ZSFG JOINT CONFERENCE COMMITTEE MEETING

AUGUST 24, 2026

MEDICAL STAFF REPORT

Contents:

ZSFG CHIEF OF STAFF-OPEN SESSION ACTION ITEMS

Presented to the JCC-ZSFG August 24, 2026
August 2026 MEC Meetings

Clinical Service Report and Rules and Regulations:

1. Neurology Service Report
2. Neurology Rules and Regulations and summary of changes

Credentials Committee-Privilege List/Standardized Procedures

1. Acupuncture Standardized Procedures
2. MERT Standardized Procedures Privileges List
3. CNM Privileges List
4. Urology Standardized Procedures and Credentialing Criteria

Appointment of an Acting Chief

1. Acting Chief of Anesthesia: Marc Steurer, MD

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on August 24, 2026
August MEC Meetings

NEUROLOGY CLINICAL SERVICE REPORTS: J. Claud Hemphill III, MD
The highlights of the Neurology report are as follows:

I. **Mission-**The Neurology Service aims to provide the highest-quality neurology specialty and selected subspecialty for patients of ZSFG and the SFHN, while supporting academic, research and teaching missions.

II. **Scope of the Clinical Service-** The team provides inpatient ward and consult services, neurocritical care, electrophysiology EEG, and neurology outpatient care. The Outpatient care is structured around large clinic sessions with general neurology, stroke, geriatrics, neuroimmunology, and neuromuscular care integrated across these sessions. The division plays a major teaching role for UCSF trainees, with graded responsibility for residents and regular involvement of medical students.

III. **Faculty and Residents-** The general ward is staffed by two neurology residents and two rotating medical students, supported by a dedicated ward attending. Overnight, one in-house consult resident provides coverage for both the ward and ICU services. In the neurocritical care unit, the team consists of an attending physician, two neurocritical care fellows, one neurology resident, one medical student, and one neurosurgery intern.

IV. The faculty group at ZSFG is composed of highly dedicated, mission-driven clinicians and researchers who have earned numerous teaching awards and institutional recognitions. Faculty are heavily engaged in national organizations and collaborations, including stroke, neurology initiatives, and global neuro-equity programs.

V. **Performance Improvement and Patient Safety (PIPS) initiatives-** Ongoing projects focus on key quality and performance metrics, including Joint Commission Primary Stroke Center requirements, AAN inpatient measures, and efforts to improve documentation and billing practices. ZSFG functions as a primary stroke center operating at a comprehensive level, managing increased stroke volumes across diverse patient populations. Performance metrics, including door-to-needle and door-to-groin puncture times, consistently meet or exceed national benchmarks. A recent case underscored how multidisciplinary collaboration and a well-coordinated system of care contributed to delivering high-quality patient outcomes. Community outreach activities remain robust, encompassing health fairs, stroke education campaigns, and blood pressure screenings, with related work published in peer-reviewed journals. Faculty experience surveys show strong professional fulfillment, alignment with institutional values, supportive leadership, and high levels of belonging. Staff engagement surveys similarly reflect high morale and positive, collaborative working relationships.

VI. **Research-** The neurology service is actively engaged in funded research initiatives. Several faculty members hold NIH, AHA, and DoD awards, and the program was recently granted a T32 Enlighten fellowship. The Balance Journal Club continues to highlight resident-led work focused on global and local equity and systems-based approaches within safety-net neurology

VII. **Financial Report-** Although the neurology service typically breaks even, the most recent fiscal year ended with an unexpected deficit of approximately $228,000. Contributing factors included the absence of the usual CPG distribution, increased malpractice insurance costs, a 7% reduction in annual professional fees, and decreased commercial insurance encounters. With all these factors, the service anticipates ongoing financial vulnerability.

VIII. **Summary-Strengths, Concerns and Future Goals-**Key strengths include mission-driven mid-career faculty, strong interdisciplinary collaborations, highly engaged staff, robust ties to UCSF Neurology, strong grant support, and an international reputation in neurocritical care, HIV neurology, and health equity. Ongoing concerns involve declining professional fees, EEG technician shortages, shifting resident workforce constraints, and outpatient clinic limitations. Goals focus on strengthening billing performance, ensuring adequate staffing, leveraging existing expertise, supporting faculty development, enhancing philanthropy, and maintaining morale amid financial and staffing challenges.

IX. **Neurology Rules and Regulations**-The MEC members expressed appreciation to Dr. J. Claud Hemphill and the Neurology Department team for their commitment to delivering high-quality care with compassion. Dr. Hemphill was acknowledged for his leadership, dedication, collaboration, and continued innovation. A motion for the committee to approve the updated Neurology Rules and Regulations was made and approved. <u>Approval from the Health Commission is requested for the Neurology Service Rules and Regulations.</u>

X. **Appointment of an Acting Chief of Anesthesia-** <u>Approval from the Health Commission is requested for the appointment of Marc Steurer, MD as an acting chief of Anesthesia.</u>

ZSFG Neurology Service Annual Report 2024-2026

J. Claude Hemphill III, MD,MAS

Kenneth Rainin Endowed Chair in Neurocritical Care

Professor of Neurology and Neurological Surgery

University of California, San Francisco

Chief, Neurology Service

Zuckerberg San Francisco General Hospital

UCSF University of California San Francisco

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

August 10, 2026

ZSFG Neurology Service: Mission & Scope

- Clinical Mission - To provide the highest quality neurology specialty and selected subspecialty services for patients of ZSFG and the SFHN
  - Within the context of a complementary academic agenda
- Clinical Scope - Inpatient and outpatient clinical services at ZSFG
- Research Mission – To support and encourage clinical & translational research complementing the clinical mission, focusing on:
  - Acute care – stroke, TBI, brain injury after cardiac arrest, seizures
  - HIV neurology
  - Global Health, Equity
- Teaching Mission – To support UCSF teaching and training of students and post-doctoral trainees in neurology

ZSFG Neurology: Inpatient Services

- General Ward Service
- General Consultation Service
- Neurocritical Care Service
- Electrophysiology (EEG) Service
- Night Resident Rotation

ZSFG Neurology: Inpatient Services

- **General Ward Service**
  - Inpatients with primary neurological problems (not in ICU)
  - Major teaching focus for residents & students
  - Personnel
    - Attending
    - 2 Neurology Residents (SR & JR)
    - 2 Medical Students (MS3)

ZSFG Neurology: Inpatient Service
General Consultation Service

- **General Consultation Service**
  - Inpatients with consultation requests from 1º service
  - Emergency Department
    - Including Acute Stroke Activations (“Code Stroke”)
  - Calls from SFHN providers outside ZSFG
  - Key rotation for resident development
  - Personnel
    - Attending
    - 1 Neurology Resident
    - 1 Medical Student (MS3)
    - Occasional sub-intern (MS4) or additional junior Neurology Resident
    - Medicine Resident ~6 months a year (St. Mary’s or UCSF)
  - 1 resident in-house overnight shift

ZSFG Neurology: Inpatient Services
Neurocritical Care Service

- **Neurocritical Care Service**
  - Patients in ICU on Neurology Service
  - Co-manage patients in ICU on Neurosurgery Service
  - Consult/co-manage patients in ICU with critical neurological problems on
    - Cardiology and MICU Services (post-arrest)
    - Trauma Surgery
  - Attending & Fellow coverage for Acute Stroke Activations
  - Personnel
    - Attending
    - 2 Neurocritical Care Fellows (day 7d and night M-Th)
    - 1 Neurology Resident
    - 1 Medical Student (MS3), (Occasional sub-intern (MS4))
    - 1 Neurosurgery Intern (3 months of the year)

ZSFG Neurology:
Neurodiagnostic Laboratory Services

- **EEG (including continuous monitoring in ICU and Wards)**
  - Eddy Amorim, MD - Director
  - Technicians: hospital funded (2) *(frequent absences due to vacation & leave)*
  - EEG upgraded 2025 (6 Natus machines)
  - Moberg ICU EEG upgraded 2026 (9 machines) – integrated with neuromonitoring; key for TBI and Stroke Programs, cardiac arrest MICU/Cardiology
  - Ceribell portable EEG system
  - Strong collaboration with nursing – Christina Bloom, Lawrence Chyall

- **EMG**
  - Bill Corn, Alexandra Brown, Mark Terrelonge
  - 1 EMG machine – 1 EMG room

ZSFG Neurology: Outpatient Services

- **General Neurology Clinics**
  - Venue - 4M (Surgical Subspecialties)
  - Sessions
    - New Patient (2 per week)
    - Follow-up (1 per week)
  - Staffing – new patient
    - Residents 3
    - Attendings 3
    - 1.5 Nurse Practitioner 0.5 (also screen eReferrals)
  - Staffing – Follow-up
    - 6-8 residents seeing their own patients
    - 2-3 attendings to staff resident patients

- **Sub-Specialty Clinics**
  - Venue - 4M (Surgical Subspecialties)
  - Sessions
    - Stroke Clinic (weekly)
    - Geriatrics Neuro (biweekly)
    - Neuroimmunology [MS] – (monthly – within New Patient)
    - Neuromuscular (monthly)
    - LP (biweekly)
  - Staffing –Specialty Clinics
    - 1 neurology attending
    - 1 Nurse Practitioner
    - 1 resident

ZSFG Neurology: Outpatient Services

- **Issues – New Patient Clinic**
  - High no-show rate makes it difficult for providers to have individual panel of patients (and prepare ahead of time)
- **Issues – Follow-up Clinic**
  - Limited rooms for attending follow-up clinics or separate subspecialty clinics
  - Only 2-3 attendings for ~40 resident patients
- **Overall**
  - Large clinics 3 half-days a week not organized the way Neurology Outpatient care provided in the community (every weekday)
  - Limited information on specific provider volume and duration of patients seen makes it difficult to model potential pro-fee billing

ZSFG Neurology Service: Training & Teaching

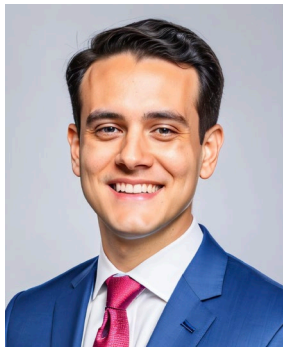
- **Neurology Residents (UCSF)**
  - Assigned ZSFG 'Chief'
    - Dennis Obat, MD
    - 4 Daytime Residents - 2 Ward, 1 Consult, 1 NCC
    - 1 Night Resident, 1 Night NCC Fellow (M-Th)
- **Outside service interns, residents (intermittent)**
  - Neurosurgery UCSF (3)
  - Internal Medicine UCSF (2)
  - St Marys Medicine (6)
- **Neurocritical Care Fellows**
  - 2 each month, part of overall UCSF Neurocritical Care fellowship
  - Non-ACGME until ACGME in July 2025; key to ZSFG Stroke Program coverage
- **Medical Students**
  - Four 3rd-year UCSF on Ward/Consult/NCC Services (Neuro 110)
  - Subinterns & Electives on Consult and NCC Service (Neuro 140)
  - 1st year UCSF students (Brain, Mind & Behavior)

ZSFG Neurology Service: Attending & Staff (ZSFG based)

Claude Hemphill
Chief of Service

Nicole Rosendale
Neurohospitalist
Inpatient Director

Alexandra Brown
Neuromuscular
Outpatient Director



Eddy Amorim
Neurocritical Care
EEG Director

Liz Hamid
Neurohospitalist
Quality Director

Vineeta Singh
Neurocritical Care

Felicia Chow
HIV Neurology
Global Health

Michael Diaz
Neurocritical Care
MS Clerkship Director

H.E. Hinson
Neurocritical Care

Bill Corn
Neuromuscular
LHH (50%)

Not pictured:

Paul Garcia
EEG/Epilepsy
UCSF (30%)

Jeff Gelfand
Neuroimmunology
UCSF (10%)

Bill Weiss
Child Neurology
UCSF

Bethany Johnson-Kerner
Child Neurology
UCSF

Aaron Berkowitz
Movement Disorders
UCSF (27%)

Jessamyn Conell-Price, MD
Associate Outpatient Director
UCSF(25%)

Mark Terrelonge, MD
Neuromuscular
UCSF(25%)

Sara Cole
Stroke Program
Coordinator

Cate Freyer
Liz Kong
Division Administrators

Locus Yuen
Billing & Coding

Sean Braden
Annemarie Stone
Outpatient NP

ZSFG Neurology Service: Other Attending Staff

- **UCSF (Parnassus & Mission Bay) – Arroyo, Byer, DeLeon, Douglas, Dubal, Josephson, La Hue, Lanata, Lindquist, Lowenstein, Nelson, Ortiz-Torres, Pleasure, Richie, Shah, Singhal, Suen, Suleiman, Waldrop, Wilson, Windon, Zuniga**

- **Community Volunteers–none**

- **Geriatric Cognitive Disorders Clinic at ZSFG**
  - Collaboration Between the UCSF Memory and Aging Center and ZSFG Geriatrics, DGIM
  - Anna Chodos and Serggio Lanata (Co-Directors)

ZSFG Neurology Service:
Faculty ZSFG/UCSF/National Service 1

- **Amorim**
  - International Liaison Committee on Resuscitation (ILCOR) Research and Registries Committee
  - AHA 2025 Guideline Writing Committee, Post-Cardiac Arrest Care
  - NCS Curing Coma Campaign, AI Modeling in Coma Science
- **Brown**
  - ZSFG Clinical Practice Group – at-large member and COMP Committee Chair
  - Neurology Education Committee (NEC) – Assistant Residency Director
  - UCSF GME Wellbeing Committee
- **Chow**
  - Clinical Competency Committee (Chair)
  - Advancement & Promotions Committee (Member)
  - Sex and Gender Enriched Neurology Advisory Committee (Member)
  - UCSF RAP Grants, Clinical HIV, Infectious Diseases, and Global Health Section
  - University of California Global Health Institute GloCal Fellowship Scientific Steering Committee
  - American Neurological Association Neuroinflammation Specialty Interest Group (Chair)
  - Advancing Clinical Therapeutics Globally (ACTG) Neurology Collaborative Science Group (Chair)
  - Continuum issue: Lifelong Learning in Neurology, Neuroinfectious Disease Issue coming out later in 2026 (Guest Editor)
  - International Post-Tuberculosis CNS Disease Working Group (chair)
  - Society for Equity Neuroscience (SEQUINS) Annual Meeting Program Committee (Member)
  - California CNS TB Expert Network (Member)

ZSFG Neurology Service:
Faculty ZSFG/UCSF/National Service 2

- **Diaz**
  - ZSFG Ethics Committee
  - UCSF Neurology Committee on Sustainable Teaching
  - UCSF Neurology Education Committee
- **Hemphill**
  - Past President, Neurocritical Care Society
  - Editorial board, *Neurocritical Care, Annals of Neurology, Neurological Research and Practice*
  - Co-Chair, Curing Coma Campaign Research Consortium
- **Hinson**
  - UCSF Neurology K Committee
  - UCSF Neurology Co-lead for the Health Equity Flexible Residency
  - UCSF Marcus Grant Program Reviewer
  - American Academy of Neurology Academic Neurology Committee
  - American Academy of Neurology Brain Health Committee
  - American Academy of Neurology Science Committee, Vice Chair
  - American Heart Association's Journal EDI Editorial Board
  - National Academy of Science and Medicine, Delegate Representing AAN
  - Editorial Board - *Neurology*, *Stroke*, and *Journal of Neurotrauma*
  - Grant reviewer for NIH, Department of Defense, and the Veteran's Administration

ZSFG Neurology Service:
Faculty ZSFG/UCSF/National Service 3

- **Rosendale**
  - UCSF Sexual Orientation and Gender Identity Advisory Committee
  - President of the AHA Bay Area Board of Directors
  - AHA Stroke Scientific Statement Oversight Committee (SOC) of the Stroke Council
  - AHA Bay Area Board of Directors
  - AAN DEI Committee member
  - AAN Health Care Equity Subcomittee Chair
  - AAN Encoding Equity Grant Workgroup member
  - AAN LGBTQI Section Research Workgroup Chair
  - Associate Editor JAMA Neurology
  - UCSF Neurology Clinical Competency Committee
  - UCSF Chancellor's Principles of Community Awards Selection Committee
  - UCSF Neurology BALANCE Co-Director
- **Singh**
  - UCSF Clinical Affairs Committee – ZSFG representative
  - ZSFG Critical Care Committee
  - Neurology Department Faculty Mentoring Committee
  - UCSF IRB committee (Parnassus)
  - American Board of Psychiatry and Neurology, Vice-Chair Neurocritical Care Test Committee

