether to allow oral argument on any such motions. The Hearing Officer's ruling on the motion must be in writing and will be provided to the Parties promptly. All motions, responses, and associated rulings must be entered into the hearing record by the Hearing Officer.

7.4.12. Record of Hearing

A court reporter shall be present to make a record of the hearing proceedings. The cost of a court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the Party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken on oath or affirmation.

7.4.13. Rights of the Parties

The Petitioner may ask the Judicial Review Committee Members and Hearing Officer questions, if reasonably relevant in the determination of the Hearing Officer, that are directly related to evaluating the impartiality of the Judicial Review Committee Members or the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee Member will be ruled on by the Hearing Officer, and challenges to the impartiality of the Hearing Officer will be ruled on by the Chief of Staff in consultation with the City Attorney's Office. Both Parties may call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents;

Deleted: p

Deleted: p

Deleted: shall

Deleted: p

Deleted: p

Deleted: shall

Deleted: p

Deleted: shall

Deleted: p

Deleted: shall

Deleted: p

Deleted: shall

Deleted: It shall be the duty of the

Deleted: p

Deleted: p

Deleted: shall be

Deleted: shall

Deleted: shall

Deleted: p

Deleted: shall

Deleted: p

Deleted: shall

Deleted: five

Deleted: 5

Deleted: working

Deleted: p

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: p

Deleted: upon its rendering

Deleted: thereon shall

Deleted: p

Deleted: Within reasonable limitations, the

Deleted: which

Deleted: Petitioner's qualifications to serve and for challenging such ...

Deleted: sides

Deleted: ,

Deleted: ,

cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available to the Judicial Review Committee; and submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Petitioner may be called by the Respondent or by the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

7.4.14. Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence, do not apply to a hearing conducted under this Article. The Hearing Officer will admit, subject to subsection 7.4.1 above, for consideration any evidence, including hearsay, the Hearing Officer determines is relevant to the determination of the issues presented during the Hearing.

7.4.15. Burdens of Presenting Evidence and Proof

- A. At the hearing, the Respondent has the initial duty to present evidence for each case or issue in support of its recommendation. The Petitioner may present evidence in response.
- B. If the Petitioner is challenging denial of an initial application for Medical Staff membership or privileges, the Petitioner bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence (meaning that something is more likely than not to be true, based on a review of all relevant information), that the Petitioner is qualified for membership and/or the denied or restricted Privileges.
- C. In relation to other recommendations, the Respondent bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that Respondent's recommendation is reasonable and warranted.

7.4.16. Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene it at the convenience of the participants without providing any specific form of notice. Upon conclusion of the presentation of oral and written evidence, the hearing is deemed closed. The Judicial Review Committee must then, outside of the presence of any person other than the Hearing Officer, conduct its deliberations and thereafter issue a written decision and accompanying report listing the basis for the decision (the "Decision") as set forth in subsection 7.4.16 below.

7.4.17. Voting

Each decision by the JRC, including the final decision on the merits of the hearing, is to be made by majority vote, which means half of the JRC plus one vote. (If there's a tie, then the status quo will be maintained. If that's on the final MEC recommendation, you should consider if that means the recommendation is rejected.)

7.4.18. Basis for Decision

The decision of the Judicial Review Committee must be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony. The Judicial Review Committee must determine whether the

Deleted: shall
Deleted: ,
Deleted: ,
Deleted: to
Deleted: Body Whose Decision Prompted the Hearing

Deleted: shall
Deleted: A
Deleted: relevant
Deleted: shall be admitted
Deleted: if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious... [5]

Deleted: Body Whose Decision Prompted the Hearing

Deleted: shall have

Deleted: action or

Deleted: shall be obligated to

Deleted: T

Deleted: shall

Deleted: The Petitioner must produce information w.h.c[h6]

Deleted: Except as provided above for initial Applica.nt[s7]

Deleted: Body Whose Decision Prompted the Hearing

Deleted: shall

Deleted: and

Deleted: its

Deleted: action or

Deleted: h

Deleted: o

Deleted: the same

Deleted: Special Notice

Deleted: shall be

Deleted: shall

Deleted: thereupon

Deleted: render

Formatted ... [9]

Formatted ... [8]

Deleted: can

Formatted ... [10]

Formatted ... [11]

Deleted: Basis for Decision

Deleted: shall

Deleted: shall

Member has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Members.

7.4.19. Decision of the Judicial Review Committee

~~Except as outlined below in this subsection,~~ within twenty (20) days after final adjournment of the hearing, the Judicial Review Committee must issue the Decision. The date for issuing the Decision may be extended by the Judicial Review Committee for good cause. But if the Petitioner is currently under suspension, the time for the Decision will be twelve (12) days after final adjournment. Final adjournment is when the Judicial Review Committee has concluded its deliberations. A copy of the Decision must be sent to the Chief Executive Officer, the MEC, the Governing Body, the Petitioner, and the Petitioner's representative (if applicable). The Decision must contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Petitioner and the Respondent must be provided a written explanation of the procedure for appealing the Decision. The Decision of the Judicial Review Committee is considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

Deleted: W

7.5. Appeal

7.5.1. Time for Appeal

Within twenty (20) days after receipt of the decision of the Judicial Review Committee, either the Petitioner or the Respondent may request an appellate review by the Governing Body. Said request must be delivered to the Chief of Staff in writing, in person or by certified mail, and must include a brief statement as to the reasons for appeal. If such appellate review is not requested within such period, both sides are deemed to have accepted the recommendation involved, and that recommendation then becomes, pending ratification by the Governing Body, final and effective immediately.

Deleted: Body Whose Decision Prompted the Hearing

7.5.2. Grounds for Appeal

On appeal, the Governing Body may exercise its independent judgment in determining:

(1) whether there was substantial failure of the Judicial Review Committee to comply with the procedures required by these Bylaws so as to deny fair hearing, (2) whether the decision is reasonable and warranted, and/or (3) whether any bylaw, rule, or policy relied on by the Judicial Review Committee is unreasonably applied or interpreted.

Deleted: and

7.5.3. Time, Place, and Notice

In the event of an appeal to the Governing Body, the Governing Body will within thirty (30) days after receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Body will provide notice of the time, place, and date of the appellate review. The date of the appellate review must be within sixty (60) days from the date of receipt of the request for the appellate review; however, when a request for appellate review comes from a Member who is under suspension, the review must be held as soon as practical, but not to exceed thirty (30) days from the date of receipt of the request. The time for appellate review may be extended by the President of the Governing Body for good cause.

Deleted: shall

7.5.4. Nature of Appellate Review

The proceedings ~~of~~ the Governing Body ~~under Section 7.5~~ are in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Governing Body may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. Each ~~Party~~ shall have the right to present a written statement in support of the ~~Party's~~ position on appeal, to personally appear and make oral argument, and ~~to be~~ represented by an attorney. At the conclusion of oral argument, if allowed, the Governing Body may ~~then~~, at a time convenient to itself, conduct deliberations outside the presence of the ~~Parties~~ and ~~each Party's~~ representatives. The Governing Body may affirm, modify, or reverse the decision of the Judicial Review Committee or, at its discretion, refer the matter for further review and recommendation.

Deleted: by

Deleted: shall be

Deleted: p

Deleted: p

Deleted: the right

Deleted: thereupon

Deleted: appellate and respondent

Deleted: the

Deleted: p

7.5.5. Final Decision

Within thirty (30) days after the conclusion of the proceedings before the Governing Body ~~(including both the appellate hearing and subsequent deliberations)~~, the Governing Body ~~must~~ render a final decision in writing and deliver copies ~~of that decision~~ to the Applicant or Member of the Medical Staff and to the Chief of Staff, in person or by certified mail.

Deleted: shall

Deleted: shall

Deleted: thereof

7.5.6. Delegation to Governing Body Members on the Joint Conference Committee

Nothing herein ~~prevents~~ the Governing Body from delegating the appellate process to those Governing Body Members appointed to the Joint Conference Committee. In such an event, the Governing Body Members of the Joint Conference Committee ~~must~~ submit a written report and recommendations to the full Governing Body for approval.

Deleted: shall

Deleted: shall

7.5.7. Further Review

Unless the Governing Body refers the matter back to the Judicial Review Committee for further review and recommendations, the final decision of the Governing Body following the appeal procedures set forth in these Bylaws ~~will~~ be effective immediately and ~~is~~ not subject to further review. If the matter is referred back to the Judicial Review Committee for further review and recommendations, ~~the Judicial Review~~ Committee ~~will~~ promptly conduct its review and make its recommendations to the Governing Body. This further review process and the report back to the Governing Body ~~must not~~ exceed thirty (30) days except as the ~~Parties~~ may otherwise stipulate.

Deleted: shall

Deleted: shall

Deleted: be

Deleted: said

Deleted: shall

Deleted: shall

Deleted: in no event

Deleted: p

Deleted: shall be

Deleted: may be

Deleted: or action

7.5.8. Right to One Hearing Only

Except as otherwise provided in these Bylaws, no Applicant or Member ~~is~~ entitled to more than one (1) evidentiary hearing and one (1) appellate review ~~hearing~~ on ~~any~~ matter which ~~is~~ the subject of an adverse recommendation.

Deleted: shall be

Deleted: may be

Deleted: or action

7.5.9. Affiliated Professionals, House Staff, Medical Students, and Trainees

Affiliated Professionals, House Staff, Medical Students, and Trainees are not entitled to the procedural rights set forth in these Bylaws ~~except as expressly listed in subsection 7.2.3 for Affiliated Professionals~~.

Deleted: 4

7.5.10. Denial of Applications for Failure to Meet the Minimum Qualifications

Applicants ~~are~~ not entitled to the procedural rights of these Bylaws if the Applicant's membership, Privileges, applications, or requests are denied because of the Applicant's failure: to have a current California license to practice medicine, dentistry, clinical psychology, or podiatry; to maintain an unrestricted DEA certificate (when it is required under these Bylaws); to maintain professional liability insurance (as required by the Bylaws); ~~to meet any of the other basic standards specified in Article 2 of the Bylaws;~~ or to file a complete application.

Deleted: shall

Deleted: be

Deleted: or

Deleted: ,

7.5.11. Automatic Suspension or Limitation of Privileges

A Member ~~or Affiliated Professional~~ ~~is~~ not entitled to any procedural rights when the ~~Practitioner's~~ license or legal credential to practice has been revoked or suspended as set forth in Article 6 of these Bylaws. In other cases described in Article 6 of these Bylaws, the issues which may be considered at a hearing, if requested, ~~may~~ not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue to practice in the Hospital with those limitations imposed. Members whose Privileges are automatically suspended and/or who have resigned the Member's Medical Staff membership for failing to complete medical records or for failing to maintain malpractice insurance are not entitled under these Bylaws to any procedural rights, except when a suspension for failure to complete medical records will exceed fourteen (14) days and must be reported to the ~~Member's professional licensing organization (such as the~~ Medical Board) pursuant to California Business and Professions Code Section 805.

Deleted: shall

Deleted: be

Deleted: Member's

Deleted: shall

Deleted: California

* * *

ARTICLE 8. STRUCTURE OF THE MEDICAL STAFF

8.1. Medical Staff Year

The Medical Staff Year is July 1 through June 30.

8.2. Officers of the Medical Staff

The officers of the Medical Staff are the Chief of Staff, Chief of Staff-Elect, or, in alternate years, the Chief of Staff-Past.

Deleted: shall be

8.2.1. Qualifications of Officers

Officers must be Members of the Active Medical Staff at the time of nomination and election and must remain Members in good standing during the Member's term of office.

Deleted: shall

8.2.2. Election of Chief of Staff-Elect

The Chief of Staff-Elect of the MEC will be elected at the Annual Meeting of the Medical Staff in alternate years for a one (1) year term unless a vacancy as described in this Article indicates a need to have an additional election to fill the positions.

Deleted: shall

The Nominating Committee must present a candidate to the Active Medical Staff Members in attendance at the Annual Meeting of the Medical Staff. Other nominations may be taken from the floor, with the approval of the nominee, prior to the meeting.

Deleted: shall

If floor nominations are made, a hand vote will be taken to elect the Chief of Staff-Elect. A simple majority of the Active Medical Staff Members attending the meeting will determine the election. If no floor nominations are made, a vote of acclamation will be requested by the presiding Chief of Staff.

Deleted: shall

8.2.3. Term of Office

The Chief of Staff will serve a two (2) year term of office. The Chief of Staff-Elect will serve a one (1) year term from the beginning of the Medical Staff year and assume the responsibilities of the Chief of Staff at the end of that term. Upon completion of the two (2) year term as the Chief of Staff, the outgoing Chief of Staff will serve one (1) year as Chief of Staff-Past and be available to serve as Acting Chief of Staff in the first year of the Chief of Staff's two-year term. The Chief of Staff-Elect will be available to serve as Acting Chief of Staff in the second year of the Chief of Staff's two-year term. The standard term of office for the Chief of Staff is two (2) years. When the Nominating Committee believes continuity should be prioritized due to particular circumstances, the Chief of Staff may be re-elected to serve one (1) additional year. In the event that the Chief of Staff is re-elected, then the Chief of Staff Past will continue as an officer of the Medical Staff.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: m

Deleted: s

8.2.4. Vacancies in Office

In the event of the temporary absence of the Chief of Staff, the Chief of Staff must designate a Member of the MEC or a previous Chief of Staff to serve as the acting Chief of Staff, including chairing the MEC meetings.

Deleted: shall

Deleted: July 2020, with July 2022 revision

If the position of the Chief of Staff becomes permanently vacant during the first year of the two (2) year term, the Chief of Staff-Past will assume all designated responsibilities through the end of the Medical Staff Year. If the Chief of Staff-Past is unable to serve, the MEC will appoint an Acting Chief of Staff who will serve through the end of the Medical Staff Year. If the vacancy occurs in the second year of the Chief of Staff's elected term, the Chief of Staff-Elect will assume the duties of the office through the end of the Medical Staff Year and then continue as the Chief of Staff for a two (2) year term.

Deleted: shall

8.2.5. Duties of Officers

A. Chief of Staff

The Chief of Staff will:

Deleted: Shall

- 1) Serve as Chief of the Medical Staff;
- 2) Represent the views, policies (including strategic planning and budget considerations), needs and grievances of the Medical Staff and MEC to the Governing Body, to the Chief Executive Officer, and to the Vice Dean;
- 3) Receive and present to the MEC the activities of the Governing Body;
- 4) Report Medical Staff activities to the Governing Body;
- 5) Be the spokesperson for the Medical Staff and the MEC in external professional and public relations;
- 6) Appoint committee Chairs and approve Members to all Medical Staff committees except the MEC and Joint Conference Committee;
- 7) Call, preside at, and be responsible for the agenda of all regular and special meetings of the MEC and of the Medical Staff;
- 8) Be responsible for the enforcement of Medical Staff Bylaws and for corrective action as provided for in these Bylaws;
- 9) In the interim between MEC meetings, performing those responsibilities of the MEC that, in their reasonable opinion, must be accomplished prior to the next regular or special meeting of the MEC;
- 10) Serve as a Member of the Joint Conference Committee;
- 11) Serve as a Member of the Credentials Committee;
- 12) Preside at the Annual Meeting of the Medical Staff;
- 13) Serve as an interface between the Medical Staff and the leadership of the hospital; and
- 14) Attend any Medical Staff committee meetings as necessary and appropriate in the Chief of Staff's discretion.

Deleted: m

Deleted: s

B. Chief of Staff-Elect

The Chief of Staff-Elect will:

Deleted: shall

- 1) Perform duties as assigned by the Chief of Staff and, in the absence of the Chief of Staff, assume the duties and have the authority of the Chief of Staff.

Deleted: shall

Deleted: July 2020, with July 2022 revision

2) Serve as Chair of the Bylaws Committee, or co-chair the committee with the Chief of Staff;

3) Serve as a member of the Credentials Committee;

Deleted: M

4) Serve on the MEC;

5) Beginning six (6) months prior to assuming the role of Chief of Staff, serve as a member of the Joint Conference Committee; and

Deleted: M

6) Assume the office of Chief of Staff at the end of the current Chief of Staff's term.

C. Chief of Staff-Past

The Chief of Staff-Past will:

Deleted: shall

1) Perform duties as assigned by the Chief of Staff and assume the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;

Deleted: shall

2) Chair the Nominating Committee of the Medical Staff;

3) Serve on the MEC, Joint Conference Committee and the Credentials Committee.

8.2.6. Removal of Officers

A Medical Staff Officer may be removed from office for any valid cause including, but not limited to, failure to carry out the duties of the office, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these Bylaws, removal of Medical Staff officers may be initiated by the MEC or upon the written request of twenty percent (20%) of the Active Medical Staff. Such removal may be effected by majority vote of the MEC Members or by a two-thirds vote of the Active Medical Staff. Voting on the removal of an elected officer will be by secret written ballot.

Deleted: shall

ARTICLE 9. CLINICAL SERVICES

9.1. Organization of Clinical Services

9.1.1. Overall Supervision

Each Clinical Service will have a Chief who is responsible for the overall supervision of the clinical work, teaching, and research within that Clinical Service. Each Clinical Service may be organized into subsections.

Deleted: shall

Deleted: shall

Deleted: be

9.1.2. Clinical Services

The Clinical Services are as follows: Anatomic Pathology, Anesthesiology and Peri-Operative Care, Community Primary Care, Oral & Maxillofacial Surgery, Dermatology, Emergency Medicine, Family and Community Medicine, Laboratory Medicine, Internal Medicine, Neurology, Neurosurgery, Obstetrics-Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology and Head & Neck Surgery, Pediatrics, Psychiatry, Radiology, Surgery, and Urology.

9.2. Qualifications, Selection and Tenure of Chiefs of Services

Deleted: Clinical

9.2.1. Qualifications

A. All Chiefs of Service must be board certified or re-certified in their respective specialty.

Deleted: shall

Deleted: July 2020, with July 2022 revision

- B. Chiefs of Service must have a University faculty appointment, excepting the Chief of the Community Primary Care Service (CPC).
- C. Chiefs of Service may be the Chair or Vice Chair of the Chief's respective University department.
- D. Chiefs of Service must be Members of the Active Medical Staff, and Clinical Privileges will be determined as set forth in Article 6 of these Bylaws.

Deleted: shall

Deleted: shall

Deleted: shall

9.2.2. Selection of a Chief of Service

- A. Upon notification that a Chief of Service will vacate the Chief of Service's position prior to the appointment of a new Chief of Service, the UCSF Department Chair and Vice Dean, in consultation with the Chief Executive Officer and Chief of Staff, will select a proposed Interim Chief of Service. After approval by MEC, the Chief of Staff will then forward the recommendation to the Governing Body to appoint the selected individual as the Interim Chief of Service.
- B. Within six months of a vacancy for a Chief of Service, the Chief of Staff, in consultation with the Vice Dean, UCSF Department Chair and Chief Executive Officer, will appoint a search committee for a new Chief of Service. The search committee will be chaired by a Member of the Active Medical Staff and be composed of Members of the Active Medical Staff, University faculty, the Vice Dean or their designee, and the Hospital Chief Executive Officer or their designee. If the Department has clinically active Affiliated Professionals, at least one Affiliated Professional member of the Department will also be invited to join the search committee. The composition of the search committee will be approved by the University's Academic Affairs Office.
- C. The Chief of Staff must consult with the Director of Health or designee, and the Chief Executive Officer, in appointing the ad hoc search committee for the selection of the Chief of Community Primary Care (CPC). The search committee for the Chief of CPC must be chaired by a Member of the Active Medical Staff and must include Members of the Active Medical Staff, Members of the CPC, the Director of Health or their designee, and the Chief Executive Officer or their designee, and at least one Affiliated Professional member of CPC.
- D. The recommendations of the Chief of Service search committee will be made to the Chief of Staff and UCSF Department Chair who will, in consultation with the Vice Dean and Chief Executive Officer, nominate the new Chief of Service for that service. The recommendations of the search committee for the Chief of CPC will be made to the Chief of Staff who will, with the approval of the Director of Health, nominate the Chief of CPC.
- E. Following recommendation of the Chief of Service candidate to the Chief of Staff and UCSF Department Chair, the UCSF Department Chair will conditionally offer the position to the Chief of Service Candidate and, in consultation with the Vice Dean, negotiate terms of the contract and support.
- F. Once the candidate for Chief of Service has accepted the conditional offer, the Chief of Staff will proceed with facilitating the formal nomination process. The Chief of Service nomination will be acted upon by the MEC. Ratification of the nomination will be accomplished by a two-thirds vote, and be forwarded to the Governing Body for approval.

Deleted: Service

Deleted: Service

Deleted: Service

Deleted: the Chief of Staff, in consultation with the Chief Executive Officer, the UCSF Department Chair, and Vice Dean, shall appoint an Interim Chief of Service

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: CPC

Deleted: shall

Deleted: shall

Deleted: <#>The ad hoc search committee shall provide a progress report on the committee's deliberations to the Chief of Staff.

Deleted: <#>shall

Deleted: <#>shall

Deleted: <#>with the approval of the UCSF Department Chair ...

Deleted: <#>Clinical

Deleted: <#>shall

Deleted: <#>shall

Deleted: shall

Deleted: shall

Deleted: .

Deleted: shall

Deleted: July 2020, with July 2022 revision

- G. Upon approval of the Governing Body of the new Chief of Service, the nominee will assume the office of Chief of Service for that service.
- H. If the MEC or Governing Body disapprove the nomination, the Chief of Staff must reconstitute an ad hoc search committee.

Deleted: shall

Deleted: the Clinical

Deleted: shall

9.2.3. Review and Reappointment

- A. Chiefs of Clinical Services must be reviewed every five (5) years or at any time as requested by the Chief of Staff, the Vice Dean, or the Chief Executive Officer. Continuation as the Chief of Service is contingent upon a favorable result of this review.
- B. The review will be led by the Vice Dean and Vice Dean's Office, and the results will be discussed with the Chief of Staff and the Chief Executive Officer.
- C. A summary of the review will be placed in the Chief of Service's credentials file that includes strengths/accomplishments and areas for improvement.
- D. The Chief of Staff, in consultation with the Vice Dean and Chief Executive Officer, will make a recommendation regarding the reappointment of a Chief of a Clinical Service based on the review committee's findings. The reappointment requires approval by a majority vote of the MEC and the Governing Body.

Deleted: shall

Deleted: Chief of the Clinical Service

Deleted: shall

Deleted: conducted by

Deleted: ,

Deleted: the Vice Dean,

Deleted: shall

Deleted: Service Chief

Deleted: shall

Deleted: shall

9.2.4. Removal of a Chief of Service

- A. Request for removal of a Chief may be initiated by:
- 1) A two-thirds vote that includes a combination of the Clinical Service's Active Medical Staff Members;
 - 2) The Vice Dean, Chief Executive Officer, or Chief of Staff; or
 - 3) By two-thirds vote of the MEC.
- B. When a request for removal has been initiated, a Review Committee will be appointed by the Chief of Staff in consultation with the Vice Dean, UCSF Department Chair and the Chief Executive Officer. The findings of the Review Committee must be acted upon by the MEC.
- C. The recommendation of the MEC will be forwarded to the Governing Body for approval.

Deleted: of

Deleted: all

Deleted: and Active Affiliated Professionals

Deleted: s of the Clinical Service

Deleted: shall

Deleted: Executive Administrator

Deleted: shall

Deleted: shall

9.2.5. Temporary Absence of a Chief of Service

- A. When a Chief of a Clinical Service is temporarily absent from the position for more than thirty (30) days, prompt notification must be made to the Chief of Staff. Upon receipt of such notice, the Chief of Staff will appoint an Acting Chief for the Clinical Service in consultation, when feasible, with the permanent Chief of Service, the UCSF Department Chair, the Vice Dean, and the Chief Executive Officer.
- B. Appointment of an Acting Chief of a Clinical Service for more than ninety (90) days requires the approval of the MEC and the Governing Body.

Deleted: shall

Deleted: shall

Deleted: Chief of the Clinical Service

Deleted: shall

Deleted: , the Vice Dean

9.3. Functions of a Chief of Service

Each Chief will:

Deleted: shall

9.3.1. Credentialing/Privileging

Deleted: July 2020, with July 2022 revision

- A. Recommend criteria for clinical privileges in the Clinical Service;
- B. Recommend a sufficient number of qualified and competent individuals to provide care/clinical services;
- C. Make reports to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for each Applicant seeking privileges in the Clinical Service;
- D. Make recommendations to the Credentials Committee regarding the qualifications and competence of Affiliated Professionals in the Clinical Service;
- E. Make recommendations for granting temporary privileges; and
- F. Be responsible for the evaluation of all new appointees and report thereon to the Credentials Committee.

9.3.2. Performance Improvement

- A. Continuously monitor and evaluate the quality and appropriateness of patient care provided within the clinical service, including:
 - 1) Recommend for approval by the Credentials Committee and MEC the criteria to be used in conduct of Ongoing Professional Practice Evaluation (OPPE) and conduct periodic OPPE for each Member and Affiliated Professional of the Clinical Service at an interval not to exceed twelve (12) months. Data used to complete OPPE forms will be maintained and stored in each Clinical Service for the duration of each medical staff Member's tenure, but in no event less than ten (10) years.
 - 2) Monitor and evaluate the quality and appropriateness of patient care provided by the attending staff;
 - 3) Monitor and evaluate the quality and appropriateness of House Staff supervision by attending staff; and
 - 4) Monitor and evaluate the quality and appropriateness of patient care provided by House Staff.
- B. Continuously monitor the professional performance of all individuals who have delineated clinical privileges or standardized procedures in the Clinical Service, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
- C. Hold regular Performance Improvement Conferences no less than quarterly to present and discuss specific patient cases and best practices;
- D. Appoint ad hoc committees and working groups as necessary to carry out quality improvement activities; and
- E. Conduct a Focused Professional Practice Evaluation (FPPE) of any individual with privileges or standardized procedures in the Clinical Service if there is a reasonable basis to be concerned that the individual's professional qualifications, clinical ability, judgment, character, physical or mental health, professional ethics, or other matters might directly or indirectly affect patient care.

Deleted: ;

Deleted: ed

Deleted: least every

Deleted:

Deleted:

Deleted:

Deleted:

Deleted: and Aaffiliated Pprofessionals

Deleted: , emotional stability

Deleted: July 2020, with July 2022 revision

1) The FPPE must consider the individual's overall performance as well as specific cases. Comparison with historical, departmental, and external benchmarks may be considered.

Deleted: shall

2) A peer review panel may be appointed to conduct an FPPE.

Deleted:

3) Recommendations from an FPPE may be used as the basis for continued routine monitoring and education or for pursuing formal corrective action.

Deleted:

9.3.3. Education and Research

- A. Be accountable to the Vice Dean and the UCSF Department Chairs for the conduct of graduate and undergraduate medical education and UCSF based research programs conducted in the Chief's Clinical Service; and
- B. Be responsible for the establishment, implementation, and effectiveness of the orientation and supervision of the teaching, education, and research programs in the Clinical Service.

9.3.4. Administration

- A. Designate an Acting Chief when unavailable for more than twenty (24) hours but less than thirty (30) days and communicate the designee to the Chief of Staff and Medical Staff Office. After thirty (30) days, the process described in subsection 9.2.5 must be followed.
- B. Be responsible and accountable to the Governing Body, through the Chief of Staff, for all clinically and administratively related activities within the Clinical Service;
- C. Be a Member of MEC and regularly disseminate decisions made and issues discussed at MEC meetings to the Members of the Clinic Service. It is the expectation that the Chiefs of the Clinical Services will attend at least fifty percent (50%) of the MEC meetings each year and that they will send a designee when unable to attend.
- D. Be responsible for the integration of the Clinical Services into the primary functions of the organization;
- E. Be responsible for the coordination and integration of interdepartmental and intradepartmental services;
- F. Review and update the Clinical Service Rules and Regulations at least every two years;
- G. Be responsible for the orientation of new Members and for the enforcement of the Medical Staff Bylaws and Rules and Regulations and the Hospital's policies and procedures within the respective Clinical Service;
- H. Ensure adequate input from the Chief's Clinical Service at Medical Staff committee meetings through attendance by service Members;
- I. Be responsible for implementation within the Clinical Service of actions taken by the Governing Body and the MEC;
- J. Participate in the administration of the Chief's Clinical Service through cooperation with the Nursing Service, Hospital Administration, and all personnel involved in matters affecting patient care;

Deleted: absent

Deleted: S

Deleted: will

Deleted: ;

Deleted: shall

Deleted: shall

Deleted: July 2020, with July 2022 revision

- K. Report and make recommendations to Hospital Administration when necessary with respect to matters affecting patient care in the Clinical Service, including personnel, space, resources, supplies, special regulations, standing orders and techniques;
- L. Be responsible for the process of assessing and recommending off-site sources that provide patient care services not available at the Hospital;
- M. Assist in the preparation of annual records, including budgetary planning, pertaining to the Clinical Service as may be required by the Chief of Staff, the MEC, the Vice Dean, Chief Executive Officer, or the Governing Body;
- N. Delegate to a vice chief or other Active Staff Member of the Clinical Service such duties as appropriate;
- O. Establish divisions, sections, or services within the Clinical Service and appoint Chiefs thereof, subject to the approval of the MEC and the Governing Body;
- P. Develop and implement policies and procedures that guide and support the provisions of services;
- Q. Maintain quality improvement programs; and
- R. Make a presentation to the MEC at least every two (2) years on the activities of the Clinical Service.

9.4. Functions of Clinical Services

- S. Each Clinical Service must establish written criteria consistent with the policies of the MEC for the granting of Clinical Privileges and Standardized Procedures.
- T. Each Clinical Service is responsible for maintaining and supervising a high quality education and training program for graduate and undergraduate education in the health sciences.
- U. Each Clinical Service is responsible for the supervision of House Staff and the House Staff training programs.
- V. The Chief of CPC will collaborate with the appropriate Chiefs of Clinical Services and the Vice Dean to maintain and supervise high quality training experiences within the CPC clinical sites for graduate and undergraduate students in the health sciences.
- W. Each Clinical Service will develop criteria under which consultation will be required; these shall not preclude a requirement for consultation when the Chief of Service determines that a patient would benefit from such consultation.
- X. Each Clinical Service will meet as frequently as necessary, but at least quarterly, to consider findings from the ongoing monitoring and evaluation of quality and appropriateness of the care and treatment provided to patients. Written summaries and recommendations of any and all new policies or changes in policies will be submitted to the Medical Executive Committee for its approval.

9.5. Assignment to Clinical Service

The MEC will, after consideration of recommendations of the Clinical Services as transmitted through the Credentials Committee, recommend initial Clinical Service assignments for all Applicants. All Medical and Affiliated Staff Members shall be assigned to at least one

Deleted: h

Deleted: management

Deleted: .

Deleted: shall

Deleted: shall be

Deleted: shall be

Deleted: shall

Deleted: shall

Deleted: Chief of the Clinical Service

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: July 2020, with July 2022 revision

Clinical Service and be granted clinical privileges or standardized procedures that are relevant to the care provided in that Clinical Service. The exercise of clinical privileges or standardized procedures within any Clinical Service are subject to the Medical Staff Bylaws, the Rules and Regulations of that Clinical Service, and the authority of the Chief of Service.

Deleted: shall be

Deleted: Chief of the Clinical Service

ARTICLE 10. MEDICAL STAFF AND AFFILIATE PROFESSIONALS LEADERSHIP

Deleted: PHYSICIAN

10.1. Definitions of Medical Staff and Affiliate Professional Leaders (in addition to Chiefs of Service as set forth in Article 9)

Deleted: Physician

The term Medical Staff and Affiliate Professional Leaders includes the following positions:

Deleted: Physician

- A. **Central Leadership Positions:** (1) Medical Directors or Associate Chief Medical Officers of multi-specialty service lines or (2) Medical Directors of hospital departments that pertain to multiple services. (See Appendix 3.)

Deleted: cut across all

Deleted: ,

Examples: 1. Medical Directors or Associate Chief Medical Officers of Critical Care, Perioperative Services, Trauma; 2. Medical Directors of Risk Management, Quality Improvement, Care Experience, Informatics, Infection Control.

- B. **Service Leadership Positions:** Medical Directors or Vice Chiefs of units or services within a single Clinical Service.

Examples: Medical Directors of Family Health Center, Medicine Inpatient Services, EMS Base Station, Sleep Center, Diabetes Program, Asthma Clinic.

10.2. Qualifications of Medical Staff and Affiliated Professional Leaders

Deleted: Physician

Leaders must be Members of the Active Medical or Affiliated Staff at the time of appointment and must remain Members in good standing during the Member's tenure.

Deleted: Physician

Deleted: shall

10.3. Appointment of Medical Staff and Affiliated Professional Leaders

Deleted: Physician

- A. Central leadership positions are appointed by an open search process organized by the Chief Medical Officer or designee. The search committee is composed of clinical stakeholder leaders. The candidate selected must be approved by the Chief Medical Officer, Chief Executive Officer, and Vice Dean.
- B. Service Leadership positions are appointed by the Chief of Service.

10.4. Term of Appointment

- A. Central leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief Medical Officer in consultation with Executive Leadership.
- B. Service Leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief of Service in consultation with the Chief Medical Officer.

10.5. Reporting Relationships

- A. Central leadership positions report to the Chief Medical Officer.

Deleted: July 2020, with July 2022 revision

- B. Service Leadership positions report jointly to their Chief of Service and Hospital Administration via the Chief Medical Officer for this administrative role.

Deleted: Service Chief

Deleted: h

Deleted: leadership

Deleted: Physician

Deleted: Physician

10.6. Duties of Medical Staff and Affiliated Professional Leaders

- A. In partnership with the Nurse dyad, the Leader is responsible for the quality of patient care, patient experience, and operational management of care provided by the clinical unit in alignment with True North goals and hospital leadership vision.
- B. The central function of this position is to serve as the Leader for the clinical area, engaging front line providers to optimize operational, clinical quality, patient experience, and financial metrics. This includes meeting clinical enterprise performance and outcome benchmarks set by Hospital Administration.
- C. Specific duties are detailed in the job descriptions.

Deleted: physician

Deleted: l

Deleted: h

Deleted: leadership

10.7. Salary Support for Medical Staff and Affiliated Professional Leader Effort

Deleted: Physician

- A. Central leadership positions are funded via the Affiliation Agreement Central Medical Staff and Affiliated Professional Leadership account.
- B. Service Leadership positions are funded by the Service.

Deleted: Physician

Deleted: July 2020, with July 2022 revision

ARTICLE 11. COMMITTEES OF THE MEDICAL STAFF

11.1. Committee Designation

Standing committees, subcommittees, and ad hoc committees of the Medical Staff described in these Bylaws and in the Committee Manual are created for and meet the purpose of peer evaluation and improvement of the quality of care rendered in the Hospital. Medical Staff functions covered by appropriate committees include, but are not limited to, executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting Medical and Affiliated Members, impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.

Deleted: ,

Deleted: ,

Deleted: d

Deleted: the

Deleted: and Affiliated Professionals

11.2. General Provisions

11.2.1. Ad Hoc Committees

As the need arises, the Chief of Staff, with the advice and counsel of the MEC, may appoint ad hoc committees to deal with specific problems including the evaluation and improvement of the quality of care rendered in the Hospital. Each such ad hoc committee will keep permanent records of its proceedings and activities and submit a report of its activities to the MEC.

Deleted: These

Deleted: s

Deleted: shall

Deleted: shall render

Deleted: shall

11.2.2. Parliamentary Procedure

All meetings of all committees and subcommittees of the Medical Staff are to be conducted following Robert's Rules of Order or a less formal implementation of the concepts included in Robert's Rules of Order.

Deleted: shall

Deleted: shall

Deleted: M

Deleted: shall

11.2.3. Scheduling

Medical Staff committees will hold regular meetings as specified in these Bylaws, the meeting schedule of which will be reviewed and/or revised by the Chair at the beginning of each academic year. The committee members will be advised in writing, at least one (1) week in advance of scheduled meetings, of any necessary changes to the established meeting schedule. If no meeting schedule is otherwise described in these Bylaws, the committee will meet at least quarterly unless otherwise required in the description for each committee.

11.2.4. Appointment of Chairs of Committees

Standing committee chairs are appointed by the Chief of Staff except when chairs are specified in these Bylaws. Subcommittee chairs of standing committees are appointed by the Chairs of each respective standing committee. Standing committees of the Medical Staff are chaired only by Members of the Active Medical Staff or a voting Affiliated Professional member of the committee.

Deleted: shall be

Deleted: shall be

Deleted: shall be

Deleted: all

Deleted: s

Deleted: shall be

Deleted: s

Deleted: shall

Deleted: M

Deleted: shall

Deleted: of the active Medical Staff shall

Deleted: M

Deleted: 23

11.2.5. Committee Membership Appointment

Members hip of each committee is appointed by the committee chair, after consultation with the Chief of Staff or Chief Executive Officer, as appropriate. The MSSD will maintain an accurate membership and attendance roster of all committees of the Medical Staff.

Active Medical Staff Members and Affiliated Professionals appointed to Medical Staff committees will have committee voting prerogatives. Individuals who are not Active Medical Staff Members or Affiliated Professionals will be appointed as non-voting committee members.

unless the Chair specifies voting prerogatives at the beginning of the Medical Staff year. Any such voting prerogatives will be documented in committee minutes at the beginning of the Medical Staff year and remain in effect for the committee membership appointment period of one (1) year.