ZSFG Neurology Service: Faculty Awards

- **Brown**
  - Golden Toe Award for Resident Teaching, UCSF Department of Neurology, 2019
  - Jan Shrem and Maria Manetti Shrem Endowed Professorship
  - UC Women's Initiative for Professional Development (UCWI)
- **Chow**
  - Golden Toe Award for Resident Teaching, UCSF Department of Neurology, 2023
- **Corn**
  - Golden Toe Award for Resident Teaching, UCSF Department of Neurology, 2016
- **Hamid**
  - Golden Toe Award for Resident Teaching, UCSF Department of Neurology, 2024
- **Rosendale**
  - Golden Toe Award for Resident Teaching, UCSF Department of Neurology, 2022
  - UCSF Chancellor Award for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Leadership, 2022
  - American Academy of Neurology Health Care Equity Research Award, 2023
  - HEADS UP Scholar Travel Award, AHA International Stroke Conference, 2024
  - Faculty Mentoring Award - UCSF Neurology Dept, 2025
  - Audrey S. Penn Lectureship Award – ANA, 2025
  - Cheryl Jay Master Clinician Award - UCSF Neurology Dept, 2026
  - Annual Neurology Research Incentive Plan Award - UCSF Neurology Dept, 2024-26
- **Singh**
  - Cheryl Jay Master Clinician Award, UCSF Department of Neurology, 2022
  - UCSF at ZSFG Exceptional Physician Award, 2023
  - Association of Indian Neurologists in America Lifetime Achievement Award, 2024

ZSFG Neurology Service: PI Activities

- **General**
  - Faculty Meeting (monthly)
  - Morning Report (each weekday)
  - Professor Rounds (twice monthly)

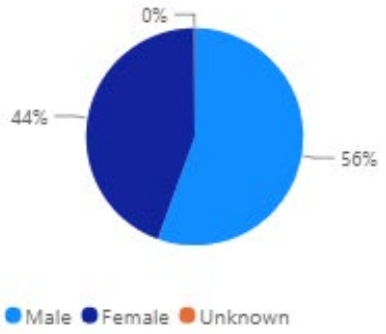
- **Projects**
  - Joint Commission Primary Stroke Center metrics
  - AAN Inpatient Metrics
  - Documentation and Billing

Stroke Program PI 1

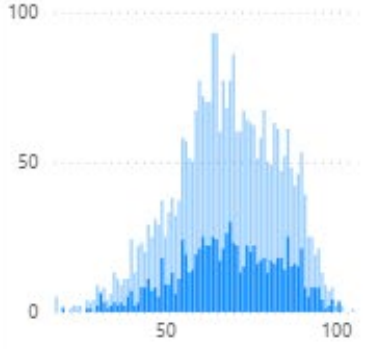
Stroke Volume

Year	ICH	ISCHEMIC	MIMIC	SAH	TIA	Total
2020	89	291	4	18	14	416
2021	75	307	6	18	10	416
2022	79	306	11	19	16	431
2023	72	329	8	17	10	436
2024	85	326	6	20	11	448
2025	101	353	5	11	20	490
2026	32	152	2	11	14	211

Sex



Age



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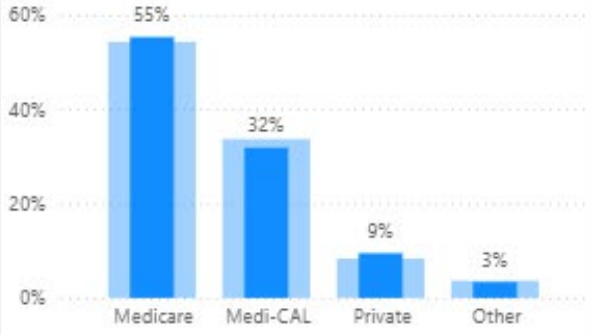
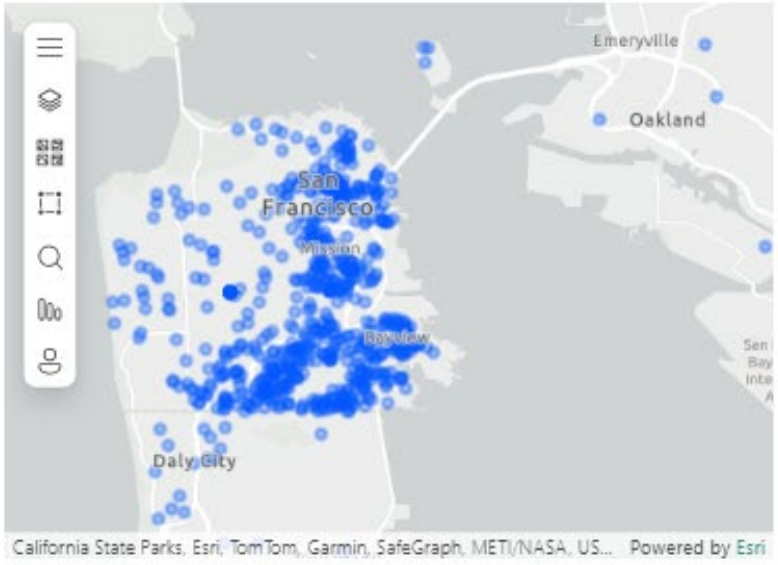


Home Zip Code



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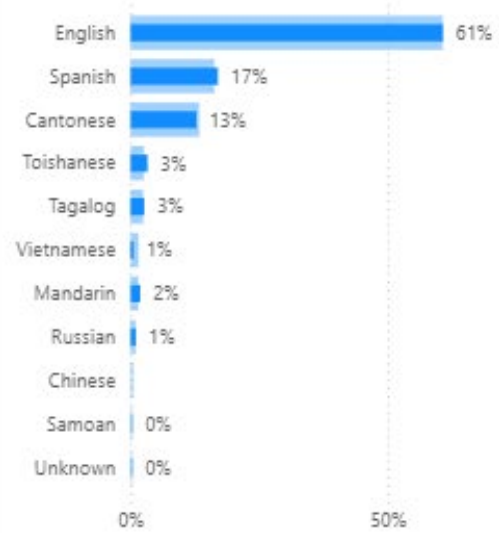
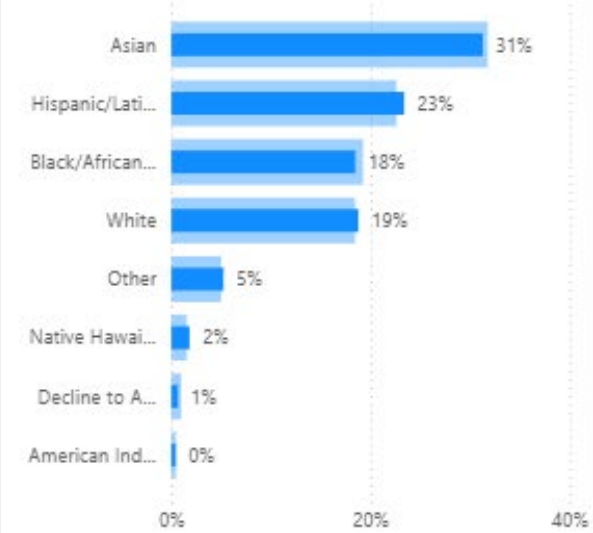


Race/Ethnicity



All patients

August 10, 2026

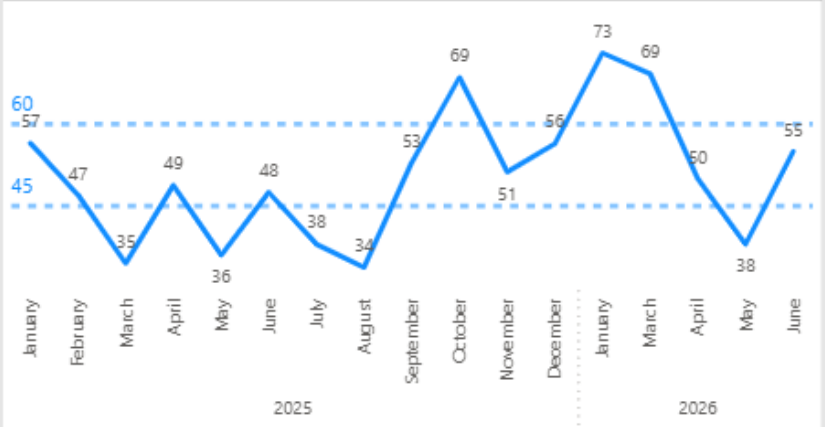
Stroke Program PI 2

Acute Intervention for Ischemic Stroke

Year	Count Ischemic Stroke Patients	Count Thrombolysis for AIS	Count Mimics	Rate Thrombolysis for AIS
2020	272	45	4	16.5%
2021	292	51	6	17.5%
2022	290	67	8	23.1%
2023	311	51	7	16.4%
2024	313	53	5	16.9%
2025	329	60	5	18.2%
2026	149	17	1	11.4%
Total	1956	344	36	17.6%

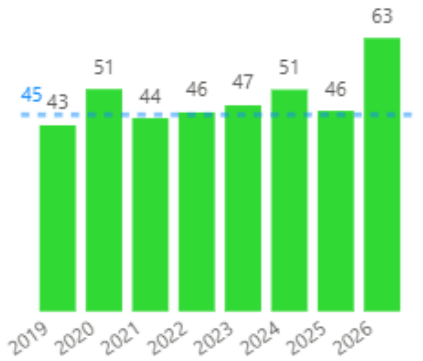
DTN time (minutes)

Does not include mimics



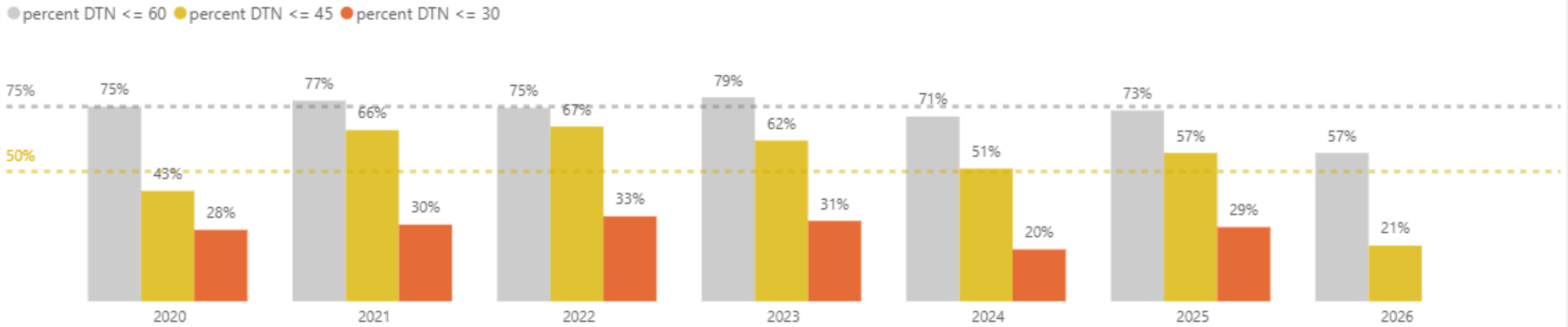
Average DTN Time (min)

Does not include mimics



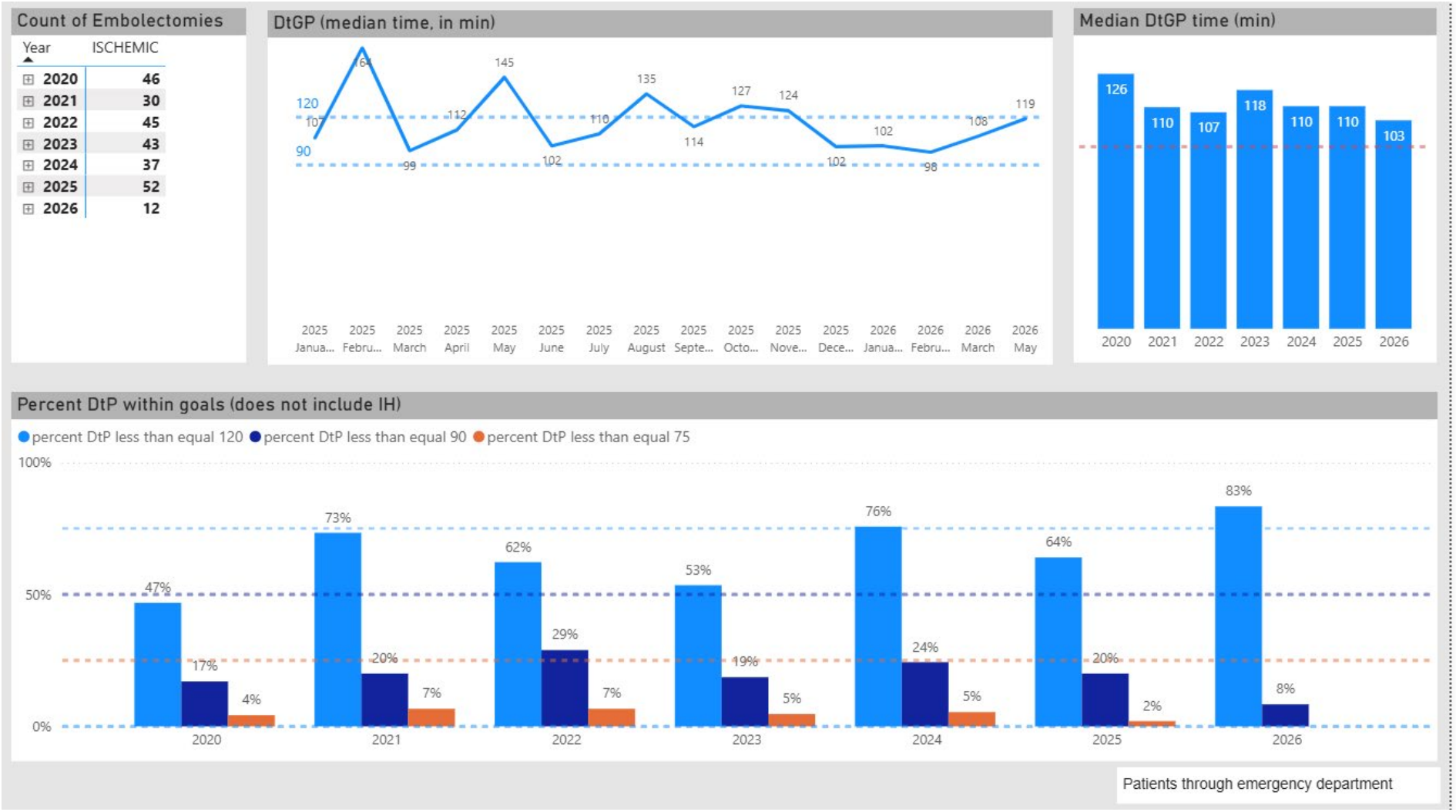
Percent DTN within goals

Does not include mimics



Patients through emergency department

Stroke Program PI 3

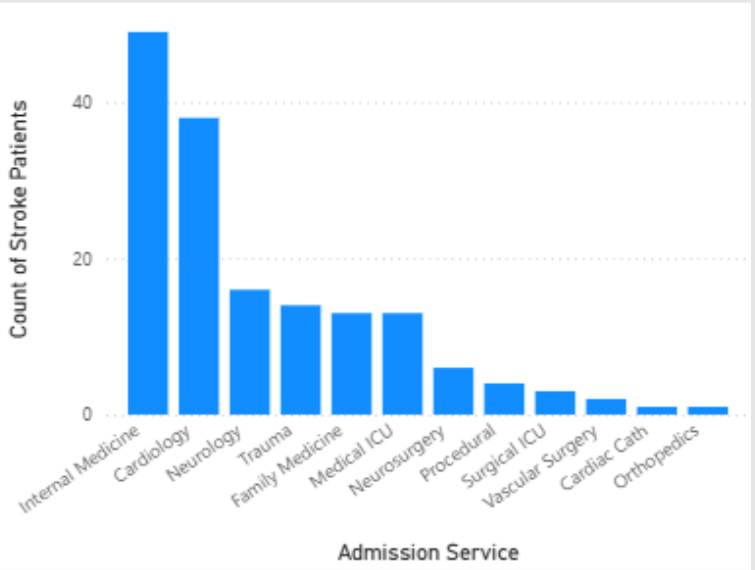


Door to groin puncture as key metric for interventional stroke treatment (mechanical embolectomy) – intersection of ED, Neurology, Radiology, Anesthesia, Nursing

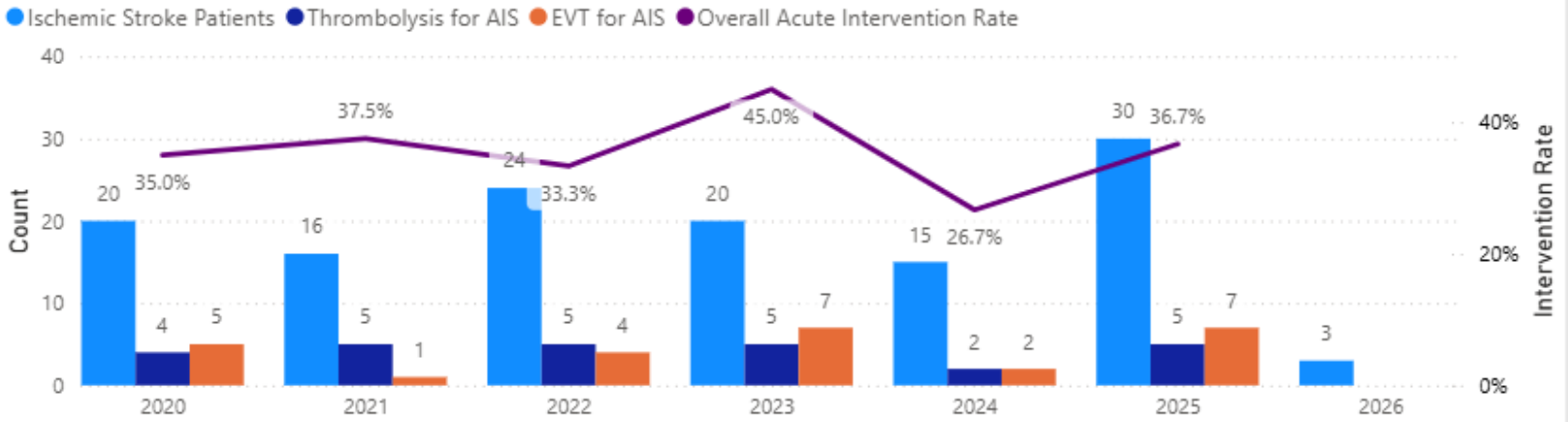
Stroke Program PI

In House Stroke Volume

Year	ICH	ISCHEMIC	MIMIC	SAH	TIA	Total
2020		19				**19**
2021	4	16			2	**22**
2022		18	3		1	**22**
2023	1	18	1			**20**
2024	2	15	1			**18**
2025	5	28		1	3	**37**
2026		3				**3**



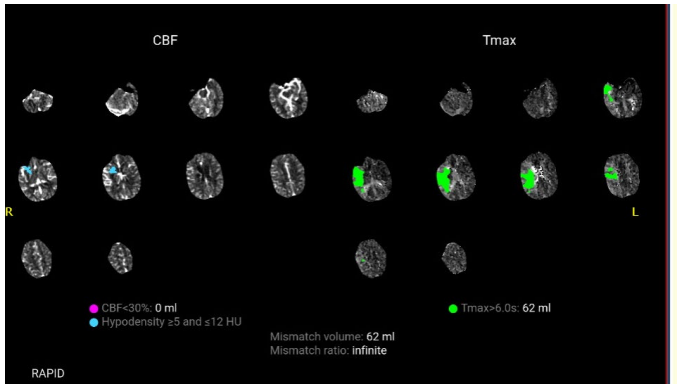
Acute Intervention for Ischemic Stroke- In House Patients

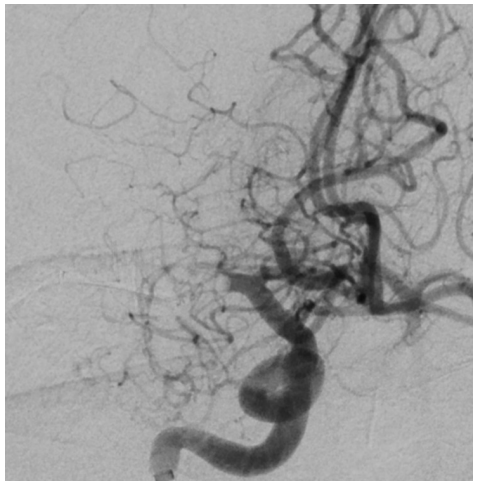


Year	Count Ischemic Stroke Patients	Count Thrombolysis for AIS	Rate Thrombolysis for AIS	Count EVT for AIS	Rate EVT	Count Thrombolysis + EVT	Rate Thrombolysis + EVT	Rate Overall Acute Intervention
2020	20	4	20.0%	5	25.0%	2	10.0%	35.0%
2021	16	5	31.3%	1	6.3%			37.5%
2022	24	5	20.8%	4	16.7%	1	4.2%	33.3%
2023	20	5	25.0%	7	35.0%	3	15.0%	45.0%
2024	15	2	13.3%	2	13.3%			26.7%
2025	30	5	16.7%	7	23.3%	1	3.3%	36.7%
2026	3							
Total	**128**	**26**	**20.3%**	**26**	**20.3%**	**7**	**5.5%**	**35.2%**

Stroke Program Patient Care

- **75 yo woman with hypertension (+ new Afib dx this admit)**
  - Last known well (LKW) ~9 hours prior to hospital arrival
  - Left face and arm weakness, slurred speech
- **Code Stroke "Mission Protocol" – ED, Neurology immediate CT scan**
  - NIHSS 6
  - Extended window IV thrombolysis with TNK, DTN 59 min
  - R M1 occlusion, NIR deferred because of mildly affected clinical exam
- **Around change of shift the next morning, noted to have worsening exam**
  - NIHSS 12
  - Repeat CT Stroke protocol with large area of tissue at risk
  - To NIR for embolectomy →TICI 0/2c
  - NIHSS 2
  - Discharged HOME on day 3





Health Fest

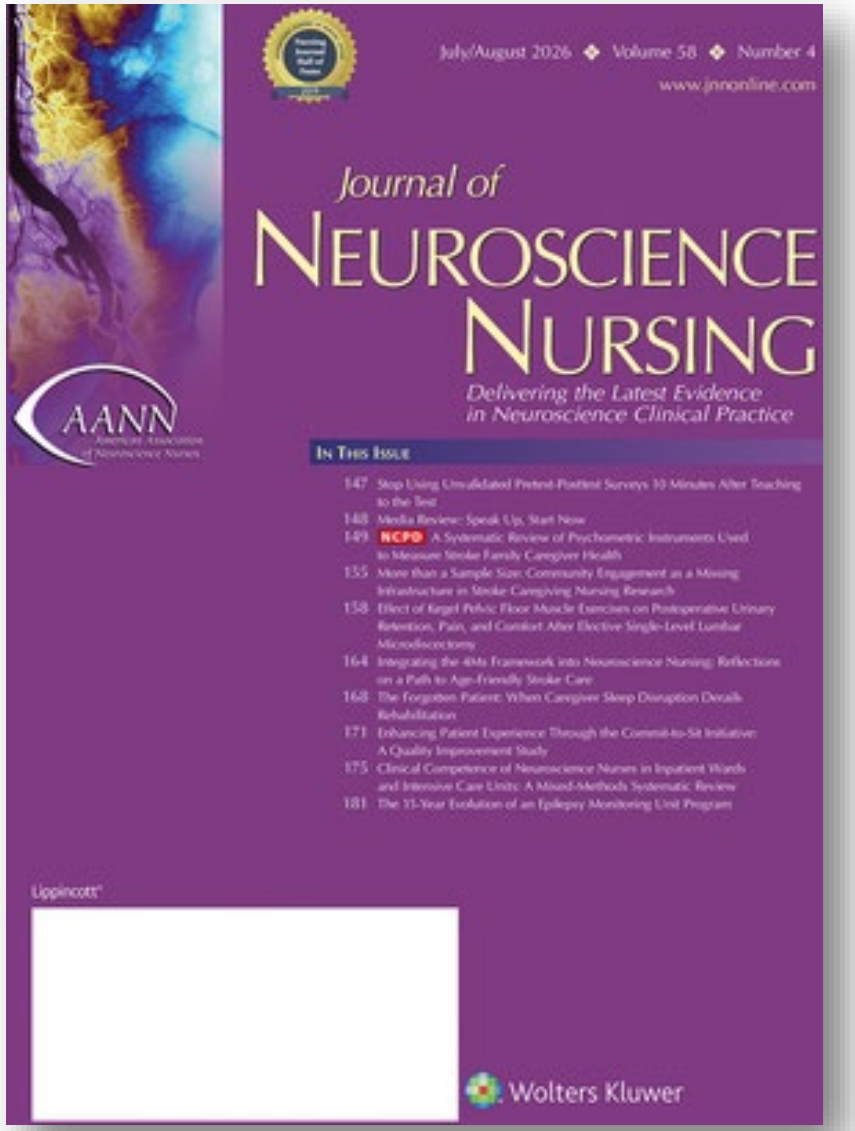

SPOT A STROKE
B E F A S


FREE!
BLOOD PRESSURE
SCREENINGS
EXIT


The Southeast Community Center Presents
The 13th Annual District 10
Health Fest
From Healthy Roots to Autumn Radiance
Saturday, October 18, 2025
11AM – 4PM
A dynamic, community powered celebration featuring:
Holistic Health
FREE Health Screenings
Healing & Wellness Hubs
Fun Fitness Activities
Vendor Row
Family-Friendly Activities
Entertainment & Cultural Performances
Hosted in the heart of District 10 — bringing together collective joy, neighbors, practitioners, and partners to nourish the body, mind, and spirit.
Learn more at:
D10HealthFest25.eventbrite.com
Information about vendors and activities will be added as they are confirmed.
Spread the word — Health is Community!
San Francisco Public Health
POP-UP VILLAGE
San Francisco Water Power Sewer
Services of the San Francisco Public Utilities Commission
SECC
Southeast Community Center

Community Health Fair

Journal



Clinical Nursing Focus

Development and Implementation of a Tailored, Reproducible Stroke Awareness Event at an Urban Community Market

Sara Cole[1,*], Tristen James[2], Dominica Randazzo[3], Rebecca Hidalgo-Salomon[4], Lawrence Chyall[5], Jesse Claude Hemphill III[6]

BACKGROUND: Despite more than 30 years of public health campaigns, critical gaps persist in community stroke symptom recognition and awareness of the importance of calling 9-1-1. Underserved communities experience disproportionately higher risk of stroke and poorer outcomes, and they have lower reported knowledge of stroke symptoms and are less likely to receive acute time-sensitive treatments. This quality improvement initiative outlines a pathway for stroke centers to address these disparities through reproducible and customizable pop-up health awareness events that also fulfill regulatory requirements. **METHODS:** The nurse leaders of 2 hospital stroke programs serving the same city in California developed a collaborative stroke awareness event at an urban farmers' market in a high-risk, underserved neighborhood. Volunteers conducted a brief intervention in the form of a survey to engage participants and share information. **RESULTS:** The event successfully engaged a diverse audience and fostered partnerships at a pop-up offering on one Sunday morning in May. A total of 128 community members participated, and 113 surveys were included in the final analysis. Pre-intervention, 42% of participants confidently recognized stroke symptoms, which increased to 88% postintervention ($P < 0.0001$). Participants' confidence in recognizing the importance of calling 9-1-1 increased from 22% preintervention to 93% postintervention ($P < 0.0001$). **CONCLUSION:** An event plan for offering stroke awareness information enabled the facilitating hospitals to effectively share critical health information and gain insights into the communities served. The survey responses suggested significant improvement in stroke awareness within a limited timeframe. The collaborative event also succeeded in fostering relationships across organizations, departments, and between health care and the community.

Introduction

Intravenous thrombolytic (IVT) and endovascular therapies can significantly decrease morbidity and mortality from stroke, the fifth leading cause of death and a leading cause of disability in the United States.[1,2] Despite the effectiveness of these treatments, only a small proportion of patients receive them, in large part because patients do not present to an acute care hospital in time.[3] Data from the Paul Coverdell National Acute Stroke Program registry (2008 to 2018) show that, at best, 15.2% of patients with acute ischemic stroke were treated with IVT and only 5.5% received endovascular therapy.[4] An earlier presentation could have

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ZSFG Neurology Service: Quality Improvement Efforts

- **Implementation of AAN Inpatient Quality Metrics using EPIC**
  - Data that can be extracted without modification to nursing workflows
  - Abstraction of progress notes
  - Focus on reports that will inform clinical practice, improve patient care / flow / billing
  - New reports in development with DPH reporting team
- **Monday Memory Clinic in partnership with GUIDE Medicare Program and Dementia Care Aware**
  - One neurologist and one geriatrician per week plus GUIDE-funded care navigator
- **Standardization of Inpatient Workflows**
  - Multidisciplinary rounds
  - Resident panel sizes and duty hours management
  - EEG order and placement
- **Documentation and Billing**
  - Reviewing all LLOC notes leads to numerous templates improvements
  - Tableau visualization and regular analysis inform drivers to profee trends
  - Developed templates for ZSFG divisions for MLR / QI in partnership w Medicine and CPG

Diversity, Equity, and Inclusion

- **ZSFG Neurology Service as "Equity Division" within overall department**
- **Focus on**
  - Women leaders within division (Rosendale – Inpatient; Brown – Outpatient; Hamid – Quality; Hinson / Chow – Research)
  - Research (Amorim – URM)
  - Diversity involvement at local and national level (Neurology Dept Outreach and Opportunity Committee, AAN LGBTQ+ leadership)
  - Resident curriculum
    - Outpatient – "Neurology of the Underserved" rotation
    - Inpatient - integrated into weekly didactic lecture series
  - BALANCE / ENLIGHTEN T32 as marquis program based in ZSFG division

BALANCE: Glo**BAL** Neurology, **N**euroinfe**C**tious Diseases, and Health **E**quity

OUR MISSION

To develop transformative and sustainable solutions that address neurologic health inequities in San Francisco, the US, and beyond.

UCSF BALANCE (Glo**BAL N**eurology, Neuroinfe**C**tious Diseases, and Health **E**quity) is dedicated to reducing the enormous burden of neurologic disease in our local and global communities. BALANCE aims to catalyze neurologists toward a shared goal of improving the neurologic health of vulnerable populations worldwide, one patient at a time.

WHO WE ARE

We are a community of neurologists and neuroscientists who believe in the universal right to neurologic health and well-being.

WHAT WE DO

We engage and collaborate with diverse partners across disciplines to advance neurologic health through education, training, research, and patient care. We champion the neurologic health of patients in our clinics, our communities, and across the globe. We believe "real change, enduring change, happens one step at a time."

HOW WE DO IT

With empathy, respect, and integrity.

BALANCE

BALANCE Leadership & Faculty Affiliates

LEADERSHIP TEAM

Felicia Chow, MD, MAS
Co-Director

Nicole Rosendale, MD
Co-Director

*27 faculty affiliates within Department of Neurology

Noriko Anderson, MD

Riley Bove, MD

Alexandra Brown, MD

Nerissa Ko, MD, MAS

Serggio Lanata, MD, MS

Bruce Miller, MD

Winston Chiong, MD, PhD

Christine Fox, MD, MAS

Heather Fullerton, MD, MAS

Bruce Ovbiagele, MD, MAS

Mercedes Paredes, MD, PhD

Karen Parko, MD

Nicholas Galifianakis, MD

Raquel Gardner, MD

Jeffrey Gelfand, MD

Katherine Possin, PhD

Mark Terrelonge, MD, MPH

Victor Valcour, MD, PhD

Ari Green, MD

Joanna Hellmuth, MD, MHS

Anthony Kim, MD, MAS

Jon VanLeeuwen, PhD

Michael Wilson, MD

Charles Windon, MD

BALANCE

BALANCE: The past year

- Continuing to recruit faculty affiliates, now 27 and growing

- BALANCE Journal Club
  - 4th Monday of each month, hosted by ZSFG
  - Coordinate with Parnassus, MB, and VA to develop a 4-hospital audience every other month

- BALANCE Faculty Panel Series

- BALANCE ‘resident section’ focusing on resident efforts in global and local equity space, systems-thinking in safety net neurology

- T32 ENLIGHTEN Training Grant awarded

BALANCE

ENLIGHTEN T32 GLOBAL AND NEURO EQUITY

- T32 research fellowship in global and local neurologic health equity research methods.
- 2-year program, 2 fellows / year (4 fellows currently)
- Didactic and training experiences, incl: ENLIGHTEN research seminar, AAN ENLIGHTEN Summit and Research Symposium, formal coursework, and field experience.

ENLIGHTEN

Engaging Neuroscience Leaders In Glocal HealTh Experiences in Neurology

Team at UCSF

Bruce Ovbiagele
Program Director

Felicia Chow
Program Director

Carolina Gonzalez
Program Manager

Riley Bove, MD
Associate Professor
Neurology
https://bovelab.ucsf.edu/

Winston Chiong, MD, PhD
Professor
Neurology
https://decisionlab.ucsf.edu/

Maria Glymour, ScD, MS
Professor
Epidemiology & Biostatistics

Serggio Lanata, MD, MS
Associate Professor
Neurology
https://www.gbhi.org/profiles/serggio-lanata

Christina Mangurian, MD, MAS
Professor and Vice Dean for Faculty
Psychiatry
https://integration.ucsf.edu/premium-collaborative

Victor Valcour, MD, PhD
Professor
Neurology
https://valcourlab.ucsf.edu/

Kristine Yaffe, MD
Professor and Vice Chair
Psychiatry
https://yaffe.ucsf.edu/

Gennatas Sthathis, MBBS, AICMS, PhD
Assistant Professor, Epidemiology & Biostatistics
https://www.lambdamd.org/

Matthew Gribble, PhD
Associate Professor
Medicine

Team Outside of UCSF

Walter Royal, III, MD
Professor and Chair, Department of Neurology
Morehouse School of Medicine

Amytis Towfighi, MD
Professor of Neurology
Keck School of Medicine of USC
Founding Director of the Southern California Healthcare Delivery Science Center

Joseph Zunt, MD, MPH
Professor, Departments of Neurology and Global Health
University of Washington
Research areas: CNS infections, Peru, research training
www.fogartyfellows.org

Chizobam Ani, MD, MPH, PhD
Associate Professor, Internal Medicine
Charles R. Drew University of Medicine and Science
Research areas: Cardiovascular disease epidemiology, cardio-metabolic disease epidemiology, cardiovascular disease outcome disparities

Gretchen Birbeck, MD, MPH, DTMH, FANA
Professor, Department of Neurology, Epilepsy
University of Rochester Medical Center
Research areas: Clinical research including neuroepidemiology, health services research and clinical trials to study malaria, neuro-HIV and aging and seizures in tropical settings.