Deleted: This

Deleted: shall

Deleted: shall

Voting privileges, if issued by the Chair, will be for all matters before the committee during the course of the year.

Deleted: shall

11.2.6. Quorum

Unless otherwise stipulated in these Bylaws, a committee or subcommittee quorum consists of at least three (3) voting committee members present at the time of the discussion or vote. For the MEC, a quorum consists of at least ten (10) or more MEC members who are Members of the Active or Affiliated Medical Staff and are present at the time of the discussion or vote.

Deleted: is constructed by

Deleted: Members of the Active Medical Staff

Deleted: shall

11.2.7. Manner of Action

Having established a voting quorum, the action of a simple majority of the voting committee members present will represent the action of the committee. Action may be taken without a meeting when, in the discretion of the Committee Chair, the action is sufficiently straightforward that discussion and deliberation is not necessary. In such an event, and if there are no objections from the voting committee members, action may be taken by vote through email or similar method and upon the approval of the number of voting committee members that constitutes a quorum.

Deleted: M

Deleted: shall

Deleted: M

Deleted: who are Active Members

Deleted: M

11.2.8. Attendance Requirements

Excused absences can be issued by Chairs or Chiefs if requests for absences are submitted before the scheduled meeting. Any committee may invite the attendance of any individuals who may be useful to its work. All voting committee members are expected to attend or have a designee present for fifty percent (50%) of the committee's meetings.

Deleted: M

11.2.9. Notice of Meetings

Chairs are responsible for scheduling meetings and providing adequate notice to committee members.

Deleted: M

11.2.10. Minutes and Reporting

- A. Minutes of all meetings, unless otherwise stated, will be forwarded to the Medical Staff Services Department, which will serve as the official repository for official business of the Medical Staff. Chairs of Committees will utilize a standardized meeting minutes template maintained by the Medical Staff Services Department. (See Appendix 4.)
- B. Minutes of meetings will include, at a minimum, summaries and recommendations of any and all new policies or changes in policy. Such recommendations will be submitted to the Medical Executive Committee for its approval.
- C. Each committee must submit reports to MEC on its activities, including policy recommendations, per the guidelines set forth below. Each report must be approved by the committee, to include subcommittees, before being brought forward to the MEC. Such reports will be made by the committee chair, or designee if not available:
Ambulatory Care.....Annually

Deleted: shall

Deleted: shall

Deleted: Office

Deleted: ,

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: 23

Bylaws	No less than every two years
Cancer	Twice yearly
Credentials	Every month
Critical Care	Twice yearly
Ethics	Twice yearly
Infection Control	Twice yearly
Well Being	Twice yearly
Operating Room	Twice yearly
Pharmacy and Therapeutics	Every month
Performance Improvement and Patient Safety	Every month
Utilization Management Committee	Twice yearly
Lab Committee	Every three months

Deleted: Every three

Deleted: months

Deleted: Medical Staff

Deleted: Every three months

Deleted: Every three months

- D. Minutes of all meetings of standing committees, as well as any committee addressing peer review processes, are confidential as peer review processes under Section 1157 of the Evidence Code as is all material caused to be prepared for the use of said committees. Likewise, any business before these peer review bodies must be treated with the utmost confidentiality and not be discussed or disseminated outside of the protection of the peer review body or organization except as allowed or required by law.

Deleted: for Clinical Services of the Medical Staff

Deleted: shall be considered

Deleted: and privileged

Deleted: shall

Deleted: or Clinical Services

Deleted: shall

Deleted: shall

Deleted: for Clinical Service

Deleted: group's

Deleted: M

Deleted: M

Deleted: M

11.2.11. Special Meetings

Special meeting of any standing committee may be called or requested by the Chair or Chief thereof, by the Chief of Staff, or by one-third (1/3) of the committee's voting members, but not less than two (2) voting members. The agenda must be included in the call to meeting. Notice must be given in writing at least two (2) weeks in advance of such called meeting to all voting members of the committee. Only matters included in the agenda may be considered at a special meeting.

Deleted: M

11.2.12. Terms of Committee Members

Unless otherwise specified, committee members are appointed for term of one (1) year.

11.2.13. Removal

If a member of a committee ceases to be a Member in good standing of the Medical Staff or an Affiliated Professional in good standing or suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that committee member may be removed by the Chair and Chief of Staff. Any committee member whose employment or contract relationship with the Hospital or whose membership in the Medical or Affiliated Staff ends under any provision of these Bylaws is automatically removed from membership in each committee on which they had served.

Deleted: M

Deleted: , or loses employment or contract relationship with the Hospital,

Deleted: Member

11.2.14. Vacancies

Unless otherwise specifically provided, vacancies on any committee will be filled in the same manner in which an original appointment to such committee is made, provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Chair and Chief of Staff.

Deleted: shall

11.3. Medical Executive Committee (MEC)

11.3.1. Composition of MEC

The MEC consists of a group of voting members and group of non-voting members.

Deleted: 23

Voting members the Officers of the Medical Staff, the Chiefs of the twenty (20) Clinical Services identified in subsection 9.1.2 herein, the Director of Health, the Chief Medical Officer of the San Francisco Health Network, the Chief Executive Officer, the Vice Dean, the Chair of the Credentials Committee, the Chief Medical Officer (CMO), the Chief of Performance Excellence, four (4) At-Large representatives (each either a Member or Affiliated Professional, with at least one Affiliated Professional) elected in accordance with these Bylaws, and up to three (3) representatives of the House Staff appointed by the Chief of Staff.

Non-voting members include the Chief Nursing Officer, an Affiliated Professional who co-chairs the Committee for Interdisciplinary Practice (CIDP), the Associate Chief Medical Officer (ACMO) of Medical Surgical Services, the ACMO of Perioperative Services, the ACMO of Critical Care Services, the ACMO of Care Coordination, the ACMO of Performance Excellence, the Medical Director of Performance Excellence and Improvement, the Chief Pharmacy Officer for the San Francisco Department of Public Health.

The Chief of Staff may invite other persons to attend meetings.

11.3.2. Attendance and Voting

- A. It is the expectation that all Members and Affiliated Professionals on MEC will attend MEC meetings and will send an alternate when unable to attend. If a Member or Affiliated Professional fails to attend fifty percent (50%) of the MEC meetings during a Medical Staff Year, the Chief of Staff may appoint an alternate to serve in that Member or Affiliated Professional's place for the following Medical Staff Year.
- B. Each At-Large representative has one (1) vote.
- C. When a Chief of Service cannot attend a meeting, the Chief may designate an alternate to attend and exercise a proxy vote in the Chief's absence.
- D. When a Chief of Service also holds the position of an officer of the Medical Staff or serves as the Vice Dean, no additional member of the MEC will be named, and that single individual will represent both membership categories and have only one (1) vote.
- E. The three (3) representatives of the House Staff will collectively have a single vote.

11.3.3. Officers and At-Large Representatives

- A. The current or acting Chief of Staff will serve as the Chair of the MEC.
- B. The Chief of Staff-Elect will serve a one (1) year term when elected at the annual meeting of the Medical Staff or will serve for the remainder of the unexpired term of the vacancy the Chief of Staff-Elect fills when elected by the MEC.
- C. The Chief of Staff-Past will serve a one (1) year term after completion of the Chief's year as Chief of Staff.
- D. The four (4) At-Large MEC representatives who are elected will not serve more than three (3) consecutive one (1) year terms. However, an At-Large representative may not be appointed to a successive term if the At-Large representative has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.

Deleted: Section

Deleted: -

Deleted: the Chief Nursing Officer,

Formatted: Indent: First line: 0.5"

Deleted: Medical

Deleted: Director

Deleted: Medical

Deleted: Director

Deleted: Medical Director

Deleted: the Affiliated Professional who co-chairs the Clinical Interdisciplinary Practice (CIDP) Subcommittee, four (4) At-Large representatives (each either a Member or Affiliated Professional, with at least one Affiliated Professional) elected in accordance with these BylawsSection 10.4-2 herein, and up to three (3) representatives of the House Staff appointed by the Chief of Staff...

Deleted: Medical Staff

Deleted: of the

Deleted: shall

Deleted: shall

Deleted: Member

Deleted: a Clinical

Deleted: Chief of the Clinical Service

Deleted: M

Deleted: s

Deleted: Members

Deleted: shall

Deleted: Members

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Members

Deleted: shall

Deleted: Member

Deleted: shall

Deleted: Member

Deleted: 23

- E. Vacancies in any of the four (4) At-Large ~~representative positions~~ arising during the Medical Staff Year ~~will~~ be filled by the nomination of a Member of the Active Medical Staff ~~or Affiliated Professional~~ by the Chief of Staff and approval by a vote of the MEC.

Deleted: Members

Deleted: shall

11.3.4. Duties of MEC

The Medical Staff delegates to the MEC broad authority to oversee the operations of the Medical Staff. Under the leadership of the Chief of Staff, and without limiting this broad delegation of authority, the MEC ~~must~~ perform in good faith the duties listed below.

Deleted: shall

- F. Represent and act on behalf of the Medical ~~and Affiliated~~ Staff, subject to such limitations as may be imposed by these Bylaws;
- G. Coordinate the activities of the Medical Staff committees and of the Clinical Services;
- H. Receive and act upon reports and recommendations from Medical Staff Committees and Clinical Services;
- I. Provide a forum in which the Medical Staff leadership can discuss issues and recommendations with the Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, and Vice Dean;
- J. Fulfill the Medical ~~and Affiliated~~ Staff's accountability to the Governing Body for the quality of care rendered to patients;
- K. Ensure that the Medical Staff ~~and Affiliated Professionals~~ are kept abreast of new laws, regulations, licensing and accreditation standards, and CMS Conditions of Participation;
- L. Review the credentials of all Applicants and make recommendations to the Governing Body for ~~Member and Affiliated Staff~~ appointments, assignments to departments, and delineation of Clinical Privileges ~~and Standardized Procedures~~;
- M. Review the recommendations from the Credentials Committee and make recommendations to the Governing Body for reappointment and renewal or changes in Clinical Privileges, ~~Affiliate Status and Standardized Procedures~~;
- N. Ensure the professional and ethical conduct and competent clinical performance of Medical ~~and Affiliated~~ Staff Members, including the initiation of investigations and corrective action when warranted;
- O. Review and approve all hospital-wide administrative and environment of care policies and clinical policies proposed by Medical Staff committees; and
- P. Make recommendations directly to the Governing Body for its approval regarding the following:
- 1) The Medical Staff's structure;
 - 2) The mechanism used to review credentials and to delineate individual clinical privileges;
 - 3) ~~Appointment and reappointment for~~ ~~Medical and Affiliated Staff Members~~;
 - 4) Delineated Clinical Staff Privileges ~~or Affiliated Status~~ for each eligible individual;

Deleted: is

Deleted: Medical Staff

Deleted: Professional

Deleted: and Affiliated Professionals

Deleted: ,

Deleted: ;

Deleted: Individuals for Medical Staff Membership

Deleted: Members and Affiliated Professionals

Formatted: Indent: Left: 0.75", Hanging: 0.25"

Deleted: or Standardized Procedures

Deleted: 23

5) The mechanism for hearing procedures and the mechanism by which Membership on the Medical or Affiliated Staff may be terminated

Deleted: m

Deleted: ;

6) The appropriate steps associated with restrictions on Clinical Staff Privileges or Affiliated Status ; and

Formatted: Bylaws 4 - A,B,C, Indent: Left: 0.75"

Deleted: Standardized Procedures for Members and Affiliated Professionals and Affiliated Staff Members...

7) The organization of the quality assessment and improvement activities of the Medical and Affiliated Staff.

Deleted: 6

Q. To amend these Bylaws and Rules and Regulations in accordance with Article 16, in the case of a documented need for an urgent amendment necessary to comply with law, regulation, or deficiency issued by The Joint Commission or state or federal regulating body; and

Deleted: ,

Deleted: Section 16.,

Deleted: .

R. To take such other actions as may reasonably be deemed necessary in the best interest of the Medical Staff and Hospital. The authority delegated pursuant to this subsection 11.3.4 may be removed by amendment of these Bylaws and Rules and Regulations.

Deleted: ,

11.4. Nominating Committee

11.4.1. Composition

The Committee will be chaired by the Chief of Staff-Past or, in years in which there is no Chief of Staff-Past, the Chief of Staff. The Chair will appoint four (4) Members from the Active Medical Staff to serve on the committee, and at least one of these appointees will be from the Community Primary Care Service and at least one (1) will be an Affiliated Professional. The Vice Dean, Chief Medical Officer, and Chief Executive Officer will also be Members of the committee.

Deleted: shall

Formatted: Line spacing: Multiple 1.08 li

Deleted: shall

Deleted: shall

Deleted: shall

11.4.2. Duties

The committee will act upon the following requirements:

Deleted: shall

- A. Nominate a Member of the Active Medical Staff to serve as Chief of Staff-Elect prior to the end of the first year of the Chief of Staff's term of office.
- B. Should the incumbent Chief of Staff be re-nominated to serve an additional year, a previous Chief of Staff will also be nominated as Chief of Staff-Past until a new Chief of Staff-Elect is nominated.
- C. Nominate four (4) Members of the Active Medical and Affiliated Staff to serve a one-year term as Members-At-Large on the MEC (including at least one (1) Affiliated Professional). Members-At-Large may not serve more than three (3) consecutive years. An At-Large Member may not be appointed to a successive term if that Member has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.
- D. Election of the Medical Staff Officers will occur at the Annual Meeting in accordance with subsection 8.2.2 herein.

Deleted: In no event shall an individual serve more than six consecutive years as Chief of Staff.

Deleted: shall

11.4.3. Meetings

The Committee will meet as needed to carry out these duties and will maintain records of its activities and meetings.

Deleted: Section

Deleted: shall

Deleted: ,

Deleted: shall

Deleted: 23

11.5. Ambulatory Care Committee

11.5.1. Composition

This committee will consist of Medical Staff Members from the Clinical Services:

- E. A minimum of one (1) Active Physician Member of the Medical Staff or Affiliated Professional from: Medicine, Medical Subspecialty, Family and Community Medicine, Community Primary Care (CPC), Pediatrics, Obstetrics-Gynecology, Surgical Service, and Emergency Medicine. Members of the Medical Staff from other Clinical Services may be on the committee as deemed appropriate by the Co-chairs and Chief of Staff. This may include, but is not limited to, representatives from Hospital Administration, Nursing, Information Services, Laboratory Medicine, Pharmacy, Radiology, and Quality Management.
- F. The committee will be co-chaired by an Active Member of the Medical Staff from Community Primary Care and the Associate Chief Medical Officer for Specialty Care and Diagnostics or the Associate Chief's designee.

11.5.2. Duties

The committee will:

- A. Address cross-department operational issues, with a focus on communication, coordination of services, and inter-disciplinary problem solving. The committee will engage on-and off-campus primary care, medical and surgical specialty services, and diagnostic and ancillary services in identifying and addressing areas of need.
- B. Serve as a forum to discuss issues related to the planning, development, quality, and delivery of integrated ambulatory care services.
- C. Lead the development of Hospital policies, procedures, practices, and measurement tools that are common to department, services, and programs providing ambulatory care services.
- D. Review clinic-specific practices as needed to ensure that they are aligned with the Hospital's mission and operational and organizational systems.
- E. Identify opportunities to improve care in the ambulatory setting; that relate to clinical, diagnostic, or ancillary services; that relate to patient experience; or at the request of committee members or the Chief of Staff.
- F. Develop and maintain a communication network for the Hospital and CPC leaders in ambulatory care.
- G. Facilitate linkages and collaboration between; primary care in the sub-specialty care providers; hospital based and community based providers; and medical providers and other clinical disciplines.

11.5.3. Meetings

This Committee will meet at least quarterly but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

11.5.4. Reporting

Deleted: shall

Deleted: p

Deleted: shall

Deleted: shall

Deleted: and

Deleted:

Deleted: M

Deleted: between

Deleted: between

Deleted: shall

Deleted: shall

Deleted: 23

This Committee must submit a written report to the MEC on its activities, including policy recommendations, annually.

Deleted: S

Deleted: s

11.6. Bylaws Committee

11.6.1. Composition

This Committee will consist of at least seven (7) Members of the Active Medical Staff including the Chief of Staff, Chief of Staff-Elect, Chiefs of Staff-Past, the Chief Medical Officer, one representative from Hospital Administration, one representative from the Dean's Office, and one representative from the CPC service. The Chair will be the Chief of Staff-Elect or co-chaired with the Chief of Staff. While Affiliated Staff Members are not voting members, they may be invited to join the committee to give input to voting members.

Deleted: shall

Deleted: shall

Deleted: Staff

Deleted: Professionals

11.6.2. Duties

The Committee will conduct a periodic review of the Medical Staff Bylaws and Rules and Regulations no less than every two years, and submit recommendations for changes to the MEC prior to any required notification of the Active Medical and Affiliated Staff.

Deleted: shall

Deleted: ,

Deleted: shall

11.6.3. Meetings

The Committee will meet at least annually but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

Deleted: shall

Deleted: shall

11.7. Cancer Committee

11.7.1. Composition

The Cancer Committee will consist of five (5) Active Medical Staff Members representing each of Diagnostic Radiology, Pathology, Medical Oncology, Palliative Care, and General Surgery. Other Members will include: the Cancer Program Administrator, an Oncology Nurse, a Radiation Oncologist, a Social Worker, a Certified Tumor Registrar, a Performance Improvement representative, someone from Clinical Research, a Genetics professional/counselor, someone from Rehabilitation Services, a Registered Dietician, and a Pharmacist.

Deleted: shall

Deleted: shall

11.7.2. Duties

The Cancer Committee will:

Deleted: shall

- A. Actively supervise the Tumor Registry doing quality review of abstracting, staging, and completeness of extent of disease information. This will include ensuring that the Tumor Registry meets the standards of the American College of Surgeons and Commission on Cancer.
- B. Appoint and oversee the functions of the Tumor Board, a separate, multidisciplinary, weekly consultative and education committee.
- C. Perform continuous quality improvement functions for the Medical Staff with respect to cancer patients. These include working with individual Clinical Services and Hospital Administration as well as performing patient care evaluations as mandated by the Commission on Cancer.
- D. Ensure that consultative services from all major disciplines are available for all Hospital cancer patients.

Deleted: shall

Deleted: shall

Deleted: 23

- E. Ensure that educational programs for the Medical **and Affiliated** Staff include all major cancer treatment sites.

11.7.3. Meetings

This Committee **will** meet at least quarterly and maintain permanent records of its proceedings and activities.

Deleted: shall

Deleted: shall

11.7.4. Reporting

This Committee must submit a written report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

Deleted: S

Deleted: s

11.8. Credentials Committee

11.8.1. Composition

The Credentials Committee **will** consist of at least eight (8) Members of the Active Medical Staff, including the Chief of Staff, an officer of the MEC, one (1) Member from the CPC service, and **at least one Affiliated Staff** Member of the Interdisciplinary Practice Subcommittee. Two (2) of the Members **will** be Chiefs or Assistant Chiefs of Clinical Services and at least one Member **will** be from a clinical area where surgery is practiced (Surgery, Ob/Gyn., Orthopedics, Otolaryngology, or Neurosurgery).

Deleted: shall

Deleted: an

Deleted: shall

Deleted: shall

11.8.2. Duties

The Credentials Committee **will**:

Deleted: shall

- F. Review the credentials of Applicants and make recommendations for membership **and Affiliate Status** and delineation of Clinical Privileges **and Standardized Procedures** in compliance with these Bylaws;

Deleted: and

Deleted:

Deleted: p

Deleted: standardized procedures

Deleted: shall

- G. Make a report to the MEC on each Applicant for Medical **and Affiliated** Staff membership, **Clinical Privileges, and Affiliate Status** which **will** include recommendations from the appropriate **Chief of Service; and**

Deleted: Clinical Service Chief

- H. Review all information available regarding the competence of Medical **and Affiliated** Staff Members, and as a result of such review makes recommendations for the granting of **Clinical Privileges or Affiliate Status**, reappointments, and the assignment of Applicants to the various Clinical Services as provided in these Bylaws.

Deleted: and Affiliated Professionals

Deleted: p

Deleted: P

Deleted: standardized procedures

11.8.3. Meetings

The Credentials Committee **will** meet monthly at least ten (10) times per year and maintain a permanent record of its procedures and activities.

Formatted: Not Highlight

Deleted: shall

11.8.4. Reporting

The Credentials Committee must report to the MEC regarding approval of **Medical and Affiliated Staff**, which includes recommendations from the appropriate **Chief of Service** monthly.

Deleted: ,

Deleted: shall

Deleted: R

Deleted: Professionals

Deleted: shall

Deleted: Clinical Service Chief

11.8.5. Subcommittees

- A. **Clinical Interdisciplinary Practice Subcommittee (CIDP)**

Commented [LG(42)]: Note – Updated formatting to match committees with larger lists of subcommittees below.

- (1) Composition

Deleted: 23

The Subcommittee will consist of the Chief Nursing Officer, the Chief Executive Officer or their designees, and an equal number of Physicians appointed by the MEC and registered nurses appointed by the Chief Nursing Officer. Affiliated Staff Members who are licensed or certified in professions other than nursing will also be included in the Subcommittee.

(2) Duties

This Subcommittee will:

Review and approve standardized procedures and privileges and protocols for patient care activities of the Affiliated Staff Members in accordance with the requirements of Title 22 of the California Code of Regulations governing committees on interdisciplinary practice.

(3) Meetings

This Subcommittee will meet at least quarterly and maintain permanent record of its proceedings and activities.

(4) Reporting

This Subcommittee must report and forward recommendations to the Credentials Committee on a monthly basis regarding approval as an Affiliated Staff Member.

11.9. Critical Care Committee

11.9.1. Composition

This Committee will consist of: Active Medical Staff Members who are Directors or Assistant Directors of critical care units and the Emergency Department; a nurse representative from each critical care unit and the Emergency Department; and one (1) representative each from Nursing Administration, Hospital Quality Management, Post Anesthesia Recovery, and Respiratory Therapy. One (1) House Staff Member will also be invited to serve.

11.9.2. Duties

This Committee will coordinate procedures, practices, and equipment in the various emergency areas in critical care units of the Hospital and will make recommendations to the MEC regarding these and related quality of care matters.

11.9.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

11.9.4. Reporting

This Committee must submit a report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.9.5. Subcommittees

A. Donor Council Subcommittee

(1) Composition

The Subcommittee will consist of at least one representative, who is a Medical Staff Member or Affiliated Professional from each of the following areas: Critical Care; Medical

Deleted: shall

Formatted: Line spacing: Multiple 1.08 li

Deleted: Director of Nursing

Deleted: Director of Nursing

Deleted: L

Deleted: health

Deleted: al

Deleted: registered nurses

Deleted: shall

Deleted: as necessary

Deleted: shall

Formatted: Not Highlight

Deleted: Professionals

Deleted: shall

Deleted: shall

Deleted: R

Deleted: Professional

Deleted: shall

Deleted: ,

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: S

Deleted: s

Deleted: shall

Deleted: responsible

Deleted: ,

Deleted: 23

Staff, Attending Neurologist/Neurosurgeon, a nurse representative from each critical care unit, the Emergency Department, and the Medical-Surgical, Peri-Operative, and Perinatal divisions. The Subcommittee will also include a representative from the Hospital's Organ Procurement Organization (OPO). A physician will serve as Chair of this Subcommittee.

(2) Duties

The Subcommittee will:

- Review data collected by the OPO;
- Prepare reports on donor statistics for Quality Management and the Critical Care Committee;
- Review and revise Hospital policies, as needed;
- Review and discuss concerns related to the donor process; and
- Coordinate education activities hospital-wide, as needed.

(3) Meetings

The Subcommittee will meet quarterly and maintain permanent records of its proceedings and activities.

(4) Reporting

The subcommittee must report to the Critical Care Committee on a twice-yearly basis.

11.10. Ethics Committee

11.10.1. Composition

The Committee will consist of no fewer than fifteen (15) Members. These Members will include: representatives of the Medical and Nursing Staffs, the Critical Care Units, the inpatient and outpatient departments; representatives of Hospital Administration and the Quality Management Department; and a Deputy City Attorney. One (1) Member of the House Staff will also be invited to serve.

11.10.2. Duties

This Committee will educate the Hospital community regarding ethical principles, facilitate interchange in ethical decisions, and help develop ethical guidelines. The Committee, or a subgroup of the Committee, will also meet as needed to provide consults on specific situations or issues.

11.10.3. Meetings

The Ethics Committee will meet monthly at least ten (10) times a year and maintain a permanent record of its proceedings and activities.

11.10.4. Reporting

The Ethics Committee must submit a written report to the MEC including policy recommendations, on a twice-yearly basis.

11.11. Infection Control Committee

11.11.1. Composition

Deleted: ,

Deleted: ,

Deleted: ,

Deleted: ,

Deleted: ,

Deleted: and

Deleted: Donor Network West (DNW)

Deleted: shall

Deleted: s

Deleted: s

Deleted: shall

Deleted: DNW

Deleted: s

Deleted: shall

Deleted: will

Deleted: R

Deleted: s

Deleted: shall

Deleted: shall

Deleted: ,

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: the

Deleted: S

Deleted: s

Deleted: 23

This Committee will consist of Members from the Active Medical Staff from several services and others with expertise in clinical care and operations pertinent to infection prevention and control.

Current members include:

A. Medical Staff:

1. Medicine, with expertise in Infectious Diseases and Infection Prevention and Control
2. Laboratory Medicine
3. Family Medicine, with expertise in Infectious Disease
4. Pediatrics
5. Anesthesiology

B. Infection Prevention and Control Program Manager

C. Chief Quality Officer

D. Infectious Disease Pharmacist

E. Director of Microbiology or designee

F. 4A Skilled Nursing Facility Nurse Manager

G. Inpatient Nursing Administrative Representative

H. Patient Safety Officer

I. Senior Industrial Hygienist

J. Infection Control Department Members, including Infection Control Practitioners, Analyst, and Data Manager

K. Environmental Services

L. Facilities Management, or Designee

M. Occupational Health, or Designee

N. Materials Management Representative

O. Administration Representative

P. Food and Nutrition Services Representative

Q. Respiratory Therapy Representative

R. Any other department representative or consultant deemed advisable by the committee chair

S. Additional Ad Hoc or Consultant Members (non-voting), as needed

11.11.2. Duties

Deleted: shall

Formatted: Indent: Left: 0.5", No bullets or numbering

Deleted: diverse services involved in clinical care and operations. Current mMembers include:¶
Medical Staff:¶
Laboratory Medicine¶
Medicine, with expertise in Infectious Disease¶
Medicine, with expertise in Occupational Health (when position is filled)¶
Pediatrics¶
Anesthesiology¶
Infection Prevention and Control Program Manager¶
Chief Quality Officer¶
Inpatient Nursing Administrative Representative¶
4A SNF Nurse Manager¶
Outpatient Nursing Director¶
Patient Ssafety Officer¶
Senior Industrial Hygienist¶
Infection Control Department Members, including Infection Control Practitioners, Analyst, and Data Manager¶
Infectious Diseases Pharmacist¶
Environmental Services¶
Facilities Management¶
Occupational Health¶
Additional Ad Hoc or Consultant Members (non-voting):¶
Sterile Processing Department Manager;¶
Operating Room Manager; and¶
Food & Nutritional Services Director.¶

Deleted: 23

This Committee ~~is~~ responsible for directing the infection control program for the Hospital and other entities covered under the Hospital license, such as on-site clinics and the 4A Skilled Nursing Facility. The Committee ~~will~~ guide and help prioritize the activities of the Infection Control staff; assist with definitions and guidelines for surveillance of infections; receive reports of infection rates, clusters of infections, and outbreaks; promote a prevention program designed to minimize infection hazards; review procedures and programs for surveillance and prevention of infections in healthcare workers and other ~~staff~~; and review and approve infection control policies and procedures. The Infection Control Committee may institute appropriate control measures or investigations when there is a reasonable concern of danger to patients or ~~staff~~.

Deleted: shall be

11.11.3. Meetings

This Committee ~~will~~ meet at least bimonthly ~~and~~ maintain a record of proceedings and activities.

Deleted: shall

11.11.4. Reporting

The Infection Control Committee ~~must~~ submit a written report to the MEC on its activities, including policy recommendations, ~~semi-annually~~.

Deleted: S

Deleted: quarterly

11.12. Well Being Committee

Deleted: Medical Staff

11.12.1. Composition

The Well Being Committee ~~is~~ comprised of no less than three (3) Active Members of the Medical ~~and Affiliated~~ Staff, a majority of which, including the Chair, ~~will~~ be physicians. Insofar as possible, ~~members~~ of this Committee ~~should~~ not serve as active participants ~~of~~ other peer review or continuous quality improvement committees.

Deleted: Medical Staff

11.12.2. Duties

The duties of the committee ~~are~~ as follows:

Deleted: shall be

- T. To foster and actively support the well-being of Medical Staff Members and, ~~as appropriate and consistent with labor agreements, if applicable, Affiliated Professionals;~~
- U. To support Chiefs of Service in addressing ~~well-being~~ issues among ~~Medical Staff Members and Affiliated Professionals on~~ their team, including faculty, staff, and trainees;
- V. To provide education to ~~Medical and Affiliated Staff~~ Members about illness and impairment issues specific to ~~such~~ Members;
- W. To facilitate self-referral by Medical Staff Members ~~and, as appropriate, Affiliated Professionals and~~ referral by other organization staff;
- X. To facilitate referral of the affected ~~Medical Staff Members and, as appropriate, Affiliated Professionals~~ to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
- Y. To provide for the maintenance of the confidentiality of the Medical Staff Members ~~and Affiliated Professionals, as appropriate and consistent with existing human resources practices and labor memorandums of understanding,~~ seeking referral or referred for assistance, except: as limited by law ~~or ethical obligation; as allowed by these Bylaws or any labor agreement;~~ or when the safety of a patient is threatened;
- Z. To assure evaluation of the credibility of a complaint, allegation, or concern;

Deleted: Professionals

Deleted: other staff Members in leadership positions

Deleted: W

Deleted: and

Deleted: of

Deleted: and Affiliated Professionals

Deleted: of the Medical Staff

Deleted: and Affiliated Professionals

Deleted: Professionals

Deleted: Staff Members

Deleted: Medical Staff

Deleted: d

Deleted: and Affiliated Professionals

Deleted: and Affiliated

Deleted: and Affiliated Professionals

Deleted: ,

Deleted: 23

AA. To monitor the affected Medical Staff Member or Affiliated Professional and the safety of patients until the rehabilitation or any disciplinary process is completed;

Deleted: or Affiliated

Deleted: or Affiliated Professional

BB. To assure a reporting to the Medical Staff leadership in instances in which a Medical Staff Member or Affiliated Professional is providing unsafe treatment; and

Deleted: or Affiliated

Deleted: or Affiliated Professional

CC. To provide assistance, counseling, and referrals for disruptive Medical Staff Members or Affiliated Professionals.

Deleted: or Affiliated

Deleted: and Affiliated Professionals.

11.12.3. Meetings

Deleted: ; and.

The Committee will meet at least every 3 months, and more frequently as necessary. It will maintain only such record of its proceedings and activities as it deems advisable.

Deleted: <#>To organize and oversee "Schwartz Rounds", which are ad hoc multidisciplinary rounds for Members and hospital staff Members around difficult and/or challenging cases.

11.12.4. Reporting

The Well Being Committee must submit a written report to MEC on its activities, including policy recommendations, semi-annually.

Deleted: shall

Deleted: shall

11.13. Operating Room Committee

11.13.1. Composition

This Committee will consist of:

- Medical Staff Members representing all services performing procedures within the perioperative areas;
- The Department of Anesthesia;
- The Perioperative Nursing Director;
- The Chief of the Infection Control Committee;
- The Director of the Blood Bank;
- A representative from Hospital Administration; and
- One (1) non-voting Member of the House Staff (who will be invited to serve).

Deleted: S

Deleted: s

Deleted: quarterly

Deleted: shall

11.13.2. Duties

Deleted: shall

Deleted: .

The Operating Room Committee is responsible for the evolution of the safe, proper, and efficient utilization of Operating & Procedural Rooms within the Hospital, including the Surgical and Procedural unit and the operating rooms in Labor & Delivery. This Committee is responsible for the development of policies and procedures regarding the safe, proper, and efficient conduct of surgical procedures.

Deleted: shall be

Deleted: on the ground floor,

Deleted: shall be

11.13.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

Deleted: shall

11.13.4. Reporting

The Operating Room Committee must submit a written report to MEC on its activities, including policy recommendations, on a twice-yearly basis.

Deleted: S

Deleted: s

11.14. Pharmacy and Therapeutics Committee

11.14.1. Composition

Deleted: 23

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the Community Primary Care service. In addition, representatives from the Pharmaceutical Service, the Nursing Service, Nutrition Services, Hospital Administration, Affiliated Professionals and other services as appropriate will serve with a vote. The Director of Pharmaceutical Services, or designee, will serve as Secretary to the Committee. A Member of the Medical Staff with expertise in pharmacology shall serve as Chair. The Chief Pharmacy Officer will serve as Vice Chair.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

11.14.2. Duties

This Committee is responsible for the development and surveillance of all drug use policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to pharmaceuticals in this Hospital and its clinics. It will also perform the following specific functions:

Deleted: shall be

Deleted: shall

Deleted: shall

- A. Serve as an advisory group to the Medical Staff and the Department of Pharmaceutical Services on matters pertaining to the choice of available drugs;
- B. Publish and maintain the Hospital formulary;
- C. Establish and maintain standards concerning the use and control of investigational drugs and of research in the use of approved drugs;
- D. Make recommendations concerning drugs to be stocked on nursing units and other special services;
- E. Prevent unnecessary duplication in stocking pharmaceuticals;
- F. Evaluate clinical data concerning new pharmaceuticals requested for use in this Hospital and make recommendations to the MEC regarding what pharmaceuticals should be made available and placed on the formulary;
- G. Review and recommend changes to medication use policies, guidelines, and standardized medication orders to ensure safe and appropriate prescribing, administration, and monitoring of medications;
- H. Review and recommend changes in the electronic health record platform (*e.g.*, Epic) to improve the quality, safety, and efficiency of care delivered;
- I. Review medication-related issues and content from groups including but not limited to the Clinical Decision Support Committee and the Procedural Sedation Subcommittee, and examples include review of ordersets, best practice advisories, smartsets, medication alerts, and guidelines for use;
- J. Promote medication use safety; and
- K. Report issues to the Performance Improvement and Patient Safety Committee.

Deleted: Medical Executive Committee

11.14.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

Deleted: shall

Deleted: shall

11.14.4. Reports

Deleted: 23

This Committee shall submit a written report to MEC on its activities, including policy recommendations to the MEC monthly.

Deleted: S

Deleted: s

11.14.5. Subcommittees

The Committee will conduct the majority of its business through five (5) subcommittees. The Chair of each subcommittee will be a member of the Pharmacy and Therapeutics Committee and will be appointed by the Chair of the Committee with the approval of the Chief of Staff.

Deleted: shall

Deleted: shall

Deleted: M

Deleted: shall

A. Antibiotic Advisory Subcommittee

This Subcommittee is responsible for reviewing antibiotics and related therapies. The Subcommittee will assist the Formulary Review Subcommittee in conducting drug use evaluations for antibiotic therapy. The subcommittee will work closely with the Infection Control Committee and the Clinical Laboratories.

Deleted: shall be

Deleted: shall

B. Formulary Review Subcommittee

This Subcommittee is responsible for evaluating all requests for changes to the Formulary including additions of new drugs, new uses for current drugs, and deletions from the Formulary. The Subcommittee will also conduct periodic reviews of drug classes to assess appropriate use and promulgate guidelines for the use of drugs in clinical areas as appropriate.

Deleted: shall be

Deleted: shall

C. Nutrition Subcommittee

The Subcommittee will recommend therapeutic enteral and parenteral nutritional formulations for the Formulary and monitor and assess nutritional therapies. Additionally, the Subcommittee will review and approve policies and procedures relating to nutritional therapy of the Food and Nutritional Service, Outpatient Nutrition Service, and the Nutritional Support Services, including the Diet Manual.

Deleted: shall

Deleted: shall

Deleted: serve to

D. Pain Management Subcommittee

This Subcommittee will recommend and periodically review a program to promote effective pain management. It will collaborate with the Medication Error Reduction Plan Subcommittee around policies related to pharmacotherapy of pain. It will review and recommend policies and procedures pertinent to pain management.

Deleted: shall

E. Medication Error Reduction Plan Subcommittee

This Subcommittee will set system-wide and department-specific policies to reduce medication errors and adverse drug events. The subcommittee will review and revise the California Department of Public Health-mandated Medication Error Reduction Plan annually to assess effectiveness and identify weaknesses or deficiencies that could contribute to errors. The subcommittee will also review and report all unusual occurrences related to medications and make recommendations to the Pharmacy and Therapeutics Committee on ways to prevent such occurrences in the future.

Deleted: shall

Deleted: shall

Deleted:

Deleted: shall

11.14.6. Subcommittee Reporting

The subcommittees will report to the Pharmacy and Therapeutics Committee monthly.

11.15. Performance Improvement and Patient Safety Committee (PIPS)

This is a Joint Hospital Administration and Medical Staff committee responsible for implementing the objectives of the organization-wide performance improvement and patient

Deleted: Leadership

Deleted: 23

safety program. The committee takes an interdisciplinary and proactive approach to the prevention of adverse events, medical errors, and near misses, and promotes patient outcomes/safety and reduction of health disparities as the core values in providing quality patient care.

11.15.1. Composition

This Committee will consist of at least seven (7) physician representatives from the Active Medical Staff. Up to three (3) additional representatives from clinical services may include Affiliated Professionals. It will also include one (1) representative from each of Radiology, Clinical Lab, Pharmacy, Infection Prevention and Control, and Nursing. In addition, the Executive Leadership Team including the Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Pharmacy Officer, and UCSF Vice Dean will serve with one vote. The Administrative Director of Utilization Management and the Patient Safety Officer will also be Members. The Chief Executive Officer, Chief Medical Officer, or an Associate Chief Medical Officer will serve as the Chair, and the Chief Quality Officer will serve as Vice-Chair.

Deleted: shall

Deleted: shall

Deleted: T

Deleted: the

Deleted: shall

Deleted: ,

Deleted: shall

Deleted: Vice

Deleted: shall

Deleted: shall

11.15.2. Duties

This Committee:

- A. On an annual basis, reviews the effectiveness of Hospital Performance Improvement and Patient Safety Program in meeting the organizational-wide purpose, goals, and objectives and revises the program as necessary.
- B. Identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from focused reviews and sentinel events in the Joint Commission Sentinel Event Alerts, patient case reviews, risk management reports, hospital claims, patient and staff surveys, utilization review data, patient/visitor concerns, clinical service and ancillary/diagnostic department performance improvement reports, ongoing medical record review, and other sources as appropriate.
- C. Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and performance improvement committees as appropriate.
- D. Makes recommendations based on an evaluation of the care provided (e.g., efficacy, appropriateness) and how well it is done (e.g., availability, timelines, effectiveness, continuity with other services, safety, efficiency, respect, and caring).
- E. Submits an annual report to the MEC.
- F. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources through the designation of Performance Improvement.

11.15.3. Meetings

The Committee will meet monthly at least ten (10) times a year. The Committee will maintain permanent records of its proceedings and activities.

Deleted: shall

Deleted: shall

11.15.4. Reporting

Deleted: 23

The Performance Improvement and Patient Safety Committee must report and forward recommendations monthly to the Joint Conference Committee through the Chief Medical Officer and Chief Quality Officer, based on the review and recommendations made by the MEC.

Deleted: R

Deleted: s

Deleted: s

11.15.5. Subcommittees

The Committee will maintain and utilize the following subcommittees to do the work as described:

A. Code Blue Subcommittee

(1) Composition

This subcommittee will consist of physician representatives from Cardiology, Emergency Department, Pulmonary Service, and Anesthesia. Additional representatives from Respiratory, Nursing Pharmacy, Product Evaluation and Quality Management will also serve.

Deleted: P

Deleted: m

(2) Duties

This subcommittee will oversee the organization of the Code Blue Team (e.g., personnel composition, Member's roles and responsibilities, availability of equipment, scope of service area, and communication mechanisms). All findings from codes related to quality improvement activities will be reported to this subcommittee for evaluation and recommendations.

Deleted: O

Deleted: ,

Deleted: shall

(3) Meetings

The Code Blue Subcommittee will meet monthly and maintain permanent records of its proceedings and activities.

Deleted: shall

Deleted: shall

(4) Reporting

The Code Blue Subcommittee must submit a written report to PIPS on a once-yearly basis.

Deleted: S

Deleted: s

Deleted: to

Deleted: twice

Deleted: .

Deleted: S

Deleted: shall

B. Event Analysis & System Improvement Subcommittee (EASI)

(1) Composition

This subcommittee will consist of at least eight (8) Members of the Active Medical Staff, including representatives from the Clinical Services of Medicine, Surgery, Pediatrics, Family and Community Medicine, Obstetrics and Gynecology, Psychiatry, and Emergency Medicine. In addition, representatives from Hospital Risk Management, UCSF Risk Management, Hospital Administration, Quality Management, and the Chief Nursing Officer or designee will also serve. The Medical Director of Risk Management or designee will serve as Chair for this subcommittee. The Director of Risk Management will serve as Vice Chair.

Deleted: shall

Deleted: shall

Deleted: S

Deleted: shall

(2) Duties

The Subcommittee will:

Deleted: shall

- Provide oversight of the quality and safety event review process;
- Provide oversight to ensure identification of clinical risk, system vulnerabilities, and opportunities for quality improvement;
- Ensure implementation of recommend corrective action to mitigate or eliminate future recurrence of similar events; and

Deleted: 23

- d. Establish a framework that improves clinical and operational systems, patient safety, and quality outcomes using a shared accountability model.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times per year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Subcommittee must submit a written report to PIPS on a twice-yearly basis.

C. Transfusion Subcommittee

(1) Composition

This subcommittee will consist of the Nurse Manager for the Operating Room, the Nurse Manager for the Surgical Clinics, the Blood Bank Manager, the Director of the Transfusion Service/ Blood Bank, and at least one (1) Member each from the Departments of Anesthesia, Surgery, Obstetrics, Pediatrics/Neonatology, Hematology/Oncology, and Emergency Services.

(2) Duties

This subcommittee will review transfusion-related issues in the Hospital, including the appropriateness of the use of blood and blood components, blood component wastage, and all transfusion reactions. The findings of such reviews will be reported to the PIPS Committee and Chiefs of the Clinical Services, when appropriate. The subcommittee will develop and approve policies and procedures regarding transfusion practices and make recommendations based on results.

(3) Reporting

This subcommittee must submit a written report to PIPS on a twice-yearly basis.

D. Trauma Program Operational Process Performance Subcommittee

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director, and the Trauma Program Manager will serve as Vice Chair. The subcommittee will consist of the representatives from the Departments of Emergency Medicine, Anesthesia, Neurosurgery, Orthopedics, Radiology, Physical Medicine, Rehabilitation, Respiratory Therapy, Perioperative Services, Laboratory Medicine, and Pediatrics; the Nursing Directors or Managers of the Surgical ICU, Emergency Department, Surgical Nursing, PACU, and Operating Room; Neurosurgical, Emergency Department, and Surgical CNS representatives; Risk Management and Quality Management Nursing representatives; Trauma PI Coordinators, Trauma, Orthopedic, and Neurosurgical NP representatives; the Medical Director of SFFD Emergency Medical Services Division, ZSFG Base Hospital Coordinator, EMSA Medical Director and Trauma Coordinator, and San Mateo EMS Clinical Coordinator, and other professionals who are invited to participate as needed.

(2) Duties

This subcommittee will address, assess, and correct global trauma program and system issues. The membership will review all major clinical activities and systems of trauma care and will:

Deleted: S

Deleted: shall

Deleted: shall

Deleted: S

Deleted: s

Deleted: e

Deleted: Transfusion S

Deleted: shall

Deleted: Senior Supervising Technologist

Deleted: /Division Chief of the

Deleted: S

Deleted: shall

Deleted: shall

Deleted: S

Deleted: shall

Deleted: ;

Deleted: S

Deleted: s

Deleted: e

Deleted: S

Deleted: shall

Deleted: shall

Deleted: S

Deleted: shall

Deleted: ,

Deleted: ,

Deleted: ,

Deleted: ,

Deleted: S

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: 23

- a. Evaluate system and medical performance through objective and systematic monitoring;
- b. Identify, analyze, and track problems;
- c. Develop and implement plans for improvement, resolution, and modification of current systems of trauma care;
- d. Communicate the results of reviews and plans of correction to all program related services/departments;
- e. Trend and measure the effectiveness of corrective action; and
- f. Document the reporting of patient safety initiatives and continuous quality improvement activities.

Deleted: ed

Deleted: .

(3) Meetings

This subcommittee will meet on a monthly basis at least ten (10) times per year and maintain permanent records of its proceedings and activities.

Deleted: S

Deleted: shall

Deleted: shall

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

E. Trauma Multidisciplinary Peer Review Subcommittee

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director. The subcommittee will consist of the Chiefs-of-Service, or their designated representatives, of the following Departments: Surgery, Emergency Medicine, Anesthesia, Neurosurgery, Orthopedic Surgery, Radiology, Laboratory Medicine/Blood Bank, and Pediatrics. Additional members include the Co-Directors of Surgical ICU, the Hospital Director of Patient Safety and Performance Improvement, and all members of the Department of Surgery regularly participating in the care of acutely injured patients. Other attendees will include the Trauma Program Manager and Trauma Performance Improvement staff.

Deleted: S

Deleted: shall

Deleted: S

Deleted: shall

Deleted: M

Deleted: shall

Deleted: M

Deleted: shall

(2) Duties

This subcommittee will assure the equality and appropriateness of trauma care at this Hospital as it relates to performance of individual providers and the interaction between providers of different disciplines. The subcommittee will review clinical activity and outcomes (deaths, complications, errors) and will:

Deleted: S

Deleted: shall

Deleted: S

Deleted: shall

Deleted: shall

Deleted: .

Deleted: .

Deleted: M

Deleted: .

Deleted: .

Deleted: 23

- e. Measure the effectiveness of any corrective action taken or protocols generated.

(3) Meetings

The subcommittee will meet on a monthly basis at least ten (10) times/year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

F. Tissue Subcommittee

(1) Composition

This subcommittee will consist of attending physicians from Pathology (including the Chief of Pathology) selected by the Tissue Subcommittee Chair, and other members that the Chief of Staff appoints from surgical subspecialties and other areas.

(2) Duties

- a. The Tissue Subcommittee is responsible for the review of selected surgical case reports; those with pathology reports will correlate pre and post-operative diagnosis and pathology findings. Discrepancies will be presented to the Performance Improvement and Patient Safety Committee. The Tissue Subcommittee will review tissue specimens submitted to Pathology to ensure proper tissue handling and adequate completion of requisition forms.

- b. The subcommittee will also make recommendations based on results.

(3) Meetings

The Tissue Subcommittee will meet as needed, but no less than twice per year, and maintain permanent records of its proceedings and activities.

(4) Reporting

The Tissue Subcommittee must submit a written report to PIPS quarterly.

G. Procedural Sedation Subcommittee

This subcommittee will oversee the administration of moderate or deep sedation and anesthesia. The activities of the subcommittee will include physician and registered nursing training and formulating policy and procedures for the administration of moderate or deep sedation and anesthesia by non-anesthesia trained personnel.

(1) Composition

The subcommittee will be Co-Chaired by the Chief of Anesthesia or designee and a nursing administrator and consist of physician and nursing representatives from all clinical services providing procedural sedation, including: Gastroenterology, Radiology, Oral and Maxillofacial Surgery, Pulmonology, Emergency Medicine, Critical Care, Women's Option Clinic, Neonatal Intensive Care Unit, Post Anesthesia Care Unit, the Cardiac catheterization lab, and the Clinical and Translational Science Institute.

Deleted: S

Deleted: shall

Deleted: shall

Deleted: e

Deleted: Tissue S

Deleted: shall

Deleted: M

Deleted: shall be

Deleted: shall

Deleted: M

Deleted: ;

Deleted: shall

Deleted: shall

Deleted: S

Deleted: s

Deleted: S

Deleted: shall

Deleted: S

Deleted: shall

Deleted: :

Deleted: shall

Deleted: 23

(2) Duties

This subcommittee is tasked with setting systemwide and department-specific procedural sedation policy to ensure the safe delivery of procedural sedation and to meet regulatory compliance requirements for procedural sedation throughout the institution. Policies will be reviewed and revised no less frequently than every three years. The subcommittee will track audit data on a quarterly basis. All procedural sedation-related unusual occurrences will be discussed and any recommendations forwarded to the involved department.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times annually and maintain permanent records of its meetings and activities.

(4) Reporting

The subcommittee must submit a written report to PIPS on a twice-yearly basis.

11.16. Utilization Management Committee

11.16.1. Composition

This Committee will consist of at least three (3) Members of the Active Medical Staff or Affiliated Professionals, including the Associate Chief Medical Officer of Care Coordination (or their designee), who will serve as the Chair of the committee. The Committee must include at least two doctors of medicine or osteopathy. The committee will include representation from Ambulatory Care and Behavioral Health Services. Other individuals from the clinical, administrative, and support services whose participation is deemed necessary to increase the effectiveness of the work of the committee will be invited to meetings as needed.

11.16.2. Duties

This Committee has two primary functions:

- A. Provide oversight for all Utilization Management functions, and
- B. Make rational and system-coordinated recommendations on the priority of clinical services and resource allocation related to clinical care based on best available evidence.

11.16.3. Utilization Data Review

The Committee will review data related to Utilization Management at least semi-annually, including, but not limited to:

- Medical necessity/appropriateness of hospital admissions and readmissions
- Medical necessity/appropriateness of continued stay and treatment authorizations
- Lengths of stay variations and timeliness of discharge
- Professional services furnished, including drugs and biologicals
- Appropriate availability and use of ancillary services
- Overuse, underuse, and timeliness in provision of services
- Therapeutic procedures
- Adequacy of medical record documentation
- Third party payer denials
- Utilization of the Tertiary Care Contract

Deleted: :

Deleted:

Deleted:

Deleted: shall

Deleted:

Deleted: :

Deleted: shall

Deleted: shall

Deleted: S

Deleted: s

Deleted: :

Deleted: c

Deleted: shall

Deleted: seven

Deleted: five

Deleted: 5

Deleted: 7

Deleted: and Affiliated

Deleted: 1)

Deleted: Chief Medical Officer or the

Deleted: Medical Director

Deleted: Utilization Management

Deleted: , 2) the Chief of Staff or the Chief's designee, 3) one Member from CPC, 4) a representative from Surgical Clinical Services, 5) a representative from the Medicine service and 6) two (2) or more representatives from other Clinical Services

Deleted: Additional administrative Members include the Director of Utilization Management, Chief Operating Officer, Chief Pharmacy Officer or designee, and representative of the UCSF Dean's office.

Deleted: The Chief Medical Officer or Medical Director of Utilization Management shall serve as Chair and the Chief Operating Officer or designee shall serve as Vice Chair.

Deleted: c

Deleted: shall have

Deleted: quarterly

Deleted: 23

- Contracted Health Plan utilization and cost data
- Out-of-network referral costs
- Utilization Review Plan (review and approve annually)

Review of the above data elements may be concurrent or retrospective, and may be conducted on a sample basis for cases reasonably assumed to be outliers based on lengths of stay or extraordinary high costs. The Utilization Management Committee will work closely with financial services, social services, case management, patient placement services, and the Medical Staff to maximize appropriate utilization of resources. The Utilization Management Committee will report relevant findings to the Medical Executive Committee including problems, areas of opportunity, and actions addressed with departments, Clinical Services, Medical Staff, and other hospital entities.

Deleted: UMC

11.16.4. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities. The Utilization Management Committee will work closely with relevant stakeholders (including but not limited to Patient Financial Services, Behavioral Health Services, Ambulatory Care Services, and the Medical Staff) to maximize appropriate utilization of resources. One meeting per year must be dedicated to review of the Utilization Review Plan.

Deleted: This Committee shall will meet at least quarterly and shall maintain permanent records of its proceedings and activities....

11.16.5. Reporting

This Committee must submit a written report on its activities to the MEC, including policy recommendations, semi-annually.

Deleted: S

Deleted: s

Deleted:

Deleted: quarterly

11.17. Laboratory Utilization Committee

11.17.1. Composition

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the CPC service. The laboratory medicine resident will be invited and encouraged to participate. In addition, representatives from the Hospital Administration as well as nursing, pathology, Infectious Diseases, and Primary Care services, Specialty Care Services, and other services as appropriate will serve with a vote. The Director of Clinical Laboratory Services, or designee, will serve as Chair of the Committee.

Deleted: shall

Deleted: ID

Deleted: shall

Deleted: shall

11.17.2. Duties

This Committee is responsible for the development and surveillance of all laboratory testing policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the selection and availability of clinical laboratory tests, their reporting structure, and the communication of newly available tests to the clinical staff. The Committee will also perform the following specific functions:

Deleted: shall be

Deleted: shall

Deleted: It shall

- A. Serve as an advisory group to the Medical Staff and the Department of Clinical Laboratory Services on matters pertaining to the choice of available laboratory testing;
- B. Evaluate clinical data concerning new clinical lab tests requested for use in this Hospital and make recommendations to the Medical Executive Committee regarding what lab tests should be made available for order in the EHR;

Deleted: 23

C. Advise clinical staff in the appropriate analysis and follow-up for specific laboratory tests;

D. Advise in relation to and determine designation status for critical lab values and modify protocols for notification of critical results;

E. Manage the approval process and utilization of laboratory tests sent to outside reference labs; and

F. Report issues to the PIPS Committee as needed.

Deleted: /

Deleted: Performance Improvement and Patient Safety

11.17.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

Deleted: shall

Deleted: shall

11.17.4. Reports

This Committee must submit a written report to MEC on its activities, including policy recommendations, quarterly.

Deleted: S

Deleted: s

Deleted: to the MEC

Deleted: ¶

Deleted: 23

Page 1: [1] Deleted

Mercer, Mary

4/8/26 1:56:00 PM

Page 1: [2] Deleted

Mercer, Mary

4/8/26 1:56:00 PM

ZSFG Medical Staff Bylaws

ARTICLE 12. MEETINGS OF THE ENTIRE MEDICAL STAFF

12.1. Annual Meeting

An annual Medical Staff meeting will be held within sixty (60) days of the end of the Medical Staff year.

Each Member of the Active Medical Staff is expected to attend the annual meeting of the Medical Staff at least once every two years and special Medical Staff Meetings duly convened pursuant to these Bylaws.

The agenda at the annual Medical Staff meeting will be:

- A. Call to order
- A. Approval of minutes of previous annual or special meetings of the Medical Staff
- B. Annual Reports
 - 1) Director of Health
 - 2) Chief Executive Officer
 - 3) Dean, School of Medicine
 - 4) Vice Dean
 - 5) Chief of Staff
- C. Old Business
- D. New Business
- E. Adjournment

12.2. Special Meetings

- A. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting within ten (10) days after receipt of a written request for same signed by not less than ten percent (10%) of the Active Medical Staff and stating the purpose for such meeting. The Chief of Staff will designate the time and place of any special meeting.
- B. A written or printed notice stating place, day, and hour of any special meeting of the Medical Staff must be delivered, whether personally, by electronic mail or by mail, to each Active Member not less than seven (7) days before the date of such meeting. If mailed, the notice of the meeting is deemed delivered when deposited, postage prepaid, in a United States mail addressed to each staff Member at the address appearing on the records of the Hospital. The attendance of a Member at a meeting constitutes a waiver of notice of such meeting. No business may be transacted at any special meeting except that stated in the notice calling the meeting.
- C. Twenty percent (20%) of the Active Medical Staff constitutes a quorum for special meetings.
- D. The agenda will include reading of the notice of the meeting, transaction of business for which the meeting was called, and adjournment.

Deleted: shall

Deleted: of

Deleted: after

Deleted: shall

Deleted: <#>Voting¶

A simple majority of the Active Members attending the meeting shall will determine the outcome of the vote.¶

Deleted: shall

Deleted: twenty

Deleted: 2

Deleted: starting

Deleted: shall

Deleted: shall

Deleted: shall be

Deleted: shall

Deleted: shall

Deleted: -five

Deleted: 5

Deleted: shall

Formatted: Font: Bold

Deleted: A

Deleted: R

Deleted: T

Deleted: A

ZSFG Medical Staff Bylaws

12.3Voting

A simple majority of the Active Members attending either the Annual meeting or a Special meeting will determine the outcome of the vote.

Formatted: Outline numbered + Level: 2 + Numbering
Style: 1, 2, 3, ... + Start at: 3 + Alignment: Left + Aligned
at: 1" + Indent at: 1.29"

ARTICLE 13. CONFIDENTIALITY OF INFORMATION; IMMUNITY AND RELEASES

13.1. Authorization and Conditions

By applying to be a Member, Affiliated Professional, or other role with the Medical Staff, as well as by applying for or exercising clinical privileges and/or standardized procedures with the Hospital, an Applicant:

Deleted: for

- A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's professional ability and qualifications;
- B. Authorizes persons and organizations to provide information concerning such Applicant to the Medical Staff;
- C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under subsection 13.2.4 below; and
- D. Acknowledges that the provisions of this Article are express conditions to any application described in this Section 13.1.

Deleted: Section

Deleted: for Medical Staff Membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital

13.2. Confidentiality of Information

13.2.1. General

Discussions, deliberations, records, and proceedings of all Medical Staff committees having responsibility of evaluation and improvement of quality of care rendered in this Hospital will, to the fullest extent permitted by law, be confidential. This confidentiality protection includes, but is not limited to, information regarding any Member, Applicant, or Affiliated Professional, meetings of the Medical Staff, meetings of Clinical Services, meetings of committees of the Medical Staff, and meetings of ad hoc committees created by the MEC.

Deleted: shall

Deleted: or

Deleted: to this Medical Staff

13.2.2. When Disclosure is Permitted

- A. Dissemination or disclosure of discussions, deliberations, records, and proceedings may only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the MEC. Actions taken to address systems issues, information about corrective actions, conclusions, referrals for other investigations, and other high-level information may be shared if authorized by the Chief of Staff in consultation with the Vice-Dean, Chief Executive Officer, and/or City Attorney's Office.
- B. In all other cases, access to such information and records is limited to authorized Members or Affiliated Professionals for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentially be maintained.
- C. Information which is disclosed to the Governing Body or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities will be maintained by that body as confidential.
- D. Information contained in the credentials file of any Member or Affiliated Professional may be disclosed consistent with other provisions of these Bylaws, as required by law, or

Deleted: shall

Deleted: t

Deleted: shall

Deleted: be

Deleted: shall

Deleted: July 2020, with July 2022 revision

with the Member's or Affiliated Professional's consent to other medical staffs, hospitals, professional licensing boards, or medical schools.

- E. Initiation of a corrective action investigation, submission of a report pursuant to Section 805 of the Business and Professions Code to the Member's or Affiliated Professional's professional licensing organization (such as the Medical Board), and adverse actions related to medical staff membership, privileges, and/or standardizes procedures, will be reported to the peer review bodies of any other component of the San Francisco Health Network in which the Member or Affiliated Professional provides patient care services.

Deleted: n

Deleted: 805

Deleted: California

Deleted: and/or

Deleted: shall

13.2.3. Breach of Confidentiality

Effective quality of care activities, peer review, and consideration of the qualifications of Members, Affiliated Professionals, and Applicants to perform specific procedures must be based on free and candid discussions within a quality improvement process. Any breach of confidentiality of the discussions, deliberations, records, or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Members or Affiliated Professionals, violates these Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in any other proceeding as to matters protected by this confidentiality provision.

13.2.4. Immunity from Liability

- A. For Action Taken by the Medical Staff and Hospital.

Each representative of the Medical Staff and Hospital is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

Deleted: shall be

Deleted: or

- B. For Providing Information.

Each representative of the Medical Staff and Hospital and all third parties is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an Applicant to or Member or Affiliated Professional of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

Deleted: shall be

Deleted: or

Deleted:

13.2.5. Activities and Information Covered

The confidentiality and immunity provided by this Article applies to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

Deleted: shall apply

- A. Application for appointment, reappointment, clinical privileges, or standardized procedures;
- B. Corrective action;
- C. Hearings and appellate reviews;

Deleted: or

Deleted: July 2020, with July 2022 revision

- D. Utilization and quality assurance reviews;
- E. Activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- F. Queries and reports concerning the National Practitioner Data Bank, peer review body or organization, [or a professional licensing organization \(such as the Medical Board of California\)](#), and similar queries and reports.

Deleted: the

Deleted: July 2020, with July 2022 revision

ARTICLE 14. CONFLICTS AND DISPUTE RESOLUTION

14.1. Conflicts and Disputes between the Medical Staff and the MEC

- A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the MEC and the Medical Staff upon receipt of a written petition, signed by at least twenty percent (20%) of the Active Medical Staff Members, that sets forth the rule, policy, or other significant matter at issue.
- B. The meeting will include up to five representatives of the Active Medical Staff selected by the petitioners and an equal number of MEC Members selected by the Chief of Staff. The meeting will be chaired by the Chief of Staff, who will not be considered as one of the MEC representatives and who will not have voting privileges at this meeting.
- C. The representatives of the Medical Staff and of the MEC will exchange information relevant to the conflict and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital.
- D. Resolution at this level requires a majority vote of the representatives of the Medical Staff and a majority vote of the representatives of the MEC.
- E. Unresolved matters will be submitted to the Governing Body for final resolution.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Joint Conference Committee

14.2. Conflicts and Disputes between the Medical Staff and the Governing Body

- A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the Medical Staff and the Governing Body upon a majority vote of the MEC or petition of at least twenty percent (20%) of the Active Members. The Chief of Staff will work with the Secretary of the Governing Body to ensure compliance with public notice requirements.
- B. The Medical Staff will be represented by two officers of the Medical Staff and three Active Medical Staff Members selected by the Chief of Staff. The Governing Body will be represented by the Governing Body members on the Joint Conference Committee. The Hospital Chief Executive Officer and Vice-Dean will also be invited to attend this meeting and will not have voting privileges at this meeting.
- C. The meeting will be chaired by the Chair of the Joint Conference Committee.
- D. The meeting participants will gather and share relevant information and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the governing responsibilities of the Governing Body, and the safety and quality of patient care at the Hospital.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: the

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: July 2020, with July 2022 revision

E. Resolution at this level requires a majority vote of each of the following groups: (a) the representatives of the Medical Staff; and (b) the representatives of the Governing Body. Any such proposed resolution must be approved by a majority of the full Governing Body.

F. Unresolved matters must be submitted to the Governing Body for final resolution. The Governing Body will make its final determination giving consideration to the actions and recommendations of the Medical Staff, must not be arbitrary and capricious, and must act in keeping with its legal responsibilities to act to protect the safety and quality of patient care and to ensure the responsible governance of the Hospital.

Deleted: physicians

Deleted:

Deleted: a majority vote of

Deleted: shall

Deleted: shall

Deleted: great weight

Deleted: shall

Deleted: shall

Deleted: be

Deleted: July 2020, with July 2022 revision

ARTICLE 15. RULES AND REGULATIONS

15.1. Rules and Regulations of the Medical Staff

The Medical Staff will be governed by such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These will relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Member. Agreement to abide by the Bylaws includes agreement to abide by the Rules and Regulations. The Rules and Regulations are incorporated into these Bylaws as if set forth herein. In keeping with The Joint Commission guidelines, amendments to the Rules and Regulations are delegated to the Medical Executive Committee (MEC) and Governing Body.

Deleted: shall

Deleted: . Accordingly, amendments

Deleted: me

Deleted: subject

Deleted: same requirements as amendments to these Bylaws...

Deleted: shall

Deleted: shall

Deleted: shall

15.2. Rules and Regulations of the Clinical Services

Each Clinical Service must formulate its own rules and regulations and proctoring protocol for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations must be consistent with these Bylaws. Substantive changes must be reflected in the biennial clinical services report to the Medical Executive Committee and approved by the MEC and the Governing Body.

ARTICLE 16. ADOPTION AND AMENDMENT

16.1. Medical Staff Responsibility

16.1.1. Initial Responsibility

The Medical Staff has the initial responsibility and authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments thereto, which will be effective when approved by the Governing Body. Such approval must not be unreasonably withheld. This responsibility will be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing quality and efficient patient care and maintaining a harmony of purpose and effort with the Governing Body. Neither the Governing Body nor the Medical Staff may unilaterally amend the Medical Staff Bylaws.

Deleted: shall have

Deleted: shall

Deleted: shall

Deleted: shall

16.1.2. Hospital Chief Executive Officer

The Hospital Chief Executive Officer must be consulted as to the impact of any proposed Bylaws amendments on Hospital operations and as to the feasibility of proposed amendments. The Hospital Chief Executive Officer may also develop and recommend Bylaws amendments to the Bylaws Committee or MEC for consideration.

Deleted: shall

16.1.3. Proposed Amendments

Proposed amendments will be reviewed and considered at a meeting of the Joint Conference Committee prior to distribution to the Medical Staff for a vote. The Governing Body Members of the Joint Conference Committee have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

Deleted: shall

16.2. Amendments

Deleted: July 2020, with July 2022 revision

Deleted: 3

The City Attorney's Office ~~shall~~ serve as counsel for the Medical Staff in relation to any amendments and will provide input on suggested amendments to these Bylaws.

Deleted: shall

The MEC ~~will~~ vote on the proposed amendments and upon an affirmative vote of ~~a~~ majority of a quorum ~~must~~ submit the amendments to the Active Medical Staff for approval or disapproval as set forth in Section 16.3 herein.

Deleted: shall

Deleted: two-thirds (2/3)

Deleted: shall

Upon a petition signed by at least twenty percent (20%) of the Active Medical Staff, amendments to these Bylaws and Rules and Regulations may be submitted to the Medical Staff and the Governing Body (and without the approval of MEC) for a vote. In such an event, the proposed amendments ~~will~~ be reviewed and considered at the next regularly scheduled meetings of the MEC and Governing Body prior to distribution to the Medical Staff. The MEC and the Governing Body have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

Deleted: shall

16.3. Method

16.3.1. Combined

The Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

- A. The affirmative vote ~~of a majority~~ of the Active Members of the Medical Staff who cast votes on the matter, provided at least fourteen (14) days advance notice accompanied by the proposed Bylaws or amendments (such notice and voting may be conducted electronically); and
- B. The affirmative vote of a majority of the Governing Body.

Deleted: of two-thirds (2/3)

16.3.2. Governing Body Vote

The Governing Body ~~must~~ vote on proposed amendments within forty-five (45) days from the date of receipt. If the Governing Body does not approve the proposed amendments, it ~~must~~ specify its reasons in writing and forward them to the Chief of Staff, the MEC, and the Bylaws Committee.

Deleted: shall

Deleted: shall

16.3.3. Approval of Amendments

Amendments must be approved by both the Medical Staff and the Governing Body before they take effect, excepting the situations set forth in Sections 16.4 and 16.5 herein.

Deleted: shall

16.4. Corrections

The MEC ~~has~~ the power to approve corrections, such as reorganization or renumbering of the Bylaws, or correcting punctuation, spelling, or other errors of grammar or inaccurate cross-references. Such amendments ~~are~~ effective immediately and ~~are~~ permanent. The action to make such corrections ~~must~~ be taken by motion and acted upon in the same manner as any other motion before the MEC. Substantive amendments are not permitted pursuant to this Section.

Deleted: shall have

Deleted: shall be

Deleted: shall be

Deleted: shall

16.5. Urgent Amendments

In the case of a documented need for an urgent amendment to these Bylaws and Rules and Regulations necessary to comply with law, regulation, or deficiency issued by the Joint Commission or state of federal regulating body, ~~the Rules and Regulations~~ may be amended for

Deleted: these

Deleted: Bylaws

Deleted: July 2020, with July 2022 revision

Deleted: 3

that sole purpose by a two-thirds (2/3) affirmative vote of the MEC and by an affirmative vote of each Governing Body representative on the Joint Conference Committee. In such an event, the amendment must be submitted to the Medical Staff and Governing Body for retrospective review and approval, through the process outlined in this Article. This process must be initiated within 60 days of the Joint Conference Committee vote described in this Section. Per guidelines of The Joint Commission, Urgent Amendments to the Bylaws must follow the standard process for Bylaws Amendments as set forth in Articles 16.2 and 16.3 of these Bylaws. If there is a dispute regarding such an amendment, the Medical Staff may pursue the conflict management process set forth in Article 14 of these Bylaws.

Deleted: shall

ARTICLE 17. MISCELLANEOUS PROVISIONS

17.1. Notice and Duty to Advise of Contact Information

Each Member, Affiliated Professional, or Applicant has an ongoing, affirmative duty to ensure that the MSSD has accurate contact information, including email address, personal telephone number, and mailing address, for that Member, Affiliated Professional, or Applicant. This duty includes the duty to promptly (within five (5) business days) update the MSSD of any changes to that contact information. For UCSF faculty or employees, the UCSF email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well. For City employees, the City-provided email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well.

Deleted: of

Except in relation to Notice related to Articles 6 and 7, above, any notification or other communication required by these Bylaws to be given by email is considered delivered when sent, and there is no obligation to ensure that such email is received or read by the Member, Affiliated Professional, or Applicant. However, if the MSSD receives a notification that an email is undeliverable, the MSSD will, within five (5) days, attempt to contact the Member, Affiliated Professional, or Applicant to obtain an accurate email address and/or to send the notification or other communication through alternative means to ensure the Member, Affiliated Professional, or Applicant learns of the issue.

Deleted: or Special Notice

Deleted: shall

Deleted: three

Deleted: 3

Deleted: business

17.2. Sharing of Information for Disciplinary and Other Investigatory Purposes

During the course of Medical Staff processes outlined by these Bylaws, information may be obtained or disclosed that requires additional investigation outside of Medical Staff processes. By way of example and without limitation, information may be learned that relates to: unprofessional conduct of Hospital staff or people in other City or UCSF departments; alleged discrimination, harassment, or retaliation; patient privacy violations; patient abuse; an unsafe work environment; misuse of public resources; mistreatment of patients or other staff; fraudulent billing or other medical practices; medical malpractice; or other ethics or civil or criminal law violations. In each instance listed above, and in other instances as determined by the Chief of Staff or by any Medical Staff committee member or subcommittee member that learns such information, the Medical Staff, through the Chief of Staff or MSSD, must notify the Hospital Administration and the City Attorney's Office of the nature of the allegations or information within seven (7) days of learning such information in order to allow Hospital Administration and the City Attorney's Office to determine if a referral needs to be made to City and/or UCSF

Deleted: July 2020, with July 2022 revision

Deleted: 3

Human Resources departments, other City and/or UCSF departments, or law enforcement for a separate investigation for potential discipline or other purposes. Such disclosure may also be required by law or by Hospital, City, or UCSF policies or rules. The City Attorney's Office must be consulted if there is any question about what kind of information is to be disclosed.

In addition, there may be instances where parallel review or investigations occur related to the kinds of incidents or alleged misconduct listed in this section. By way of example, an incident might be submitted via a Safety And Feedback Events (SAFE) report (maintained by the Quality Management Department) that initially necessitates review by Risk Management, and the underlying information may quickly result in a referral for concurrent review by the Medical Staff, DPH or UCSF Human Resources, and/or the DPH Office of Compliance and Privacy Affairs. In the process of the investigation, the flow of information associated with these concurrent reviews can be complicated, and the City Attorney's Office should be consulted as early as possible to help ensure information only flows in the directions authorized by law and by DPH and Hospital policies. Each of these processes may result in a separate outcome, with distinct recommendations or action. Also, appropriate coordination between these separate processes can help ensure timely action that can correct issues that lead to errors, allow for improvement of clinical practice, result in appropriate regulatory reporting, and when needed result in disciplinary or other corrective action.

17.3. Notice to MSSD and City Attorney's Office of Investigation by Professional Licensing Entity

In the event that any Member or Affiliated Professional is given notice that the Member or Affiliated Professional is under investigation by any entity that has responsibility for issuance or oversight of the Member's or Affiliated Professional's professional license or certification (such as by the Medical Board of California, the Osteopathic Medical Board of California, or any other similar entity), the Member must give notice of such investigation within seven (7) days of learning of the investigation to the MSSD and the City Attorney's Office. Any request for medical records of any Hospital patient associated with any such investigation must be given to Hospital Health Information Systems for processing. In addition, the Member or Affiliated Professional must also promptly notify (within seven (7) days) the MSSD and City Attorney's Office any decision or action against the Member's or Affiliated Professional's license or certification by the entity conducting the investigation.

17.4. Notice to MSSD and Chief of Service Regarding Action Against Privileges at Another Institution and Any Other Disclosable Event Related to Application/Reapplication for Privileges

In the event that any Member or Affiliated Professional is given notice that their privileges have been suspended, restricted, or terminated at another institution for any amount of time, including voluntary acceptance of a suspension, restriction, or termination, for a medical disciplinary cause or reason, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days. This time limit may only be extended in exceptional circumstances (e.g., illness or injury) and in consultation by the Chief of Staff with the Hospital CEO.

In the event that any Member or Affiliated Professional is the subject of any action listed in this paragraph, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days of the occurrence of that action or item. This

Deleted: July 2020, with July 2022 revision

Deleted: 3

time limit may only be extended in exceptional circumstances (e.g., illness or injury) and in consultation by the Chief of Staff with the Hospital CEO. The items that are reportable to the MSSD and the Member's Chief of Service include all of the following:

- A. Actions related to the person's liability for or insurance coverage related to their professional activities, including: actions, arbitrations, claims, or lawsuits related to the provision of patient care; reporting of any professional liability claim to an insurance carrier; the making of any settlement, arbitration, decision, or judgment in any professional liability case in which the person or their insurer had to or agreed to make any monetary payment; denial, cancellation, or the threat of denial or cancelation of professional liability insurance coverage; or being named as a defendant in a malpractice case and then being dropped from the case.
- A. Actions related to or that could impact patient care, including filing, withdrawal, or completion of any administrative, government, or court case or hearing involving allegations that the provider: failed to comply with laws, statutes, regulations, or other legal requirements related to the practice of their profession or provision of services to patients; violated of any criminal law (excluding minor traffic violations); was liable for any injury caused by the person's negligent or willful act or omission in rendering services; or was challenged or sanctioned regarding the person's admission, treatment, discharge, charging, collection, or utilization management related to patient care.
- B. Actions or investigation (whether undertaken, pending, or completed) involving the denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary or involuntary relinquishment of the provider's: medical or affiliated staff membership at any facility; medical or affiliated staff privileges at any facility; provision of clinical care for ninety (90) days or more; status as a student in good standing in any program related to clinical practice; membership or fellowship in any local, county, state, regional, national, or international professional organization; faculty position or membership; specialty board certification; license or certificate to practice any profession in any state, country, or jurisdiction; or Drug Enforcement Administration or other controlled substances registration.
- C. Any issue that impairs or could impair the person's ability to carry out their professional obligations in a manner that meets the standards of care in the community, under these Bylaws, or in relation to other Hospital policies, including: any physical or mental health condition or status; any communicable health conditions that could pose a significant health and safety risk to patients; or chemical dependency or substance abuse that might adversely affect the provider's ability to competently and safely perform the essential functions of a practitioner in their area of p

Deleted: ¶

Deleted: July 2020, with July 2022 revision

Deleted: 3

**THE PRISCILLA CHAN AND MARK ZUCKERBERG
SAN FRANCISCO GENERAL HOSPITAL
AND TRAUMA CENTER**

April 2026

Draft

MEDICAL STAFF BYLAWS

ZSFG Medical Staff Bylaws

PREAMBLE

WHEREAS, The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG or Hospital) is a public hospital organized under the laws of the State of California and the Charter of the City and County of San Francisco; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, research, and undergraduate and postgraduate education in the health sciences; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Hospital Administration and the Governing Body are necessary to fulfill the Hospital's obligations to its patients.