Bernadette Boden-Albala, MPH, DrPH
Professor, Department of Health, Society, & Behavior, Program of Public Health, and Neurology
University of California, Irvine
Research areas: Social epidemiology, social determinants of disease, stroke and cardiovascular disease prevention and mortality, health disparities, global health, social support, social networks

George Howard, DrPH
Professor, Biostatistics
University of Alabama at Birmingham
Research areas: Stroke, prevention, risk fa
studies, and randomized clinical trials

International Team

Fred Sarfo, MD, PhD
Associate Professor and Chair of Neurology
Kwame Nkrumah University of Science & Technology, Ghana
Research areas: Stroke research, Parkinsons disease, HIV and Infectious diseases

Mashina Chomba, MBChB, MMed
Consultant Neurologist, Internal Medicine
University Teaching Hospital, Lukasa, Zambia

Hector Garcia, MD, PhD
Professor, Department of Microbiology
University Peruana Cayetano Heredia, Lima, Peru
Research areas: Parasitic disease of the nervous system, Cysticercosis and neurocysticercosis as pathogens affecting the nervous system, Cystic Echinococcosis

Deanna Saylor, MD, MHS
Associate Professor of Neurology
Johns Hopkins School of Medicine (based in Zambia)
Research area: Global neurology, stroke, multiple sclerosis, neuro-HIV, neuroepidemiology

Marcio Soto-Añari, PhD
Professor of Psychology
Universidad Católica de San Pablo, Arequipa, Peru

ZSFG Neurology Service: Funded Research Projects 1

- **Amorim**
  - DOD VIPTERC Award: HT9425-25-1-0170
  - AHA Transformational Award: 25TPA1474517
  - AHA Diversity Supplement 24DIVSUP1274116
  - Regents of the University of California RAP
  - Weill Neurohub: Next Great Ideas
  - DOD Idea Award HT9425-23-1-0242
  - Cures Within Reach
  - AHA AMFDP Faculty Development Program
  - NIH BRIDGE2AI 1OT2OD032701
  - NIH R01NS128342

- **Chow**
  - NIH Reimagining the IMAGINE-TBM trial: Using metagenomics and host transcriptomics to improve our ability to diagnose tuberculous meningitis and assess response to treatment in a randomized clinical trial
  - NIH T32 ENgaging Leaders In Global and local HealTh Equity in Neurology (ENLIGHTEN)
  - NIH R01 Fostering new lessons from collaborations to study stimulants, HIV, and brain aging in existing cohorts with key data (FLASHBACK)
  - NIH R01 Sex differences in the contribution of cerebrovascular injury and immune activation to neurocognitive impairment in HIV infection

ZSFG Neurology Service: Funded Research Projects

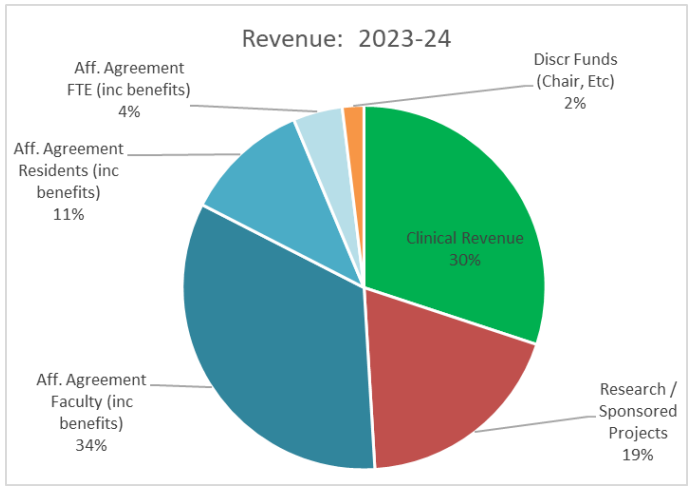
- **Hemphill**
  - NIH funded clinical trials (co-PI or site PI) – ASPIRE, ICECAP, NOVEL, SATURN

- **Hinson**
  - DOD Grant: Decision Support Tools Addressing Traumatic Brain Injury in BRIDGE (STAT-BRIDGE)
  - DOD Grant: Safety of Transcutaneous Electrical stimulation Potentiating Recovery in Acute spinal cord Injury SyndromEs (STEP-RAISE)
  - DOD Medical Monitor: Transforming Research and Clinical Knowledge in Traumatic Brain Injury Network (TRACK-TBI NET)
  - BARDA / GE Innovation Center Co Investigator: BARDA Pilot study in acquired brain injury patients exploring association of noninvasive optic nerve sheath diameter (ONSD) measurements with intracranial pressure (ICP)

- **Rosendale**
  - The Dana Foundation
  - UCSF RAP Award

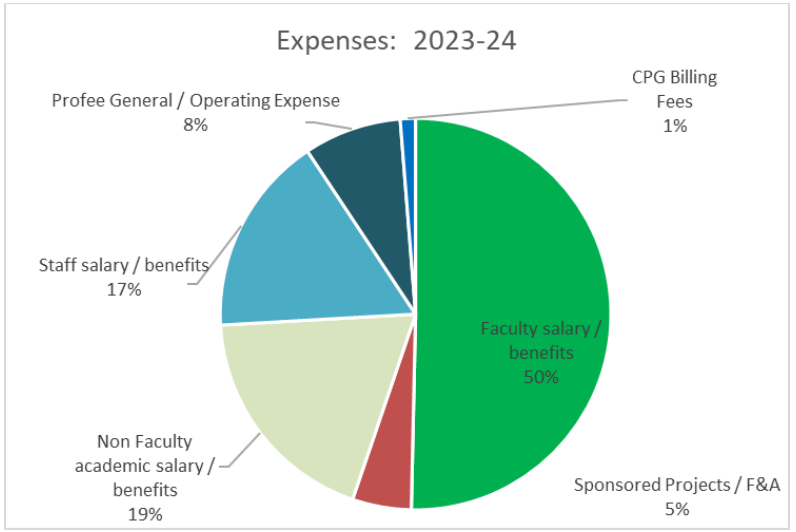
- **Singh**
  - NIH-funded Clinical Trial (site-PI) FASTEST
  - TRACK-SCI (co-I)

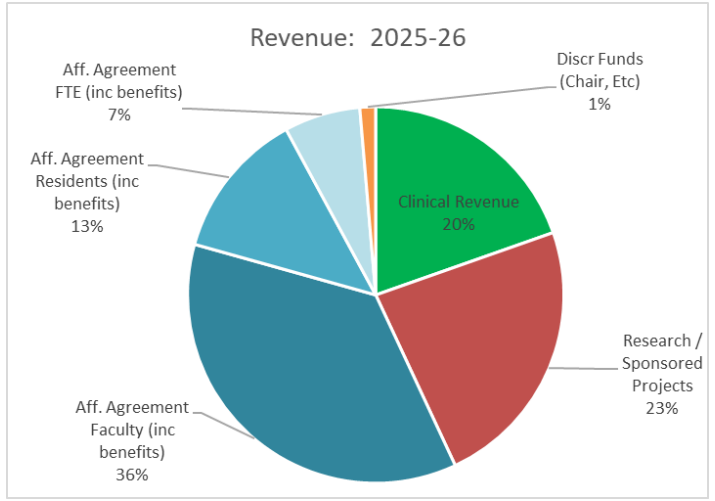
ZSFG Neurology Service:
Income/Expenses by Fund Source Fiscal 2024 vs 2026



July 2023 - June 2024	
Revenue	**Budget**
Clinical Revenue	$ 2,876,430
Research / Sponsored Projects	$ 1,817,810
Aff. Agreement Faculty (inc benefits)	$ 3,202,644
Aff. Agreement Residents (inc benefits)	$ 1,068,620
Aff. Agreement FTE (inc benefits)	$ 420,483
Discr Funds (Chair, Etc)	$ 184,568
	$ 9,570,555

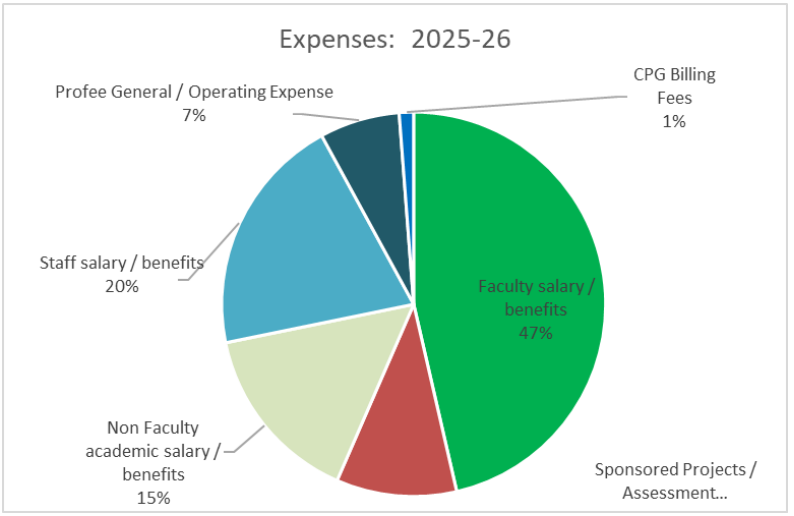
Expenses	Budget
Faculty salary / benefits	$ 4,483,419
Sponsored Projects / F&A	$ 435,096
Non Faculty academic salary / benefits	$ 1,680,409
Staff salary / benefits	$ 1,474,107
Profee General / Operating Expense	$ 719,356
CPG Billing Fees	$ 112,497
	$ 8,904,884





July 2025 - June 2026	
Revenue	**Budget**
Clinical Revenue	$ 2,185,706
Research / Sponsored Projects	$ 2,610,094
Aff. Agreement Faculty (inc benefits)	$ 4,042,692
Aff. Agreement Residents (inc benefits)	$ 1,422,139
Aff. Agreement FTE (inc benefits)	$ 728,876
Discr Funds (Chair, Etc)	$ 150,625
	$ 11,140,132

Expenses	Budget
Faculty salary / benefits	$ 5,199,693
Sponsored Projects / Assessment	$ 1,136,521
Non Faculty academic salary / benefits	$ 1,708,990
Staff salary / benefits	$ 2,269,334
Profee General / Operating Expense	$ 756,067
CPG Billing Fees	$ 135,687
	$ 11,206,290



Books Closed on FY26

- **Deficit of $228,000 for ZSFG Neurology Service**
- **First deficit year since FY18**
- **Not anticipated**
  - No end of year CPG distribution
    (in part due to dramatic increase in malpractice insurance)
  - Decline in annual professional fees of $111,653 (7%)
    - 4% decrease in billed encounters (1/3 from fewer EEGs due to tech absences)
    - Decrease in professional fees for commercial insurance (24% fewer encounters)
      - Decreased by $138,000 (from 28% to 21% of total pro-fees)
      - Commercial usually acute stroke, ICU, neurotrauma
- **Anticipated deficit of $443,000 for FY27 assuming no CPG distributions and Medi-Cal decrease of 7.5%**

Faculty Experience Surveys 1

Occupational Well-being Measures: Comparison with Benchmark

(4/1/2024 - 5/26/2026) Attending Physicians - Neurology [Specialty]

KEY [c]: Benchmark Mean | Strength | Neutral | Opportunity for Improvement

Domain	Measure	Score[a] (Standard Deviation)	Standard Deviation to Benchmark[b]
Outcome Measure	Professional Fulfillment	7.95 (1.80)	0.53
	Burnout *	1.06 (1.20)	0.85
Workplace Efficiency	Efficiency of Clinical Practice	7.45 (1.60)	0.88
Culture of Wellness	Collegiality	9.11 (1.57)	0.82
	Personal-Organizational Values Alignment	8.33 (1.44)	1.10
	Belonging	8.93 (1.02)	1.01
	Teamwork Climate	9.11 (0.87)	0.71
	Supportive Leadership Behaviors	9.44 (0.97)	0.76
Individual Factors	Self-Valuation	6.07 (1.68)	0.21

Faculty Experience Surveys

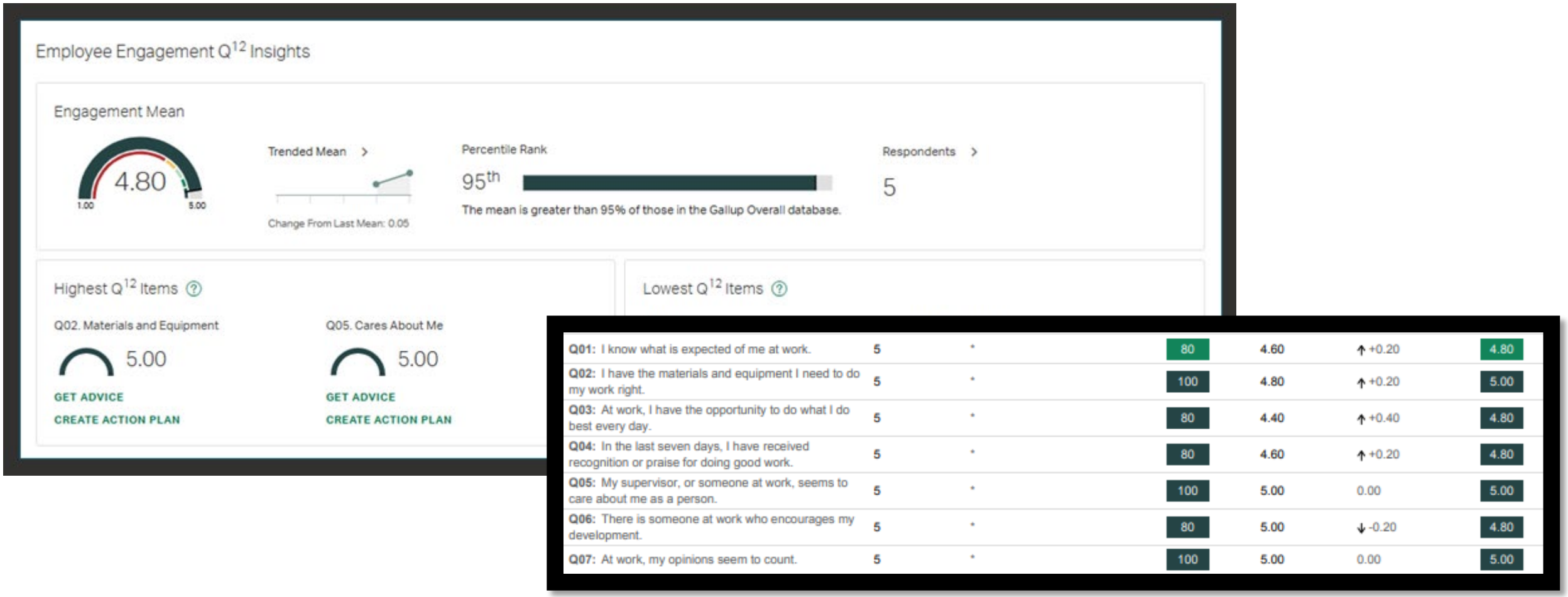
Occupational Well-being Measures: Comparison with Broader Population

Broader Population: SOM Attendings at ZSFG

KEY [b]: Benchmark Mean | Strength | Neutral | Opportunity for Improvement

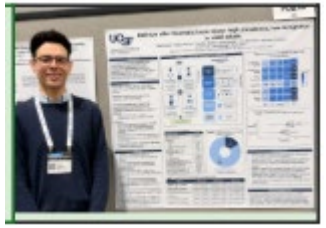
Domain	Measure	Standard Deviation to Broader Population Mean[a]
Outcome Measure	Professional Fulfillment	0.32
	Burnout	0.76
Workplace Efficiency	Efficiency of Clinical Practice	0.72
Culture of Wellness	Collegiality	0.62
	Personal-Organizational Values Alignment	0.67
	Belonging	0.72
	Teamwork Climate	0.68
	Supportive Leadership Behaviors	0.65
Individual Factors	Self-Valuation	0.08

Staff Engagement Surveys

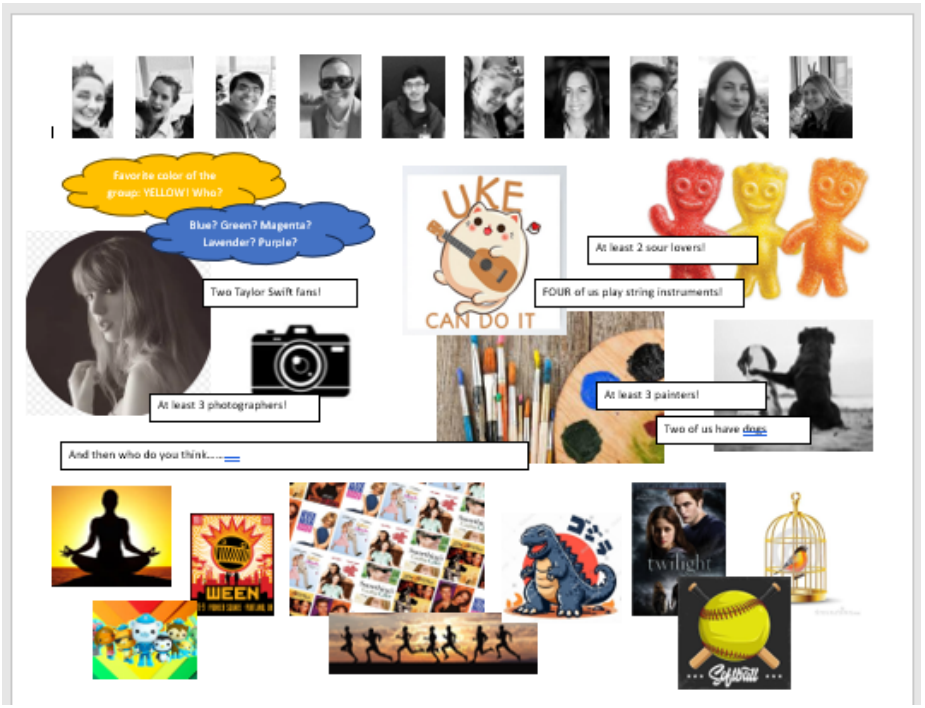


Q01: I know what is expected of me at work.	5	*	80	4.60	↑ +0.20	4.80
Q02: I have the materials and equipment I need to do my work right.	5	*	100	4.80	↑ +0.20	5.00
Q03: At work, I have the opportunity to do what I do best every day.	5	*	80	4.40	↑ +0.40	4.80
Q04: In the last seven days, I have received recognition or praise for doing good work.	5	*	80	4.60	↑ +0.20	4.80
Q05: My supervisor, or someone at work, seems to care about me as a person.	5	*	100	5.00	0.00	5.00
Q06: There is someone at work who encourages my development.	5	*	80	5.00	↓ -0.20	4.80
Q07: At work, my opinions seem to count.	5	*	100	5.00	0.00	5.00

Engagement




Society of
Critical Care Medicine


Favorite color of the group: YELLOW! Who?
Blue? Green? Magenta? Lavender? Purple?
UKE
CAN DO IT
At least 2 sour lovers!
Two Taylor Swift fans!
FOUR of us play string instruments!
At least 3 photographers!
At least 3 painters!
Two of us have dogs
And then who do you think.....
twilight


HAPPY B DAY
WE LIKE YOU A LOTTIE!