THEREFORE, the physicians, dentists, clinical psychologists, and podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws and Rules and Regulations. These Bylaws and Rules and Regulations provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with Applicants to, and Members of, the Medical Staff as well as with Affiliated Professionals whose clinical care is subject to Medical Staff oversight.

DEFINITIONS

Affiliated Professional: Individuals who are credentialed through the Medical Staff, are subject to general Medical Staff oversight, and belong to a professional category not eligible for Medical Staff Membership. They are not Members of the Medical Staff and are not afforded the due process rights set forth in these Bylaws, and they may not vote on amendments to the Bylaws or Rules and Regulations.

Attending Faculty or Attending: Member of the Medical Staff who meets the Bylaws board certification or eligibility requirements within their specialty and who supervises (or may supervise) physicians in training (residents or fellows), medical students and affiliated professionals (if required by their licensure). Attending physicians may also be faculty or volunteer faculty at University of California School of Medicine.

Applicant: Physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership. To the extent applicable based on the context listed in these Bylaws, this term also applies in relation to people who are applying to be an Affiliated Professional.

Chief of Service: Each Member of the Active Medical Staff who is selected under Section 9.2 of these Bylaws to lead a Hospital clinical service and perform the duties listed in Section 9.3 of these Bylaws for that service. Each clinical service has a Chief of Service.

Chief of Staff: The Member of the Medical Staff who is elected as outlined by Article 8 of these Bylaws to serve as an officer of the Medical Staff and who serves as the head of the Medical Staff. The Chief of Staff has the powers and duties listed in Article 8 as well as elsewhere in these Bylaws.

City: The City and County of San Francisco.

Clean Application: An application for membership to the Medical Staff for which there is no missing information, all primary source verifications have been completed, and there are no

ZSFG Medical Staff Bylaws

issues that raise concerns about the ethics, judgement, or quality of care of the application. The Chair of the Credentials Committee, in the Chair's sole discretion, will make the final determination as to whether the application is clean. Such applications may be approved by an email vote of the Credentials Committee and the Medical Executive Committee. Approval by the Governing Body must occur at a meeting of the Governing Body or a Committee of the Governing Body.

Clinical Service: A Hospital service group as listed in Article 9 of these Bylaws.

Date of Receipt: The date on which any Notice or other communication that was delivered personally or electronically, or three (3) days after it was postmarked.

Department Chair: The Chair of the Department at the University of California, San Francisco. For the Community Primary Care Service (CPC), the Director of Primary Care or their designee will act as the "Department Chair".

Director of Health: The Director of the San Francisco Department of Public Health,. The Director of Health or their designee will ensure that information that is required to be communicated to the Governing Body by these Bylaws will be communicated, and such information may be communicated to the Director of Health without jeopardizing any peer review protections.

Director of the San Francisco Health Network: The individual responsible for managing the delivery system of the Department of Public Health and who supervises the Hospital's Chief Executive Officer. Information required to be communicated to the Hospital's Chief Executive Officer may be communicated to the Director of the San Francisco Health Network without jeopardizing any peer review protections.

DPH: The San Francisco Department of Public Health.

Governing Body: The San Francisco Health Commission subject to the responsibilities designated to the Director of Health by the San Francisco Charter and Municipal Code.

Hospital: The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

Hospital Administration: Executive Staff Committee members, including the Hospital Chief Executive Officer, Senior Associate Administrators, and Associate Administrators appointed by the Director of Health or Hospital Chief Executive Officer, who implement the day-to-day operations of the Hospital.

ZSFG Medical Staff Bylaws

House Staff: Trainees in Accreditation Council for Graduate Medical Education or American Board of Medical Specialties programs.

Joint Conference Committee for Quality Assurance (JCC): the committee where members of the Governing Body, Hospital Administration and Medical Staff review and discuss the Hospital's credentialing and quality assurance and performance improvement program.

Medical Staff: The organization established by these Bylaws and consisting of the collective group of Members duly appointed under these Bylaws and that takes action on behalf of Members as outlined by these Bylaws.

Medical Staff Services Department (MSSD): The hospital department that administratively supports medical staff activities.

Medical Staff Year: The period from July 1 through June 30.

Member: Physicians, dentists, clinical psychologists, and podiatrists whose applications have been approved by the Medical Executive Committee and the Governing Body for membership on the Medical Staff.

Practitioner: A neutral term used to describe either a Member of the Medical Staff or an Affiliated Professional as defined elsewhere in these Bylaws whose Clinical Privileges and Credentialing are governed by the Medical Staff Bylaws and Rules and Regulations

Notice: A written communication delivered personally, by email, electronically, or sent by United States mail regarding an appointment, reappointment, privileges, or Medical Staff status.

San Francisco Health Network (SFHN): The healthcare delivery system of the San Francisco Health Department. Hospital and community primary care are components of this delivery system that also includes skilled nursing care, mental health, substance abuse, and jail health services.

Staff: All people who work at the Hospital, whether as paid employees or volunteers of the City or UCSF or as contractors, including people who perform clinical, administrative, facility maintenance, or other duties.

University or UCSF: The University of California, San Francisco.

Vice Chair of a Medical Staff Committee: An individual who is subordinate to the Committee Chair and need not be a Member of the Medical Staff. The Vice Chair may chair Committee meetings and may represent the Committee at Medical Executive Committee meetings in the absence of the Chair.

Vice Dean: The UCSF Vice Dean located at the Hospital.

Note 1-Designation of "Acting" Executives – The terms "Chief of Staff," "Chief of Service," "Chief Executive Officer," "Vice Dean," and "Director of Health" include any persons designated to act on each person's behalf.

Note 2-Clarification of time-based definitions – All references to days in these Bylaws are to calendar days (not business days).

ZSFG Medical Staff Bylaws

ARTICLE 1. NAME AND PURPOSES

1.1. Name

The name of this organization is the Medical Staff of The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

1.2. Purposes and Responsibilities

The purpose of the Medical Staff is to work with, and alongside, Hospital Administration and Staff to achieve the Hospital's True North (see Appendix 1). Specifically, the Medical Staff's purposes and responsibilities are to:

1.2.1. Collaborate

Collaborate with Hospital Administration to improve the services provided to patients;

1.2.2. Patient Care

Assure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital receive care at a level of quality and efficiency consistent with generally accepted standards and attainable within the Hospital's means and circumstances;

1.2.3. Professional Performance

Assure a high level of professional performance of all Applicants authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each Applicant may exercise in the Hospital and through a continuing review and evaluation of each Applicant's performance in the Hospital;

1.2.4. Educational Setting

Provide an appropriate educational setting for continuing education of the Medical Staff and Affiliated Professionals and for the education of both undergraduate and graduate students in the health sciences;

1.2.5. Community Health Education

Organize and support community health education and support services;

1.2.6. Self-Governance

Develop and maintain Bylaws for self-governance of the Medical Staff;

1.2.7. Communication

Provide a means whereby issues of mutual concerns to the Medical Staff and Hospital Administration may be discussed by the Medical Staff with the Governing Body, the Chief Executive Officer, and the Director of Health;

1.2.8. Performance Improvement and Patient Safety

Incorporate the principles of performance improvement and patient safety in the provision of clinical care; and

1.2.9. Equity

Actively support the Hospital's commitment to equity in clinical, educational, and workplace relationships and systems.

ZSFG Medical Staff Bylaws

ARTICLE 2. MEDICAL STAFF MEMBERSHIP

2.1. General Qualifications

Membership on the Medical Staff of the Hospital is a privilege that will be extended only to those Applicants who are professionally competent and continuously meet the qualifications, standards and requirements set forth in these Bylaws. Only those currently licensed physicians, dentists, clinical psychologists and podiatrists whose experience, training, ethics and demonstrated competence assure, in the judgment of the Medical Staff and the Governing Body, that any patient treated by them in the Hospital will receive quality medical care, may qualify for membership. Members of the Medical Staff must conduct themselves in the highest ethical tradition and in a manner consistent with the Code of Ethics of the American Medical Association, the American Dental Association, the American Psychological Association, the American Osteopathic Association, or the American Podiatric Medical Association. Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other Applicants for membership or privileges.

2.2. Basic Qualifications for Consideration of Application For Active and Courtesy Medical Staff for Initial Appointment or Reappointment

To qualify for initial appointment or reappointment, an Applicant or Member or Affiliated Professional must demonstrate compliance with all the basic standards set forth in this Article 2 in order to have an application for Medical Staff membership accepted for review. The Applicant must meet the following standards:

2.2.1. Licensure

Physicians must (1) be licensed to practice medicine by the Medical Board of California or Osteopathic Medical Board of California or (2) comply with all of the requirements of California Business and Professions Code Section 2113 or Section 2168 *et seq.*, including possession of a valid and current Certificate of Registration under those code sections and approval by the UCSF Dean, School of Medicine and the Vice Dean at the Hospital.

Dentists must be licensed to practice dentistry by the Dental Board of California.

Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine.

Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology.

2.2.2. Drug Enforcement Agency (DEA)

Applicants must possess by their start date a valid federal DEA number unless the Applicant will never prescribe, or supervise the prescribing of, medications.

2.2.3. Physician Board Certification

- A. Applicants must be certified or be progressing towards certification by (1) boards that are duly organized and recognized by an American Board of Medical Specialties (ABMS) or (2) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training that provides

ZSFG Medical Staff Bylaws

complete training in that specialty or subspecialty. Applicants must become board certified before their first reappointment. In surgical specialties where case requirements must be met after training, exceptions may be made, but all applicants must achieve board certification no later than six years after the initial granting of Medical Staff membership. Re-applicants who have let their board certification lapse must become board certified no later than the second reappointment after their certification lapsed.

- B. A Chief of Service may submit a written request for waiver of the certification requirement or an extension of the six-year period to become board certified to the Medical Executive Committee (MEC) for persons who demonstrate that their education, training, experience, ability, judgment, and medical skills make them sufficiently qualified to serve as Medical Staff Members. The MEC and the Governing Body will consider each request and determine whether approval is in the best interest of the patients and of the Hospital.

Persons appointed with an approved waiver as described above must be categorized with one of the following statuses:

1) Temporary Waiver

Temporary waivers are valid for the duration of the appointment or reappointment period. The temporary waiver is intended for people with a path to ABMS certification that is compatible with expectations and scope of their academic role and clinical duties. The person with the waiver is progressing toward certification by a board duly organized and recognized by the ABMS and must address their certification status at application for reappointment as outlined in this subsection 2.2.3.

2) Permanent Waiver

The waiver is permanent and automatically applies to future reappointments. The permanent waiver is intended for foreign trained practitioners that meet either of the below criteria:

- a. Have no reasonably-feasible path to ABMS certification (*i.e.*, no path at all or a path to board certification that is either highly restrictive or would place undue burden on the individual and/or Clinical Service, significantly distracting from the Applicant's primary duties).
- b. Are practicing medicine with the approval of the Medical Board of California pursuant to Section 2168 of the California Business and Professions Code.

2.2.4. Professional Liability Insurance

Individuals (both Members and Affiliated Professionals) who are not Members of the faculty of the University or are not employed by the City and County of San Francisco must maintain professional liability insurance in an amount not less than \$2 million each occurrence, \$6 million aggregate with an insurance carrier acceptable to the City's Risk Manager. Each such Member or Affiliated Professional must upon acceptance of the Medical Staff and thereafter at

ZSFG Medical Staff Bylaws

any time requested by the Credentials Committee, provide the Credentials Committee with written evidence of conforming coverage. Each such individual must promptly report to the Credentials Committee any reduction, restriction, cancellation for termination of the required insurance coverage or, if applicable, change of insurance carrier. Insurance requirements set forth in these Bylaws are subject to review by the City's Risk Manager, and may be updated by the City's Risk Manager from time to time as conditions warrant. The insurance requirements of this section may be modified on a case-by-case basis for good cause by the Hospital's Chief Executive Officer in consultation with the City's Risk Manager and the Chief of Staff.

2.2.5. Participation in Medicare, Medicaid and Other Federal Health Care Programs

Applicants must:

- A. Be eligible to participate in the Medicare, Medi-Cal, and other federal health care programs;
- B. Obtain a National Provider Identifier (NPI); and
- C. Enroll in Medicare and/or Medi-Cal and receive an enrollment confirmation letter, excluding dentists and other practitioners whose professional services are not reimbursed by Medicare and/or Medi-Cal, respectively.

2.3. Qualifications for Membership

In addition to meeting the basic qualifications, the Applicant must:

2.3.1. Experience, Education and Training

Document the Applicant's: (1) adequate experience, education, and training in the requested privileges; (2) current professional competence; (3) ability to perform the privileges requested; (4) good judgment; and (5) adequate physical and mental health to perform patient care activities, and demonstrate to the satisfaction of the Medical Staff that the Applicant is professionally and ethically competent to reliably provide the quality of care acceptable by the Medical Staff.

2.3.2. Ethics

Be determined: (1) to adhere to the lawful ethics of the Applicant's profession; (2) to work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and (3) to participate in and properly discharge Medical Staff responsibilities.

2.4. Condition and Duration of Appointment

2.4.1. Governing Body Action

Initial appointment and reappointment to the Medical Staff is made by the Governing Body. The Governing Body will act on appointments, reappointments, or revocation of appointments only after a recommendation from the Medical Staff as provided in these Bylaws.

2.4.2. Duration

Initial appointments and reappointments to the Medical Staff will each be for a period of not more than two (2) years.

ZSFG Medical Staff Bylaws

2.4.3. Clinical Privileges

Appointments to the Medical Staff confer on the appointee only such Clinical Privileges as have been granted by the Governing Body, in accordance with these Bylaws.

2.4.4. Provide Care

Every Member will provide care and supervision of the Member's patients, abide by the Medical Staff Bylaws, accept committee assignments and, when appropriate, provide emergency service care and accept consultation assignments.

2.4.5. Non-Discrimination

Members must not discriminate in the provision of care to patients based on race, religion, color, national origin, ancestry, age, disability, medical status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws.

2.4.6. Division of Fees

The practice of division of fees under any guise whatsoever is prohibited and any such division of fees is cause for exclusion or expulsion from the Medical Staff.

2.5. Harassment Prohibited

Harassment by a Member against any individual (*e.g.*, against another Medical Staff Member, House Staff, Hospital personnel or patient) on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws will not be tolerated. All allegations of harassment will be investigated according to policies adopted by the City and/or University.

2.6. Nondiscrimination

No aspect of Medical Staff membership or Clinical Privileges and/or standardized procedures will be denied on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by local, state, or federal law. The credentialing and recredentialing processes will be conducted in a non-discriminatory manner and Members responsible for credentialing decisions will be required to sign an affirmative statement that they will make decisions in a non-discriminatory manner. Additionally, the Medical Staff must not discriminate with respect to staff privileges or the provision of professional services against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O., or D.P.M.

2.7. Effect of Other Affiliations

No person is entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the person holds a certain degree, is licensed to practice in this or any other state, is a Member of any professional organization, is certified by any Clinical Board, or because such person had, or presently has, staff Membership or privileges at another health care facility.

2.8. Basic Responsibilities of the Medical Staff

Each Medical Staff Member, Affiliated Professional and each Applicant exercising temporary privileges, must continuously meet all of the following responsibilities:

ZSFG Medical Staff Bylaws

- A. Provide the Member's or Affiliated Professional's patients with care that is of a generally recognized professional level of quality and efficiency;
- B. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the Medical Staff and the Hospital;
- C. Abide by applicable laws and regulations of government agencies, standards of the Joint Commission, and the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation;
- D. Discharge such Medical Staff, Clinical Service, committee and service functions for which the Member, Affiliated Professional or Applicant exercising temporary privileges is responsible by appointment, election or otherwise; and
- E. Complete new hospital orientation prior to exercising privileges.
- F. Work cooperatively with Members, nurses, the Hospital Administration, and others so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care;
- G. Report to their Service Chief any illness, disability, or absence which could affect patient care; and cooperate, at the Member's expense, with any health evaluations as may be reasonably required by the Medical Executive Committee;
- H. Reporting to the Chief of Staff and their Service Chief within 7 days in the event of any formal action taken by government authorities to exclude the Member from participating in Medicare, Medicaid, or any other federal health care program;
- I. Report to the Chief of Staff and their Service Chief within 7 days of: (1) any reduction, suspension, revocation, or termination of their Clinical Privileges and/or membership, for medical disciplinary cause or reason, at another licensed health care facility or medical group; (2) any certifying or licensing agency's initiation of an investigation, accusation, action, or settlement, (3) any surrender of license or certification, or (4) any felony charge or conviction of a misdemeanor or felony;

2.9. Non-Compliance With Basic Qualifications

An Applicant, Member or Affiliated Professional applying for reappointment who does not meet these basic qualifications is ineligible to apply for Medical Staff membership or reappointment and the application will not be accepted for review. If it is determined during the review process that an Applicant does not meet all of the basic qualifications, the review of the application will be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee.

Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant complies with the basic qualifications for Medical Staff membership.

ARTICLE 3. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff is divided into Active, Courtesy, Provisional, Administrative, and Inactive Staff categories.

Deleted: shall be

3.1. Active Medical Staff

The Active Medical Staff consists of physicians, dentists, clinical psychologists and podiatrists qualified for Medical Staff membership who spend the majority of their clinical effort treating patients under the direction of a Clinical Service of the Medical Staff at the Hospital or DPH healthcare facilities. Members of the Active Medical Staff must be appointed to a specific Clinical Service and are eligible to vote, to hold Medical Staff offices, and to serve on Medical Staff committees. Active Medical Staff Members are required to participate in Clinical Service conferences, meetings, and continuous quality improvement.

Deleted: shall

Deleted: shall

Deleted: ,

Deleted: shall

Deleted: be

3.2. Courtesy Medical Staff

The Courtesy Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who do not spend the majority of their clinical effort, or who spend an average of less than 4 hours per week, treating patients under the direction of a Clinical Service of the Medical Staff. Courtesy Medical Staff Members must be appointed to a specific Clinical Service and may serve on Medical Staff committees. Courtesy Medical Staff Members are not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Courtesy Medical Staff Members are encouraged, but not required, to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of Service. Courtesy Medical Staff Members are required to participate in specific quality improvement activities that address their practice or involved them as a participant or witness.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Chief of the Clinical Service

3.3. Provisional Medical Staff

The Provisional Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have yet to complete initial proctoring requirements. Provisional Medical Staff Members must be appointed to a specific Clinical Service and may serve on Medical Staff Committees. Provisional Medical Staff Members are not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Provisional Medical Staff Members are required to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of Service. Provisional Medical Staff Members are required to participate in specific quality improvement activities that address their practice or involved them as a participant or witness.

Deleted: shall

Deleted: shall

Deleted: shall

Deleted: Chief of the Clinical Service

3.4. Administrative Medical Staff

The Administrative Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have a significant administrative medical role, have been granted access to Medical Records, and consult with other Members of

Deleted: shall

the Medical Staff but who do not have Clinical Privileges or provide direct care to patients. Administrative Medical Staff Members need not be appointed to a specific Clinical Service and are eligible to vote, to hold Medical Staff offices, and to serve on Medical Staff committees. Administrative Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness.

Deleted: ,

Deleted: ,

Deleted: shall

Deleted: be

3.5. Inactive Medical Staff

The Inactive Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who are missing one or more requirements to begin or continue practicing privileges. These requirements may include, but are not limited to, initial and annual hospital orientation and Environmental Health & Safety (EH&S) requirements such as TB testing and N95 fit testing. Inactive Medical Staff Members, when they have inactive status, are not eligible to vote, to hold Medical Staff offices, or to serve on Medical Staff committees. Inactive Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness.

Deleted: shall

ARTICLE 4. APPOINTMENT AND REAPPOINTMENTS

4.1. General

4.1.1. Application Process

All applications for appointment and reappointment to the Medical Staff or as an Affiliated Professional of the Medical Staff must be in writing, signed by the Applicant, and submitted to the Medical Staff Services Department (MSSD) on a form approved by the Governing Body, upon recommendation of the Credentials Committee.

4.1.2. Application Content

Every Applicant for appointment or reappointment must furnish a fully completed application, and has the burden of producing accurate and adequate information for a proper evaluation of the Applicant's current clinical competence, character, and ethics. Information in applications must include:

- A. Any previous denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment, whether voluntary or involuntary, to a professional license or DEA license;
- B. Voluntary or involuntary termination of Medical Staff membership or Affiliated Professional status, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or other health care organization;
- C. A factual synopsis of all pending and resolved professional liability actions, asserted or active within the previous five (5) years;
- D. For any resolved professional liability actions, a description of the judgment, arbitration award, settlement or other disposition; and
- E. Attestation responses regarding the following issues:
 - 1) Reason for an inability to perform essential functions of the position;
 - 2) Violations of any criminal law or statutes;
 - 3) Denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment of licensure; and
 - 4) Disciplinary activity or limitation of privileges and/or Medical Staff status.

4.1.3. Completion of Application

An application is "completed" when the Applicant has supplied all of the requested information and all necessary verifications have been obtained—including, but not limited to, current license, licensing board disciplinary records, specialty Board Certification status,

National Practitioner Data Bank (NPDB) information, DEA certificate, if appropriate, training and practice from professional school through the present, current malpractice liability insurance and history, and reference letters, as specified in subsection 4.2.2 (Completed Application), below.

4.1.4. Application Misrepresentation or Omission

Any significant misrepresentation or omission by an Applicant for appointment or reappointment is grounds for denial of the application or other appropriate corrective action, including revocation of Clinical Privileges and Medical Staff membership.

4.1.5. Effect of Application

By applying for appointment or reappointment to the Medical Staff, each Applicant:

- A. Signifies the Applicant's willingness to appear for interviews with the Medical Staff;
- B. Authorizes the Medical Staff to consult with Medical Staff Members, administrators, or other personnel of other health care facilities with which the Applicant has been associated and who may have information bearing on the Applicant's competence, character, ethical qualifications, relevant mental and physical health, and any claims history;
- C. Consents to the Medical Staff's inspection of all records and documents pertinent to the Applicant's current licensure, specific training, experience, current clinical competence and ability to perform the privileges requested and other matters that may be material to an evaluation of professional qualifications for Medical or Affiliated Staff membership;
- D. Releases from any liability the Hospital, the Medical Staff, the Governing Body, the City, and the University, for any acts performed in good faith and without malice in connection with evaluating the Applicant's credentials; and
- E. Certifies that the Applicant will promptly report to the MSSD any changes in the information submitted on the application which may subsequently occur.

4.1.6. Applicant's Right to Be Informed

Each Applicant has the right to be informed of the status of the Applicant's credentialing or recredentialing application upon request.

4.2. Initial Appointment Process

4.2.1. Applicant's Receipt of Medical Staff Information

The Applicant will be provided with a copy of, or access to, the Medical Staff Bylaws and Rules and Regulations, and Clinical Service Rules and Regulations governing the Applicant's specialty.

4.2.2. Completed Application

The completed application for initial appointment must include: detailed information concerning the Applicant's professional qualifications, including, but not limited to, education, professional training, experience, licensure, relevant physical and mental health, disciplinary history, claims history, information regarding possible involvement in professional liability actions, biographical data, requests for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate

licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations, specialty board status, University faculty appointment status, and employment status; a signed agreement that the Applicant has read and will abide by the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; and a signed statement of commitment to the confidentiality of all Medical Staff proceedings. It is the duty of the MSSD to provide an up to date copy of the Medical Staff Bylaws and the duty of the Clinical Service to provide an up to date copy of the Rules and Regulations to the Applicant for which the Applicant must attest.

4.2.3. Applicant's Burden and Incomplete Application

The Applicant has the burden of submitting complete, accurate, and adequate information for a proper evaluation of the Applicant's qualifications, including all requirements specified in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and the Rules and Regulations of the department in relation to which that Applicant is seeking to work. This burden includes the burden of resolving any doubts about these matters and of providing any additional information requested by the Chief of Service, Chief of Staff, MSSD, or the Chair of the Credentials Committee. This burden also includes the Applicant paying any costs associated with verifications where the MSSD does not have access to the verification at issue. This burden may include submission to a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the MEC and, for City employees, as consistent with City rules. The Applicant's failure to sustain this burden or the provision of information containing any misrepresentations or omissions is grounds for denial of the application or subsequent termination, suspension, or limitation of Membership or Privileges under these Bylaws.

An incomplete application may not be processed. If an Applicant fails to complete the application within sixty (60) days after the date of initial submission, it may be considered voluntarily withdrawn on the sixtieth day after initial submission. If, prior to such voluntary withdrawal, the MSSD discovers that an application is incomplete, it will provide notice to the Applicant and the Chief of Service (or their designee) of the incomplete application as soon as possible (and no later than thirty (30) days before the deadline). Such voluntary withdrawal does not entitle the Applicant to the rights set forth in these Bylaws. The Credentials Committee may, for a good cause, extend the time for completion of the application.

4.2.4. Recommendation for Medical or Affiliated Staff Membership, and Clinical Privileges

When the MSSD has received all necessary verifications, the completed application, all supporting documentation, and other relevant information (collectively the "File"), it will submit the File to the Chief of Service for review and recommendations regarding membership and Privileges. The Chief of Service will then forward their written recommendations to the Credentials Committee. If the Applicant is seeking privileges in more than one Clinical Service, then the File will be submitted to all applicable Chiefs of Service for written recommendations once all verifications are received.

4.2.5. Credentials Committee Review and Action

The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

4.2.6. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, through the Director of Health, that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges. When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

- A. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body, through the Director of Health.
- B. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.
- C. When the recommendation of the MEC is adverse to the Applicant in respect to appointment or specific Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it
- D. An Applicant who has received an adverse recommendation from the MEC as part of their initial appointment for privileges is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee and MEC.
- E. Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant should receive a favorable recommendation for Medical or Affiliated Staff membership.

4.2.7. Governing Body Review and Action

The Governing Body will act upon a favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights under Articles 6 and 7 of these

Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

- A. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.
- B. The final decision of the Governing Body must be made within forty-five (45) days of its receipt of the recommendation of the MEC. This final decision will be promptly forwarded to the MEC and the Applicant.
- C. The time periods set forth in this section are guidelines only, not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

4.3. Reappointment Process

4.3.1. Frequency

The Medical Staff must reevaluate Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical or Affiliated Staff and the continuation of Clinical Privileges.

4.3.2. Reappointment Application Process

At least one hundred twenty (120) days before the expiration of a Member's appointment, the MSSD must email the Member a reappointment application. Within thirty (30) days of the date the application was emailed, the Member must return the completed application to the MSSD, along with all required information and materials.

4.3.3. Recommendation for Reappointment

Within thirty (30) days of the completed application for reappointment, the MSSD must email the completed application to the Chief(s) of the Service(s) in relation to which the Applicant is requesting Privileges. Each Chief of Service for a Service in relation to which the Member requests or has exercised Privileges must review the Member's completed File and forward the Chief of Service's written recommendations to the Credentials Committee. The recommendations will include a statement that the recommendations are based on the Clinical Service's performance improvement information for the Medical Staff Member or Affiliated Professional, any professional liability claims, the Member's clinical activity, education, and training, and any other pertinent information. The Chief of Service(s) must return the application with written recommendation no less than sixty (60) days before the expiration of the Member's appointment.

In addition to the items listed in this subsection 4.3.3, each recommendation concerning reappointment of a Member and the Clinical Privileges to be granted upon reappointment must be based upon such Member's current professional performance including, but not limited to, ongoing Professional Practice Evaluation (OPPE) data, performance reviews, evidence of progression towards Board Certification or re-certification (if applicable), current competence, clinical or technical skills and judgment in the treatment of patients, ongoing practitioner specific continuous quality improvement evaluations, ethical conduct, attendance at Medical Staff

meetings and participation in Medical Staff affairs, compliance with these Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, results from the National Practitioner Data Bank inquiry, and mental or physical health that permits the Member to carry out the essential functions of the Member's Medical Staff category, Privileges, or Standardized Procedures with or without reasonable accommodation.

4.3.4. Credentials Committee Review and Action

The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

4.3.5. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges . When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

- D. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body.
- E. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.
- F. When the recommendation of the MEC is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it until after the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights set forth in Articles 6 and 7 of these Bylaws.

4.3.6. Governing Body Review and Action

The Governing Body will act upon favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, through the Director of Health, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural

rights under Articles 6 and 7 of these Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

- G. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.
- H. The final decision of the Governing Body must be made within forty-five (45) days after additional information is provided by MEC. This final decision will be promptly forwarded to the MEC and the Applicant.
- I. The time periods set forth in this section are guidelines only, and are not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

4.3.7. Term of Reappointment

Reappointments to any Medical Staff category will be for a maximum of two (2) years.

4.3.8. Failure to Return a Completed Reappointment Application

If the Member has not returned a completed reappointment application to the MSSD within thirty (30) days of the email required under subsection 4.3.2, above, then the MSSD will email a final reminder allowing a fifteen (15) day extension from the date of the reminder email. Failure of a Medical Staff Member or Affiliated Professional to return a completed application for reappointment at least seventy-five (75) days prior to the expiration of the Member's current term may result in automatic resignation of the Member's Privileges effective on the date the Member's current term expires. The respective Chief of Service will be notified in writing of the delinquent reappointment and pending termination. After the passing of the 15-day extension period and after the Chief of Service is notified, the MSSD will check with the Chief of Service regarding the status of the Member's Privileges, including regarding any discussion of submission of the reappointment application. If no progress has been made by the Member in addressing the reappointment application submission, the MSSD will forward information about the potential automatic resignation of the Member's Privileges to the Credentials Committee for review and a final decision regarding the automatic resignation. A Member who automatically resigns under this section will be processed as a reappointment if the Member submits a completed reappointment application within thirty (30) days from the date of termination.

4.3.9. Reapplication After Adverse Decision

An Applicant or Member who has received a final adverse decision regarding appointment, reappointment, membership, Privileges, or who has resigned after notice of an adverse recommendation or a final adverse decision, is not eligible to reapply to the Medical or Staff or for appointment as an Affiliated Professional for a period of two (2) years from the date of the final adverse decision or resignation. Thereafter, the Applicant may apply as a new

Applicant and must submit information to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

4.4. Access to Own Credentials File

Each Member will be provided with access to information in the Member's own credentials file subject to the following provisions:

- A. The Member may receive a copy of only those documents provided by or addressed to the Member as well as all Ongoing Professional Practice Evaluation and/or Focused Professional Practice Evaluation reports (OPPE and FPPE reports, respectively); and
- B. A summary of peer review information, committee findings, letters of reference, proctoring reports, and complaints will be provided to the Member by the Chief of Staff within thirty (30) days of receipt of such a request. Summaries of peer review materials will disclose the substance, but not the source, of the information.

4.5. Right to Request Corrections/Additions

Members may exercise the right to request corrections or additions to their credentials file following the protocol set forth below:

- A. Members have the right to add to the Member's own credentials file a statement responding to any information contained in the file;
- B. A Member may submit a written request to the Chief of Staff for the correction or deletion of information in the credentials file. Such requests must include a statement of the basis for the action requested;
- C. The Chief of Staff will recommend to the MEC whether or not to make the requested correction or deletion;
- D. The MEC will approve or deny the Chief of Staff's recommendation by a majority vote; and
- E. The Member will be notified by the Chief of Staff of the decision of the MEC. The decision of the MEC is final.

4.6. House Staff

House Staff are not eligible for Medical Staff membership.

4.7. Affiliated Professionals

4.7.1. General

- A. Affiliated Professionals are individuals who:
 - 1) Are employees of the City, or faculty or employees of the University, or functioning under an MOU approved by the MEC and Governing Body, and provide health services requiring them to exercise independent judgment within the area of the Affiliated Professional's professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State laws;
 - 2) Do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists; and

3) Belong to one of the following professional categories:

- Licensed Acupuncturists
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Nurse Practitioners
- Physician Assistants
- Clinical Pharmacists (PharmD)
- Optometrists
- Genetic Counselors.

- B. Although not eligible for Medical Staff membership, Affiliated Professionals are credentialed through the Medical Staff and are subject to general Medical Staff oversight.
- C. The clinical responsibilities of each Affiliated Professional must be set forth in privileges and standardized procedures developed by the Committee on Interdisciplinary Practice and approved by the Credentials Committee, MEC, and the Governing Body. Note that any reference in these Bylaws to privileges or standardized procedures for Affiliated Professionals includes both concepts as appropriate for the situation.

4.7.2. Role of Medical Staff

- A. Affiliated Professionals practice within the scope of the Affiliated Professional's licensure and as otherwise consistent with applicable Hospital and Medical Staff policies, procedures, or privileges. To the extent that state regulations require supervision of Affiliated Professionals beyond overall Medical Staff oversight, the additional supervisory relationship will occur as required by law.
- B. As employees of either the City or the University, Affiliated Professionals are recruited and hired through the usual personnel processes of each respective employing entity. Any clinical activity is contingent upon Medical Staff approval following the procedures set forth below.

4.7.3. Appointment

- A. Each Affiliated Professional who has been provisionally hired must submit an application to the MSSD for appointment to Affiliated Professional status. The Applicant must furnish all information required on the application form or reasonably requested by the Interdisciplinary Practice Committee, Credentials Committee, or the MEC. The Applicant has the burden of producing adequate information for a proper evaluation of competency, character, and ethics. An Applicant who fails to provide all requested information within thirty (30) days of the date of being notified of any deficiencies will be deemed to have withdrawn the application.
- B. An Applicant who is on the Office of Inspector General (OIG) Exclusion List is not eligible for appointment as an Affiliated Professional.
- C. An Applicant must possess a National Provider Identifier (NPI) or must have submitted an application for an NPI in order to be considered for appointment or reappointment as an Affiliated Professional.

- D. An Applicant must possess a DEA certificate or have submitted the application for a DEA certificate unless the Applicant will be working in an area where no medications are prescribed (such as Radiology or Pathology) or whose licensure does not allow prescribing medications.
- E. An Applicant must have enrolled in Medicare and received an enrollment confirmation letter, excluding PharmDs whose professional services are not reimbursed by Medicare and Nurse Practitioners hired prior to April 2004 without a master's degree.
- F. Nurse Practitioners hired by the City or University after April 2004 must have a master's degree in nursing and be board-eligible.
- G. The MSSD will forward the completed application to the Chair of the Interdisciplinary Practice Subcommittee of the Credentials Committee. The Interdisciplinary Practice Subcommittee will review the application and will forward the application together with its recommendation to the Credentials Committee.
- H. The Credentials Committee will review the application and make a recommendation to the MEC.
- I. The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Governing Body.
- J. The Governing Body will review the recommendation of the MEC and will make a decision whether to approve the Affiliated Professional.
- K. If the Governing Body denies the Applicant's admission to Affiliated Professional status, the Applicant is limited to the remedies set forth in the Grievance Procedures in the applicable Memorandum of Understanding. The Applicant is not entitled to any of the procedural rights set forth in these Bylaws.
- L. Services that require a privilege or standardized procedure may not be performed until the Applicant's credentials and privileges or appointment have been approved by the Medical Staff.
- M. An Affiliated Professional who is admitted to Affiliated Professional status is subject to a period of proctoring/evaluation under rules and procedures established by the relevant clinical service.
- N. By applying for Affiliated Professional status, the Applicant must comply with and agrees to the same provisions that apply to Applicants for Medical Staff membership set forth in the following Sections and subsections of these Bylaws:
 - a. Subsection 2.2.4 (Professional Liability Insurance);
 - b. Subsection 2.2.5 (Participation in Medicare, Medicaid and other Federal Health Care Programs);
 - c. Section 2.3 (Qualifications for Membership);
 - d. Section 2.5 (Harassment Prohibited);
 - e. Section 2.8 (Basic Responsibilities of the Medical Staff);
- O. Subsection 4.1.3 (Completion of Application);

- a. Subsection 4.1.4 (Application Misrepresentation or Omission); and
- P. Subsection 4.1.5 (Effect of Application).
- Q. Any material misrepresentation by an Applicant is grounds for denial of the application or for termination of Affiliated Professional status.