ZSFG Neurology Service: Assets

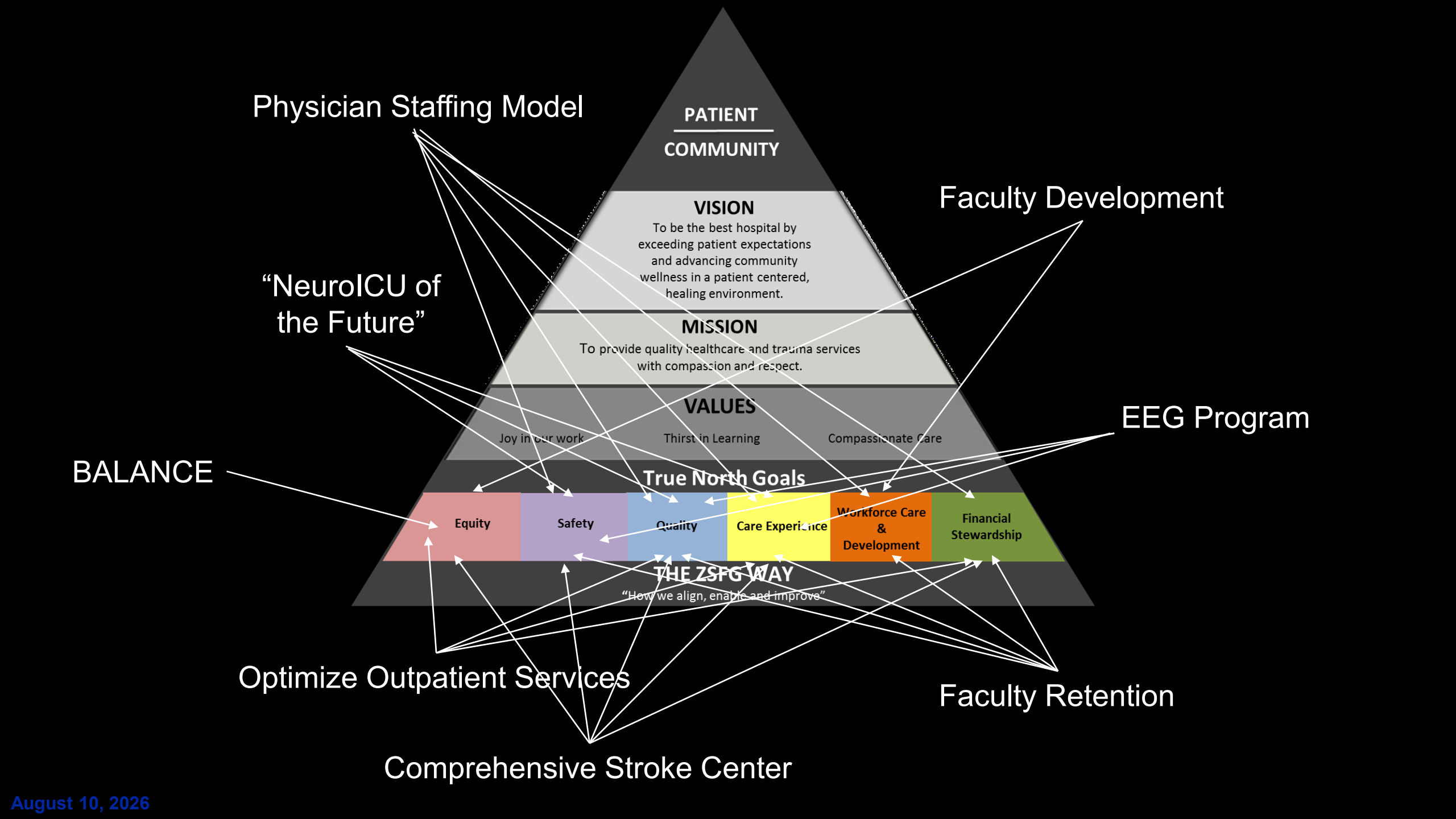
- **High quality mission-driven mid-career faculty who want to be at ZSFG**
- **Dedicated staff that support morale and mission**
- **Strong ties with UCSF Department of Neurology**
  - Conceptual support for ZSFG teaching, research, patient care missions
  - Endowed chairs directed to ZSFG (Hemphill, Brown)
- **Collaboration with other clinical services**
  - Neurosurgery – Brain and Spinal Injury Center
  - Emergency Medicine & Radiology – Stroke Program
  - Geriatrics/DGIM – Cognitive Disorders Clinic
  - Anesthesia, Surgery, Medicine – Critical Care
  - Nursing – ICU (Christina Bloom, Lawrence Chyall), 4M (Alonn Ilan)
- **Grant support**
  - Key for academic mission and maintaining subspecialty support
- **Collaboration with ZSFG**
  - Joint Commission Primary Stroke Center – Sara Cole, RN Stroke Coordinator
  - ZSFG Neurocritical Care Unit/Neuromonitoring (“NeuroICU of the Future”)
- **Quality of UCSF Neurology Residency & Fellowships**
- **International reputation for Neurocritical Care/Stroke & HIV Neurology Programs**
- **Opportunity to expand equity and global health programs - BALANCE**

ZSFG Neurology Service: Challenges

- **Decline in professional fees and managed care despite aggressive attention to billing and collections at departmental level**
  - Vulnerability to payor mix highlighted
- **EEG Staffing**
  - Major growth area that is mission critical for ICU, Neurotrauma, Cardiac Arrest, Stroke programs
  - Understaffed with unanticipated gaps of absent technologist cover. Impacts professional fee (and facility fee) billing for EEG inpatient monitoring
- **Evolution of Resident Workforce and Expectations**
  - Resident duty hours mitigated through resident weekdays off and attending assumption of duties
  - Issues not solved, just shifted
- **Outpatient clinic infrastructure**
  - Neurology is primarily an outpatient specialty
  - Inpatient has been prioritized over outpatient at ZSFG (space, time, funding)

ZSFG Neurology Service: Goals

- **Identify opportunities for improved professional fee billing of existing services and new ZSFG collaborations**
- **Adequately staff neurodiagnostic (specifically EEG) program for patient safety and care**
- **Capitalize on existing expertise, relationships with other clinical services, and hospital to implement visionary programs that highlight ZSFG**
  - "NeuroICU of the Future"
  - Safety-Net CSC (Comprehensive Stroke Center)
  - Outpatient Neurology subspecialty care
- **Mentor and support faculty towards extramurally funded clinical & translational research**
- **Enhance philanthropy to realize mission goals**
- **Maintain morale as we deal with challenges of finances and staffing**


Physician Staffing Model
"NeuroICU of the Future"
BALANCE
Optimize Outpatient Services
Comprehensive Stroke Center
Faculty Development
EEG Program
Faculty Retention
PATIENT
COMMUNITY
VISION
To be the best hospital by exceeding patient expectations and advancing community wellness in a patient centered, healing environment.
MISSION
To provide quality healthcare and trauma services with compassion and respect.
VALUES
Joy in our work
Thirst in Learning
Compassionate Care
True North Goals
Equity
Safety
Quality
Care Experience
Workforce Care & Development
Financial Stewardship
THE ZSFG WAY
"How we align, enable and improve"

City and County of San Francisco

Department of Public Health

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

Daniel Lurie
Mayor

Medical Executive Committee (MEC)
Summary of Changes for 2026 MEC Biennial Report

Document Name:	ZSFG Clinical Service Rules and Regulations
Clinical Service :	Neurology
Date of last approval:	8/12/2024
Summary of R&R updates:	Minor changes to reflect that the Neurocritical Care Fellow position is now ACGME, Morning Report responsibilities are distributed across faculty, and updated conference schedule.
Update #1:	Title and header of document updated to 2026
Update #2:	Page 5 "Organizes Morning Report…" has been removed from Chief of Service responsibilities
Update #3:	Page 6, "E-Value" has been changed to "MedHub" to reflect the online platform currently used
Update #4:	Page 10 "monthly" has been dropped because resident rotations are now of different durations
Update #5:	Page 12 and page 25 sentences dropped regarding Neurocritical Care Fellow documentation as they are now under ACGME status
Update #6	Pages 27 and 28, sentences removed from Attending Neurologists Outpatient Clinic responsibilities because students and PGY1s no longer work in this context.
Update #7	Throughout document, Neurology Chair has been updated to Nerissa Ko, MD as Interim Chair as this took place on 7/21/2026
Update #8	Appendix E, date for schedule has been updated to 2026-2027 and timing of Neuroradiology Conference has been updated

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110
August 10, 2026

NEUROLOGY SERVICE

RULES AND REGULATIONS

2026

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110
August 10, 2026

NEUROLOGY SERVICE
RULES AND REGULATIONS

TABLE OF CONTENTS

I. NEUROLOGY SERVICE ORGANIZATON

The Neurology Service is an academic component of the University of California, San Francisco (UCSF). The Service also, therefore, conforms to the UCSF regulations and policies and to the policies of the UCSF Department of Neurology. These affect particularly: staff appointments; resident training; policies and allocations; medical student teaching programs; research programs; and financial oversight. There are no perceived conflicts between the UCSF policies and the policies of Zuckerberg San Francisco General Hospital, but if a conflict should arise that relates to patient care activities, the ZSFG Medical Staff Bylaws and Rules and Regulations of ZSFG and this document will take precedence.

The Neurology Service conforms to the Medical Staff Bylaws and Rules and Regulations of Zuckerberg San Francisco General Hospital (ZSFG). This document is therefore supplementary, defining some of the specific rules and regulations that pertain to the Neurology Service and its activities.

The Rules and Regulations of the Neurology Service define certain principles, standards of practice and other rules of the organization of the Neurology Service and the duties of its members.

A. SCOPE OF SERVICE

The mission of the Neurology Service follows the traditional tripartite goals of an academic medical center: Patient Care, Education, and Research. However, in the immediate setting of patient care and patient interactions (inpatient services, outpatient clinics, telephone contact or consultation, etc.) the Neurology Service patient care mission takes precedence whenever there is a conflict or discrepancy among the three mission components. The policies and approaches to clinical service are outlined more specifically in greater detail in a separate document, *Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).*

B. MEMBERSHIP REQUIREMENTS

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

1. Privileges to practice on the Neurology Service will be commensurate with clinical training (Board Certified/Board Eligible) and documentation of an acceptable standard of clinical practice.
2. Privileges are approved by the Chief of the Neurology Service, subject to the approval of the Credentials Committee of the Medical Staff and approval of the Governing Body.
3. Individual privileges are subject to review and revision at initial appointment, throughout the period of proctoring, at the time of reappointment, at the time judged appropriate by the Chief of the Neurology Service or at any time recommended by two-thirds of the Voting Professional Staff of the Neurology Service.
4. DEA Certification is required; CPR Certification is recommended but not required.

C. ORGANIZATION AND STAFFING OF THE NEUROLOGY SERVICE

The officers of the Neurology Service are:

1. Chief of Service

The qualifications, selection, review and tenure of the Chief of the Neurology Service are in accordance with ZSFG Medical Staff Bylaws and Rules and Regulations.

Responsibilities (See ATTACHMENT D)

- Oversees the clinical, teaching and research activities of the Neurology Service.
- Reviews and recommends all new appointments, requests for privileges, and reappointments for all Neurology Service members.
- Appoints other Neurology Service officers and committee members.
- Manages financial affairs of the Neurology Service.
    - Attends and participates in the Medical Executive Committee, Chief of Service Meetings, and other meetings called by the Executive Administrator, and the Chief of Staff.
    - Participates in the Clinical Practice Group (CPG) and attends the CPG regular meetings and other meetings convened by the Chair of the CPG as needed.
    - Executes disciplinary actions as necessary, as set forth in the ZSFG Bylaws and Rules and Regulations.

2. Director of Performance Improvement and Patient Safety (PIPS)

- Appointment of the Neurology Service Director of PIPS is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
    - The Director of PIPS provides overall leadership and direction of the PIPS Plan and PIPS Committee of the Neurology Service.
    - Represents the Neurology Clinical Service on the ZSFG PIPS Committee.
    - Assists in the reappointment process of the members of the Neurology Clinical Service as it relates to quality improvement, management, and assurance.

3. Director of Neurology Outpatient Services

- Appointment of the Director of Neurology Outpatient Services is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
    - Oversight of the Neurology new patient and follow-up clinics including making the attending clinic schedule
    - Actively work with nursing and hospital leadership regarding optimizing and improving outpatient services
    - Collaborate and coordinate with referring services regarding Neurology outpatient care
    - Oversee e-Referral as it relates to Neurology Outpatient Services
    - Oversee the EMG portion of the Neurodiagnostic Laboratories
    - Coordinate Neurology Resident teaching relevant to the outpatient domain
    - Collaborate with the Neurology Chief of Service regarding overall direction of the outpatient services program

4. Director of Neurology Inpatient Services (aka Neurohospitalist Service)

- Appointment of the Director of Neurology Inpatient Services is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
    - Oversight of the Neurology Ward and Consult Services including making the attending clinic schedule
    - Actively work with nursing and hospital leadership regarding optimizing and improving inpatient services
    - Collaborate and coordinate with referring services regarding Neurology inpatient care

- Coordinate Neurology Resident teaching relevant to the inpatient domain (Ward and Consult Service)
- Collaborate with the Neurology Chief of Service regarding overall direction of the inpatient services program

5. Neurology Medical Student Education Site Director

- Appointment of the Neurology Education Site Director is the prerogative of the Neurology Chief of Service in conjunction with the overall UCSF Department of Neurology medical student clerkship director. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
  - Provide leadership and supervision regarding medical student rotations (including student electives) on the ZSFG Neurology Service
  - Orient new medical students to the rotation (or provide faculty designee to do so)
  - Actively work with the Department of Neurology medical student clerkship director and staff regarding priorities and programs
  - Assigning grades and entering them into the SOM grading portal for students on the Neuro 140 (MS4) elective rotation
  - Coordinate MedHub or other rotation evaluations, providing feedback to faculty, fellows, and residents as appropriate and leading resolution of any issues brought forward
  - Maintain relevant medical student neurology education portals appropriate for the rotation
  - Collaboration with the Chief of Service regarding overall direction for Neurology medical student education at ZSFG

6. Director of Electroencephalography (EEG) Services

- Appointment of the Director of EEG Services is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
  - Oversight of the EEG Service including making the attending clinic schedule
  - Actively work with nursing and hospital leadership regarding optimizing and improving inpatient and outpatient EEG services
  - Collaborate and coordinate with referring services regarding EEG services
  - Collaborate with the Neurology Chief of Service regarding overall direction of the inpatient services program

7. Organization of the Neurology Clinical Service

The activities of the Neurology Clinical Service are divided into the following:

a) Inpatient Adult Neurology Ward Service
b) Inpatient Adult Neurology Consultation Service
c) Inpatient Neurocritical Care Service
d) Outpatient Adult Neurology Clinics
e) Neurodiagnostic Laboratories
f) Child Neurology Service

Each of the above activities, including their organization, goals and schedules, are described in greater detail in the supplementary document, *Zuckerberg San Francisco General Hospital Service: Description of Service*, (*Appendix B*), and are briefly outlined below.

Inpatient Adult Neurology Ward Service

The Inpatient Adult Neurology Ward Service provides hospital care for adult patients with neurological diseases and their complications. The purpose of this Service is to provide optimal diagnostic and therapeutic management of patients for whom neurological disease or dysfunction is the predominating reason for hospitalization and the need for acute medical care. This embodies both specialized (care of the neurological condition, itself) and principal (medical care of associated conditions related to the neurological disease, when appropriate) care to this group of patients.

Inpatient Adult Neurology Consultation Service

The Adult Neurology Consultation Service provides specialized consultation to inpatients hospitalized under the care of other services and to emergency department or outpatients requiring urgent consultation in order to assist in providing optimal care of these patients.

Inpatient Neurocritical Care Service

The Inpatient Neurocritical Care Service provides primary hospital care and consultation for patients with acute and subacute neurological problems requiring critical care services. This includes management of acute stroke and is coordinated with the activities of the ZSFG Joint Commission certified Primary Stroke Center.

Outpatient Adult Neurology Clinics

The Outpatient Adult Neurology Clinics provide specialized neurological evaluation, management and consultation for patients suffering neurological dysfunction. It is the outpatient venue for both neurological consultation (advice to other physicians providing care) and principal neurological care (continuous direct care provided by the Clinic neurologist where appropriate).

Neurodiagnostic Laboratories

The Neurodiagnostic Laboratories currently have two components: the Electroencephalography (EEG) Laboratory (which includes Evoked Potentials) and the Electromyography (EMG) Laboratory. Each laboratory provides diagnostic services for both inpatients and outpatients.

Child Neurology Service

The Child Neurology Service provides neurological services for pediatric patients and is organized together with the Pediatrics Service and provides specialized neurological consultation for selected inpatients and outpatients in the pediatric age group (0-17 years).

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

1. Board Certified or Eligible by the American Board of Psychiatry and Neurology in Adult or Child Neurology
2. Current California Licensure
3. Current DEA Certificate

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Neurology Service is in accordance with ZSFG Bylaws, Rules and Regulations.

C. PRACTITIONER PERFORMANCE PROFILES

The Neurology Service Practitioner Performance Profiles are maintained by the Chief of the Neurology Service.

1. Modification of Clinical Services

The process for Modification of Neurology Clinical Services will be through the appropriate review process as required.

2. Staff Status Changes

The process for Staff Status Changes for members of the Neurology Service is in accordance with ZSFG Bylaws, and the Rules and Regulations.

D. AFFILIATED PROFESSIONALS

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

E. STAFF CATEGORIES

The Neurology Clinical Staff fall in the same staff categories that are described in the ZSFG Bylaws, Rules and Regulations.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF NEUROLOGY PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF NEUROLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Neurology Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES and MODIFICATION/CHANGE TO PRIVILEGES

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

The process for modification/change to the privileges for members of the Neurology Service is in accordance with the ZSFG Medical Staff Bylaws and the Rules and Regulations.

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

Monitoring (Proctoring) of individual neurologists shall be the responsibility of the Chief of the Neurology Service (or designee) and the Director of Performance Improvement and Patient Safety (PIPS) for the Neurology Service and is based on observation and review of the care of five patients for each privilege (see Appendix A).

V. EDUCATION

The Chief of the Neurology Service is responsible for Education and Research and is accountable to the Vice Dean and the UCSF Department Chair for the conduct of graduate and undergraduate medical education and UCSF based research programs conducted through the Neurology Service.

The Neurology Service is an important teaching site for the UCSF Neurology Residency Training Program (See Section VI). Surgery Interns destined for the UCSF Neurosurgery Residency Training Program and St. Mary's Internal Medicine Residents serve one-month rotations on the service intermittently through the year. The Service is also a major teaching site for the UCSF School of Medicine, including Brain, Mind, and Behavior apprenticeships (15-20 MS1s per year) and Neurology 110, the Core Neurology Clerkship (45 MS3s per year). Additionally, 2-4 UCSF and extern MS4s complete Neurology 140, the Consultation Elective in Neurology, at ZSFG yearly.

VI. NEUROLOGY SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

The Training of Neurology Residents from UCSF is a major commitment of the Neurology Service. Part of this training involves graduated responsibility as the residents advance in their training. The role and responsibility of house staff at each level of training and their supervision, along with a description of the supervision of medical students is delineated in detail in the document*, Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).* The Neurology Service is intended to be a "Resident-Directed Service" so that whenever appropriate the senior resident on the service will function as the principal coordinator and director of patient triage, evaluation and discharge. Since responsibility is 'graduated' according to the experience, ability and capability of individual house staff, it will be the responsibility of the Attending Physician to judge these qualities and act accordingly; the Chief of Service and other Attending Physicians will assist in this judgment according to their collective experience and the experience within the UCSF Neurology Residency program. Housestaff independently enter all orders, but all DNR orders must be cosigned by an Attending Physician within 24 hours and discharge orders can only be signed by a licensed physician.

The Attending Neurologist in each of the clinical venues is responsible for maintaining the highest quality of patient care, and assumes ultimate responsibility for patient management. This includes assuring that resident-directed activities, and indeed intern and medical student activities, adhere to the highest ethical and professional standards and that they compromise neither patient care nor patient amenities. The supervising Attending Neurologist must appropriately step to the foreground when needed, either for direct patient care or to assure patient understanding and

communication, but also step back when the residents are able to assume this responsibility and perform these duties at the highest level according to their level of training ability and experience. The capacity to adjust in this way, depending upon both the residents' abilities and the patients' needs, will be taken into account when evaluating Neurology Service faculty performance.

Attending Neurologist coverage is available 24 hours a day either in-person or by telephone. Residents are expected to communicate in a timely fashion with the responsible Attending Neurologist in the following circumstances:

1) Patients being considered for admission or transfer to the Neurocritical Care Service.
2) Patients being considered for cooling after cardiac arrest.
3) Patients who die on the Neurocritical Care or Neurology Ward Service without a DNR order.
4) Children seen for neurologic consultation.

Resident evaluation is coordinated through the evaluation process centralized in the Department of Neurology at UCSF. This involves a web-based evaluation system with each Attending Physician filling out a performance assessment at the end of the residents' rotation. This evaluation is discussed with the resident and also the aggregate assessments are reviewed and contribute to the overall performance evaluation of each resident. These are used by the Residency Director and the individual resident's faculty advisor as a basis for assessment of performance and advice regarding improvement. Resident performances are also discussed among Attendings at monthly faculty meetings. Feedback for individual errors or management issues is also discussed at the time of their occurrence by the Attending Physician and by the Chief of Service (or their designee) at Morning Report. All deaths on the Neurology Service are reviewed monthly by the PIPS Director and quarterly by the PIPS Committee, with attention to implications for resident and Attending management issues. Transfers from the Neurology Service are tracked by the Committee quarterly.

VII. NEUROLOGY SERVICE CONSULTATION CRITERIA

Refer to IX.G. below: Attending Physician Responsibilities.

VIII. NEUROLOGY SERVICE DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT

The Neurology Service is committed to the maintenance of the highest standards of practice and dedicated to the continued efforts to improve Neurology Service performance. The PIPS effort is embedded in the day-to-day activities of the Service and in structured activities, including Morning Report, Attending Rounds, Professor's Rounds and the PIPS Committee.

The Chief of Service, or designee (e.g. Director of PIPS), is responsible for ensuring solutions to quality care issues. As necessary, assistance is invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

The goals and objectives of the Neurology Service PIPS Program include, but are not limited to:

1) To ensure appropriate care and safety of all patients receiving care in the Neurology Service. It is understood that this care is provided chiefly in the 4M Clinic and acute medical-surgical areas (wards, ICUs, Emergency Department);
2) To minimize morbidity and mortality, as well as to avoid unnecessary days of inpatient care. Efficiency in delivery of service remains a prime objective.

The Neurology Clinical Service PIPS Program is delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

A. NEUROLOGY CLINICAL SERVICE INDICATORS

Clinical Service Indicators for the Neurology Clinical Service are delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

B. NEUROLOGY CLINICAL SERVICE PRACTITIONER PERFORMANCE PROFILES

Practitioner Performance Profiles for the Neurology Clinical Service are delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

C. MONITORING AND EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Monitoring and Evaluation of Appropriateness of Patient Care Services of the Neurology Clinical Service is delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

D. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

Monitoring and Evaluation of Professional Performance of attending physician and NP providers on the Neurology Clinical Service is accomplished by the Neurology Chief of Service using the Ongoing Provider Performance Evaluation (OPPE) program every year. An annual report of Neurology Service PIPS activities is made to the ZSFG PIPS Committee every year and is delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

E. MEDICAL RECORDS

The members of the Neurology Service are committed to the maintenance of complete, accurate, meaningful and timely medical records in accordance with the ZSFG Bylaws, Rules and Regulations that define the minimal standards for medical records of the Service.

Medical Records shall include complete documentation of patient's clinical information, diagnosis, and current status and management plan in the chart. The details of the formats and responsibilities of each member of the clinical "team" with respect to this documentation are outlined in a separate document, *Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).*

F. INFORMED CONSENT

All decisions for treatment (or withdrawal of treatment) should involve the active participation of the patient or his/her surrogate, and should be made after appropriate discussion of the risks, benefits, and alternatives.

G. ATTENDING PHYSICIAN RESPONSIBILITIES

The responsibilities of each member of the clinical neurology "team" are delineated in detail in the document, *Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).* The Attending Neurologists assigned to the individual components of the Neurology Clinical Service have the ultimate responsibility for patient management. In brief:

1) The Attending Neurologist assigned to the Adult Inpatient Ward Neurology Service will assume overall responsibility for the care of patients admitted to that Service. This entails:
    - Direct evaluation of these patients, initially within the first 24 hours of their admission, and throughout their hospital stay.
    - Supervision of all aspects of their care, including major decisions in management and close supervision of the resident staff.
    - Documentation of this participation in the form of daily notes in the medical record (weekend cross-coverage may be shared with the Attending Neurologists assigned to the Neurology Consultation Service)
    - Availability by pager or telephone 24 hours per day.

2) The Attending Neurologist assigned to the Adult Inpatient Consultation Neurology Service will assume overall responsibility for inpatient consultations. These include:
    - Direct evaluation of inpatients within 24 hours of the request for consultation usually following initial evaluation by the consultant resident.
    - Review of all neurology consultations evaluated by the neurology resident in the Emergency Department not resulting in admission (and hence not covered by the above consideration or not assumed by the Inpatient Service Ward or Neurocritical Care Attending). This may be performed at the time of evaluation or retrospectively, the following day, depending upon the complexity and acuity of the problem. This may also take place at Morning Report, with the faculty member staffing Morning Report serving as the designee of the Neurology Consultation Service Attending for purposes of case review.
    - Assure that the advice of the Neurology Service is accurate, appropriate, and well founded, and that this is communicated in a clear and timely manner.
    - Availability by pager or telephone 24 hours per day.

3) The Attending Neurologist assigned to the Neurocritical Care Service will assume overall responsibility for the care of patients admitted to that Service. This entails:
    - Direct evaluation of these patients, initially within the first 24 hours of their admission, and throughout their hospital stay.
    - Supervision of all aspects of their care, including major decisions in management and close supervision of the resident staff.
    - Documentation of this participation in the form of daily notes in the medical record.
    - Assure that the advice of the Neurology Service is accurate, appropriate, and well founded, and that this is communicated in a clear and timely manner.
    - Supervise any neurocritical care procedures performed, depending on the level of experience, training, and expertise of the fellow or resident performing the procedure
    - Availability by pager or telephone 24 hours per day.

4) The Attending Neurologist assigned to the Child Neurology Service will assume the overall responsibility of all neurology consultations involving patients in the pediatric age group in conjunction with the Child Neurology Fellow based at Benioff UCSF Children's Hospital. This includes:
    - Staffing of Child Neurology Outpatient Clinic on the ZSFG campus
    - Direct evaluation of inpatients as deemed appropriate by the requesting service and if available and on campus.
    - The adult Neurocritical Care Service Attending may participate in the care of children with critical neurological emergencies admitted to ZSFG (e.g. neurotrauma)

- The adult Neurology Consult Service may staff inpatient consults for children ages 17 years and older
- Other neurological consultations will be directed from the ZSFG Pediatrics Service to the Child Neurology Fellow on call for UCSF Benioff Children's Hospital

5) The Attending Neurologists assigned to supervision of the Neurology Clinic will assume ultimate responsibility for the patients evaluated and cared for in the Neurology Clinic. The degree of direct supervision of outpatient evaluation will depend upon the:
   - Training level, individual experience, and proven ability of the resident staff also caring for the patient, as well as
   - The complexity and difficulty of the patient problem.
   - This will range from complete and thorough evaluation by the Attending in cases where students are first evaluating patients to a brief review of the findings and plan in the case of advanced residents.
   - The Attending Neurologists in the Clinic will also serve to assure the efficient and timely triage and evaluation of patients and the highest standards and courtesy and professionalism in the clinic.

6) The Attending Neurologist assigned to either perform and interpret EMG's or interpret EEG's and Evoked Potentials will have received appropriate subspecialty training (Board Eligibility or Certification) and will assure that these are performed in a timely manner commensurate with optimal clinical care and that interpretations are made and conveyed to the referring physician in useful form, usually within one to two (1 to 2) days of their performance, depending upon the reason for the test. If privileged to do so, an attending neuromuscular neurologist may also perform botulinum toxin injections in patients for whom this is indicated.

X. MEETING REQUIREMENTS

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

All Neurology Service faculty holding a 50% or greater appointment at ZSFG will be expected to serve on ZSFG Medical Staff committees. A minimum service of one committee per 50% appointment (e.g. 100% faculty will serve on at least two medical staff committees) will be expected.

The Neurology Service will maintain the following committees and regular meetings:
1. The Neurology Service faculty meeting will occur monthly or as needed.
2. The Neurology Service PIPS committee will meet quarterly, or as needed. The composition of this committee is discussed in the ZSFG Neurology Service PIPS Plan.

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. ADDITIONAL NEUROLOGY CLINICAL SERVICE SPECIFIC INFORMATION

Orientation of Medical Staff is the responsibility of the Chief of the Neurology Service or designee. Risk Management compliance is in accordance with the ZSFG Bylaws, Rules and Regulations.

XII. VOTING CRITERIA

Members of the Neurology Clinical Service professional staff for purposes of voting on rules, regulations, and policies shall be those members whose principal clinical activities (>50%) are performed at ZSFG and who are geographically located principally on the ZSFG campus. This group shall be referred to as the *Voting Professional Staff of the Neurology Clinical Service.* Special exception will be made for individuals providing subspecialty expertise critical to the Neurology Service's overall mission (e.g., Child Neurology) who are approved by a two-thirds (2/3rds) majority of the Voting Professional Staff of the Neurology Clinical Services.

XIII. ADOPTION AND ADMENDMENT

The Neurology Service Rules and Regulations will be adopted and revised by a majority of all Active members of the Neurology Service bi-annually.

Appendix A - Zuckerberg San Francisco General Hospital Neurology Privilege Form

Neuro NEUROLOGY 2017

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

CORE PRIVILEGES

18.10 ADULT NEUROLOGY

Work up, diagnose, and treat patients on the Neurology Service and consult on patients with neurological problems in the inpatient setting and emergency department. Work up, diagnose, treat, and consult on adult patients (age 17 and older) with neurological problems in the clinics. Core privileges include lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology).

PROCTORING: Review of 5 cases REAPPOINTMENT: Review of 3 cases

18.20 CHILD NEUROLOGY

Work up, diagnose, treat, and consult on pediatric patients (under age 18 and those patients up to age 30 with neurologic conditions that typically present during childhood) with neurological problems in the inpatient and outpatient settings. Core privileges include lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases REAPPOINTMENT: Review of 3 cases

SPECIAL PRIVILEGES

18.30 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 Neurology 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

18.40 EEG

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with EEG privileges.

REAPPOINTMENT: Review of 3 cases.

18.50 EMG

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with EMG privileges.

REAPPOINTMENT: Review of 3 cases.

18.60 EVOKED POTENTIALS

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with evoked potential privileges.

REAPPOINTMENT: Review of 3 cases.

18.70 BOTULINUM TOXIN FOR MOVEMENT DISORDERS, SPASTICITY OR REFRACTORY HEADACHE

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology) and training in administration of botulinum toxin for the above indications.

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with botulinum toxin privileges.

REAPPOINTMENT: Review of 3 cases.

18.80 CRITICAL CARE

Evaluation and management of critically ill patients, including management of airway, ventilation, hemodynamics, sedation, and analgesia. Staffing of Stroke/Neurocritical Care Follow-Up Clinic and consults outside the ICU that require a neurointensivist.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology) or American Board of Emergency Medicine and eligible or certified in Neurocritical Care by the American Board of Psychiatry and Neurology or United Council for Neurologic Subspecialties.