4.7.4. Reappointment

- A. The initial appointment to Affiliated Professional status will last for a maximum period of two (2) years.
- B. Each subsequent reappointment will be for a maximum two (2) year period.
- C. Prior to the end of each appointment or reappointment period, the MSSD will provide the Affiliated Professional with an application for reappointment, and the application for reappointment must be submitted and processed according to the same procedures as for the initial appointment and is subject to the same restrictions.

4.7.5. Corrective Action

- A. Any corrective employment action against an Affiliated Professional must be done in accordance with the procedures set forth in the applicable City or University employment Memorandum of Understanding (MOU) or other applicable employment policies and rules. The Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.
- B. In the event that immediate action is necessary to prevent imminent danger to the health or safety of any individual, the Affiliated Professional's right to perform some or all duties set forth in their Job Description may be suspended immediately, in accordance with the procedures set forth in the applicable MOU. In addition, any clinical privileges or standardized procedures exercised by an Affiliated Professional that is overseen by the Medical Staff may be addressed by the Medical Staff using concepts similar to those listed in Article 6 (Corrective Action) of these Bylaws at the discretion of the Chief of Staff or MEC without affording the Affiliated Professional any procedural rights listed in Article 6. Similarly, the Chief of Service may, in consultation with the Chief of Staff, address allegations of inappropriate behavior by Affiliated Professionals using the concepts listed in this subsection 6.2.2, although there are no specific requirements of using any specific concept or process listed in this section. An Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.

ARTICLE 5. CLINICAL PRIVILEGES

5.1. Clinical Privileges

5.1.1. Process

Members and Affiliated Professionals are entitled to exercise only those Clinical Privileges specifically granted to them by the Governing Body except as provided in Section 5.2 herein regarding temporary privileges, or to practice within Standardized Procedures. The granting of Privileges or Appointment with Standardized Procedures depends upon an individual's documented experience in categories of diagnostic and treatment areas and current competence as judged by ongoing continuous quality improvement reviews. The Rules and Regulations of each Clinical Service specify the Clinical Privileges for that Service.

Clinical Privileges or appointment with Standardized procedures are required for the provision of telehealth services. Specific privileges may cover the provision of both in-person and telehealth services. Privileges or standardized procedures for Members or Affiliated Professionals who provide only telehealth services are subject to the same requirements that apply to all privileges.

5.1.2. Education, Training and Experience

Every initial application for Medical Staff or Affiliated Professional appointment must contain a request for specific Clinical Privileges desired by the Applicant. The evaluation of such requests must be based upon the Applicant's documented education, training, experience and demonstrated competence, University faculty appointment (if applicable), references, and other relevant information, including a recommendation by the Chief of Service in which such Privileges are sought. The Applicant has the burden of demonstrating qualifications and competency in the requested Clinical Privileges or Appointment as an Affiliated Professional.

5.1.3. Evaluation

Ongoing monitoring of Clinical Privileges is based on a variety of modalities which can include but not be limited to direct observation of the care provided, review of medical records, and other peer review activities.

5.2. Temporary Appointments with Clinical Privileges

5.2.1. Pending Application for Permanent Medical or Affiliated Staff Membership

- A. In the event that there is a compelling patient care need which the Chief of Service could not have anticipated, the Chief of Staff in consultation with both the CEO (or designee) and the Chair of the Credentials Committee, may grant temporary appointment with Privileges to an Applicant who has a Clean Application ~~Credentials~~ and is pending the next meeting of the Governing Body for final approval.
- B. No person with Temporary Privileges or Affiliate status may vote or hold office.
- C. Temporary Privileges or Temporary Affiliate status may be granted for a period not to exceed sixty (60) days.

5.2.2. Application and Review

The Chief of Staff, with the concurrence of the Chief Executive Officer, may grant Temporary Privileges or Temporary Affiliate status after the following has been completed:

- A. The Chair of the Credentials Committee has determined that the Applicant has a "Clean Application" as defined in the Definition section of these Bylaws.
- B. The Chief of Service provides the Chief of Staff with a compelling patient care need that could not have been anticipated and that requires that the services of the Applicant begin before the application can be approved at the next meeting of the Governing Body.

5.2.3. General Conditions

- A. There is no right to Temporary Privileges or Temporary Affiliate Status. They may be granted at the sole discretion of the Chief of Staff only after a Clean Application has been approved by the Chair of the Credentials Committee .

- B. A determination to grant Temporary Privileges or Temporary Affiliate Status is not binding or conclusive with respect to an Applicant's pending request for appointment to the Medical or Affiliated Staff.
- C. In exercising Temporary Privileges or Standardized Procedures, the Applicant will act under the supervision of the Chief of Service, or designee, to whom the Applicant is assigned and will be proctored and monitored in accordance with the Clinical Service Rules and Regulations and the proctoring provisions set forth in these Bylaws.
- D. Temporary Privileges or Temporary Affiliate Status will not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.
- E. Temporary Privileges or Temporary Affiliate Status will not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by the Bylaws.
- F. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate any or all of the Temporary Privileges or Standardized Procedures granted. In such an event, the Member Applicant is not entitled to the procedural rights set forth in Article 6 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.

5.3. Visiting Privileges

5.3.1. To Meet a Specific Need

- G. Visiting Privileges may be granted for a specified period of time, not exceeding ninety (90) days, on a case-by-case basis when a patient (or patients) of a Clinical Service requires the services of a physician, dentist, podiatrist, clinical psychologist or Affiliated Professional who is not a Member of the Medical or Affiliated Staff. If the individual with Visiting Privileges desires to join the Medical Staff, the individual must submit an application as a new appointment. No person with Visiting Privileges may vote or hold office. (Note: ZSFG Administrative Policy 22.06 refers to this position as "Consulting Clinical Physician".) The Chief of Staff, with the concurrence of the Chief Executive Officer, may authorize Visiting Privileges if:
 - 1) The person has submitted a completed application for Visiting Privileges or Affiliated Professional Status;
 - 2) The Chief of Staff reasonably believes that the person has the qualifications, ability, and judgment required for Medical or Affiliated Staff membership;
 - 3) The Chief of Service requiring a person's services recommends the person; and
 - 4) The Chief of Service has provided, in writing, the clinical need for granting such Privileges.

5.3.2. General Conditions

- A. In exercising Visiting Privileges, the Applicant must act under the supervision of the Chief of Service, to which the Applicant is assigned.

- B. Visiting Privileges or Affiliate Status must not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.
- C. Visiting Privileges or Affiliate Status will not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by them.
- D. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate the Visiting Privileges or Affiliate Status. In such an event, the practitioner is not be entitled to the procedural rights set forth in Articles 6 and 7 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.
- E. The Chief of Staff will present the candidate to the Governing Body for approval with a rationale regarding why Visiting Privileges or Affiliate Status should be granted.
- F. All requirements of ZSFG Administrative Policy 22.06 (including as it is amended in the future) must be met.

5.4. Emergency Situations and Privileges or Affiliate Status

5.4.1. Emergency Situations When More Qualified Healthcare Personnel Are Not Available

In the event of an emergency, any qualified Member or Affiliated Professional is allowed to do everything reasonable to save the life of a patient or to save a patient from serious harm. The Member or Affiliated Professional must promptly yield such care to more qualified healthcare personnel when available.

5.4.2. Emergency Situations Pertaining to a Single Patient or a Few Patients

In the event of an emergency or critical situation where no Member or Affiliated Professional possesses the expertise necessary to save the life of a patient or to save a patient from serious harm, the Chief of Staff may grant emergency Privileges or Affiliate Status to a licensed Practitioner, who has an academic appointment with the University and who possesses the requisite qualifications and expertise to treat the patient or a few patients, at the discretion of the Chief of Staff. In the event that no qualified Practitioner with an academic appointment at the University is available within the necessary clinical time frame, the Chief of Staff may grant emergency Privileges or Affiliate Status to a Practitioner with a license recognized by the state of California who possesses the requisite qualifications and expertise to treat the patient(s). Care provided under emergency Privileges or Affiliate Status will be documented in the hospital medical record related to each patient treated by that Practitioner, and a record of the Practitioner's emergency Privileges or Affiliate Status will be maintained by the MSSD, including the Practitioner's name and license, the name and medical record number of any patients treated by that Practitioner, and the dates of service. MSSD will perform primary source verification of the medical license and verification of malpractice coverage as soon as possible.

5.4.3. General Emergency Situations

General emergency situations may arise due to a disaster, such as an earthquake, weather emergency, or fire, due to an infectious disease, due to an extreme staffing shortage, or due to other circumstances. Any time such a general emergency situation arises, including but not limited to any time the Hospital activates its Emergency Management Plan, Members and Affiliated Professionals who are qualified based on training or experience may perform expanded roles outside the scope of their normal Privileges or Standardized Procedures at the discretion of the Chief of Staff in consultation with leadership from the affected clinical service areas without requiring that new Privileges be granted. The clinical services being supported by such qualified Members and Affiliated Professionals will provide any additional orientation or training that is necessary and ongoing supervision and oversight of the Practitioner during the emergency. Services provided in relation to such general emergency situations are subject to the following requirements based on the duration of the emergency:

A. Emergency Privileges or Affiliated Status for Service Less than One Month

- 1) In the event Practitioners present themselves to the Hospital during an emergency, including but not limited to when the Hospital activates its Emergency Management Plan, and the Hospital is unable to handle the immediate patient needs, Emergency Privileges or Affiliated Status may be granted by the Chief Executive Officer, the Chief of Staff, the Chief Executive Officer's designee(s), or the Chief of Staff's designee(s) to Practitioners for services less than one month in duration upon presentation of the following information, with a record to be kept by the MSSD when feasible:
 - a. A valid government-issued photo identification card such as a driver's license or a passport, and
 - b. At least one of the following:
 - i. A copy of a current license to practice;
 - ii. Primary source verification of licensure;
 - iii. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
 - iv. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in emergency circumstances; or
 - v. Confirmation by a Member or an Affiliated Professional with personal knowledge of the volunteer Practitioner's ability to act as a licensed independent Practitioner during an emergency.
- 2) During the emergency, the Medical Staff will oversee the performance of each Practitioner who has been granted emergency privileges or Affiliated Status. Based on its oversight of such Practitioner, the Medical Staff will determine within seventy-two (72) hours, and on an ongoing basis as needed after that, of the Practitioner's arrival if the emergency privilege should continue. Practitioners granted emergency Privileges or Affiliated Status must document the care they provide in a manner similar to Members of the Medical Staff when feasible.

- 3) Primary source verification of licensure and confirmation of malpractice coverage must occur as soon as the emergency is under control or within seventy-two (72) hours from the time the Practitioner presented to the Hospital, whichever comes first. If verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances, the following must be documented and maintained by the MSSD:
 - a. The reason(s) verification could not be performed within seventy-two (72) hours;
 - b. Evidence of the Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and
 - c. Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

Primary source verification of licensure is not required if the Practitioner has not provided care, treatment, or services under the emergency Privileges or Standardized Procedures.

- 4) When additional assistance is required by a clinical service due to an extreme staffing shortage and an outside Practitioner is identified who can capably perform the required duties, the Chief of Staff may grant emergency Privileges or Affiliate Status to be overseen by the clinical service and Chief of Service or the Chief of Service's designee. The MSSD will keep a record confirming the Chief of Service's or designee's agreement to the appointment and attestation that the Practitioner can adequately perform the necessary clinical care. The MSSD will determine the source of the Practitioner's malpractice coverage, the Practitioner will be granted access to the Hospital's medical record system, and the Practitioner will be given Hospital identification.

B. Emergency Privileges or Affiliate Status for Service More than One Month

The Medical Staff or Affiliated Professionals will use Emergency Privileges or Standardized Procedures using the procedures described above for emergency service less than one month. Once Hospital Leadership or the Chief of Staff determine that emergency service will be needed for more than one month, the Medical Staff will, within one month of emergency Privileges or Affiliate Status being granted to the practitioner, request that the practitioner apply for regular Hospital Privileges or Affiliate Status. If the practitioner declines to apply for regular Privileges or Affiliate Status, the Chief of Staff or designee may extend Emergency Privileges or Affiliate Status for a maximum of three additional months, for a total of no longer than four months of emergency privileges for that practitioner in most situations. The Chief of Staff may extend emergency privileges to cover the time period while the application for regular Hospital privileges is in process, which should not generally exceed three months from the time the practitioner submits the application. For Emergency Privileges or Affiliate Status longer than one month, the Chief of Staff will update the Governing Body of such Emergency Privilege or Affiliate Status.

5.5. Visiting Physicians and other Categories of Practitioners

ZSFG Administrative Policy 22.06 "Visiting Physicians" (see Appendix 2) defines "Consulting Clinical Physician", "Consulting Academic Physician", "Physician Observer", and "Visiting Research Physician". Physicians in these roles and Practitioners who would fall within

the category of Affiliated Staff do not have Privileges or Standardized Procedures unless specifically granted under Section 5.3, above, may not direct patient care, do not have access to medical records, and must follow all requirements of ZSFG Administrative Policy 22.06.

for their specific category regarding:

- A. Their role in interacting with the patient and Members.
- B. Maintenance of professional liability coverage must be either through their primary institution or own insurance company.
- C. Sponsorship by the Chief of the sponsoring Clinical Service, or for Visiting Research Physicians, the Principal Investigator with the consent of the Chief of Service.
- D. Immunizations—if in patient care settings, must meet same requirements as clinical staff.
- E. Orientation as applicable for the specific category.
- F. Identification badges if in patient care areas.
- G. Required patient consent if interacting with or observing patients.

5.6. Proctoring

5.6.1. General

All new appointees to the Medical and Affiliated Staff and existing Members requesting additional Privileges or Standardized Procedures, regardless of specialty or category of membership, will be assigned a Proctor by the Chief of Service and complete a period of proctoring, as defined in subsection 5.6.4, below.

The Proctor must have unrestricted Privileges or Standardized Procedures to perform the evaluation(s) that the Proctor will conduct. The Chief of Service will submit a form to the Credentials Committee attesting to the satisfactory completion of proctoring. Documentation of the proctoring will reside in the Clinical Service Office.

5.6.2. Function and Responsibility of the Proctor

- H. The Proctor is responsible for evaluating the practitioner's clinical competence for the requested privileges or standardized procedures.
- I. The Proctor's primary responsibility is to evaluate the Proctoree's performance. However, if the Proctor believes intervention is warranted in order to avert harm to a patient, the Proctor may take any action the Proctor finds reasonably necessary to protect the patient.

5.6.3. Responsibility of the Proctoree

The Proctoree is responsible for notifying one of the assigned Proctors for each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the Proctoree is responsible for arranging the time of the procedure with the Proctor.

5.6.4. Proctoring Duration

Proctoring will be deemed successfully completed when the Proctoree completes the proctoring as described in the Clinical Service Rules and Regulations. Proctors may begin proctoring upon initial granting of Privileges or Affiliate Status with the goal of completing

proctoring within the first six months after the initial grant, but in any case must complete proctoring within the first twelve (12) months of initial granting of new Privileges or Affiliate Status .

For Privileges or Standardized Procedures that are infrequently performed by the Member, the Chief of Service may submit a written request to the Credentials Committee to expand the proctoring period. Alternatively, the Chief of Service may request that proctoring occur at another accredited hospital. These Privileges or Standardized Procedures must be voluntarily relinquished or withdrawn if proctoring is not completed within twenty-four (24) months of the initial granting of the infrequently performed Privileges or Standardized Procedures unless the MEC and the Governing Body approve an extension.

5.6.5. Reciprocal Proctoring

Reciprocal proctoring is proctoring that is performed by non-Hospital Members at sites other than the Hospital. Reciprocal proctoring may be accepted when no Hospital Members who possess the necessary expertise are available to proctor a specific skill or procedure. Only such specific skills or procedures may be reciprocally proctored; all other elements of the Applicant's practice must be proctored by a Medical or Affiliated Staff Member of the Hospital.

Requirements for reciprocal proctoring are as follows:

- J. The reciprocal Proctor is an active member of the medical or affiliated staff at another accredited hospital;
- K. The reciprocal Proctor possesses unrestricted Privileges to perform the procedure for which the proctoring is being performed; and
- L. The Chief of Service has approved the reciprocal proctoring arrangement and the reciprocal Proctor.

For each case that is reciprocally proctored, the reciprocal Proctor must complete a Hospital proctoring form and submit it to the Clinical Service. The Clinical Service will submit an evaluation summary to the Credentials Committee.

MEDICAL STAFF BYLAWS

ARTICLE 6. MONITORING AND CORRECTIVE ACTION

6.1. Routine and Issue-Related Monitoring

6.1.1. Routine Monitoring and Education, Including Verbal and Written Counseling

Responsibilities of the Chiefs of the Clinical Services include:

- A. Ensuring the quality of patient care rendered by their service and maintaining professional standards of behavior among Members and Affiliated Professionals (Practitioners) of their service. Academic performance or University employment are University matters and City employment is a City matter, and those matters are not addressed in these Bylaws.
- B. Quality of Patient Care - Education, Monitoring and Investigation and Response to Concerns Identified.
- C. Carrying out peer review and quality improvement functions for their service. The Chief of Service may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner will be given an opportunity to respond in writing and to discuss the matter with the Chief of Service. The Chief of Service will maintain documentation of any informal actions, monitoring, or counseling.

6.1.2. Focused Professional Practice Evaluation

- A. The Focused Professional Practice Evaluation (FPPE) is a process required by the Joint Commission for evaluation by the Medical Staff of the privilege-specific competence of the Practitioner who does not have documented evidence of competently performing the requested privilege(s) at the Hospital, whether at the time of application or on reappointment. Per the Joint Commission, this process may also be used when a question arises of a currently-privileged Practitioner's ability to provide safe, high quality patient care. The FPPE occurs for a limited time period during which the Medical Staff evaluates the Practitioner's professional performance. There are two types of FPPE: Proctoring FPPE and Secondary FPPE. [

- B. Proctoring, which is outlined in Section 5.6 above, is Initial FPPE. Proctoring FPPE is required for all new privileges and standardized procedures. This includes privileges and standardized procedures requested by new applicants and all newly-requested privileges and standardized procedures for existing Practitioners. There is no exemption based on board certification, documented experience, or reputation. A Provisional Medical Staff Member or Affiliated Professional who is undergoing Proctoring FPPE will remain in provisional status until the Proctoring FPPE is completed successfully.
- C. Secondary FPPE, the second type of FPPE, is required when an issue regarding patient care or any other clinical or practice concern by a Practitioner is identified and requires more than a verbal warning but does not rise to the level of a corrective action investigation.
- D. The outcome of each type of FPPE must be documented as outlined in subsection 5.6.1 above.
- E. In addition, Secondary FPPE will always include a written summary submitted to the Credentials Committee at the time the issue is identified and the Secondary FPPE period begins. This written summary will include: the issue identified; a description of the counseling and/or training used; the method of monitoring; a target date for closure; and a final outcome/metric to be achieved for successful completion of the Secondary FPPE. At the target date for closure the assigned Proctor will submit a report to the Credentials Committee to determine closure or the need for continued monitoring. The Credentials Committee has sole power to determine whether the Secondary FPPE has been successfully completed, to extend the Secondary FPPE, or to recommend other appropriate action. Other Corrective Action may be initiated as otherwise outlined in this Article 6.
- F. Although Initial and Secondary FPPE are focused on education and improvement, any issues addressed during either type of FPPE, including but not limited to recurring issues and the failure to successfully complete Secondary FPPE, can be considered progressive steps in the Medical Staff's efforts to address performance, clinical quality, professionalism, and other issues. Information obtained from the FPPE process may also be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information. Such information may also be shared with UCSF (for UCSF employees) or City Human Resources (for City employees), as appropriate, when a problem warrants a separate investigation for potential discipline.

6.1.3. Ongoing Professional Practice Evaluation (Maintaining Privileges)

- A. The Ongoing Professional Practice Evaluation (OPPE) is a process required by the Joint Commission regarding maintaining privileges of the Medical Staff at the Hospital and serves as an ongoing monitoring system for competence and professionalism of individual Medical Staff Members and Affiliated Professionals (Practitioners). Each Practitioner will be reviewed in their respective department on a periodic basis. Per the Joint Commission, this process involves identification of professional practice trends that impact quality of care and patient safety, and such identification may require intervention

by the Medical Staff. The Joint Commission standard lists criteria that may be considered during the OPPE and possible sources of information

- B. The OPPE process occurs on the schedule maintained by the Credentials Committee in coordination with the MSSD. The OPPE process will always include a written summary submitted by the department to the Credentials Committee to include: the OPPE plan for the department; a description of the metrics selected by the department for the review; the method of monitoring; and a final outcome/metric to be achieved for successful completion of the OPPE. At the target date for closure the department will submit a report to the Credentials Committee regarding the outcome of the review. The Credentials Committee has sole power to determine whether the OPPE has been successfully completed, to extend the OPPE, or to recommend other appropriate action regarding any Practitioner who fails to show appropriate competencies. Moreover, two consecutive unsatisfactory or three consecutive marginal ratings in any metric will always require the department to initiate an FPPE.
- C. Information obtained from the OPPE process may be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information.
- D. If there is uncertainty regarding the Practitioner's professional performance, the Medical Staff should refer the issue for further evaluation of the Practitioner under these Bylaws.

6.2. Professional Standards of Behavior

6.2.1. Professional Conduct

The Chiefs of Clinical Services are responsible for monitoring the professional behavior of Practitioners of their service and addressing inappropriate behaviors as described in the Hospital institution-wide Code of Professional Conduct Policy.

Expected behaviors of Members of the Medical Staff and Affiliated Professionals:

- A. All Members and Affiliated Professionals are expected to practice with professionalism and respect towards patients, colleagues, and others, including ensuring a high quality of services rendered and that care meets professional expectations. All Practitioners are expected to maintain professional communication and confidentiality, and to promptly address improvement expectations communicated through Medical Staff, human resources, or other avenues.
- B. Examples of inappropriate behaviors include, but are not limited to, the following:
 - 1) Shouting or using vituperative language;
 - 2) Use of profanity directed at an individual;
 - 3) Slamming or throwing objects;
 - 4) Physical or verbal intimidation, harassment and/or violence;
 - 5) Hostile, condemning, or demeaning communications;
 - 6) Derisive, insulting, or demeaning criticism of performance;

- 7) Deliberate failure to abide by Hospital, Medical Staff, departmental or committee bylaws, policies and procedures, or directives, including but not limited to, refusal to comply with required duties;
- 8) Behavior inappropriate to the delivery of quality patient care; and
- 9) Retaliation against any person who addresses or reports incidents of unacceptable behavior.

Expressing contrary opinions is not disruptive conduct, nor is expressing concern regarding constructive criticism of existing policies or procedures or questioning potentially unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any individual.

6.2.2. Investigation in Response to Alleged Inappropriate Behavior

- A. Alleged violations of these Bylaws, other relevant policies, or the Code of Professional Conduct may be reported by any Hospital personnel using the confidential and Evidence Code §1157-protected Safety And Feedback Events (SAFE) reporting form maintained by the Quality Management Department and designed for this purpose, or reported in writing to a direct supervisor, the Chief of Service, or the Chief of Staff. Confidentiality will be maintained throughout the investigation of the alleged behavior and for any counseling, warning, disciplinary action, appeal, or hearing resulting from the investigation. The Chief of Service or designee will inform the person allegedly demonstrating inappropriate behavior of the report, and that person will have the opportunity to respond to or refute the allegations. If the investigation finds that the allegation does not meet the level of inappropriate behavior in violation of these Bylaws, applicable policies, or the Code of Professional Conduct, the report will be closed and dismissed. Dismissed reports will not be considered in determinations of recurrent inappropriate behaviors.
- B. The Chief of Service will conduct an initial investigation within one (1) week of becoming aware of the issue. When the Chief of Service is the subject of the alleged behavior, the Chief of Staff will conduct the investigation. The Chief of Service may discuss the event with the affected Member or Affiliated Professional. The Chief of Service or Chief of Staff will take appropriate action based on the following guidelines:
 - 1) Dismissed/No Action: The alleged behavior does not meet the level of inappropriate behavior in violation of these Bylaws, applicable policies, or the Code of Professional Conduct. The Chief of Service will report this outcome to Risk Management, including a brief explanation of why the alleged behavior did not meet the level of inappropriate behavior. The UO report will be recorded as “dismissed.” No further action will be taken.

- 2) Meeting for Resolution: The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the involved parties. The Chief of Service may convene and facilitate a face-to-face meeting for resolution between the Member or Affiliated Professional (Practitioner) and the affected party. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chief of Service will notify Risk Management of the outcome of the Meeting for Resolution.
- 3) Verbal Counseling: The behavior had the potential to adversely affect patient care and is a first confirmed inappropriate behavior event for the Practitioner. The Chief of Service will verbally counsel the Practitioner when an instance of inappropriate behavior warrants such counseling. The verbal counseling will emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the Corrective Action procedures or as allowed by these Bylaws. The Chief of Service will create a written record of the verbal counseling, including the expectations, action plan, and consequences of repeat behavior of a similar nature (which will include written counseling) communicated to the Practitioner. A Practitioner also may be directed by the Chief of Service to issue an apology to the involved party or parties. The Chief of Service will maintain documentation of the counseling and notify Risk Management of this outcome.
- 4) Written Counseling: The behavior had the potential to adversely affect patient care and is sufficiently serious to make verbal counseling insufficient or inappropriate, or it represents recurrent inappropriate behavior that previously was addressed with verbal counseling. The Chief of Service will meet with the Practitioner and write a formal letter that sets forth the serious nature of the inappropriate behavior, reiterates any previous verbal counseling in relation to similar inappropriate behavior exhibited by the Practitioner, emphasizes the responsibility of Practitioners to treat all persons at the Hospital courteously, respectfully, and with dignity, and informs the Practitioner that future similar conduct may result in referral of the matter to the MEC for possible Corrective Action. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature. The Chief of Service may also direct the Practitioner to issue an apology to the involved party or parties. The Chief of Service will send a copy of the written counseling to the Chief of Staff, the Vice Dean, and the MSSD for inclusion in the Practitioner's peer review (credentials) file. The Practitioner may submit a letter of rebuttal that will be placed in the Practitioner's peer review file. The Chief of Service will report this outcome to Hospital and UCSF ZSFG Risk Management.
- 5) Action Plans may include remedial education, referral for psychological evaluation and treatment, referral for anger management counseling, or other professional assistance programs. The Chief of Service is encouraged to consult with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer in determining the appropriate plan of action. The Chief of Service, in consultation with the Chief of Staff, Vice Dean, Chief Medical Officer and/or

Chief Executive Officer as appropriate, may revise the level of action after further information is obtained in the course of investigation and counseling.

- 6) Reporting: The Chief of Staff will report aggregate data on Code of Professional Conduct issues to the MEC no less than annually. The identity of individual Practitioners will not be disclosed in these reports.
- 7) Progressive Discipline: While, in general, progressive corrective action interventions are appropriate, there is no prescribed number or order of corrective interventions to address remediation. The choice of corrective action intervention is left to the determination of the Chief of Service or Chief of Staff

6.2.3. Medical Executive Committee Approval is not Required and Procedural Rights are not Triggered

The approval of the MEC is not required for actions taken by the Chiefs of Service as set forth in Section 6.2 of these Bylaws, nor do such actions give rise to procedural rights for the Practitioner as set forth in Article 7 herein.

6.3. Corrective Action Investigations

6.3.1. Criteria for Initiation of Corrective Action

A corrective action investigation may be initiated whenever reliable information indicates that a Practitioner may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that are reasonably likely to be any of the following:

- C. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;
- D. Unethical;
- E. Contrary to these Bylaws and/or the Medical Staff Rules and Regulations;
- F. Below applicable professional standards;
- G. Detrimental to Medical Staff or Hospital operations; and/or
- H. Inappropriate behavior of sufficient seriousness or a documented pattern of inappropriate behavior as defined as more than two (2) incidents warranting verbal or written counseling within a two (2) year period or more than two (2) incidents .

6.3.2. Initiation of Corrective Action

- A. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer.
- B. If the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer determines that Corrective Action may be warranted under this Article 6. of these Bylaws, that person or entity may request the initiation of a formal Corrective Action Investigation or may recommend particular Corrective Action. Such requests must be conveyed to the MEC in writing. The MEC

may conduct an informal review of the matter to determine whether an investigation is warranted.

- C. The Chief of Staff will notify the Chief Executive Officer and the MEC and will continue to keep them fully informed of all action taken. In addition, the Chief of Staff will promptly forward all necessary information to the committee or person that will conduct any Investigation, as that term is defined in subsection 6.3.3.

6.3.3. Formal Investigation

- A. If the MEC concludes that a formal investigation (an “Investigation”) is warranted, it will direct an Investigation to be undertaken. The MEC may conduct the Investigation itself, may assign the Investigation to an officer of the Medical Staff or a standing committee of the Medical Staff, or may appoint an ad hoc committee to conduct the Investigation. The person or group conducting the Investigation is referred to as the “Investigator.”
- B. The affected Practitioner will be given an opportunity for an interview during the course of the Investigation to discuss or refute the charges or, in the discretion of the Investigator, to otherwise provide input regarding the Investigation. Such an interview does not constitute a “hearing” as the term is used in Article 7 of these Bylaws, and none of the procedural rights under Article 7 of these Bylaws will apply to the interview or the Investigation.
- C. The Investigation will proceed in a prompt manner, and the Investigator must maintain a written record of its proceedings.
- D. The Investigator must determine whether the Practitioner has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Practitioners.
- E. The Investigator must forward a written report of the Investigation to the MEC within fifteen (15) days of completion of the Investigation. The report must include findings of fact and recommendations for appropriate corrective action, if any. The deadline for submission of the written report may be extended by the MEC for good cause.
- F. If the MEC concludes action is indicated, but no further Investigation is necessary, it must proceed to take action.

6.4. Corrective Action

6.4.1. Medical Executive Committee Action

Within fifteen (15) days of receipt of the written report of the Investigation, the MEC will take action that may include, without limitation:

- A. Determining that additional information is needed, in which case MEC will direct how that information will be obtained for consideration by the Investigator or MEC.
- B. Determining no corrective action be taken. If the MEC determines there was no credible evidence for the complaint, any adverse information included in the complaint must be removed from the Practitioner’s credentials file.
- C. Deferring action for a reasonable time when circumstances warrant.

- D. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein precludes department or committee chairs from issuing informal written or oral warnings outside of the mechanism for Corrective Action. In the event such letters are issued, the affected Practitioner may provide a written response that will be placed in the Practitioner's file.
- E. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff Practitionership or exercise of Clinical Privileges or Standardized Procedures, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring. *
- F. Recommending reduction, modification, suspension or revocation of Clinical Privileges or Affiliate Status. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended must be stated. *
- G. Recommending suspension, revocation or probation of Medical Staff membership or affiliation (i.e. revocation of Clinical Privileges or Affiliate Status, or limiting Standardized Procedures). If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended must be stated. *
- H. Taking other actions deemed appropriate under the circumstances.

** Actions reported to the Practitioner's professional licensing organization (such as the Medical Board of California) and entered into the National Provider Data Bank.*

The date for taking action may be extended by the MEC for good cause.

6.4.2. Procedural Rights

- A. When No Corrective Action is Required or a Letter is Issued or Non-Reportable Action is Taken

If the MEC determines that no corrective action is required, that only a letter of warning, admonition, reprimand, or censure should be issued, or that other action is to be taken that is not reportable to the Member or Affiliated Professional's professional licensing organization, the decision will be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body must give great weight to the MEC's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC, and the MEC still has not acted. The decision becomes final if the Governing Body affirms it or takes no action on it within seventy (70) days after receiving the Notice of Decision.

- B. When Corrective Action Requiring a Hearing is Recommended

If the MEC recommends an action that is a ground for a hearing under Section 7.2 of these Bylaws, the Chief of Staff will give the Practitioner Notice of the adverse recommendations and of the right to request a hearing in accordance with Section 7.3 of these Bylaws. In the case of Members of the Medical Staff, the Governing Body may be informed of the recommendation, but will take no action until the Member has either waived the Member's right to a hearing or completed the hearing. Affiliated Professionals do not have the right to request a hearing per these Bylaws Section 4.7.5

6.4.3. Initiation of Governing Body Action

If the MEC fails to investigate or take corrective action, contrary to the weight of the evidence, the Governing Body may direct the MEC to initiate investigation or corrective action for any Member or Affiliated Professional, but only after written notice to the MEC. If the MEC fails to take action in response to the Governing Body's direction, the Governing Body may initiate investigation and corrective action, but this corrective action must comply with these Bylaws. The Governing Body must inform the MEC in writing of such action.

6.4.4. Other Action

Nothing in this Article 6 or elsewhere in these Bylaws is intended to limit the University's or City's ability to take appropriate action with respect to employment. The University and the City have their own processes for employee discipline or other issues that are separate and distinct from processes under these Bylaws. To the extent that the University or City take action against their own employees through their respective processes, such processes include appropriate due process protections.

6.5. Summary Action

6.5.1. Criteria for Initiation

- A. Whenever the Member's or Affiliated Professional's conduct is such that a failure to take action may result in imminent danger to the health or safety of any individual, the Chief of Staff, the MEC, or the Chief of Service in which the Practitioner holds Privileges may summarily restrict or suspend the Medical Staff membership, Clinical Privileges, or Affiliate Status of such Practitioner.
- B. Unless otherwise stated, such summary restriction or suspension ("Summary Action") becomes effective immediately upon imposition, and the person or body responsible will promptly give written notice generally describing the reasons for the action to the Practitioner, and notice to the MEC, the Chief Executive Officer, and the Governing Body.
- C. The Summary Action may be limited in duration and will remain in effect for the stated period or until resolved as set forth in these Bylaws. Unless otherwise indicated by the terms of the summary action, the Chief of the involved Clinical Service will make the necessary arrangements to provide alternate coverage for proper and necessary patient care during the period of restriction or suspension.
- D. The notice of the Summary Action given to the MEC constitutes a request to initiate corrective action, and the procedures set forth in Article 6 of these Bylaws must be followed.

6.5.2. Medical Executive Committee Action

The affected Member may request an interview with the MEC. The interview must be convened as soon as reasonably practicable under the circumstances but in no event less than seven (7) days after the Summary Action was taken. The interview does not constitute a hearing, as that term is used in these Bylaws, and none of the procedural rights under Article 7 of these Bylaws apply to Summary Actions. The MEC may thereafter continue, modify, or terminate the terms of the Summary Action. It will give the Member written Notice of its decision, which

must include the information specified in Section 7.3 of these Bylaws if the action constitutes grounds for a hearing.

6.5.3. Procedural Rights

Unless the MEC terminates the Summary Action, it remains in effect during the completion of the corrective action and hearing and appellate review process. When a Summary Action is continued, the affected Member is entitled to the procedural rights set forth in Article 7 these Bylaws, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within forty (40) days after the hearing on the Summary Action was requested.

6.5.4. Initiation of Corrective Action by the Governing Body

- A. If no one authorized under Section 6.5 of these Bylaws is available to take a Summary Action to summarily restrict or suspend a Member's or Affiliated Professional's membership, Privileges, or Affiliate Status, the Governing Body (or its designee) may immediately suspend or restrict a Practitioner's Privileges if failure to do so may result in imminent danger to the health or safety of any individual, provided that the Governing Body (or its designee) has made reasonable attempts to contact the Chief of Staff, the MEC, and the Chief of the Service to which the Member is assigned before acting.
- B. Such Summary Action imposed under this subsection 6.5.4 is subject to ratification by the MEC. If the MEC does not ratify such Summary Action within two (2) working days of its imposition, excluding weekends and holidays, the Summary Action will terminate automatically.

6.5.5. Reporting

When Summary Action involves summary suspension of privileges, membership, or affiliate status, the Summary Action must be reported under Section 805 of the Business and Professions Code if such Summary Action remains in effect for a period in excess of fourteen (14) days.

6.6. Administrative Suspension of Privileges

6.6.1. Basis for Administrative Suspensions

The Chief of Staff may administratively suspend a Practitioner's Privileges or Affiliate Status for failing to complete training mandated by the hospital for regulatory purposes, failing to complete medical record documentation on a timely basis, failing to complete administrative responsibilities as required by the Chief of Service or Chief Executive Officer, and failure to obtain required health screening. Such administrative suspensions do not give rise to the due process rights of these Bylaws unless the suspension is in place for more than fourteen (14) days consecutively or thirty (30) days in a year and therefore becomes reportable to the Practitioner's professional licensing organization (such as the Medical Board).

6.6.2. Licensure

Automatic suspension or termination of Privileges or membership, or affiliate status may occur as described:

- A. Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked, limited, suspended, or expires, the Practitioner's Medical Staff

membership, Privileges, or Affiliate Status are automatically suspended as of the date such action or expiration becomes effective. Renewal of a Practitioner's license or other legal credential authorizing practice is the sole responsibility of the Practitioner. Any notices of upcoming license renewal deadlines provided by the Hospital are a courtesy, and the failure of a Practitioner to receive or review such notices does not excuse a lapsed license or legal credential.

- B. Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Privileges or Affiliate Status that are within the scope of such limitation or restriction are automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
- C. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, the Practitioner's membership status and Privileges or Affiliate Status automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- D. Whenever a Practitioner's professional liability insurance required by subsection 2.2.4 lapses, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended as of the date such lapse becomes effective shall remain suspended until adequate evidence of insurance is provided. If the Practitioner fails to provide adequate evidence of insurance within six (6) months, it is deemed as a voluntary resignation from the Medical Staff.
- E. If the employment of a Practitioner who is a City employee is terminated or suspended by the City or the employee resigns, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically terminated or suspended, respectively, on the date such employment action becomes effective. If the employment or contractual relationship of a Practitioner who is a UCSF employee or contractor is terminated or suspended by UCSF or the contractor or the employee or contractor resigns, the Practitioner's Medical Staff membership and Privileges are automatically terminated or suspended, respectively, on the date such relationship change becomes effective. And if the employment or contractual relationship of a Practitioner who is a UCSF employee is transferred to another UCSF location or the Practitioner is removed by UCSF from providing patient care at the Hospital, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended on the date such relationship change or reassignment becomes effective. This subsection E does not impose automatic suspension or termination on someone who either (i) moves employment between the City and UCSF if they are still assigned to provide patient care at the Hospital or (ii) shifts from being employed by the City or UCSF to being a volunteer at the Hospital. In either instance, the Practitioner's Medical Staff membership and Privileges or Affiliate Status may continue as allowed by these Bylaws so long as (a) the Practitioner is in good standing, (b) the Practitioner has professional liability insurance as required by subsection 2.2.4 above, and (c) the Chief of Staff approves the continuance.
- F. A Practitioner's Privileges or Affiliate Status automatically suspended under this subsection 6.6.2 may be reinstated during the then-current term only upon written notice from the Chief of Staff or the Chief of Staff's designee and with consent of the Hospital

Chief Executive Officer. Such reinstatement may include restrictions if imposed in accordance with Section 6.3. If the Practitioner provided patient care at the Hospital, or any City-affiliated institution while the Practitioner's license or credential was revoked, suspended, expired, limited, or restricted or while the Practitioner was on probation, reinstatement may not be granted until all instances of the Practitioner's patient care and billing during that time are reviewed to ensure that appropriate care was rendered, and to prevent improper billing.

6.6.3. DEA Certificate

- A. Whenever a Practitioner's DEA certificate is revoked, limited, suspended, or expires, the Practitioner is automatically and correspondingly divested of the right to prescribe or supervise prescription of medications covered by the certificate as of the date such action becomes effective throughout its term. The Practitioner must immediately notify the MSSD of any such revocation, limitation, suspension, or expiration.
- B. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medications is automatically subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

6.6.4. Medical Records

Practitioners are required to complete medical records within the time prescribed by the MEC. Failure to timely complete medical records results in an automatic suspension after notice is given. Such suspension applies to the Practitioner's right to admit, treat, or provide services to patients in the inpatient or outpatient settings. The suspension will continue until the Practitioner completes the records at issue and any related concerns are resolved.

6.6.5. Procedural Rights

Members whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned the Members's Medical Staff membership are entitled to the procedural rights set forth in Article 7 of these Bylaws only if the suspension or resignation is reported pursuant to California Business and Professions Code Section 805.

6.6.6. Notice of Administrative Suspension and Transfer of Patients

Notice of an automatic suspension must be given to the Practitioner and to the appropriate Chief of Service, and patients affected by an automatic suspension will be assigned to another Practitioner of the Clinical Service.

6.6.7. Automatic Termination

If a Practitioner is administratively suspended for more than three (3) months, the Practitioner's membership or Affiliate Status is automatically terminated. Thereafter, reinstatement to the Medical Staff requires application and compliance with the appointment applicable to new Applicants.

ARTICLE 7. HEARINGS AND APPELLATE REVIEWS

7.1. General Provisions

Except as otherwise provided in these Bylaws, the following definitions and rules apply under this Article.

- A. “Respondent” refers to the MEC in all cases when the MEC or authorized Medical Staff officers, Members, or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors, or committees took the action or rendered the decision which resulted in a hearing being requested.
- B. “Party” and “Parties” refer to the Petitioner and Respondent, individually (Party) or collectively (Parties).
- C. “Petitioner” refers to the Member who requested a hearing pursuant to subsection 7.3.2 of these Bylaws.
- D. Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws are not grounds for invalidating the action taken.
- E. If an adverse action described in subsection 7.2.1 of these Bylaws is taken or recommended, the Petitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.2. Hearings

7.2.1. Grounds for Hearings

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions regarding a Member of the Medical Staff is deemed an actual or potential adverse action and constitutes grounds for a hearing:

- A. Denial of Medical Staff appointment, reappointment, or Privileges;
- B. Revocation, suspension, restriction, or involuntary reduction of Medical Staff membership and/or Privileges;
- C. Involuntary imposition of significant consultation or proctoring outside of the FPPE process; or
- D. Any other corrective action or recommendation that must be reported to the Member’s professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

7.2.2. Termination from Medical Staff

Removal from a position as Chief of a Clinical Services or as an Officer of the Medical Staff, termination from the Medical Staff following two (2) years of inactive status, or termination from the Medical Staff following a resignation or lay off from employment with the University or the City, **does not** constitute grounds for a hearing.

7.2.3. Actions Taken Against Affiliated Professionals

Affiliated Professionals are subject to corrective action processes pursuant to their employer’s policies and procedures or through other contractual arrangements. Notwithstanding

the foregoing, clinical privileges or standardized procedures exercised by Affiliated Professionals are subject to oversight by the Medical Staff. Any performance concerns or problems with clinical care related to Affiliated Professionals that are addressed by the Medical Staff, which will occur in consultation with the City Attorney's Office serving as counsel to the Medical Staff, may result in clinical privilege or Affiliate Status restriction, suspension, or termination by the Medical Staff, including pursuant to the following:

- A. The Chief of Staff or the Chief of Staff's designee will determine how the issue is investigated. The Chief of Staff may appoint an *ad hoc committee* to investigate or advise the Chief of Staff and MEC. Any investigation should include an interview of the Affiliated Professional. Prior to the Medical Staff's restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Chief of Staff or the Chief of Staff's designee. The Chief of Staff or the Chief of Staff's designee in consultation with the MEC is authorized to make a recommendation on behalf of the Medical Staff and will do so in consultation with the City Attorney's Office. Notice of the decision will be given to the Affiliated Professional.
- B. The Chief of Staff or Chief of Staff's designee will inform the Governing Body of any recommendation that involves the restriction or suspension of Clinical Privileges or Affiliate Status of an Affiliated Professional for a cumulative total of thirty (30) days or more in any twelve (12)-month period or termination of such privileges. Prior to informing the Governing Body of the recommended restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Governing Body. The subsequent decision of the Governing Body is final.
- C. This subsection 7.2.3 does not afford an Affiliated Professional a right to a hearing under Sections 7.3 and 7.4 of these Bylaws.

7.3. Requests for Hearing

7.3.1. Notice of Proposed Action

The Medical Staff Member Petitioner must be notified in writing (by "Notice") of any recommendations that would constitute grounds for a hearing. The Notice must inform the Petitioner of the following:

- A. What action has been proposed against the Petitioner;
- B. Whether the action, if finally adopted, will be reported to the Member's professional licensing organization (such as the Medical Board) under California Business and Professions Code Section 805 and to the National Practitioner Data Bank;
- C. The reasons for the proposed action;
- D. That the Petitioner may request a hearing;
- E. That a hearing must be requested within twenty (20) days; and
- F. That the Petitioner has the hearing rights described in the Medical Staff Bylaws.

7.3.2. Request for Hearing; Waiver and Consideration of Waived Hearing by the Governing Body

The Petitioner has twenty (20) days following receipt of Notice of such recommendation to request a hearing. The hearing request must be in writing, must be communicated at minimum by electronic mail, and must be addressed to the Chief of Staff with a copy to the Chief Executive Officer. The Petitioner must state, in writing, the Petitioner's intentions with respect to attorney representation during the hearing process at the time the Petitioner sends the request for a hearing.

If the Petitioner does not request a hearing within the time and in the manner described, the Petitioner will be deemed to have waived any right to a hearing and accepted the recommendation involved. Such final recommendation, based on a waiver of the right to hearing, will be considered by the Governing Body for ratification within seventy (70) days. The Governing Body must consider such final recommendation, but the recommendation is not binding on the Governing Body, which will exercise its independent authority to render a final decision on the matter.

7.3.3. Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the President of the Governing Body or the President's designee will fulfill the functions assigned in this Section to the Chief of Staff. In such instances, the term "recommendation" used in this Section 7.3 includes any action by the Governing Body.

7.3.4. Time and Place for Hearing

Upon receipt of a timely request for a hearing made by the Petitioner, the Chief of Staff will notify the Chief Executive Officer and the MEC, appoint a Judicial Review Committee, and schedule a hearing before the Judicial Review Committee. The Chief of Staff will give notice of the hearing within twenty (20) days after receipt of the request. The notice must state the time, place, and date of the hearing. The date of the commencement of the hearing will be within twenty (20) to forty (40) days from the date the Chief of Staff received the hearing request. The date of commencement for the hearing may be extended by the Chief of Staff for good cause in the Chief's sole discretion.

7.3.5. Notice of Charges

As part of, or together with, the notice of place, time, and date of the hearing, the Chief of Staff must state in writing the reasons for the recommendation, the acts or omissions with which the Petitioner is charged, and a list of the medical records in question, when applicable. The Petitioner must be provided with a summary of the rights to which the Petitioner is entitled at the hearing. A supplemental notice of charges may be issued at any time, provided the Petitioner is given sufficient time (at least seven days) to prepare.

7.3.6. Judicial Review Committee

The Chief of Staff will appoint a Judicial Review Committee composed of not fewer than three (3) Members of the Active Medical Staff (Active Members) who will gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision-maker, or otherwise actively participated in the consideration of the matter

leading up to the recommendation. The Judicial Review Committee may have any number of members or alternates as determined by the Chief of Staff. The Chief of Staff will appoint one of these Active Members to serve as Chair. Knowledge of the matter involved does not preclude a Member from serving as a member of the Judicial Review Committee. In the event it is not possible to appoint all Judicial Review Committee members from the Active Medical Staff, the Chief of Staff may appoint any Member of the Medical Staff or other appropriate representatives affiliated with DPH. When feasible, the Judicial Review Committee will include at least one (1) Member who practices in the same specialty as a Petitioner and will include at least one (1) Member who is a UCSF employee and one (1) Member who is an SDPH employee. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable. Voir dire is expressly allowed, and it is to be conducted via written questions for the JRC members and the Hearing Officer. The parties will submit questions to the Hearing Officer, who will make a decision on which questions to allow. The Hearing Officer may include their own questions. The written answers to the voir dire questions will be submitted to both sides and to the Hearing Officer, and the Hearing Officer makes any final decision on challenges to participation

The proceedings and/or deliberations of the hearing will continue so long as three members of the Judicial Review Committee are present.

7.4. The Hearing Procedure

7.4.1. The Hearing Officer

The Chief of Staff will appoint a Hearing Officer to preside at the hearing. The Hearing Officer must be an attorney-at-law qualified to preside over a quasi-judicial hearing; however, an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities is not eligible to serve as Hearing Officer. The Hearing Officer must not be biased for or against any Party, must not gain any direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer must endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard, to assure that all participants present relevant oral and documentary evidence in an efficient and expeditious manner, and to maintain proper decorum. The Hearing Officer will determine the order of, or procedure for, presenting evidence and arguments during the hearing and has authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Judicial Review Committee Members or the Hearing Officer serving as the Hearing Officer. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as may be warranted by the circumstances. The Hearing Officer will participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer does not have a vote on the Judicial Review Committee.

7.4.2. The Chairperson of the Judicial Review Committee

The Chief of Staff will appoint the chairperson for the Judicial Review Committee. The chairperson will serve as a liaison between the Hearing Officer and the Judicial Review

Committee. The chairperson will take votes on issues to be decided by the JRC. The vote can be done in person, via telephone, via email, or through other methods. Any decision by the JRC shall be reported to the parties in terms of the numbers voting for and against each decision or outcome

7.4.3. Hearing Logistics

The hearing may take place in person, by videoconference, or in hybrid format, at the discretion of the Judicial Review Committee in consultation with the Hearing Officer.

The Judicial Review Committee will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

If any members of the Judicial Review Committee cannot attend a session, the Judicial Review Committee will decide whether to allow the session to be recorded by video and to have the absent Committee members then watch the video after the session.

The JRC will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

If any members of the JRC cannot attend a session, the JRC will decide whether to allow the session to be recorded by video and to have the absent JRC members then watch the video after the session.

The JRC itself, and not the Hearing Officer, will decide how much time to allot to the hearing, providing each side at least five hours to present its case. It is solely within the JRC's discretion to allow for additional time. The JRC may place reasonable limits on the amount of testimony or argument it wants to allow, bearing in mind the fact that written evidence in most situations is deemed admitted.

The JRC should review all non-repetitive written evidence submitted prior to making its decision.

The JRC members may ask questions of witnesses directly, preferably saving their questions for a natural pause or break in the testimony.

For most witnesses, each side must examine the witness on all relevant topics when that witness is first called to testify (extending from session to session as appropriate). This is to minimize disruption to the witnesses called to testify. Only in extreme situations and for good cause will the Hearing Officer allow a witness to be recalled to testify after each side has had a chance to examine the witness.

The JRC has authority to limit or exclude testimony of any witness based on argument by a party that the testimony is not relevant or is unnecessary. Any JRC member may make such a motion on their own, and the JRC may vote on that motion as with any other argument.

The JRC is to meet alone with the Hearing Officer after it receives the written evidence, statement of the applicable legal standard, and written summaries of the case and before the hearing commences. During that meeting the JRC may discuss any questions or has or ideas about structuring or limiting the scope or structure of the hearing. This meeting is not to be transcribed, but the JRC, working with the Hearing Officer, will provide each side with the rules

it has adopted about how the matter will proceed and a written statement of any other limits it puts on the hearing process.

7.4.4. Representation

- A. The Petitioner is entitled, at the Petitioner's own expense, to be represented at the hearing by an attorney-at-law or by a physician licensed to practice in the State of California. If the Petitioner is represented by legal counsel, the MEC may also be represented by legal counsel. The MEC may not be represented by legal counsel if the Petitioner is not so represented. If the Petitioner elects not to be represented by an attorney at the hearing, the MEC will appoint a representative from the Active Medical Staff to present the recommendation and supporting evidence and to examine witnesses. Notwithstanding the foregoing and regardless of whether the Petitioner elects to have attorney representation at the hearing, the Parties have the right to consult with legal counsel to prepare for a hearing or an appellate review.
- B. When Petitioner is represented by legal counsel, the Judicial Review Committee will determine the role of legal counsel at the hearing. The Judicial Review Committee may eject any legal counsel whose activities at the hearing are, in the judgment of the Judicial Review Committee, disruptive to the proper conduct of the hearing proceedings.
- C. The Hearing Officer has discretion to limit the role of attorneys to advising the attorney's clients rather than presenting the case.

7.4.5. Postponements and Extensions

Postponements and extensions of the time limits beyond those listed in these Bylaws may be requested by anyone, may be granted by the Hearing Officer on a showing of good cause, and will be granted upon mutual agreement of the Parties and the Judicial Review Committee.

7.4.6. Failure to Appear or Proceed

Failure without good cause of the Petitioner to personally attend and proceed at a hearing in an efficient and orderly manner constitutes voluntary acceptance of the recommendations involved, and such recommendations will be forwarded to the Governing Body immediately for adoption in that event.

7.4.7. Discovery

- A. Pre-hearing Documentation Review Expectation

The Judicial Review Committee will be provided a summative report of the investigatory and disciplinary actions taken to date on the matter being considered. Specifically, these should include at a minimum, the following documents: the investigatory committee report including findings and recommendations that were submitted to MEC, the motion and final MEC recommendation to the Governing Body, and any statements submitted by the Medical Staff member /Petitioner in participation of the investigatory committee process or in response to MEC action.

The parties may submit a written summary of the case not to exceed 5 single-spaced pages 15 days prior to the hearing to the Hearing Officer and the JRC members. The written summary may reference information that party plans to show through evidence and testimony. But not more than 5 pages may be submitted (e.g., no exhibits or attachments).

No less than 15 days before the start of the hearing, the JRC is to be given the recommendation of MEC in its entirety. The JRC is to be advised that the MEC recommendation is just a recommendation and that the JRC is charged with making a final decision on the issue. If the Member submitted any written rebuttal or response to the MEC recommendation prior to requesting a hearing, that written rebuttal or response is also to be provided to the JRC in the same timeframe.

Written evidence (the exhibits for each side) is to be exchanged between the parties and submitted to the Hearing Officer and the JRC 15 days prior to the start of the hearing. Exhibits must be marked sequentially with letters for the Member requesting the hearing and numbers for MEC. Each page of the written evidence should be marked with sequential numbering (Bates numbering) with a different prefix identifying which side originally provide the record.

All documents that are kept in the ordinary course of business—including but not limited to medical records, policies, emails, reports, Medical Staff Office files, a person's Medical Staff credentialing and privileges file, OPPEs/FPPEs, any written reports or summaries of the investigation leading to the hearing, and human resources files—are automatically admitted into evidence for consideration by the JRC. If a party has an objection to consideration of such written evidence, the objection must be made in writing, must be specific to any document listing the reasons for the objection, and must be provided to the Hearing Officer at least 5 days prior to the hearing. The Hearing Officer will rule on any objections, bearing in mind that the rules of evidence do not apply to the hearing and that in most situations the proper way to challenge evidence is for a party to argue about the weight, if any, the JRC should assign to the evidence. Only extreme cases—such as submission of privileged, attorney-client protected information or submission of evidence that is demonstrably false from an assessment of the context—support a decision by the Hearing Officer sustaining an objection. If an objection to a document is upheld by the Hearing Officer, the document or the aspect of the document that was objected to, is not to be considered by the JRC. Each side has the right during the hearing to comment on whether exhibits are reliable and what weight to give each exhibit. For sake of clarity, time during the hearing should not be spent arguing objections based on the rules of evidence because the rules of evidence do not apply and because the JRC is sophisticated and can be reminded of its duty to make a judgement about what weight to give evidence.

B. Legal Standard

A proposed statement of the legal standard applicable to the hearing is to be submitted to the Hearing Officer 15 days prior to the start of the hearing. The Hearing Officer will then decide what statement of the legal standard applicable to the hearing will be provided to the JRC. The Hearing Officer may adopt any portion of the proposed written statements and/or may draft their own language. The statement of the legal standard must be provided to the JRC at least 5 days prior to the start of the hearing.

C. Rights of Inspection and Copying

The Petitioner may inspect and copy (at the Petitioner's own expense) any documentary information relevant to the charges that the Respondent has in its possession or under its control. The Respondent may inspect and copy (at its expense) any documentary information relevant to the charges that the Petitioner has in the Petitioner's possession or under the Petitioner's control. The request for discovery must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least twenty (20) days prior to the hearing is good cause for a continuance of the hearing. The Petitioner may not retain or possess unredacted medical records that contain any protected health information, and any unredacted records must be kept securely during the Hearing process. Petitioner must consult with the City Attorney's Office before accessing any patient medical record for purposes of preparing for the Hearing in order to ensure compliance with state and federal privacy rules.

D. Limits on Discovery

The Hearing Officer will rule on discovery disputes the Parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either Party does not extend to confidential information referring solely to individually identifiable Members other than the Petitioner, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information. Protected health information of any patient is generally not to be disclosed during discovery and may only be produced in redacted form. If the volume of materials makes redaction unfeasible, then the Judicial Review Committee must impose reasonable restrictions, in consultation with the City Attorney's Office, to ensure that protected health information is not removed from the Hospital or disclosed.

E. Ruling on Discovery Disputes

In ruling on discovery disputes, factors that the Hearing Officer may consider include, but are not limited to, the following:

- 1) Whether the information sought may be introduced to support or defend the charges;
- 2) Whether the information is "exculpatory" or "inculpatory" in nature;
- 3) The burden on the Party in possession of producing the requested information; and
- 4) What other discovery requests the Party has previously submitted resisted.

7.4.8. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The Respondent may object to the introduction of evidence that was not provided during the appointment or reappointment process or investigation of other matter at issue in the hearing. The information will be barred from the hearing by the Hearing Officer unless the Petitioner can prove the Petitioner previously acted diligently with respect to providing evidence and could not have submitted the information at issue.

7.4.9. Pre-Hearing Document Exchange

At the request of either Party, the Parties must exchange copies of all documents that will be introduced at the hearing. The documents must be exchanged at least seven (7) days before commencement of the hearing. A failure to do so is good cause for a continuance.

7.4.10. Witness Lists

At the request of either Party, each Party must furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that Party at the hearing.

Nothing in the foregoing sentence precludes the testimony of additional witnesses whose possible participation was not reasonably anticipated. The Parties must notify each other as soon as a Party becomes aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least seven (7) days prior to the hearing date at which the witness is to appear constitutes good cause for a continuance.

7.4.11. Procedural Disputes

- A. The Parties have a duty to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
- B. The Parties are entitled to file motions as deemed necessary to give full effect to the rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the Judicial Review Committee. Such motions must be in writing and must specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving Party must deliver a copy of the motion to the opposing Party, who will have seven (7) days to submit a written response to the Hearing Officer, with a copy to the moving Party. The Hearing Officer will determine whether to allow oral argument on any such motions. The Hearing Officer's ruling on the motion must be in writing and will be provided to the Parties promptly. All motions, responses, and associated rulings must be entered into the hearing record by the Hearing Officer.

7.4.12. Record of Hearing

A court reporter shall be present to make a record of the hearing proceedings. The cost of a court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the Party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken on oath or affirmation.

7.4.13. Rights of the Parties

The Petitioner may ask the Judicial Review Committee Members and Hearing Officer questions, if reasonably relevant in the determination of the Hearing Officer, that are directly related to evaluating the impartiality of the Judicial Review Committee Members or the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee Member will be ruled on by the Hearing Officer, and challenges to the impartiality of the Hearing Officer will be ruled on by the Chief of Staff in consultation with the City Attorney's Office. Both Parties may: call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents;

cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available to the Judicial Review Committee; and submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Petitioner may be called by the Respondent or by the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

7.4.14. Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence do not apply to a hearing conducted under this Article. The Hearing Officer will admit, subject to subsection 7.4.1 above, for consideration any evidence, including hearsay, the Hearing Officer determines is relevant to the determination of the issues presented during the Hearing.

7.4.15. Burdens of Presenting Evidence and Proof

- A. At the hearing, the Respondent has the initial duty to present evidence for each case or issue in support of its recommendation. The Petitioner may present evidence in response.
- B. If the Petitioner is challenging denial of an initial application for Medical Staff membership or privileges, the Petitioner bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence (meaning that something is more likely than not to be true, based on a review of all relevant information), that the Petitioner is qualified for membership and/or the denied or restricted Privileges.
- C. In relation to other recommendations, the Respondent bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that Respondent's recommendation is reasonable and warranted.

7.4.16. Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene it at the convenience of the participants without providing any specific form of notice. Upon conclusion of the presentation of oral and written evidence, the hearing is deemed closed. The Judicial Review Committee must then, outside of the presence of any person other than the Hearing Officer, conduct its deliberations and thereafter issue a written decision and accompanying report listing the basis for the decision (the "Decision") as set forth in subsection 7.4.16 below.

7.4.17. Voting

Each decision by the JRC, including the final decision on the merits of the hearing, is to be made by majority vote, which means half of the JRC plus one vote. (If there's a tie, then the status quo will be maintained. If that's on the final MEC recommendation, you should consider if that means the recommendation is rejected.)

7.4.18. Basis for Decision

The decision of the Judicial Review Committee must be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony. The Judicial Review Committee must determine whether the

Member has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Members.

7.4.19. Decision of the Judicial Review Committee

Except as outlined below in this subsection, within twenty (20) days after final adjournment of the hearing, the Judicial Review Committee must issue the Decision. The date for issuing the Decision may be extended by the Judicial Review Committee for good cause. But if the Petitioner is currently under suspension, the time for the Decision will be twelve (12) days after final adjournment. Final adjournment is when the Judicial Review Committee has concluded its deliberations. A copy of the Decision must be sent to the Chief Executive Officer, the MEC, the Governing Body, the Petitioner, and the Petitioner's representative (if applicable). The Decision must contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Petitioner and the Respondent must be provided a written explanation of the procedure for appealing the Decision. The Decision of the Judicial Review Committee is considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

7.5. Appeal

7.5.1. Time for Appeal

Within twenty (20) days after receipt of the decision of the Judicial Review Committee, either the Petitioner or the Respondent may request an appellate review by the Governing Body. Said request must be delivered to the Chief of Staff in writing, in person or by certified mail, and must include a brief statement as to the reasons for appeal. If such appellate review is not requested within such period, both sides are deemed to have accepted the recommendation involved, and that recommendation then becomes, pending ratification by the Governing Body, final and effective immediately.

7.5.2. Grounds for Appeal

On appeal, the Governing Body may exercise its independent judgment in determining:

(1) whether there was substantial failure of the Judicial Review Committee to comply with the procedures required by these Bylaws so as to deny fair hearing, (2) whether the decision is reasonable and warranted, and/or (3) whether any bylaw, rule, or policy relied on by the Judicial Review Committee is unreasonably applied or interpreted.

7.5.3. Time, Place, and Notice

In the event of an appeal to the Governing Body, the Governing Body will within thirty (30) days after receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Body will provide notice of the time, place, and date of the appellate review. The date of the appellate review must be within sixty (60) days from the date of receipt of the request for the appellate review; however, when a request for appellate review comes from a Member who is under suspension, the review must be held as soon as practical, but not to exceed thirty (30) days from the date of receipt of the request. The time for appellate review may be extended by the President of the Governing Body for good cause.

7.5.4. Nature of Appellate Review

The proceedings of the Governing Body under Section 7.5 are in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Governing Body may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. Each Party shall have the right to present a written statement in support of the Party's position on appeal, to personally appear and make oral argument, and to be represented by an attorney. At the conclusion of oral argument, if allowed, the Governing Body may then, at a time convenient to itself, conduct deliberations outside the presence of the Parties and each Party's representatives. The Governing Body may affirm, modify, or reverse the decision of the Judicial Review Committee or, at its discretion, refer the matter for further review and recommendation.

7.5.5. Final Decision

Within thirty (30) days after the conclusion of the proceedings before the Governing Body (including both the appellate hearing and subsequent deliberations), the Governing Body must render a final decision in writing and deliver copies of that decision to the Applicant or Member of the Medical Staff and to the Chief of Staff, in person or by certified mail.

7.5.6. Delegation to Governing Body Members on the Joint Conference Committee

Nothing herein prevents the Governing Body from delegating the appellate process to those Governing Body Members appointed to the Joint Conference Committee. In such an event, the Governing Body Members of the Joint Conference Committee must submit a written report and recommendations to the full Governing Body for approval.

7.5.7. Further Review

Unless the Governing Body refers the matter back to the Judicial Review Committee for further review and recommendations, the final decision of the Governing Body following the appeal procedures set forth in these Bylaws will be effective immediately and is not subject to further review. If the matter is referred back to the Judicial Review Committee for further review and recommendations, the Judicial Review Committee will promptly conduct its review and make its recommendations to the Governing Body. This further review process and the report back to the Governing Body must not exceed thirty (30) days except as the Parties may otherwise stipulate.

7.5.8. Right to One Hearing Only

Except as otherwise provided in these Bylaws, no Applicant or Member is entitled to more than one (1) evidentiary hearing and one (1) appellate review hearing on any matter which is the subject of an adverse recommendation.

7.5.9. Affiliated Professionals, House Staff, Medical Students, and Trainees

Affiliated Professionals, House Staff, Medical Students, and Trainees are not entitled to the procedural rights set forth in these Bylaws except as expressly listed in subsection 7.2.3 for Affiliated Professionals.

7.5.10. Denial of Applications for Failure to Meet the Minimum Qualifications

Applicants are not entitled to the procedural rights of these Bylaws if the Applicant's membership, Privileges, applications, or requests are denied because of the Applicant's failure: to have a current California license to practice medicine, dentistry, clinical psychology, or podiatry; to maintain an unrestricted DEA certificate (when it is required under these Bylaws); to maintain professional liability insurance (as required by the Bylaws); to meet any of the other basic standards specified in Article 2 of the Bylaws; or to file a complete application.

7.5.11. Automatic Suspension or Limitation of Privileges

A Member or Affiliated Professional is not entitled to any procedural rights when the Practitioner's license or legal credential to practice has been revoked or suspended as set forth in Article 6 of these Bylaws. In other cases described in Article 6 of these Bylaws, the issues which may be considered at a hearing, if requested, may not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue to practice in the Hospital with those limitations imposed. Members whose Privileges are automatically suspended and/or who have resigned the Member's Medical Staff membership for failing to complete medical records or for failing to maintain malpractice insurance are not entitled under these Bylaws to any procedural rights, except when a suspension for failure to complete medical records will exceed fourteen (14) days and must be reported to the Member's professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

* * *

ARTICLE 8. STRUCTURE OF THE MEDICAL STAFF

8.1. Medical Staff Year

The Medical Staff Year is July 1 through June 30.

8.2. Officers of the Medical Staff

The officers of the Medical Staff are the Chief of Staff, Chief of Staff-Elect, or, in alternate years, the Chief of Staff-Past.

8.2.1. Qualifications of Officers

Officers must be Members of the Active Medical Staff at the time of nomination and election and must remain Members in good standing during the Member's term of office.

8.2.2. Election of Chief of Staff-Elect

The Chief of Staff-Elect of the MEC will be elected at the Annual Meeting of the Medical Staff in alternate years for a one (1) year term unless a vacancy as described in this Article indicates a need to have an additional election to fill the positions.

The Nominating Committee must present a candidate to the Active Medical Staff Members in attendance at the Annual Meeting of the Medical Staff. Other nominations may be taken from the floor, with the approval of the nominee, prior to the meeting.

If floor nominations are made, a hand vote will be taken to elect the Chief of Staff-Elect. A simple majority of the Active Medical Staff Members attending the meeting will determine the election. If no floor nominations are made, a vote of acclamation will be requested by the presiding Chief of Staff.

8.2.3. Term of Office

The Chief of Staff will serve a two (2) year term of office. The Chief of Staff-Elect will serve a one (1) year term from the beginning of the Medical Staff year and assume the responsibilities of the Chief of Staff at the end of that term. Upon completion of the two (2) year term as the Chief of Staff, the outgoing Chief of Staff will serve one (1) year as Chief of Staff-Past and be available to serve as Acting Chief of Staff in the first year of the Chief of Staff's two-year term. The Chief of Staff-Elect will be available to serve as Acting Chief of Staff in the second year of the Chief of Staff's two-year term. The standard term of office for the Chief of Staff is two (2) years. When the Nominating Committee believes continuity should be prioritized due to particular circumstances, the Chief of Staff may be re-elected to serve one (1) additional year. In the event that the Chief of Staff is re-elected, then the Chief of Staff Past will continue as an officer of the Medical Staff.

8.2.4. Vacancies in Office

In the event of the temporary absence of the Chief of Staff, the Chief of Staff must designate a Member of the MEC or a previous Chief of Staff to serve as the acting Chief of Staff, including chairing the MEC meetings.

If the position of the Chief of Staff becomes permanently vacant during the first year of the two (2) year term, the Chief of Staff-Past will assume all designated responsibilities through the end of the Medical Staff Year. If the Chief of Staff-Past is unable to serve, the MEC will appoint an Acting Chief of Staff who will serve through the end of the Medical Staff Year. If the vacancy occurs in the second year of the Chief of Staff's elected term, the Chief of Staff-Elect will assume the duties of the office through the end of the Medical Staff Year and then continue as the Chief of Staff for a two (2) year term.

8.2.5. Duties of Officers

A. Chief of Staff

The Chief of Staff will:

- 1) Serve as Chief of the Medical Staff;
- 2) Represent the views, policies (including strategic planning and budget considerations), needs and grievances of the Medical Staff and MEC to the Governing Body, to the Chief Executive Officer, and to the Vice Dean;
- 3) Receive and present to the MEC the activities of the Governing Body;
- 4) Report Medical Staff activities to the Governing Body;
- 5) Be the spokesperson for the Medical Staff and the MEC in external professional and public relations;
- 6) Appoint committee Chairs and approve Members to all Medical Staff committees except the MEC and Joint Conference Committee;
- 7) Call, preside at, and be responsible for the agenda of all regular and special meetings of the MEC and of the Medical Staff;
- 8) Be responsible for the enforcement of Medical Staff Bylaws and for corrective action as provided for in these Bylaws;
- 9) In the interim between MEC meetings, performing those responsibilities of the MEC that, in their reasonable opinion, must be accomplished prior to the next regular or special meeting of the MEC;
- 10) Serve as a Member of the Joint Conference Committee;
- 11) Serve as a Member of the Credentials Committee;
- 12) Preside at the Annual Meeting of the Medical Staff;
- 13) Serve as an interface between the Medical Staff and the leadership of the hospital; and
- 14) Attend any Medical Staff committee meetings as necessary and appropriate in the Chief of Staff's discretion.

B. Chief of Staff-Elect

The Chief of Staff-Elect will:

- 1) Perform duties as assigned by the Chief of Staff and, in the absence of the Chief of Staff, assume the duties and have the authority of the Chief of Staff.

- 2) Serve as Chair of the Bylaws Committee, or co-chair the committee with the Chief of Staff;
- 3) Serve as a member of the Credentials Committee;
- 4) Serve on the MEC;
- 5) Beginning six (6) months prior to assuming the role of Chief of Staff, serve as a member of the Joint Conference Committee; and
- 6) Assume the office of Chief of Staff at the end of the current Chief of Staff's term.

C. Chief of Staff-Past

The Chief of Staff-Past will:

- 1) Perform duties as assigned by the Chief of Staff and assume the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;
- 2) Chair the Nominating Committee of the Medical Staff;
- 3) Serve on the MEC, Joint Conference Committee and the Credentials Committee.

8.2.6. Removal of Officers

A Medical Staff Officer may be removed from office for any valid cause including, but not limited to, failure to carry out the duties of the office, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these Bylaws, removal of Medical Staff officers may be initiated by the MEC or upon the written request of twenty percent (20%) of the Active Medical Staff. Such removal may be effected by majority vote of the MEC Members or by a two-thirds vote of the Active Medical Staff. Voting on the removal of an elected officer will be by secret written ballot.

ARTICLE 9. CLINICAL SERVICES

9.1. Organization of Clinical Services

9.1.1. Overall Supervision

Each Clinical Service will have a Chief who is responsible for the overall supervision of the clinical work, teaching, and research within that Clinical Service. Each Clinical Service may be organized into subsections.

9.1.2. Clinical Services

The Clinical Services are as follows: Anatomic Pathology, Anesthesiology and Peri-Operative Care, Community Primary Care, Oral & Maxillofacial Surgery, Dermatology, Emergency Medicine, Family and Community Medicine, Laboratory Medicine, Internal Medicine, Neurology, Neurosurgery, Obstetrics-Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology and Head & Neck Surgery, Pediatrics, Psychiatry, Radiology, Surgery, and Urology.

9.2. Qualifications, Selection and Tenure of Chiefs of Services

9.2.1. Qualifications

- A. All Chiefs of Service must be board certified or re-certified in their respective specialty.

- B. Chiefs of Service must have a University faculty appointment, excepting the Chief of the Community Primary Care Service (CPC).
- C. Chiefs of Service may be the Chair or Vice Chair of the Chief's respective University department.
- D. Chiefs of Service must be Members of the Active Medical Staff, and Clinical Privileges will be determined as set forth in Article 6 of these Bylaws.

9.2.2. Selection of a Chief of Service

- A. Upon notification that a Chief of Service will vacate the Chief of Service's position prior to the appointment of a new Chief of Service, the UCSF Department Chair and Vice Dean, in consultation with the Chief Executive Officer and Chief of Staff, will select a proposed Interim Chief of Service. After approval by MEC, the Chief of Staff will then forward the recommendation to the Governing Body to appoint the selected individual as the Interim Chief of Service.
- B. Within six months of a vacancy for a Chief of Service, the Chief of Staff, in consultation with the Vice Dean, UCSF Department Chair and Chief Executive Officer, will appoint a search committee for a new Chief of Service. The search committee will be chaired by a Member of the Active Medical Staff and be composed of Members of the Active Medical Staff, University faculty, the Vice Dean or their designee, and the Hospital Chief Executive Officer or their designee. If the Department has clinically active Affiliated Professionals, at least one Affiliated Professional member of the Department will also be invited to join the search committee. The composition of the search committee will be approved by the University's Academic Affairs Office.
- C. The Chief of Staff must consult with the Director of Health or designee, and the Chief Executive Officer, in appointing the ad hoc search committee for the selection of the Chief of Community Primary Care (CPC). The search committee for the Chief of CPC must be chaired by a Member of the Active Medical Staff and must include Members of the Active Medical Staff, Members of the CPC, the Director of Health or their designee, and the Chief Executive Officer or their designee, and at least one Affiliated Professional member of CPC.
- D. The recommendations of the Chief of Service search committee will be made to the Chief of Staff and UCSF Department Chair who will, in consultation with the Vice Dean and Chief Executive Officer, nominate the new Chief of Service for that service. The recommendations of the search committee for the Chief of CPC will be made to the Chief of Staff who will, with the approval of the Director of Health, nominate the Chief of CPC.
- E. Following recommendation of the Chief of Service candidate to the Chief of Staff and UCSF Department Chair, the UCSF Department Chair will conditionally offer the position to the Chief of Service Candidate and, in consultation with the Vice Dean, negotiate terms of the contract and support.
- F. Once the candidate for Chief of Service has accepted the conditional offer, the Chief of Staff will proceed with facilitating the formal nomination process. The Chief of Service nomination will be acted upon by the MEC. Ratification of the nomination will be accomplished by a two-thirds vote and be forwarded to the Governing Body for approval.