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with Critical Care Privileges

REAPPOINTMENT: Review of 3 cases

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

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

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

PROCTORING: All OPPE metrics acceptable REAPPOINTMENT: All OPPE metrics acceptable

_____ _____

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

APPROVED BY

_____ _____

Division Chief Date

_____ _____

Service Chief Date

Appendix B - Zuckerberg San Francisco General Hospital Neurology Clinical Service:

Description of Service

(Maintained in the Department of Neurology)

This document describes the Neurology Service at Zuckerberg San Francisco General Hospital, including its mission, the organization of its clinical services, the duties and regulations regarding various personnel and the schedule of activities. It serves as a supplement to the document, *Rules and Regulations, Neurology Service, Zuckerberg San Francisco General Hospital.*

The Neurology Service at Zuckerberg San Francisco General Hospital is divided into several principal components that contribute to fulfilling its clinical mission. These include the **Adult Inpatient Neurology Ward Service, Adult Inpatient Neurology Consultation Service, Neurocritical Care Service,** and **Neurology Outpatient Clinics**. The service also oversees the **Neurodiagnostic Laboratories**, including the electroencephalography (EEG), electromyography (EMG) laboratories (in combination with the Hospital) and cooperates with the Pediatric Service in providing **Child Neurology Service** specialty care. These are complementary components that contribute to the continuity of patient care and the continuity and breadth of education, as well as provide a platform for clinical research.

These activities are driven by a strong commitment to the overall service mission of Zuckerberg San Francisco General Hospital and by the association with and commitment to the University of California, San Francisco and particularly its Department of Neurology. The Neurology Service believes that specialized neurological care is an essential component of the patient care services at ZSFG. Likewise, the Neurology Service at ZSFG is an important component of the UCSF Neurology Department and both enhances the academic activities of the Department and benefits from the programs, leadership and resources of the 'parent' Department. This document focuses on the clinical services and emphasizes the organization and hierarchical responsibilities of physician members of 'team' in relation to the component activities. It also explains the weekly schedules for the three inpatient services that are included at the end of this document.

Mission of the Neurology Service

The mission of the Service follows the traditional tripartite goals of an Academic Medical Center: patient care, education and research.

Patient Care. This is the principal focus of day-to-day activity of the Service and the component of our mission that underlies the Service's very existence. The Service's objective is to provide exemplary patient care and clinical service to the patient community served by ZSFG within the limits of available resources. This is the ***first priority*** of all activities related to patients. The Service aims to provide timely, knowledgeable and humane service to all individuals within the framework of the institution.

Education. ZSFG is a major postgraduate and medical student teaching venue in the UCSF system. The major educational emphasis of the Service, and one that lies at its very core, relates to the UCSF Neurology Residency Training Program. The Neurology Resident rotations at ZSFG are among the most important of the three years of this specialty training. This importance is based on the nature and traditions of this Institution and to the patient populations served. In turn, the Resident Trainees provide critical service to the Hospital and to these patients. The supervision of residents is aimed at allowing *graduated responsibility* based both upon the years of training and upon the individual capabilities of the trainee, while at the same time providing the safeguards of appropriate Attending Staff supervision. This training is effected principally through experience and instruction at the bedside and organized formally through the various inpatient teaching and work rounds and individual review of patients in the outpatient setting.

Medical student teaching, particularly at the third year level, is also an important activity that receives major attention of the Service. Customarily 4-5 students rotate monthly on the Service as part of their mandatory neurology clerkship. They rotate among the inpatient Ward, Consultation, and Neurocritical Care services. Fourth year students may also elect rotation on the Inpatient Consultation and Neurocritical Care Services. Teaching of students involves bedside rounds as well as group didactic sessions centering on ‘case vignettes; designed to broaden their familiarity with the full spectrum of neurological disease.

Research. The ZSFG Neurology Service considers the development of Clinical and Translational Research directed at elucidating and ameliorating the diseases afflicting the patients cared for at ZSFG to be critically important and a central aspect of its mission. There is a direct connection with the UCSF Brain and Spinal Injury Center at ZSFG. There are now ongoing clinical research studies in HIV-AIDS, stroke, and traumatic brain injury.

Without vigorous and strong commitment to each of the three components of the mission, the Neurology Service would lose its identity and *raison d’etre*, at least in its current form. Each of these components contributes directly (e g. shared personnel and resources) and indirectly (e.g. quality of personnel and intellectual rigor) to the strength of the other. None can be sacrificed or compromised without important impact on the other.

The following section describes each component of the Clinical Service.

Inpatient Adult Neurology Ward Service

The Inpatient Neurology Ward Service provides specialized care for patients with neurological Diseases and their complications. Its purpose is to admit and care for patients in which the need for neurological diagnosis and treatment is preeminent and for those who have received principal care from the Service when they develop other complications requiring hospitalization. The physician and physician-in-training personnel centrally contributing to the Service include: the General Inpatient Ward Attending Neurologist, the Senior neurology Resident, the Junior Neurology Resident, PGY1(s) when present, and the third-year Medical Students spending their required Neurology Clerkship on the Service. Other personnel are also

critical to the operation of the Service, including particularly the Neuroimaging unit of the Department of Radiology, the nurses on the various units, the Social Worker assigned to the Service, and the Neurorehabilitation 'team' from Physical, Occupational and Speech Therapy; these components will not be discussed further here, however, except as they relate to the schedule and expectations of the Service. The following describes some of the expectations and responsibilities of each of the aforementioned physician and physician-in-training team members.

Ward Service Attending Neurologist – The general Ward Service Attending Neurologist is ultimately responsible for care of patients on the Service except for those housed in the Intensive Care Unit (ICU). This involves both supervisory and direct patient evaluation and management. With respect to the latter, the following rules should be followed, with rare exceptions:

- S/he will directly evaluate and provide an admission note on all new patients within 24 hours of admission and earlier if indicated by the type or complexity of the illness.

- S/he will directly evaluate and provide a progress note on all patients ***daily***. This will generally be done in the context of daily Attending Work Rounds made with the Neurology Residents. Weekend cross-coverage may be shared with the Inpatient Neurology Consult Attending.

- S/he will oversee the entire staff but generally confer with and communicate with the Senior Resident in directing the Service. S/he will directly participate in all decisions regarding invasive diagnostic studies, therapy and life support.

- Since the Service is committed to functioning as an academic teaching service, the Attending Physician needs to make judgments and adjustments with respect to when s/he needs to assume the primary physician role and when s/he can delegate this role to the resident staff. This will depend on the individual capabilities of the resident and on the complexity and nature of the patients' illnesses. At all times the Attending must be sufficiently familiar with the details of the patients' management to assure that optimal care is being administered. The latter includes not only the accuracy of diagnosis and the appropriateness of therapies, but also the manner and thoroughness of communication with families and other personnel involved in the patients' overall care. The Attending must set and assure the standard with respect to professionalism and highest ethical and personal interactions.

- The Ward attending physician also plays an overall role in coordinating the educational experience of the MS3 students rotating on the various ZSFG neurology services. Case vignettes (standardized and provided by the Department of Neurology medical clerkship director) should be discussed with the entire group of rotating MS3 students at least once each week.

Ward Service Senior Neurology Resident – This resident directly manages the Ward Service and serves as the overall "Practice Group Leader" for all the Neurology residents rotating at

ZSFG at a given time. This resident importantly oversees the details of day-to-day decisions regarding triage and admission, as well as diagnosis and therapy. S/he rounds daily with the Attending Neurologist on Ward Attending Work Rounds and participates in Resident Work Rounds. S/he directs patient-related decisions in consultation with the Attending Physicians as needed. S/he also plays a major role in teach Medical Students the fundamental aspects of neurology, including the neurological examination and basic care of those with neurological impairment. The formal duties thus include:

- Directly supervising care of all patients on the Ward Service. This requires direct evaluation of each patient and ongoing monitoring of all diagnostic studies, therapy and patient status.
- Overseeing the quality and timeliness of chart documentation by the Junior Resident and adding a formulation, clarification summary note on complex admissions or during the course of a complex course of illness.
- Assuring the timely completion of discharge notes, including sharing this duty with the Junior Resident.
- Reporting to, consulting with, and rounding with the Attending Neurologists daily.
- Assisting and filling in for the Junior Resident during the daytime when they are absent or too busy to provide timely coverage of patients on the Service, or consultation on other services including the Emergency Department.
- Attending Morning Report.
- Planning the biweekly Professor's Rounds, including case selection and organization.
- Planning the on-call and other house staff scheduling (after the first few months, this may be delegated to the Junior Resident).
- Participating in Outpatient Clinics.
- Overseeing Resident Work Rounds during the week.
- Coordinating rounding schedules and resident responsibilities for the weekend days.

Ward Service Junior Neurology Resident – Although not the neurologist of record (since this is the Attending Physician), the Junior Resident serves as *the neurology Ward team member who is the primary interface* with the patient (and family, associates, etc.). S/he provides documentation of the patient's illness, manages and schedules tests, and deals with the logistics of care with the assistance of the PGY1 (when available). This resident will usually carry the 'Ward Service Pager' (**415-327-WARD**) during the day.

- Rounds each weekday on all patients on the service, and on weekends assigned, overseeing evaluation and care during these rounds. After the initial months of the new academic year, the Junior Resident can 'run' these rounds at the discretion of the Senior Resident.
- Provides a full admission note emphasizing neurologic aspects of diagnosis, formulation, planned evaluations and therapies.
- Provides independent daily progress notes summarizing the patient's status (including disposition), analysis and formulation of diagnosis and plan. The junior Ward resident also reviews, amends, and co-signs medical student notes.

- Presents patients to the Attending or Professor on Rounds if the students are not available for this duty. Additionally, presents and demonstrates the salient neurological findings and discusses diagnosis and rationale of the plan at the bi-weekly "Professor's Rounds" Clinical Case Conference.
- Attends Morning Report.
- Participates in Outpatient Clinics

Student Clerks – The primary responsibility of medical students relates to their education. However, because the Service adheres to the general philosophy that their *active* participation in the patient care team is an important vehicle for education, the students will also participate in the care activities. These include:

- Rounding daily on all patients on the Service.
- Assisting in patient care by: evaluating assigned patients on admission, following those patients daily, performing (under direct supervision) lumbar punctures and similar procedures on these patients, contributing daily notes summarizing results of diagnostic studies, patient status and changes in therapies and plans (not to substitute for the Resident notes), and contributing a recent review of the literature as a further guide to those caring for the patient. The students should also summarize the Attending Round evaluation of patients, including the principal new findings revealed by the history and examination and the diagnostic opinion and plan provided by the Attending Neurologist.

Neurology Inpatient Consultation Services

The Neurology Inpatient Consultation Services are divided into two components: an Adult Neurology Consultation Service and a Child Neurology Consultation Service. Together they provide specialized neurological consultation for the other inpatient services, the Emergency Department and, when needed, outpatient clinics of ZSFG. They are staffed by an Attending Neurologist assigned to each Service who assumes ultimate responsibility for the performance of the Services and the care delivered, and a Junior Resident who is the focus of the activities of both components. A student subPGY1 and MS3 student clerks may also be assigned to the Service to assist in these tasks.

Rules of Consultation Service – In order to provide optimal service for the care of patients and assistance to the primary physicians caring for patients requiring neurological expertise, there are expectations requiring the timeliness, level of expertise, and communication of this service. These are embodied in the following guidelines:

- All requested *routine consultations* will be seen by the consulting resident on the day of the request unless the requesting physician directly stipulates that a delay of up to 48 hours is acceptable. This means that consultations not seen by the daytime coverage will be evaluated by the resident on duty at night. SubPGY1 students may evaluate these patients, first, but the resident will still see them on the same day.

- All *urgent consultations* will be seen by the consulting resident within two hours of request and emergency consultations seen even more rapidly. Exceptions may relate to conflicts among urgent patients; these should be explicitly triaged by the consultation resident in agreement with the requesting physician or seen by another resident (e.g. Ward resident) if needed.
- *Acute Stroke Activations* represent an important exception to the expected time of evaluation. *Acute Stroke Activations* (also referred to as "Stroke Codes") are formal emergency activation in the hospital which specify the location of the relevant patient. Neurology residents are expected to respond in person immediately (physical presence within 5 minutes), and in the rare case in which they are performing a procedure (e.g. lumbar puncture) that cannot be safely immediately interrupted, then they are to call the hospital location (usually ED) in order to notify of the delay.
- All adult inpatients should be presented to and evaluated by the Attending Adult Neurologist within 24 hours of the requested consultation. Difficult or urgent patients should be discussed by telephone or directly evaluated more rapidly. Exceptions include Emergency Department consultations in which patients are discharged; these cases should be discussed before discharge or retrospectively the next day, depending upon the complexity of the problem. Patients evaluated on Saturday may be reviewed and evaluated by the Attending on Monday if they are not complex and such review is not urgent.
- In the case of patients seen in the Emergency Department or outpatient clinics during daytime hours who clearly require admission to the Neurology Ward or Neurocritical Care Service, the Consultation Resident should serve as a triage officer. This entails entering a brief note, seeing that emergency management is begun and that appropriate laboratory studies are ordered, and then turning the patient over to the Inpatient Service team for definitive admission evaluation (and admission note) and care. The exception to this policy will be when the inpatient resident team is not immediately available due to other patient care responsibilities; Attending Rounds are not a sufficient reason for the Inpatient Resident Staff to defer this task.
- The conclusions and recommendations of the Consultation Service should be clearly and rapidly communicated to the physicians of the primary service caring for the patient. This principally involves inclusion of the consultation note in the chart with designation of who has reviewed the case. For non-routine consultations and at times for routine consultations as well, the resident is also responsible for more active communication to the physicians requesting the consult. This entails direct telephone contact and discussion or, under certain circumstances, faxing of a copy of the Consultation Note or e-mail communication. In some cases, the Attending Physician will undertake telephone communication.
- All contact and communication with other services, as well as with nursing and other personnel should be conducted with the highest level of professionalism and courtesy. Residents must recognize that there is no such thing as an "inappropriate" request for consultation or assistance. If assistance is requested, it is needed.

The responsibilities and expectations of the members of the team are outlined as follows:

Attending Adult Neurologist – The Attending Adult Neurologist is responsible for the overall quality of the Consultation Service. This physician must review all patients consulted. With the exceptions enumerated above (discharged ED patients) this entails direct evaluation of the patients in a timely (within 24 hours) manner. More urgent consultations are discussed by telephone or directly seen within a shorter time frame depending upon the complexity or urgency of the problem. In the case of those patients directly evaluated, a note reflecting the evaluation and describing any additions or corrections of the resident's evaluation (or students and resident's notes) as well as a clear set of recommendations should be placed in the chart. In brief, the Attending:

- Oversees all aspects of the Consultation Service, assuring the quality of its evaluations, recommendations and service delivery.
- Evaluates and provides a note on all patients within 24 hours of the request. This note should clearly articulate the problem and recommendations and also invite further questions and discussion if needed.
- Reviews in detail all patients seen by the resident but not available for direct evaluation (e.g. ED patients). A designee such as the Neurology attending supervising Morning Report may serve this function.

Attending Child Neurologist – The practice and standards for the Attending Child Neurologists are the same as for the Attending Adult Neurologist as just described with the exception that when emergency consultation is needed and the Attending Child Neurologist is not directly available, the ZSFG Pediatrics Service will contact the Child Neurology Fellow on call at UCSF Benioff Children's Hospital by telephone for advice. If bedside immediate evaluation is deemed necessary (such as in the case of a critically ill child), an adult neurologist may initiate the Attending duties (Consult Attending if child age $\geq$ 17, Neurocritical Care Attending if child is admitted to the hospital and is critically ill) until the Child Neurology Attending or Fellow is available.

Neurology Consultation Resident – This individual serves as the focus of the Service, triaging all Consultations and evaluating all patients seen during the daytime hours as well as following up on all patients evaluated by the covering residents during night or weekend hours. This resident is the primary interface of the Neurology Service with other services in the Hospital. S/he is therefore expected to provide courteous, friendly and willing service at all times. Their evaluation of patients should address the broad spectrum of patient needs conveyed by the individuals caring for these patients. This resident will be responsible for the Consultation pager **(415-327-NERV)** carrying it during the daytime and passing it on to the night or weekend call resident. Among the specific responsibilities are the following:

- Evaluation of consultations in the various venues (inpatient wards, ED and outpatient clinics) following the time guidelines above.
- Providing an initial note at the time of the initial evaluation (designated, "will present to the Service Attending" or the like before evaluation by the Attending) in the medical record, and providing follow-up notes as indicated (usually at least every other day, depending upon the patient's condition and the availability of results of diagnostic studies

and the effects of therapeutic intervention). If patients are no longer to be followed by the Service, an *explicit* note in the chart should say this and invite re-consultation as needed.
- Supervising student sub-PGY1 and MS3 clerks on the Service and directly evaluating any patients seen by these individuals *before* they are presented to the Attending Neurologist. This requires an **independent note** by the resident documenting her/his examination and finds.
- Communication with the primary service as outlined above.
- Attending Morning Report.