- G. Upon approval of the Governing Body of the new Chief of Service, the nominee will assume the office of Chief of Service for that service.
- H. If the MEC or Governing Body disapprove the nomination, the Chief of Staff must reconstitute an ad hoc search committee.

9.2.3. Review and Reappointment

- A. Chiefs of Clinical Services must be reviewed every five (5) years or at any time as requested by the Chief of Staff, the Vice Dean, or the Chief Executive Officer. Continuation as the Chief of Service is contingent upon a favorable result of this review.
- B. The review will be led by the Vice Dean and Vice Dean's Office, and the results will be discussed with the Chief of Staff and the Chief Executive Officer.
- C. A summary of the review will be placed in the Chief of Service's credentials file that includes strengths/accomplishments and areas for improvement.
- D. The Chief of Staff, in consultation with the Vice Dean and Chief Executive Officer, will make a recommendation regarding the reappointment of a Chief of a Clinical Service based on the review committee's findings. The reappointment requires approval by a majority vote of the MEC and the Governing Body.

9.2.4. Removal of a Chief of Service

- A. Request for removal of a Chief may be initiated by:
 - 1) A two-thirds vote that includes a combination of the Clinical Service's Active Medical Staff Members ;
 - 2) The Vice Dean, Chief Executive Officer, or Chief of Staff; or
 - 3) By two-thirds vote of the MEC.
- B. When a request for removal has been initiated, a Review Committee will be appointed by the Chief of Staff in consultation with the Vice Dean, UCSF Department Chair and the Chief Executive Officer. The findings of the Review Committee must be acted upon by the MEC.
- C. The recommendation of the MEC will be forwarded to the Governing Body for approval.

9.2.5. Temporary Absence of a Chief of Service

- A. When a Chief of a Clinical Service is temporarily absent from the position for more than thirty (30) days, prompt notification must be made to the Chief of Staff. Upon receipt of such notice, the Chief of Staff will appoint an Acting Chief for the Clinical Service in consultation, when feasible, with the permanent Chief of Service, the UCSF Department Chair, the Vice Dean, and the Chief Executive Officer.
- B. Appointment of an Acting Chief of a Clinical Service for more than ninety (90) days requires the approval of the MEC and the Governing Body.

9.3. Functions of a Chief of Service

Each Chief will:

9.3.1. Credentialing/Privileging

- A. Recommend criteria for clinical privileges in the Clinical Service;
- B. Recommend a sufficient number of qualified and competent individuals to provide care/clinical services;
- C. Make reports to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for each Applicant seeking privileges in the Clinical Service;
- D. Make recommendations to the Credentials Committee regarding the qualifications and competence of Affiliated Professionals in the Clinical Service;
- E. Make recommendations for granting temporary privileges; and
- F. Be responsible for the evaluation of all new appointees and report thereon to the Credentials Committee.

9.3.2. Performance Improvement

- A. Continuously monitor and evaluate the quality and appropriateness of patient care provided within the clinical service, including:
 - 1) Recommend for approval by the Credentials Committee and MEC the criteria to be used in conduct of Ongoing Professional Practice Evaluation (OPPE) and conduct periodic OPPE for each Member and Affiliated Professional of the Clinical Service at an interval not to exceed twelve (12) months. Data used to complete OPPE forms will be maintained and stored in each Clinical Service for the duration of each medical staff Member's tenure, but in no event less than ten (10) years.
 - 2) Monitor and evaluate the quality and appropriateness of patient care provided by the attending staff;
 - 3) Monitor and evaluate the quality and appropriateness of House Staff supervision by attending staff; and
 - 4) Monitor and evaluate the quality and appropriateness of patient care provided by House Staff.
- B. Continuously monitor the professional performance of all individuals who have delineated clinical privileges or standardized procedures in the Clinical Service, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;
- C. Hold regular Performance Improvement Conferences no less than quarterly to present and discuss specific patient cases and best practices;
- D. Appoint ad hoc committees and working groups as necessary to carry out quality improvement activities; and
- E. Conduct a Focused Professional Practice Evaluation (FPPE) of any individual with privileges or standardized procedures in the Clinical Service if there is a reasonable basis to be concerned that the individual's professional qualifications, clinical ability, judgment, character, physical or mental health, professional ethics, or other matters might directly or indirectly affect patient care.

- 1) The FPPE must consider the individual's overall performance as well as specific cases. Comparison with historical, departmental, and external benchmarks may be considered.
- 2) A peer review panel may be appointed to conduct an FPPE.
- 3) Recommendations from an FPPE may be used as the basis for continued routine monitoring and education or for pursuing formal corrective action.

9.3.3. Education and Research

- A. Be accountable to the Vice Dean and the UCSF Department Chairs for the conduct of graduate and undergraduate medical education and UCSF based research programs conducted in the Chief's Clinical Service; and
- B. Be responsible for the establishment, implementation, and effectiveness of the orientation and supervision of the teaching, education, and research programs in the Clinical Service.

9.3.4. Administration

- A. Designate an Acting Chief when unavailable for more than twenty (24) hours but less than thirty (30) days and communicate the designee to the Chief of Staff and Medical Staff Office. After thirty (30) days, the process described in subsection 9.2.5 must be followed.
- B. Be responsible and accountable to the Governing Body, through the Chief of Staff, for all clinically and administratively related activities within the Clinical Service;
- C. Be a Member of MEC and regularly disseminate decisions made and issues discussed at MEC meetings to the Members of the Clinic Service. It is the expectation that the Chiefs of the Clinical Services will attend at least fifty percent (50%) of the MEC meetings each year and that they will send a designee when unable to attend.
- D. Be responsible for the integration of the Clinical Services into the primary functions of the organization;
- E. Be responsible for the coordination and integration of interdepartmental and intradepartmental services;
- F. Review and update the Clinical Service Rules and Regulations at least every two years;
- G. Be responsible for the orientation of new Members and for the enforcement of the Medical Staff Bylaws and Rules and Regulations and the Hospital's policies and procedures within the respective Clinical Service;
- H. Ensure adequate input from the Chief's Clinical Service at Medical Staff committee meetings through attendance by service Members;
- I. Be responsible for implementation within the Clinical Service of actions taken by the Governing Body and the MEC;
- J. Participate in the administration of the Chief's Clinical Service through cooperation with the Nursing Service, Hospital Administration, and all personnel involved in matters affecting patient care;

- K. Report and make recommendations to Hospital Administration when necessary with respect to matters affecting patient care in the Clinical Service, including personnel, space, resources, supplies, special regulations, standing orders and techniques;
- L. Be responsible for the process of assessing and recommending off-site sources that provide patient care services not available at the Hospital;
- M. Assist in the preparation of annual records, including budgetary planning, pertaining to the Clinical Service as may be required by the Chief of Staff, the MEC, the Vice Dean, Chief Executive Officer, or the Governing Body;
- N. Delegate to a vice chief or other Active Staff Member of the Clinical Service such duties as appropriate;
- O. Establish divisions, sections, or services within the Clinical Service and appoint Chiefs thereof, subject to the approval of the MEC and the Governing Body;
- P. Develop and implement policies and procedures that guide and support the provisions of services;
- Q. Maintain quality improvement programs; and
- R. Make a presentation to the MEC at least every two (2) years on the activities of the Clinical Service.

9.4. Functions of Clinical Services

- S. Each Clinical Service must establish written criteria consistent with the policies of the MEC for the granting of Clinical Privileges and Standardized Procedures.
- T. Each Clinical Service is responsible for maintaining and supervising a high quality education and training program for graduate and undergraduate education in the health sciences.
- U. Each Clinical Service is responsible for the supervision of House Staff and the House Staff training programs.
- V. The Chief of CPC will collaborate with the appropriate Chiefs of Clinical Services and the Vice Dean to maintain and supervise high quality training experiences within the CPC clinical sites for graduate and undergraduate students in the health sciences.
- W. Each Clinical Service will develop criteria under which consultation will be required; these shall not preclude a requirement for consultation when the Chief of Service determines that a patient would benefit from such consultation.
- X. Each Clinical Service will meet as frequently as necessary, but at least quarterly, to consider findings from the ongoing monitoring and evaluation of quality and appropriateness of the care and treatment provided to patients. Written summaries and recommendations of any and all new policies or changes in policies will be submitted to the Medical Executive Committee for its approval.

9.5. Assignment to Clinical Service

The MEC will, after consideration of recommendations of the Clinical Services as transmitted through the Credentials Committee, recommend initial Clinical Service assignments for all Applicants. All Medical and Affiliated Staff Members shall be assigned to at least one

Clinical Service and be granted clinical privileges or standardized procedures that are relevant to the care provided in that Clinical Service. The exercise of clinical privileges or standardized procedures within any Clinical Service are subject to the Medical Staff Bylaws, the Rules and Regulations of that Clinical Service, and the authority of the Chief of Service.

ARTICLE 10. MEDICAL STAFF AND AFFILIATE PROFESSIONALS LEADERSHIP

10.1. Definitions of Medical Staff and Affiliate Professional Leaders (in addition to Chiefs of Service as set forth in Article 9)

The term Medical Staff and Affiliate Professional Leaders includes the following positions:

- A. **Central Leadership Positions:** (1) Medical Directors or Associate Chief Medical Officers of multi-specialty service lines or (2) Medical Directors of hospital departments that pertain to multiple services. (See Appendix 3.)

Examples: 1. Medical Directors or Associate Chief Medical Officers of Critical Care, Perioperative Services, Trauma; 2. Medical Directors of Risk Management, Quality Improvement, Care Experience, Informatics, Infection Control.

- B. **Service Leadership Positions:** Medical Directors or Vice Chiefs of units or services within a single Clinical Service.

Examples: Medical Directors of Family Health Center, Medicine Inpatient Services, EMS Base Station, Sleep Center, Diabetes Program, Asthma Clinic.

10.2. Qualifications of Medical Staff and Affiliated Professional Leaders

Leaders must be Members of the Active Medical or Affiliated Staff at the time of appointment and must remain Members in good standing during the Member's tenure.

10.3. Appointment of Medical Staff and Affiliated Professional Leaders

- A. Central leadership positions are appointed by an open search process organized by the Chief Medical Officer or designee. The search committee is composed of clinical stakeholder leaders. The candidate selected must be approved by the Chief Medical Officer, Chief Executive Officer, and Vice Dean.
- B. Service Leadership positions are appointed by the Chief of Service.

10.4. Term of Appointment

- A. Central leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief Medical Officer in consultation with Executive Leadership.
- B. Service Leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief of Service in consultation with the Chief Medical Officer.

10.5. Reporting Relationships

- A. Central leadership positions report to the Chief Medical Officer.

- B. Service Leadership positions report jointly to their Chief of Service and Hospital Administration via the Chief Medical Officer for this administrative role.

10.6. Duties of Medical Staff and Affiliated Professional Leaders

- A. In partnership with the Nurse dyad, the Leader is responsible for the quality of patient care, patient experience, and operational management of care provided by the clinical unit in alignment with True North goals and hospital leadership vision.
- B. The central function of this position is to serve as the Leader for the clinical area, engaging front line providers to optimize operational, clinical quality, patient experience, and financial metrics. This includes meeting clinical enterprise performance and outcome benchmarks set by Hospital Administration.
- C. Specific duties are detailed in the job descriptions.

10.7. Salary Support for Medical Staff and Affiliated Professional Leader Effort

- A. Central leadership positions are funded via the Affiliation Agreement Central Medical Staff and Affiliated Professional Leadership account.
- B. Service Leadership positions are funded by the Service.

ARTICLE 11. COMMITTEES OF THE MEDICAL STAFF

11.1. Committee Designation

Standing committees, subcommittees, and ad hoc committees of the Medical Staff described in these Bylaws and in the Committee Manual are created for and meet the purpose of peer evaluation and improvement of the quality of care rendered in the Hospital. Medical Staff functions covered by appropriate committees include, but are not limited to, executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting Medical and Affiliated Members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.

11.2. General Provisions

11.2.1. Ad Hoc Committees

As the need arises, the Chief of Staff, with the advice and counsel of the MEC, may appoint ad hoc committees to deal with specific problems including the evaluation and improvement of the quality of care rendered in the Hospital. Each such ad hoc committee will keep permanent records of its proceedings and activities and submit a report of its activities to the MEC.

11.2.2. Parliamentary Procedure

All meetings of all committees and subcommittees of the Medical Staff are to be conducted following Robert's Rules of Order or a less formal implementation of the concepts included in Robert's Rules of Order.

11.2.3. Scheduling

Medical Staff committees will hold regular meetings as specified in these Bylaws, the meeting schedule of which will be reviewed and/or revised by the Chair at the beginning of each academic year. The committee members will be advised in writing, at least one (1) week in advance of scheduled meetings, of any necessary changes to the established meeting schedule. If no meeting schedule is otherwise described in these Bylaws, the committee will meet at least quarterly unless otherwise required in the description for each committee.

11.2.4. Appointment of Chairs of Committees

Standing committee chairs are appointed by the Chief of Staff except when chairs are specified in these Bylaws. Subcommittee chairs of standing committees are appointed by the Chairs of each respective standing committee. Standing committees of the Medical Staff are chaired only by Members of the Active Medical Staff or a voting Affiliated Professional member of the committee.

11.2.5. Committee Membership Appointment

Membership of each committee is appointed by the committee chair, after consultation with the Chief of Staff or Chief Executive Officer, as appropriate. The MSSD will maintain an accurate membership and attendance roster of all committees of the Medical Staff.

Active Medical Staff Members and Affiliated Professionals appointed to Medical Staff committees will have committee voting prerogatives. Individuals who are not Active Medical Staff Members or Affiliated Professionals will be appointed as non-voting committee members

unless the Chair specifies voting prerogatives at the beginning of the Medical Staff year. Any such voting prerogatives will be documented in committee minutes at the beginning of the Medical Staff year and remain in effect for the committee membership appointment period of one (1) year.

Voting privileges, if issued by the Chair, will be for all matters before the committee during the course of the year.

11.2.6. Quorum

Unless otherwise stipulated in these Bylaws, a committee or subcommittee quorum consists of at least three (3) voting committee members present at the time of the discussion or vote. For the MEC, a quorum consists of at least ten (10) or more MEC members who are Members of the Active or Affiliated Medical Staff and are present at the time of the discussion or vote.

11.2.7. Manner of Action

Having established a voting quorum, the action of a simple majority of the voting committee members present will represent the action of the committee. Action may be taken without a meeting when, in the discretion of the Committee Chair, the action is sufficiently straightforward that discussion and deliberation is not necessary. In such an event, and if there are no objections from the voting committee members, action may be taken by vote through email or similar method and upon the approval of the number of voting committee members that constitutes a quorum.

11.2.8. Attendance Requirements

Excused absences can be issued by Chairs or Chiefs if requests for absences are submitted before the scheduled meeting. Any committee may invite the attendance of any individuals who may be useful to its work. All voting committee members are expected to attend or have a designee present for fifty percent (50%) of the committee's meetings.

11.2.9. Notice of Meetings

Chairs are responsible for scheduling meetings and providing adequate notice to committee members.

11.2.10. Minutes and Reporting

- A. Minutes of all meetings, unless otherwise stated, will be forwarded to the Medical Staff Services Department, which will serve as the official repository for official business of the Medical Staff. Chairs of Committees will utilize a standardized meeting minutes template maintained by the Medical Staff Services Department. (See Appendix 4.)
- B. Minutes of meetings will include, at a minimum, summaries and recommendations of any and all new policies or changes in policy. Such recommendations will be submitted to the Medical Executive Committee for its approval.
- C. Each committee must submit reports to MEC on its activities, including policy recommendations, per the guidelines set forth below. Each report must be approved by the committee, to include subcommittees, before being brought forward to the MEC. Such reports will be made by the committee chair, or designee if not available:
Ambulatory Care.....Annually

Bylaws	No less than every two years
Cancer	Twice yearly
Credentials	Every month
Critical Care	Twice yearly
Ethics	Twice yearly
Infection Control	Twice yearly
Well Being	Twice yearly
Operating Room	Twice yearly
Pharmacy and Therapeutics	Every month
Performance Improvement and Patient Safety	Every month
Utilization Management Committee	Twice yearly
Lab Committee	Every three months

- D. Minutes of all meetings of standing committees, as well as any committee addressing peer review processes, are confidential as peer review processes under Section 1157 of the Evidence Code as is all material caused to be prepared for the use of said committees. Likewise, any business before these peer review bodies must be treated with the utmost confidentiality and not be discussed or disseminated outside of the protection of the peer review body or organization except as allowed or required by law.

11.2.11. Special Meetings

Special meeting of any standing committee may be called or requested by the Chair or Chief thereof, by the Chief of Staff, or by one-third (1/3) of the committee's voting members, but not less than two (2) voting members. The agenda must be included in the call to meeting. Notice must be given in writing at least two (2) weeks in advance of such called meeting to all voting members of the committee. Only matters included in the agenda may be considered at a special meeting.

11.2.12. Terms of Committee Members

Unless otherwise specified, committee members are appointed for term of one (1) year.

11.2.13. Removal

If a member of a committee ceases to be a Member in good standing of the Medical Staff or an Affiliated Professional in good standing or suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that committee member may be removed by the Chair and Chief of Staff. Any committee member whose employment or contract relationship with the Hospital or whose membership in the Medical or Affiliated Staff ends under any provision of these Bylaws is automatically removed from membership in each committee on which they had served.

11.2.14. Vacancies

Unless otherwise specifically provided, vacancies on any committee will be filled in the same manner in which an original appointment to such committee is made, provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Chair and Chief of Staff.

11.3. Medical Executive Committee (MEC)

11.3.1. Composition of MEC

The MEC consists of a group of voting members and group of non-voting members.

Voting members the Officers of the Medical Staff, the Chiefs of the twenty (20) Clinical Services identified in subsection 9.1.2 herein, the Director of Health, the Chief Medical Officer of the San Francisco Health Network, the Chief Executive Officer, the Vice Dean, the Chair of the Credentials Committee, the Chief Medical Officer (CMO), the Chief of Performance Excellence, four (4) At-Large representatives (each either a Member or Affiliated Professional, with at least one Affiliated Professional) elected in accordance with these Bylaws, and up to three (3) representatives of the House Staff appointed by the Chief of Staff.

Non-voting members include the Chief Nursing Officer, an Affiliated Professional who co-chairs the Committee for Interdisciplinary Practice (CIDP), the Associate Chief Medical Officer (ACMO) of Medical Surgical Services, the ACMO of Perioperative Services, the ACMO of Critical Care Services, the ACMO of Care Coordination, the ACMO of Performance Excellence, the Medical Director of Performance Excellence and Improvement, the Chief Pharmacy Officer for the San Francisco Department of Public Health,.

The Chief of Staff may invite other persons to attend meetings.

11.3.2. Attendance and Voting

- A. It is the expectation that all Members and Affiliated Professionals on MEC will attend MEC meetings and will send an alternate when unable to attend. If a Member or Affiliated Professional fails to attend fifty percent (50%) of the MEC meetings during a Medical Staff Year, the Chief of Staff may appoint an alternate to serve in that Member or Affiliated Professional's place for the following Medical Staff Year.
- B. Each At-Large representative has one (1) vote.
- C. When a Chief of Service cannot attend a meeting, the Chief may designate an alternate to attend and exercise a proxy vote in the Chief's absence.
- D. When a Chief of Service also holds the position of an officer of the Medical Staff or serves as the Vice Dean, no additional member of the MEC will be named, and that single individual will represent both membership categories and have only one (1) vote.
- E. The three (3) representatives of the House Staff will collectively have a single vote.

11.3.3. Officers and At-Large Representatives

- A. The current or acting Chief of Staff will serve as the Chair of the MEC.
- B. The Chief of Staff-Elect will serve a one (1) year term when elected at the annual meeting of the Medical Staff or will serve for the remainder of the unexpired term of the vacancy the Chief of Staff-Elect fills when elected by the MEC.
- C. The Chief of Staff-Past will serve a one (1) year term after completion of the Chief's year as Chief of Staff.
- D. The four (4) At-Large MEC representatives who are elected will not serve more than three (3) consecutive one (1) year terms. However, an At-Large representative may not be appointed to a successive term if the At-Large representative has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.

- E. Vacancies in any of the four (4) At-Large representative positions arising during the Medical Staff Year will be filled by the nomination of a Member of the Active Medical Staff or Affiliated Professional by the Chief of Staff and approval by a vote of the MEC.

11.3.4. Duties of MEC

The Medical Staff delegates to the MEC broad authority to oversee the operations of the Medical Staff. Under the leadership of the Chief of Staff, and without limiting this broad delegation of authority, the MEC must perform in good faith the duties listed below.

- F. Represent and act on behalf of the Medical and Affiliated Staff, subject to such limitations as may be imposed by these Bylaws;
- G. Coordinate the activities of the Medical Staff committees and of the Clinical Services;
- H. Receive and act upon reports and recommendations from Medical Staff Committees and Clinical Services;
- I. Provide a forum in which the Medical Staff leadership can discuss issues and recommendations with the Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, and Vice Dean;
- J. Fulfill the Medical and Affiliated Staff's accountability to the Governing Body for the quality of care rendered to patients;
- K. Ensure that the Medical Staff and Affiliated Professionals are kept abreast of new laws, regulations, licensing and accreditation standards, and CMS Conditions of Participation;
- L. Review the credentials of all Applicants and make recommendations to the Governing Body for Member and Affiliated Staff appointments, assignments to departments, and delineation of Clinical Privileges and Standardized Procedures;
- M. Review the recommendations from the Credentials Committee and make recommendations to the Governing Body for reappointment and renewal or changes in Clinical Privileges, Affiliate Status and Standardized Procedures;
- N. Ensure the professional and ethical conduct and competent clinical performance of Medical and Affiliated Staff Members, including the initiation of investigations and corrective action when warranted;
- O. Review and approve all hospital-wide administrative and environment of care policies and clinical policies proposed by Medical Staff committees; and
- P. Make recommendations directly to the Governing Body for its approval regarding the following:
 - 1) The Medical Staff's structure;
 - 2) The mechanism used to review credentials and to delineate individual clinical privileges.
 - 3) Appointment and reappointment for Medical and Affiliated Staff Members;
 - 4) Delineated Clinical Staff Privileges or Affiliated Status for each eligible individual;

- 5) The mechanism for hearing procedures and the mechanism by which Membership on the Medical or Affiliated Staff may be terminated
 - 6) The appropriate steps associated with restrictions on Clinical Staff Privileges or Affiliated Status ; and
 - 7) The organization of the quality assessment and improvement activities of the Medical and Affiliated Staff.
- Q. To amend these Bylaws and Rules and Regulations in accordance with Article 16, in the case of a documented need for an urgent amendment necessary to comply with law, regulation, or deficiency issued by The Joint Commission or state or federal regulating body; and
- R. To take such other actions as may reasonably be deemed necessary in the best interest of the Medical Staff and Hospital. The authority delegated pursuant to this subsection 11.3.4 may be removed by amendment of these Bylaws and Rules and Regulations.

11.4. Nominating Committee

11.4.1. Composition

The Committee will be chaired by the Chief of Staff-Past or, in years in which there is no Chief of Staff-Past, the Chief of Staff. The Chair will appoint four (4) Members from the Active Medical Staff to serve on the committee, and at least one of these appointees will be from the Community Primary Care Service and at least one (1) will be an Affiliated Professional. The Vice Dean, Chief Medical Officer, and Chief Executive Officer will also be Members of the committee.

11.4.2. Duties

The committee will act upon the following requirements:

- A. Nominate a Member of the Active Medical Staff to serve as Chief of Staff-Elect prior to the end of the first year of the Chief of Staff's term of office.
- B. Should the incumbent Chief of Staff be re-nominated to serve an additional year, a previous Chief of Staff will also be nominated as Chief of Staff-Past until a new Chief of Staff-Elect is nominated.
- C. Nominate four (4) Members of the Active Medical and Affiliated Staff to serve a one-year term as Members-At-Large on the MEC (including at least one(1) Affiliated Professional). Members-At-Large may not serve more than three (3) consecutive years. An At-Large Member may not be appointed to a successive term if that Member has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.
- D. Election of the Medical Staff Officers will occur at the Annual Meeting in accordance with subsection 8.2.2 herein.

11.4.3. Meetings

The Committee will meet as needed to carry out these duties and will maintain records of its activities and meetings.

11.5. Ambulatory Care Committee

11.5.1. Composition

This committee will consist of Medical Staff Members from the Clinical Services:

- E. A minimum of one (1) Active Physician Member of the Medical Staff or Affiliated Professional from: Medicine, Medical Subspecialty, Family and Community Medicine, Community Primary Care (CPC), Pediatrics, Obstetrics-Gynecology, Surgical Service, and Emergency Medicine. Members of the Medical Staff from other Clinical Services may be on the committee as deemed appropriate by the Co-chairs and Chief of Staff. This may include, but is not limited to, representatives from Hospital Administration, Nursing, Information Services, Laboratory Medicine, Pharmacy, Radiology, and Quality Management.
- F. The committee will be co-chaired by an Active Member of the Medical Staff from Community Primary Care and the Associate Chief Medical Officer for Specialty Care and Diagnostics or the Associate Chief's designee.

11.5.2. Duties

The committee will:

- A. Address cross-department operational issues, with a focus on communication, coordination of services, and inter-disciplinary problem solving. The committee will engage on-and off-campus primary care, medical and surgical specialty services, and diagnostic and ancillary services in identifying and addressing areas of need.
- B. Serve as a forum to discuss issues related to the planning, development, quality, and delivery of integrated ambulatory care services.
- C. Lead the development of Hospital policies, procedures, practices, and measurement tools that are common to department, services, and programs providing ambulatory care services.
- D. Review clinic-specific practices as needed to ensure that they are aligned with the Hospital's mission and operational and organizational systems.
- E. Identify opportunities to improve care in the ambulatory setting: that relate to clinical, diagnostic, or ancillary services; that relate to patient experience; or at the request of committee members or the Chief of Staff.
- F. Develop and maintain a communication network for the Hospital and CPC leaders in ambulatory care.
- G. Facilitate linkages and collaboration between: primary care in the sub-specialty care providers; hospital based and community based providers; and medical providers and other clinical disciplines.

11.5.3. Meetings

This Committee will meet at least quarterly but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

11.5.4. Reporting

This Committee must submit a written report to the MEC on its activities, including policy recommendations, annually.

11.6. Bylaws Committee

11.6.1. Composition

This Committee will consist of at least seven (7) Members of the Active Medical Staff including the Chief of Staff, Chief of Staff-Elect, Chiefs of Staff-Past, the Chief Medical Officer, one representative from Hospital Administration, one representative from the Dean's Office, and one representative from the CPC service. The Chair will be the Chief of Staff-Elect or co-chaired with the Chief of Staff. While Affiliated Staff Members are not voting members, they may be invited to join the committee to give input to voting members.

11.6.2. Duties

The Committee will conduct a periodic review of the Medical Staff Bylaws and Rules and Regulations no less than every two years and submit recommendations for changes to the MEC prior to any required notification of the Active Medical and Affiliated Staff.

11.6.3. Meetings

The Committee will meet at least annually but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

11.7. Cancer Committee

11.7.1. Composition

The Cancer Committee will consist of five (5) Active Medical Staff Members representing each of Diagnostic Radiology, Pathology, Medical Oncology, Palliative Care, and General Surgery. Other Members will include: the Cancer Program Administrator, an Oncology Nurse, a Radiation Oncologist, a Social Worker, a Certified Tumor Registrar, a Performance Improvement representative, someone from Clinical Research, a Genetics professional/counselor, someone from Rehabilitation Services, a Registered Dietician, and a Pharmacist.

11.7.2. Duties

The Cancer Committee will:

- A. Actively supervise the Tumor Registry doing quality review of abstracting, staging, and completeness of extent of disease information. This will include ensuring that the Tumor Registry meets the standards of the American College of Surgeons and Commission on Cancer.
- B. Appoint and oversee the functions of the Tumor Board, a separate, multidisciplinary, weekly consultative and education committee.
- C. Perform continuous quality improvement functions for the Medical Staff with respect to cancer patients. These include working with individual Clinical Services and Hospital Administration as well as performing patient care evaluations as mandated by the Commission on Cancer.
- D. Ensure that consultative services from all major disciplines are available for all Hospital cancer patients.

- E. Ensure that educational programs for the Medical and Affiliated Staff include all major cancer treatment sites.

11.7.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.7.4. Reporting

This Committee must submit a written report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.8. Credentials Committee

11.8.1. Composition

The Credentials Committee will consist of at least eight (8) Members of the Active Medical Staff, including the Chief of Staff, an officer of the MEC, one (1) Member from the CPC service, and at least one Affiliated Staff Member of the Interdisciplinary Practice Subcommittee. Two (2) of the Members will be Chiefs or Assistant Chiefs of Clinical Services and at least one Member will be from a clinical area where surgery is practiced (Surgery, Ob/Gyn., Orthopedics, Otolaryngology, or Neurosurgery).

11.8.2. Duties

The Credentials Committee will:

- F. Review the credentials of Applicants and make recommendations for membership and Affiliate Status and delineation of Clinical Privileges and Standardized Procedures in compliance with these Bylaws;
- G. Make a report to the MEC on each Applicant for Medical and Affiliated Staff membership, Clinical Privileges, and Affiliate Status which will include recommendations from the appropriate Chief of Service; and
- H. Review all information available regarding the competence of Medical and Affiliated Staff Members and as a result of such review makes recommendations for the granting of Clinical Privileges or Affiliate Status, reappointments, and the assignment of Applicants to the various Clinical Services as provided in these Bylaws.

11.8.3. Meetings

The Credentials Committee will meet monthly at least ten (10) times per year and maintain a permanent record of its procedures and activities.

11.8.4. Reporting

The Credentials Committee must report to the MEC regarding approval of Medical and Affiliated Staff, which includes recommendations from the appropriate Chief of Service monthly.

11.8.5. Subcommittees

- A. **Clinical Interdisciplinary Practice Subcommittee (CIDP)**
 - (1) Composition

Commented [LG(1)]: Note – Updated formatting to match committees with larger lists of subcommittees below.

The Subcommittee will consist of the Chief Nursing Officer, the Chief Executive Officer or their designees, and an equal number of Physicians appointed by the MEC and registered nurses appointed by the Chief Nursing Officer. Affiliated Staff Members who are licensed or certified in professions other than nursing will also be included in the Subcommittee.

(2) Duties

This Subcommittee will:

Review and approve standardized procedures and privileges and protocols for patient care activities of the Affiliated Staff Members in accordance with the requirements of Title 22 of the California Code of Regulations governing committees on interdisciplinary practice.

(3) Meetings

This Subcommittee will meet at least quarterly and maintain permanent record of its proceedings and activities.

(4) Reporting

This Subcommittee must report and forward recommendations to the Credentials Committee on a monthly basis regarding approval as an Affiliated Staff Member.

11.9. Critical Care Committee

11.9.1. Composition

This Committee will consist of: Active Medical Staff Members who are Directors or Assistant Directors of critical care units and the Emergency Department; a nurse representative from each critical care unit and the Emergency Department; and one (1) representative each from Nursing Administration, Hospital Quality Management, Post Anesthesia Recovery, and Respiratory Therapy. One (1) House Staff Member will also be invited to serve.

11.9.2. Duties

This Committee will coordinate procedures, practices, and equipment in the various emergency areas in critical care units of the Hospital and will make recommendations to the MEC regarding these and related quality of care matters.

11.9.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

11.9.4. Reporting

This Committee must submit a report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.9.5. Subcommittees

A. Donor Council Subcommittee

(1) Composition

The Subcommittee will consist of at least one representative, who is a Medical Staff Member or Affiliated Professional from each of the following areas: Critical Care; Medical

Staff; Attending Neurologist/Neurosurgeon; a nurse representative from each critical care unit; the Emergency Department; and the Medical-Surgical, Peri-Operative, and Perinatal divisions. The Subcommittee will also include a representative from the Hospital's Organ Procurement Organization (OPO). A physician will serve as Chair of this Subcommittee.

(2) Duties

The Subcommittee will:

- Review data collected by the OPO;
- Prepare reports on donor statistics for Quality Management and the Critical Care Committee;
- Review and revise Hospital policies, as needed;
- Review and discuss concerns related to the donor process; and
- Coordinate education activities hospital-wide, as needed.

(3) Meetings

The Subcommittee will meet quarterly and maintain permanent records of its proceedings and activities.

(4) Reporting

The subcommittee must report to the Critical Care Committee on a twice-yearly basis.

11.10. Ethics Committee

11.10.1. Composition

The Committee will consist of no fewer than fifteen (15) Members. These Members will include: representatives of the Medical and Nursing Staffs, the Critical Care Units, the inpatient and outpatient departments; representatives of Hospital Administration and the Quality Management Department; and a Deputy City Attorney. One (1) Member of the House Staff will also be invited to serve.

11.10.2. Duties

This Committee will educate the Hospital community regarding ethical principles, facilitate interchange in ethical decisions, and help develop ethical guidelines. The Committee, or a subgroup of the Committee, will also meet as needed to provide consults on specific situations or issues.

11.10.3. Meetings

The Ethics Committee will meet monthly at least ten (10) times a year and maintain a permanent record of its proceedings and activities.

11.10.4. Reporting

The Ethics Committee must submit a written report to the MEC including policy recommendations, on a twice-yearly basis.

11.11. Infection Control Committee

11.11.1. Composition

This Committee will consist of Members from the Active Medical Staff
from several services and others with expertise in clinical care and operations pertinent to infection prevention and control.

Current members include:

A. Medical Staff:

1. Medicine, with expertise in Infectious Diseases and Infection Prevention and Control
2. Laboratory Medicine
3. Family Medicine, with expertise in Infectious Disease
4. Pediatrics
5. Anesthesiology

B. Infection Prevention and Control Program Manager

C. Chief Quality Officer

D. Infectious Disease Pharmacist

E. Director of Microbiology or designee

F. 4A Skilled Nursing Facility Nurse Manager

G. Inpatient Nursing Administrative Representative

H. Patient Safety Officer

I. Senior Industrial Hygienist

J. Infection Control Department Members, including Infection Control Practitioners, Analyst, and Data Manager

K. Environmental Services

L. Facilities Management, or Designee

M. Occupational Health, or Designee

N. Materials Management Representative

O. Administration Representative

P. Food and Nutrition Services Representative

Q. Respiratory Therapy Representative

R. Any other department representative or consultant deemed advisable by the committee chair

S. Additional Ad Hoc or Consultant Members (non-voting), as needed

Deleted: diverse services involved in clinical care and operations.

Formatted: Normal

Deleted: ¶

Deleted: <#>Medicine, with expertise in Occupational Health (when position is filled)¶

Deleted: <#>Inpatient Nursing Administrative Representative¶

Deleted: Outpatient

Deleted: Director

Deleted: <#>Infectious Diseases Pharmacist¶

Formatted: Indent: Left: 0.5", No bullets or numbering

11.11.2. Duties

This Committee is responsible for directing the infection control program for the Hospital and other entities covered under the Hospital license, such as on-site clinics and the 4A Skilled Nursing Facility. The Committee will: guide and help prioritize the activities of the Infection Control staff; assist with definitions and guidelines for surveillance of infections; receive reports of infection rates, clusters of infections, and outbreaks; promote a prevention program designed to minimize infection hazards; review procedures and programs for surveillance and prevention of infections in healthcare workers and other staff; and review and approve infection control policies and procedures. The Infection Control Committee may institute appropriate control measures or investigations when there is a reasonable concern of danger to patients or staff.

11.11.3. Meetings

This Committee will meet at least bimonthly and maintain a record of proceedings and activities.

11.11.4. Reporting

The Infection Control Committee must submit a written report to the MEC on its activities, including policy recommendations, semi-annually.

11.12. Well Being Committee

11.12.1. Composition

The Well Being Committee is comprised of no less than three (3) Active Members of the Medical and Affiliated Staff, a majority of which, including the Chair, will be physicians. Insofar as possible, members of this Committee should not serve as active participants of other peer review or continuous quality improvement committees.

11.12.2. Duties

The duties of the committee are as follows:

- T. To foster and actively support the well-being of Medical Staff Members and, as appropriate and consistent with labor agreements, if applicable, Affiliated Professionals;
- U. To support Chiefs of Service in addressing well-being issues among Medical Staff Members and Affiliated Professionals on their team, including faculty, staff, and trainees;
- V. To provide education to Medical and Affiliated Staff Members about illness and impairment issues specific to such Members ;
- W. To facilitate self-referral by Medical Staff Members and, as appropriate, Affiliated Professionals and referral by other organization staff;
- X. To facilitate referral of the affected Medical Staff Members and, as appropriate, Affiliated Professionals to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
- Y. To provide for the maintenance of the confidentiality of the Medical Staff Members and Affiliated Professionals, as appropriate and consistent with existing human resources practices and labor memorandums of understanding, seeking referral or referred for assistance, except: as limited by law or ethical obligation; as allowed by these Bylaws or any labor agreement; or when the safety of a patient is threatened;

Deleted: <#>Additional Ad Hoc or Consultant Members (non-voting);
Sterile Processing Department Manager;
Operating Room Manager; and
Food & Nutritional Services Director.

- Z. To assure evaluation of the credibility of a complaint, allegation, or concern;
- AA. To monitor the affected Medical Staff Member or Affiliated Professional and the safety of patients until the rehabilitation or any disciplinary process is completed;
- BB. To assure a reporting to the Medical Staff leadership in instances in which a Medical Staff Member or Affiliated Professional is providing unsafe treatment; and
- CC. To provide assistance, counseling, and referrals for disruptive Medical Staff Members or Affiliated Professionals

11.12.3. Meetings

The Committee will meet at least every 3 months, and more frequently as necessary. It will maintain only such record of its proceedings and activities as it deems advisable.

11.12.4. Reporting

The Well Being Committee must submit a written report to MEC on its activities, including policy recommendations, semi-annually.

11.13. Operating Room Committee

11.13.1. Composition

This Committee will consist of:

- Medical Staff Members representing all services performing procedures within the perioperative areas;
- The Department of Anesthesia;
- The Perioperative Nursing Director;
- The Chief of the Infection Control Committee;
- The Director of the Blood Bank;
- A representative from Hospital Administration; and
- One (1) non-voting Member of the House Staff (who will be invited to serve)

11.13.2. Duties

The Operating Room Committee is responsible for the evolution of the safe, proper, and efficient utilization of Operating & Procedural Rooms within the Hospital, including the Surgical and Procedural unit and the operating rooms in Labor & Delivery. This Committee is responsible for the development of policies and procedures regarding the safe, proper, and efficient conduct of surgical procedures.

11.13.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

11.13.4. Reporting

The Operating Room Committee must submit a written report to MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.14. Pharmacy and Therapeutics Committee

11.14.1. Composition

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the Community Primary Care service. In addition, representatives from the Pharmaceutical Service, the Nursing Service, Nutrition Services, Hospital Administration, Affiliated Professionals and other services as appropriate will serve with a vote. The Director of Pharmaceutical Services, or designee, will serve as Secretary to the Committee. A Member of the Medical Staff with expertise in pharmacology shall serve as Chair. The Chief Pharmacy Officer will serve as Vice Chair.

11.14.2. Duties

This Committee is responsible for the development and surveillance of all drug use policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to pharmaceuticals in this Hospital and its clinics. It will also perform the following specific functions:

- A. Serve as an advisory group to the Medical Staff and the Department of Pharmaceutical Services on matters pertaining to the choice of available drugs;
- B. Publish and maintain the Hospital formulary;
- C. Establish and maintain standards concerning the use and control of investigational drugs and of research in the use of approved drugs;
- D. Make recommendations concerning drugs to be stocked on nursing units and other special services;
- E. Prevent unnecessary duplication in stocking pharmaceuticals;
- F. Evaluate clinical data concerning new pharmaceuticals requested for use in this Hospital and make recommendations to the MEC regarding what pharmaceuticals should be made available and placed on the formulary;
- G. Review and recommend changes to medication use policies, guidelines, and standardized medication orders to ensure safe and appropriate prescribing, administration, and monitoring of medications;
- H. Review and recommend changes in the electronic health record platform (*e.g.*, Epic) to improve the quality, safety, and efficiency of care delivered;
- I. Review medication-related issues and content from groups including but not limited to the Clinical Decision Support Committee and the Procedural Sedation Subcommittee, and examples include review of ordersets, best practice advisories, smartsets, medication alerts, and guidelines for use;
- J. Promote medication use safety; and
- K. Report issues to the Performance Improvement and Patient Safety Committee.

11.14.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.14.4. Reports

This Committee shall submit a written report to MEC on its activities, including policy recommendations to the MEC monthly.

11.14.5. Subcommittees

The Committee will conduct the majority of its business through five (5) subcommittees. The Chair of each subcommittee will be a member of the Pharmacy and Therapeutics Committee and will be appointed by the Chair of the Committee with the approval of the Chief of Staff.

A. Antibiotic Advisory Subcommittee

This Subcommittee is responsible for reviewing antibiotics and related therapies. The Subcommittee will assist the Formulary Review Subcommittee in conducting drug use evaluations for antibiotic therapy. The subcommittee will work closely with the Infection Control Committee and the Clinical Laboratories.

B. Formulary Review Subcommittee

This Subcommittee is responsible for evaluating all requests for changes to the Formulary including additions of new drugs, new uses for current drugs, and deletions from the Formulary. The Subcommittee will also conduct periodic reviews of drug classes to assess appropriate use and promulgate guidelines for the use of drugs in clinical areas as appropriate.

C. Nutrition Subcommittee

The Subcommittee will recommend therapeutic enteral and parenteral nutritional formulations for the Formulary and monitor and assess nutritional therapies. Additionally, the Subcommittee will review and approve policies and procedures relating to nutritional therapy of the Food and Nutritional Service, Outpatient Nutrition Service, and the Nutritional Support Services, including the Diet Manual.

D. Pain Management Subcommittee

This Subcommittee will recommend and periodically review a program to promote effective pain management. It will collaborate with the Medication Error Reduction Plan Subcommittee around policies related to pharmacotherapy of pain. It will review and recommend policies and procedures pertinent to pain management.

E. Medication Error Reduction Plan Subcommittee

This Subcommittee will set system-wide and department-specific policies to reduce medication errors and adverse drug events. The subcommittee will review and revise the California Department of Public Health-mandated Medication Error Reduction Plan annually to assess effectiveness and identify weaknesses or deficiencies that could contribute to errors. The subcommittee will also review and report all unusual occurrences related to medications and make recommendations to the Pharmacy and Therapeutics Committee on ways to prevent such occurrences in the future.

11.14.6. Subcommittee Reporting

The subcommittees will report to the Pharmacy and Therapeutics Committee monthly.

11.15. Performance Improvement and Patient Safety Committee (PIPS)

This is a Joint Hospital Administration and Medical Staff committee responsible for implementing the objectives of the organization-wide performance improvement and patient safety program. The committee takes an interdisciplinary and proactive approach to the prevention of adverse events, medical errors, and near misses, and promotes patient outcomes/safety and reduction of health disparities as the core values in providing quality patient care.

11.15.1. Composition

This Committee will consist of at least seven (7) physician representatives from the Active Medical Staff. Up to three (3) additional representatives from clinical services may include Affiliated Professionals. It will also include one (1) representative from each of Radiology, Clinical Lab, Pharmacy, Infection Prevention and Control, and Nursing. In addition, the Executive Leadership Team including the Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Pharmacy Officer, and UCSF Vice Dean will serve with one vote. The Administrative Director of Utilization Management and the Patient Safety Officer will also be Members. The Chief Executive Officer, Chief Medical Officer, or an Associate Chief Medical Officer will serve as the Chair, and the Chief Quality Officer will serve as Vice-Chair.

11.15.2. Duties

This Committee:

- A. On an annual basis, reviews the effectiveness of Hospital Performance Improvement and Patient Safety Program in meeting the organizational-wide purpose, goals, and objectives and revises the program as necessary.
- B. Identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from focused reviews and sentinel events in the Joint Commission Sentinel Event Alerts, patient case reviews, risk management reports, hospital claims, patient and staff surveys, utilization review data, patient/visitor concerns, clinical service and ancillary/diagnostic department performance improvement reports, ongoing medical record review, and other sources as appropriate.
- C. Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and performance improvement committees as appropriate.
- D. Makes recommendations based on an evaluation of the care provided (e.g., efficacy, appropriateness) and how well it is done (e.g., availability, timelines, effectiveness, continuity with other services, safety, efficiency, respect, and caring).
- E. Submits an annual report to the MEC.
- F. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources through the designation of Performance Improvement.

11.15.3. Meetings

The Committee will meet monthly at least ten (10) times a year. The Committee will maintain permanent records of its proceedings and activities.

11.15.4. Reporting

The Performance Improvement and Patient Safety Committee must report and forward recommendations monthly to the Joint Conference Committee through the Chief Medical Officer and Chief Quality Officer, based on the review and recommendations made by the MEC.

11.15.5. Subcommittees

The Committee will maintain and utilize the following subcommittees to do the work as described:

A. Code Blue Subcommittee

(1) Composition

This subcommittee will consist of physician representatives from Cardiology, Emergency Department, Pulmonary Service, and Anesthesia. Additional representatives from Respiratory, Nursing Pharmacy, Product Evaluation and Quality Management will also serve.

(2) Duties

This subcommittee will oversee the organization of the Code Blue Team (*e.g.*, personnel composition, Member's roles and responsibilities, availability of equipment, scope of service area, and communication mechanisms). All findings from codes related to quality improvement activities will be reported to this subcommittee for evaluation and recommendations.

(3) Meetings

The Code Blue Subcommittee will meet monthly and maintain permanent records of its proceedings and activities.

(4) Reporting

The Code Blue Subcommittee must submit a written report to PIPS on a once-yearly basis.

B. Event Analysis & System Improvement Subcommittee (EASI)

(1) Composition

This subcommittee will consist of at least eight (8) Members of the Active Medical Staff, including representatives from the Clinical Services of Medicine, Surgery, Pediatrics, Family and Community Medicine, Obstetrics and Gynecology, Psychiatry, and Emergency Medicine. In addition, representatives from Hospital Risk Management, UCSF Risk Management, Hospital Administration, Quality Management, and the Chief Nursing Officer or designee will also serve. The Medical Director of Risk Management or designee will serve as Chair for this subcommittee. The Director of Risk Management will serve as Vice Chair.

(2) Duties

The Subcommittee will:

- a. Provide oversight of the quality and safety event review process;
- b. Provide oversight to ensure identification of clinical risk, system vulnerabilities, and opportunities for quality improvement;

- c. Ensure implementation of recommend corrective action to mitigate or eliminate future recurrence of similar events; and
- d. Establish a framework that improves clinical and operational systems, patient safety, and quality outcomes using a shared accountability model.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times per year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Subcommittee must submit a written report to PIPS on a twice-yearly basis.

C. Transfusion Subcommittee

(1) Composition

This subcommittee will consist of the Nurse Manager for the Operating Room, the Nurse Manager for the Surgical Clinics, the Blood Bank Manager, the Director of the Transfusion Service/ Blood Bank, and at least one (1) Member each from the Departments of Anesthesia, Surgery, Obstetrics, Pediatrics/Neonatology, Hematology/Oncology, and Emergency Services.

(2) Duties

This subcommittee will review transfusion-related issues in the Hospital, including the appropriateness of the use of blood and blood components, blood component wastage, and all transfusion reactions. The findings of such reviews will be reported to the PIPS Committee and Chiefs of the Clinical Services, when appropriate. The subcommittee will develop and approve policies and procedures regarding transfusion practices and make recommendations based on results.

(3) Reporting

This subcommittee must submit a written report to PIPS on a twice-yearly basis.

D. Trauma Program Operational Process Performance Subcommittee

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director, and the Trauma Program Manager will serve as Vice Chair. The subcommittee will consist of the representatives from the Departments of Emergency Medicine, Anesthesia, Neurosurgery, Orthopedics, Radiology, Physical Medicine, Rehabilitation, Respiratory Therapy, Perioperative Services, Laboratory Medicine, and Pediatrics; the Nursing Directors or Managers of the Surgical ICU, Emergency Department, Surgical Nursing, PACU, and Operating Room; Neurosurgical, Emergency Department, and Surgical CNS representatives; Risk Management and Quality Management Nursing representatives; Trauma PI Coordinators, Trauma, Orthopedic, and Neurosurgical NP representatives; the Medical Director of SFFD Emergency Medical Services Division, ZSFG Base Hospital Coordinator, EMSA Medical Director and Trauma Coordinator, and San Mateo EMS Clinical Coordinator; and other professionals who are invited to participate as needed.

(2) Duties

This subcommittee will address, assess, and correct global trauma program and system issues. The membership will review all major clinical activities and systems of trauma care and will:

- a. Evaluate system and medical performance through objective and systematic monitoring;
- b. Identify, analyze, and track problems;
- c. Develop and implement plans for improvement, resolution, and modification of current systems of trauma care;
- d. Communicate the results of reviews and plans of correction to all program related services/departments;
- e. Trend and measure the effectiveness of corrective action; and
- f. Document the reporting of patient safety initiatives and continuous quality improvement activities.

(3) Meetings

This subcommittee will meet on a monthly basis at least ten (10) times per year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

E. Trauma Multidisciplinary Peer Review Subcommittee

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director. The subcommittee will consist of the Chiefs-of-Service, or their designated representatives, of the following Departments: Surgery, Emergency Medicine, Anesthesia, Neurosurgery, Orthopedic Surgery, Radiology, Laboratory Medicine/Blood Bank, and Pediatrics. Additional members include the Co-Directors of Surgical ICU, the Hospital Director of Patient Safety and Performance Improvement, and all members of the Department of Surgery regularly participating in the care of acutely injured patients. Other attendees will include the Trauma Program Manager and Trauma Performance Improvement staff.

(2) Duties

This subcommittee will assure the equality and appropriateness of trauma care at this Hospital as it relates to performance of individual providers and the interaction between providers of different disciplines. The subcommittee will review clinical activity and outcomes (deaths, complications, errors) and will:

- a. Evaluate provider performance through objective and systematic monitoring;
- b. Analyze problems related to provider performance and develop plans for improvement, resolution, and modification of current practices;

- c. Communicate the results of review and plans of correction to all members of the Committee and the Trauma Panel;
 - d. Facilitate and direct a development of clinical management guidelines or protocols for the management trauma; and
 - e. Measure the effectiveness of any corrective action taken or protocols generated.
- (3) Meetings

The subcommittee will meet on a monthly basis at least ten (10) times/year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

F. Tissue Subcommittee

(1) Composition

This subcommittee will consist of attending physicians from Pathology (including the Chief of Pathology) selected by the Tissue Subcommittee Chair, and other members that the Chief of Staff appoints from surgical subspecialties and other areas.

(2) Duties

- a. The Tissue Subcommittee is responsible for the review of selected surgical case reports; those with pathology reports will correlate pre and post-operative diagnosis and pathology findings. Discrepancies will be presented to the Performance Improvement and Patient Safety Committee. The Tissue Subcommittee will review tissue specimens submitted to Pathology to ensure proper tissue handling and adequate completion of requisition forms.
- b. The subcommittee will also make recommendations based on results.

(3) Meetings

The Tissue Subcommittee will meet as needed, but no less than twice per year, and maintain permanent records of its proceedings and activities.

(4) Reporting

The Tissue Subcommittee must submit a written report to PIPS quarterly.

G. Procedural Sedation Subcommittee

This subcommittee will oversee the administration of moderate or deep sedation and anesthesia. The activities of the subcommittee will include physician and registered nursing training and formulating policy and procedures for the administration of moderate or deep sedation and anesthesia by non-anesthesia trained personnel.

(1) Composition

The subcommittee will be Co-Chaired by the Chief of Anesthesia or designee and a nursing administrator and consist of physician and nursing representatives from all clinical

services providing procedural sedation, including: Gastroenterology, Radiology, Oral and Maxillofacial Surgery, Pulmonology, Emergency Medicine, Critical Care, Women's Option Clinic, Neonatal Intensive Care Unit, Post Anesthesia Care Unit, the Cardiac catheterization lab, and the Clinical and Translational Science Institute.

(2) Duties

This subcommittee is tasked with setting systemwide and department-specific procedural sedation policy to ensure the safe delivery of procedural sedation and to meet regulatory compliance requirements for procedural sedation throughout the institution. Policies will be reviewed and revised no less frequently than every three years. The subcommittee will track audit data on a quarterly basis. All procedural sedation-related unusual occurrences will be discussed and any recommendations forwarded to the involved department.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times annually and maintain permanent records of its meetings and activities.

(4) Reporting

The subcommittee must submit a written report to PIPS on a twice-yearly basis.

11.16. Utilization Management Committee

11.16.1. Composition

This Committee will consist of at least three (3) Members of the Active Medical Staff or Affiliated Professionals, including the Associate Chief Medical Officer of Care Coordination (or their designee), who will serve as the Chair of the committee. The Committee must include at least two doctors of medicine or osteopathy. The committee will include representation from Ambulatory Care and Behavioral Health Services. Other individuals from the clinical, administrative, and support services whose participation is deemed necessary to increase the effectiveness of the work of the committee will be invited to meetings as needed.

11.16.2. Duties

This Committee has two primary functions:

- A. Provide oversight for all Utilization Management functions, and
- B. Make rational and system-coordinated recommendations on the priority of clinical services and resource allocation related to clinical care based on best available evidence.

11.16.3. Utilization Data Review

The Committee will review data related to Utilization Management at least semi-annually, including, but not limited to:

- Medical necessity/appropriateness of hospital admissions and readmissions
- Medical necessity/appropriateness of continued stay and treatment authorizations
- Lengths of stay variations and timeliness of discharge
- Professional services furnished, including drugs and biologicals
- Appropriate availability and use of ancillary services
- Overuse, underuse, and timeliness in provision of services

- Therapeutic procedures
- Adequacy of medical record documentation
- Third party payer denials
- Utilization of the Tertiary Care Contract
- Contracted Health Plan utilization and cost data
- Out-of-network referral costs
- Utilization Review Plan (review and approve annually)

Review of the above data elements may be concurrent or retrospective, and may be conducted on a sample basis for cases reasonably assumed to be outliers based on lengths of stay or extraordinary high costs. The Utilization Management Committee will work closely with financial services, social services, case management, patient placement services, and the Medical Staff to maximize appropriate utilization of resources. The Utilization Management Committee will report relevant findings to the Medical Executive Committee including problems, areas of opportunity, and actions addressed with departments, Clinical Services, Medical Staff, and other hospital entities.

11.16.4. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities. The Utilization Management Committee will work closely with relevant stakeholders (including but not limited to Patient Financial Services, Behavioral Health Services, Ambulatory Care Services, and the Medical Staff) to maximize appropriate utilization of resources. One meeting per year must be dedicated to review of the Utilization Review Plan.

11.16.5. Reporting

This Committee must submit a written report on its activities to the MEC, including policy recommendations, semi-annually.

11.17. Laboratory Utilization Committee

11.17.1. Composition

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the CPC service. The laboratory medicine resident will be invited and encouraged to participate. In addition, representatives from the Hospital Administration as well as nursing, pathology, Infectious Diseases, and Primary Care services, Specialty Care Services, and other services as appropriate will serve with a vote. The Director of Clinical Laboratory Services, or designee, will serve as Chair of the Committee.

11.17.2. Duties

This Committee is responsible for the development and surveillance of all laboratory testing policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the selection and availability of clinical laboratory tests, their reporting structure, and the communication of newly available tests to the clinical staff. The Committee will also perform the following specific functions:

- A. Serve as an advisory group to the Medical Staff and the Department of Clinical Laboratory Services on matters pertaining to the choice of available laboratory testing;

- B. Evaluate clinical data concerning new clinical lab tests requested for use in this Hospital and make recommendations to the Medical Executive Committee regarding what lab tests should be made available for order in the EHR;
- C. Advise clinical staff in the appropriate analysis and follow-up for specific laboratory tests;
- D. Advise in relation to and determine designation status for critical lab values and modify protocols for notification of critical results;
- E. Manage the approval process and utilization of laboratory tests sent to outside reference labs; and
- F. Report issues to the PIPS Committee as needed.

11.17.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.17.4. Reports

This Committee must submit a written report to MEC on its activities, including policy recommendations, quarterly.

ZSFG Medical Staff Bylaws

ARTICLE 12. MEETINGS OF THE ENTIRE MEDICAL STAFF

12.1. Annual Meeting

An annual Medical Staff meeting will be held within sixty (60) days of the end of the Medical Staff year.

Each Member of the Active Medical Staff is expected to attend the annual meeting of the Medical Staff at least once every two years and special Medical Staff Meetings duly convened pursuant to these Bylaws.

The agenda at the annual Medical Staff meeting will be:

- A. Call to order
- A. Approval of minutes of previous annual or special meetings of the Medical Staff
- B. Annual Reports
 - 1) Director of Health
 - 2) Chief Executive Officer
 - 3) Dean, School of Medicine
 - 4) Vice Dean
 - 5) Chief of Staff
- C. Old Business
- D. New Business
- E. Adjournment

12.2. Special Meetings

- A. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting within ten (10) days after receipt of a written request for same signed by not less than ten percent (10%) of the Active Medical Staff and stating the purpose for such meeting. The Chief of Staff will designate the time and place of any special meeting.
- B. A written or printed notice stating place, day, and hour of any special meeting of the Medical Staff must be delivered, whether personally, by electronic mail or by mail, to each Active Member not less than seven (7) days before the date of such meeting. If mailed, the notice of the meeting is deemed delivered when deposited, postage prepaid, in a United States mail addressed to each staff Member at the address appearing on the records of the Hospital. The attendance of a Member at a meeting constitutes a waiver of notice of such meeting. No business may be transacted at any special meeting except that stated in the notice calling the meeting.
- C. Twenty percent (**20%**) of the Active Medical Staff constitutes a quorum for special meetings.
- D. The agenda will include reading of the notice of the meeting, transaction of business for which the meeting was called, and adjournment.

ZSFG Medical Staff Bylaws

12.3 Voting

A simple majority of the Active Members attending either the Annual meeting or a Special meeting will determine the outcome of the vote.

ARTICLE 13. CONFIDENTIALITY OF INFORMATION; IMMUNITY AND RELEASES

13.1. Authorization and Conditions

By applying to be a Member, Affiliated Professional, or other role with the Medical Staff, as well as by applying for or exercising clinical privileges and/or standardized procedures with the Hospital, an Applicant:

- A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's professional ability and qualifications;
- B. Authorizes persons and organizations to provide information concerning such Applicant to the Medical Staff;
- C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under subsection 13.2.4 below; and
- D. Acknowledges that the provisions of this Article are express conditions to any application described in this Section 13.1.

13.2. Confidentiality of Information

13.2.1. General

Discussions, deliberations, records, and proceedings of all Medical Staff committees having responsibility of evaluation and improvement of quality of care rendered in this Hospital will, to the fullest extent permitted by law, be confidential. This confidentiality protection includes, but is not limited to, information regarding any Member, Applicant, or Affiliated Professional, meetings of the Medical Staff, meetings of Clinical Services, meetings of committees of the Medical Staff, and meetings of ad hoc committees created by the MEC.

13.2.2. When Disclosure is Permitted

- A. Dissemination or disclosure of discussions, deliberations, records, and proceedings may only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the MEC. Actions taken to address systems issues, information about corrective actions, conclusions, referrals for other investigations, and other high-level information may be shared if authorized by the Chief of Staff in consultation with the Vice-Dean, Chief Executive Officer, and/or City Attorney's Office.
- B. In all other cases, access to such information and records is limited to authorized Members or Affiliated Professionals for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentially be maintained.
- C. Information which is disclosed to the Governing Body or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities will be maintained by that body as confidential.
- D. Information contained in the credentials file of any Member or Affiliated Professional may be disclosed consistent with other provisions of these Bylaws, as required by law, or

with the Member's or Affiliated Professional's consent to other medical staffs, hospitals, professional licensing boards, or medical schools.

- E. Initiation of a corrective action investigation, submission of a report pursuant to Section 805 of the Business and Professions Code to the Member's or Affiliated Professional's professional licensing organization (such as the Medical Board), and adverse actions related to medical staff membership, privileges, and/or standardizes procedures will be reported to the peer review bodies of any other component of the San Francisco Health Network in which the Member or Affiliated Professional provides patient care services.

13.2.3. Breach of Confidentiality

Effective quality of care activities, peer review, and consideration of the qualifications of Members, Affiliated Professionals, and Applicants to perform specific procedures must be based on free and candid discussions within a quality improvement process. Any breach of confidentiality of the discussions, deliberations, records, or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Members or Affiliated Professionals, violates these Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in any other proceeding as to matters protected by this confidentiality provision.

13.2.4. Immunity from Liability

- A. For Action Taken by the Medical Staff and Hospital.
Each representative of the Medical Staff and Hospital is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.
- B. For Providing Information.
Each representative of the Medical Staff and Hospital and all third parties is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an Applicant to or Member or Affiliated Professional of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

13.2.5. Activities and Information Covered

The confidentiality and immunity provided by this Article applies to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- A. Application for appointment, reappointment, clinical privileges, or standardized procedures;
- B. Corrective action;
- C. Hearings and appellate reviews;

- D. Utilization and quality assurance reviews;
- E. Activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- F. Queries and reports concerning the National Practitioner Data Bank, peer review body or organization, or a professional licensing organization (such as the Medical Board of California), and similar queries and reports.

ARTICLE 14. CONFLICTS AND DISPUTE RESOLUTION

14.1. Conflicts and Disputes between the Medical Staff and the MEC

- A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the MEC and the Medical Staff upon receipt of a written petition, signed by at least twenty percent (20%) of the Active Medical Staff Members, that sets forth the rule, policy, or other significant matter at issue.
- B. The meeting will include up to five representatives of the Active Medical Staff selected by the petitioners and an equal number of MEC Members selected by the Chief of Staff. The meeting will be chaired by the Chief of Staff, who will not be considered as one of the MEC representatives and who will not have voting privileges at this meeting.
- C. The representatives of the Medical Staff and of the MEC will exchange information relevant to the conflict and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital.
- D. Resolution at this level requires a majority vote of the representatives of the Medical Staff and a majority vote of the representatives of the MEC.
- E. Unresolved matters will be submitted to the Governing Body for final resolution.

14.2. Conflicts and Disputes between the Medical Staff and the Governing Body

- A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the Medical Staff and the Governing Body upon a majority vote of the MEC or petition of at least twenty percent (20%) of the Active Members. The Chief of Staff will work with the Secretary of the Governing Body to ensure compliance with public notice requirements.
- B. The Medical Staff will be represented by two officers of the Medical Staff and three Active Medical Staff Members selected by the Chief of Staff. The Governing Body will be represented by the Governing Body members on the Joint Conference Committee. The Hospital Chief Executive Officer and Vice-Dean will also be invited to attend this meeting and will not have voting privileges at this meeting.
- C. The meeting will be chaired by the Chair of the Joint Conference Committee.
- D. The meeting participants will gather and share relevant information and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the governing responsibilities of the Governing Body, and the safety and quality of patient care at the Hospital.

- E. Resolution at this level requires a majority vote of each of the following groups: (a) the representatives of the Medical Staff; and (b) the representatives of the Governing Body. Any such proposed resolution must be approved by a majority of the full Governing Body.
- F. Unresolved matters must be submitted to the Governing Body for final resolution. The Governing Body will make its final determination giving consideration to the actions and recommendations of the Medical Staff, must not be arbitrary and capricious, and must act in keeping with its legal responsibilities to act to protect the safety and quality of patient care and to ensure the responsible governance of the Hospital.

ARTICLE 15. RULES AND REGULATIONS

15.1. Rules and Regulations of the Medical Staff

The Medical Staff will be governed by such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These will relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Member. Agreement to abide by the Bylaws includes agreement to abide by the Rules and Regulations. The Rules and Regulations are incorporated into these Bylaws as if set forth herein. In keeping with The Joint Commission guidelines, amendments to the Rules and Regulations are delegated to the Medical Executive Committee (MEC) and Governing Body.

15.2. Rules and Regulations of the Clinical Services

Each Clinical Service must formulate its own rules and regulations and proctoring protocol for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations must be consistent with these Bylaws. Substantive changes must be reflected in the biennial clinical services report to the Medical Executive Committee and approved by the MEC and the Governing Body.

ARTICLE 16. ADOPTION AND AMENDMENT

16.1. Medical Staff Responsibility

16.1.1. Initial Responsibility

The Medical Staff has the initial responsibility and authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments thereto, which will be effective when approved by the Governing Body. Such approval must not be unreasonably withheld. This responsibility will be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing quality and efficient patient care and maintaining a harmony of purpose and effort with the Governing Body. Neither the Governing Body nor the Medical Staff may unilaterally amend the Medical Staff Bylaws.

16.1.2. Hospital Chief Executive Officer

The Hospital Chief Executive Officer must be consulted as to the impact of any proposed Bylaws amendments on Hospital operations and as to the feasibility of proposed amendments. The Hospital Chief Executive Officer may also develop and recommend Bylaws amendments to the Bylaws Committee or MEC for consideration.

16.1.3. Proposed Amendments

Proposed amendments will be reviewed and considered at a meeting of the Joint Conference Committee prior to distribution to the Medical Staff for a vote. The Governing Body Members of the Joint Conference Committee have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.2. Amendments

The City Attorney's Office serves as counsel for the Medical Staff in relation to any amendments and will provide input on suggested amendments to these Bylaws.

The MEC will vote on the proposed amendments and upon an affirmative vote of a majority of a quorum must submit the amendments to the Active Medical Staff for approval or disapproval as set forth in Section 16.3 herein.

Upon a petition signed by at least twenty percent (20%) of the Active Medical Staff, amendments to these Bylaws and Rules and Regulations may be submitted to the Medical Staff and the Governing Body (and without the approval of MEC) for a vote. In such an event, the proposed amendments will be reviewed and considered at the next regularly scheduled meetings of the MEC and Governing Body prior to distribution to the Medical Staff. The MEC and the Governing Body have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.3. Method

16.3.1. Combined

The Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

- A. The affirmative vote of a majority of the Active Members of the Medical Staff who cast votes on the matter, provided at least fourteen (14) days advance notice accompanied by the proposed Bylaws or amendments (such notice and voting may be conducted electronically); and
- B. The affirmative vote of a majority of the Governing Body.

16.3.2. Governing Body Vote

The Governing Body must vote on proposed amendments within forty-five (45) days from the date of receipt. If the Governing Body does not approve the proposed amendments, it must specify its reasons in writing and forward them to the Chief of Staff, the MEC, and the Bylaws Committee.

16.3.3. Approval of Amendments

Amendments must be approved by both the Medical Staff and the Governing Body before they take effect, excepting the situations set forth in Sections 16.4 and 16.5 herein.

16.4. Corrections

The MEC has the power to approve corrections, such as reorganization or renumbering of the Bylaws, or correcting punctuation, spelling, or other errors of grammar or inaccurate cross-references. Such amendments are effective immediately and are permanent. The action to make such corrections must be taken by motion and acted upon in the same manner as any other motion before the MEC. Substantive amendments are not permitted pursuant to this Section.

16.5. Urgent Amendments

In the case of a documented need for an urgent amendment to these Bylaws and Rules and Regulations necessary to comply with law, regulation, or deficiency issued by the Joint Commission or state of federal regulating body, the Rules and Regulations may be amended for

that sole purpose by a two-thirds (2/3) affirmative vote of the MEC and by an affirmative vote of each Governing Body representative on the Joint Conference Committee. In such an event, the amendment must be submitted to the Medical Staff and Governing Body for retrospective review and approval, through the process outlined in this Article. This process must be initiated within 60 days of the Joint Conference Committee vote described in this Section. Per guidelines of The Joint Commission, Urgent Amendments to the Bylaws must follow the standard process for Bylaws Amendments as set forth in Articles 16.2 and 16.3 of these Bylaws. If there is a dispute regarding such an amendment, the Medical Staff may pursue the conflict management process set forth in Article 14 of these Bylaws.

ARTICLE 17. MISCELLANEOUS PROVISIONS

17.1. Notice and Duty to Advise of Contact Information

Each Member, Affiliated Professional, or Applicant has an ongoing, affirmative duty to ensure that the MSSD has accurate contact information, including email address, personal telephone number, and mailing address, for that Member, Affiliated Professional, or Applicant. This duty includes the duty to promptly (within five (5) business days) update the MSSD of any changes to that contact information. For UCSF faculty or employees, the UCSF email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well. For City employees, the City-provided email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well.

Except in relation to Notice related to Articles 6 and 7, above, any notification or other communication required by these Bylaws to be given by email is considered delivered when sent, and there is no obligation to ensure that such email is received or read by the Member, Affiliated Professional, or Applicant. However, if the MSSD receives a notification that an email is undeliverable, the MSSD will, within five (5) days, attempt to contact the Member, Affiliated Professional, or Applicant to obtain an accurate email address and/or to send the notification or other communication through alternative means to ensure the Member, Affiliated Professional, or Applicant learns of the issue.

17.2. Sharing of Information for Disciplinary and Other Investigatory Purposes

During the course of Medical Staff processes outlined by these Bylaws, information may be obtained or disclosed that requires additional investigation outside of Medical Staff processes. By way of example and without limitation, information may be learned that relates to: unprofessional conduct of Hospital staff or people in other City or UCSF departments; alleged discrimination, harassment, or retaliation; patient privacy violations; patient abuse; an unsafe work environment; misuse of public resources; mistreatment of patients or other staff; fraudulent billing or other medical practices; medical malpractice; or other ethics or civil or criminal law violations. In each instance listed above, and in other instances as determined by the Chief of Staff or by any Medical Staff committee member or subcommittee member that learns such information, the Medical Staff, through the Chief of Staff or MSSD, must notify the Hospital Administration and the City Attorney's Office of the nature of the allegations or information within seven (7) days of learning such information in order to allow Hospital Administration and the City Attorney's Office to determine if a referral needs to be made to City and/or UCSF

Human Resources departments, other City and/or UCSF departments, or law enforcement for a separate investigation for potential discipline or other purposes. Such disclosure may also be required by law or by Hospital, City, or UCSF policies or rules. The City Attorney's Office must be consulted if there is any question about what kind of information is to be disclosed.

In addition, there may be instances where parallel review or investigations occur related to the kinds of incidents or alleged misconduct listed in this section. By way of example, an incident might be submitted via a Safety And Feedback Events (SAFE) report (maintained by the Quality Management Department) that initially necessitates review by Risk Management, and the underlying information may quickly result in a referral for concurrent review by the Medical Staff, DPH or UCSF Human Resources, and/or the DPH Office of Compliance and Privacy Affairs. In the process of the investigation, the flow of information associated with these concurrent reviews can be complicated, and the City Attorney's Office should be consulted as early as possible to help ensure information only flows in the directions authorized by law and by DPH and Hospital policies. Each of these processes may result in a separate outcome, with distinct recommendations or action. Also, appropriate coordination between these separate processes can help ensure timely action that can correct issues that lead to errors, allow for improvement of clinical practice, result in appropriate regulatory reporting, and when needed result in disciplinary or other corrective action.

17.3. Notice to MSSD and City Attorney's Office of Investigation by Professional Licensing Entity

In the event that any Member or Affiliated Professional is given notice that the Member or Affiliated Professional is under investigation by any entity that has responsibility for issuance or oversight of the Member's or Affiliated Professional's professional license or certification (such as by the Medical Board of California, the Osteopathic Medical Board of California, or any other similar entity), the Member must give notice of such investigation within seven (7) days of learning of the investigation to the MSSD and the City Attorney's Office. Any request for medical records of any Hospital patient associated with any such investigation must be given to Hospital Health Information Systems for processing. In addition, the Member or Affiliated Professional must also promptly notify (within seven (7) days) the MSSD and City Attorney's Office any decision or action against the Member's or Affiliated Professional's license or certification by the entity conducting the investigation.

17.4. Notice to MSSD and Chief of Service Regarding Action Against Privileges at Another Institution and Any Other Disclosable Event Related to Application/Reapplication for Privileges

In the event that any Member or Affiliated Professional is given notice that their privileges have been suspended, restricted, or terminated at another institution for any amount of time, including voluntary acceptance of a suspension, restriction, or termination, for a medical disciplinary cause or reason, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days. This time limit may only be extended in exceptional circumstances (e.g., illness or injury) and in consultation by the Chief of Staff with the Hospital CEO.

In the event that any Member or Affiliated Professional is the subject of any action listed in this paragraph, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days of the occurrence of that action or item. This

time limit may only be extended in exceptional circumstances (e.g., illness or injury) and in consultation by the Chief of Staff with the Hospital CEO. The items that are reportable to the MSSD and the Member's Chief of Service include all of the following:

- A. Actions related to the person's liability for or insurance coverage related to their professional activities, including: actions, arbitrations, claims, or lawsuits related to the provision of patient care; reporting of any professional liability claim to an insurance carrier; the making of any settlement, arbitration, decision, or judgment in any professional liability case in which the person or their insurer had to or agreed to make any monetary payment; denial, cancellation, or the threat of denial or cancellation of professional liability insurance coverage; or being named as a defendant in a malpractice case and then being dropped from the case.
- A. Actions related to or that could impact patient care, including filing, withdrawal, or completion of any administrative, government, or court case or hearing involving allegations that the provider: failed to comply with laws, statutes, regulations, or other legal requirements related to the practice of their profession or provision of services to patients; violated of any criminal law (excluding minor traffic violations); was liable for any injury caused by the person's negligent or willful act or omission in rendering services; or was challenged or sanctioned regarding the person's admission, treatment, discharge, charging, collection, or utilization management related to patient care.
- B. Actions or investigation (whether undertaken, pending, or completed) involving the denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary or involuntary relinquishment of the provider's: medical or affiliated staff membership at any facility; medical or affiliated staff privileges at any facility; provision of clinical care for ninety (90) days or more; status as a student in good standing in any program related to clinical practice; membership or fellowship in any local, county, state, regional, national, or international professional organization; faculty position or membership; specialty board certification; license or certificate to practice any profession in any state, country, or jurisdiction; or Drug Enforcement Administration or other controlled substances registration.
- C. Any issue that impairs or could impair the person's ability to carry out their professional obligations in a manner that meets the standards of care in the community, under these Bylaws, or in relation to other Hospital policies, including: any physical or mental health condition or status; any communicable health conditions that could pose a significant health and safety risk to patients; or chemical dependency or substance abuse that might adversely affect the provider's ability to competently and safely perform the essential functions of a practitioner in their area of practice.