Student Clerk – The primary responsibility of medical students relates to their education. However, because the Service adheres to the general philosophy that their *active* participation in the patient care team is an important vehicle for education, the students will also participate in the care activities. These include:

- Rounding daily with the Consult Service.
- Assisting in patient care by: evaluating assigned patients and following those patients as appropriate. The students should also summarize the Attending Round evaluation of patients, including the principal new findings revealed by the history and examination and the diagnostic opinion and plan provided by the Attending Neurologist.

Inpatient Neurocritical Care Service

The Neurocritical Care Service provides primary and consultative coverage for patients with critical neurological conditions. These include patients with acute stroke, neurotrauma, seizures, and neuromuscular conditions. Additionally patients on other clinical services, including neurosurgery, trauma surgery, medical intensive care, and cardiology, who have critical neurological issues are seen. The Neurocritical Care Service provides faculty coverage for acute stroke intervention as part of the Primary Stroke Center and comprehensive stroke center services.

Neurocritical Care Attending – The Neurocritical Care Attending will assume supervision of care for patients on the Neurology Service while they are in the ICU.

S/he will directly evaluate and provide an admission note on all new patients within 24 hours of admission to the ICU and earlier in indicated by the type or complexity of the illness. S/he will directly evaluate and complete a progress note on all patients ***daily***.

- S/he will generally confer with and communicate with the Neurology Neurocritical Care resident in supervising this component of the Service. S/he will directly participate in all decision regarding invasive diagnostic studies, therapy and life support.

- Since the Service is committed to functioning as an academic teaching service, the Neurocritical Care Attending Physician needs to make judgments and adjustments with respect to when s/he needs to assume the primary physician role and when s/he can

delegate this role to the resident staff. This will depend on the individual capabilities of the resident and on the complexity and nature of the patients' illnesses. However, all major decisions and procedures will be reviewed by the Neurocritical Care Attending. At all times, the Neurocritical Care Attending must be sufficiently familiar with the details of the patients' management to assure that optimal care is being administered. The latter includes not only the accuracy of diagnosis and the appropriateness of therapies, but also the manner and thoroughness of communication with families and other personnel involved in the patients' overall care. The Attending must set and assure the standards with respect to professionalism and highest ethical and personal interactions.

- The Neurocritical Care Attending will staff the weekly Stroke Clinic.
- The Neurocritical Care Attending will be available by pager and telephone 24 hours a day.

Neurocritical Care Fellow- As ZSFG is a principle teaching institution for the UCSF Neurocritical Care fellowship, the Neurocritical Care Fellow will serve the function as team leader for morning work rounds. The fellow will also serve as the primary contact for the Neurology Consult resident regarding acute stroke and neurocritical care cases.

Neurocritical Care Neurology Resident- The Neurology resident rotating on the Neurocritical Care Service will be responsible for daily rounding and notes on all patients on the Neurocritical Care Service. This resident will be responsible for ordering or recommending tests and treatments for service patients. Additionally, the resident will

- Serve as the primary conduit for communication with families of patients on the Neurology Service in the ICU.
- Serve as the primary conduit for communication with other clinical services seeking neurocritical care consultation
- Provide basic teaching to the student clerk on the service

Student Clerk – The primary responsibility of medical students relates to their education. However, because the Service adheres to the general philosophy that their *active* participation in the patient care team is an important vehicle for education, the students will also participate in the care activities. These include:

- Rounding daily with the Neurocritical Care Service.
- Assisting in patient care by: evaluating assigned patients and following those patients as appropriate. The students should also summarize the Attending Round evaluation of patients, including the principal new findings revealed by the history and examination and the diagnostic opinion and plan provided by the Attending Neurologist.

Neurology Resident In-house Night Coverage

Resident Night Coverage – Neurology overnight in-house coverage is provided seven days a week by a Night Resident who serves from approximately 7 PM through Morning Report the next day. This night coverage system was instituted in response to changes in housestaff duty hours. The overnight resident will handle all consultations and oversee the care of the Ward and Neurocritical Care patients during this period. S/he will also be available by telephone as a resource for advice and consultation by the SFHN. S/he will carry all service pagers during this time. All admission and consultations will be 'checked out' with the daytime resident staff before or during Morning Report or in a sign-out session on the weekends. Cases requiring attending or fellow input will be discussed by telephone or by direct presentation to the Attending or Neurocritical Care Fellow/Attending on call.

Neurology Outpatient Clinics

As Neurology evolves increasingly to an outpatient specialty, the importance of this activity will continue to increase, both with respect to service delivery and teaching. The outpatient clinic activity of the Adult Service now uses the 4M Clinics facility and includes three regular weekly sessions: two General New Patient clinics (Thursday afternoon and Friday morning) and one follow-up clinic (Tuesday afternoon). There are also four subspecialty clinics: a weekly Stroke Clinic, a monthly Geriatics-Neuro Clinic, a monthly Neuroimmunology Clinic which is imbedded into a new patient clinic, and a monthly Epilepsy Clinic. The Child Neurology Clinic meets Friday mornings in the Pediatric area.

Because the allotted time (including room and nurse availability) for the principal Neurology Clinics is constrained, it is critical that the clinics start on time and that patient flow is maintained so that they can end on time as well. Attendings, Residents and Students are therefore expected to arrive on time. The Clinics have become important teaching vehicles for students, expanding their range and volume of experience. This must continue, yet not unduly inconvenience patients nor impede patient 'throughput.' Much of the patient care in the clinics is performed by Residents for similar reasons, along with economic considerations. The following outlines some of the responsibilities of the personnel in the Adult Neurology Clinics.

Attending Neurologists – Usually three Attendings are assigned to each New Patient clinic session and two or three to the Follow-up clinic session. Their duties include: overseeing residents and any nurse practitioners, applying the principles of graduated responsibility described earlier; and direct evaluation of patients as needed to facilitate patient flow. Their activities in this context include:

- Directing the Clinic. One of the Attending Neurologists in each clinic will assume the role of director for that session. Associated duties include triaging (when each patient is to be seen, by whom, and into which room); assigning patients based on their complexity and suitability for teaching is an important duty. These activities are important to increase the efficiency of the session and require someone to maintain an overview for the day.

- Evaluating patients seen by Residents. The requirement for Attending supervision varies according to the experience and capability of the individual residents, as well as the problem of the patient. Hence, the supervision requirements range from careful and thorough assessment of new patients seen by PGY1s or beginning first-year Neurology Residents to brief review of the findings and plan of Senior Residents seeing patients in follow-up. The Attending Physician is responsible for knowing the patient flow and assignments and providing judgment regarding the supervisory needs of the patients being seen.
- Direct evaluation of patients. Because of the need to maintain patient flow and the limited value of some patients as 'teaching cases,' the Attending Neurologist assigned to Clinic often needs to join directly in the effort to evaluate patients not seen by the Residents or NPs. In these instances, the Attending will assume full responsibility for care of these patients or triage for resident follow-up.

Neurology Residents – The Neurology residents providing Outpatient Service to ZSFG do this as part of an independent outpatient rotation, as well as during their inpatient rotation at the Hospital and during other rotations when they participate in their Continuity Clinic here.

- Adult Neurology New Patient Clinics: Neurology residents on the dedicated outpatient rotation at ZSFG as well as mixed outpatient rotations across the UCSF-staffed hospitals staff the adult Neurology New Patient Clinics. The Neurology Residents assigned to the ZSFG Ward and Consult services also participate in a limited role in the ZSFG Adult Neurology New Patient Clinics, usually once weekly. At the early Junior level, the resident's patients will usually be reviewed in some detail with the Attending, while at the Senior level the review is much less detailed. Since this is a graduated process, the judgment of how much supervision is needed should be determined by the Attending Physician. It is imperative that the Residents arrive in the clinic on time and that they begin seeing patients as soon as they are available. Results of evaluations should be conveyed to the referring physicians by computerized note, fax, e-mail or telephone.
- Adult Neurology Follow-up Clinics: Each UCSF Neurology Resident maintains a continuity clinic at ZSFG and they generally staff this clinic once monthly during the time slot for the Adult Neurology Follow-up Clinics. The residents should consider the clinic as a *time assignment* rather than strictly on the basis of patients scheduled. In general, they will see only those patients that they have been following long-term. However, if they are not fully booked with follow-up patients, they will be assigned to evaluate either patients that are new to them, but who were seen in new patient clinic by a provider who does not have a follow-up clinic, or follow-up patients who need to be seen before the availability of their 'continuity' neurologist permits. Assignment will be made by the Attending Physician supervising the clinic session.
- Child Neurology Clinic: these clinics are staffed by Child Neurology fellows and attendings as designated.

Neurodiagnostic Laboratory

The Neurodiagnostic Laboratory represents a joint enterprise with ZSFG in which the Neurology Service provides the professional expertise in overseeing and interpreting test results and the Hospital provides the facilities, equipment and technical support. This document considers only the aspects supplied by the Neurology Service – the "professional component."

The Laboratory is organized into two sections operating separately except for aspects of scheduling and support: EEG, and EMG.

EEG – the EEG Laboratory is an important resource for patient care with its value relating principally, although not exclusively, to the diagnosis of seizure disorders and toxic-metabolic brain disease. The EEG's are interpreted by one of the Neurology Attendings who provides special expertise in EEG and epilepsy. It is important that this is done on a timely basis. Networking arrangements allow digital EEG records to be transmitted. The scheduling and responsibility for the timeliness of service is assumed by the Clinic clerks, in conjunction with the technician. In addition to the high-level specialized expertise, the requirements of the Laboratory include:

- Timely interpretation of records. Interpretation of routine records should be within 72 hours and interpretation of urgent records within 12 hours. If requested, these reports can be available to the referring physician immediately after reading by voice, fax or computer entry into the medical record. The office can be contacted for an earlier reading.
- While it is desirable that scheduling of routine testing occurs within one week of request, current resources do not allow this. Exceptions for both inpatients and outpatients will be triaged by the Senior Neurology Resident.
- Emergency EEG's are occasionally performed by the Neurology Residents after hours. This extra service will vary with the training of the resident on call, the medical need and the concomitant workload with the decision being made by the resident, after evaluating the patient, in consultation with the Consult Attending.

EMG – The EMG Laboratory likewise provides a needed on-site facility for evaluation of nerve and muscle disorders. Since the EMG examination is more akin to a physician consultation than to a simple (mechanized) laboratory test, the professional staff is rate-limiting for this facility. The Director of this Laboratory will assure not only the quality of the Service, but its timeliness, in order to assure high standards of care for the Hospital and Neurology Services at ZSFG. The goals of the laboratory are to provide timely and quality service similar to that of EEG, including:

- Availability of the unit for scheduling routine studies as soon as possible, and for acute needs (e.g. for diagnosis of myasthenia gravis or inpatient studies) within two days of request. Unfortunately, due to other responsibilities, the availability of the present

Director is limited and, hence, there are unwanted delays in scheduling studies. Urgent studies are performed upon request, however.

- Reports should be available to the referring physician immediately after reading by voice, fax or computer entry into the medical record. The office can be contacted for an earlier reading.

Conferences and Rounds

The formal aspects of the teaching and patient care activities of the Service are structured in a series of conferences and rounds. Some of these are included in the schedule that follows in this document. The structure and purpose are discussed here.

House Staff Work Rounds – This is a critical aspect of patient care. These are the daily morning work rounds on the various services and involve the residents and students assigned to the specific services. During these rounds all inpatients on the Neurology Ward Service are evaluated by direct examination and chart (including laboratory results) review, and the plans for diagnosis and treatment are discussed, reviewed and assigned for implementation. These begin first thing in the morning, usually at 7:00 A.M. (Monday through Friday). On Neurocritical Care Work Rounds, patients on the Neurosurgery Service are seen beginning at 7:00 A.M. each weekday, with other patients on the Neurocritical Care Service to follow. Neurology Consult work rounds are usually done prior to Morning Report by the Inpatient Neurology Consultation Resident. Residents from the various services then meet at Morning Report.

Morning Report – This is held each weekday and is attended by the neurology Residents assigned to ZSFG inpatient Neurology services and the night coverage Resident. The primary purpose of this exercise relates to Quality Management of the Service, with teaching an important secondary goal. All new inpatients seen by any of the adult inpatient services (Ward, Consultation, Neurocritical Care) will be briefly (beginning with a concise one minute synopsis) presented to the Chief of Service or their designee, and those presenting diagnostic or therapeutic difficulty will be highlighted for further discussion. This includes patients seen in the ED and sent home. Similarly, any active or unsettled diagnostic or therapeutic issues with patients admitted or initially consulted earlier will be discussed. The Attending neurologists rotating on the inpatient services are encouraged but not required to attend Morning Report. The objective of this exercise is to provide a consistent and uniform level of care and oversight for the Neurology Service through this common reporting mechanism. This also facilitates subspecialty consultation and entry of patients into clinical research protocols.

Consult Attending Rounds – These are held daily and are a mixture of patient care (first priority) and teaching rounds. Teaching is at the Resident level and directed to issues of diagnosis and practical management. The timing of these rounds will vary with the Attending's schedule of other activities but generally will begin either early in the morning or in the afternoon, allowing all patients to be evaluated by the Attending within 24 hours of the consultation. Problem or difficult diagnosis/management patients will be staffed outside of this schedule. When the regular Attending assigned to this rotation for the month cannot be available, another Neurologist needs to be available to substitute.

Ward Attending Rounds – During these rounds the Attending Neurologist reviews (visiting each patient and reviewing their diagnostic studies and progress generally) the Service with the Senior resident (and/or Junior resident if available) and completes the Attending notes. These notes are generally brief and relate to overall diagnostic and care summary issues; they are supplementary, but not a substitute for the more detailed Resident notes. These are almost exclusively patient care rounds with some supplementary teaching if time allows. These rounds are generally done immediately after Morning Report each weekday and in the mornings on weekends.

Neurocritical Care Attending Rounds – These are held daily. Patients are presented to the Neurocritical Care Attending by the student or resident primarily responsible for the patient. Diagnostic and treatment plans are reviewed and updated. These rounds also serve an important teaching function and may be supplemented by didactic teaching and medical literature review when appropriate.

Professor's Rounds – This conference is held on Tuesday mornings, usually biweekly. One or two cases are presented to a visiting professor. They will generally be chosen from the inpatient and outpatient services because: 1) they represent interesting examples of diagnoses that are worthy of sharing with others, or 2) represent difficult diagnostic or management problems. The Senior Resident on the Ward Service will be responsible for organizing the cases and seeing that the patients and other material (neuroimages, electrophysiology) are available for review. For the Case Conferences, the Junior Resident will generally present the case (succinctly) and demonstrate the relevant (but not extraneous) findings; the Junior or Senior Resident will also present a brief review of the problem related to the major issues exemplified by the patient. Participation by physicians and consultants from other services is encouraged.

Neuroimaging Conference – This is presented by Neuroradiology in combination with Neurology and Neurosurgery every Friday. A list of cases to be presented is submitted by the Junior Ward Resident the afternoon before the conferences; late additions may be added on to the conference. Additionally, on other days pertinent neuroimages will be reviewed with the Neuroradiology staff on an *ad hoc* basis.

Resident Neurology Didactic Conference – This is a weekly conference, usually at noon on Mondays, during which a faculty member provides an educational lecture on a specific topic directed at residents and students. As part of this, once a month there is a journal club in which a specific article of interest is reviewed and once a month there is a Neurology M&M session in which the Senior Ward resident reviews one or more cases for quality improvement purposes.

Appendix C - ZSFG Neurology Clinical Service Performance Improvement & Patient Safety Plan

Organization and Responsibility:

1. **Department Chairperson:** Nerissa Ko, M.D., Professor and Interim Chair, UCSF Department of Neurology, has delegated responsibility for the ZSFG Neurology **Performance Improvement and Patient Safety (PIPS)** Program to J. Claude Hemphill, M.D.,M.A.S., Professor of Neurology, Chief of Neurology at ZSFG.

2. **Performance Improvement and Patient Safety (PIPS) Coordinator:** Liz Hamid, M.D., Assistant Professor of Neurology

3. **Performance Improvement and Patient Safety Committee:**
Liz Hamid, M.D., Associate Professor of Neurology, Neurology PIPS Coordinator; J. Claude Hemphill, III, M.D.,M.A.S., Professor of Neurology, Chief of Neurology at ZSFG; Cate Freyer, MBA, Neurology Service Division Manager*;* Sara Cole, RN, ZSFG Stroke Program

4. **Performance Improvement and Patient Safety (PIPS) Plan:**
The ZSFG Neurology Performance Improvement and Patient Safety Plan is reviewed every second year by the Neurology Chief of Service

Departmental Review and Evaluation:

1. The Neurology Service PIPS Committee meets quarterly, with the following regular agenda items:
- Review of all deaths on the Neurology Service. The PIPS Officer reviews the charts of each of these patients monthly and summarizes each case for the Committee.
- Review of sentinel events, and stroke quality measures.
- Discussion of patient care issues generated from Morning Report, Professor's Rounds, and Monthly M&M Conference
- Selected PIPS issues, including ongoing projects. These are determined by the Committee on an ongoing basis. Emphasis is on high-risk or high-volume issues or where possible problems or inefficiencies have been identified by attending staff, residents, nursing, patients or other individuals. These reviews are limited to issues that can be adequately researched using available resources. Special review is considered for issues related to the Primary Stroke Center.

2. **Staff Meeting:** The ZSFG Neurology Service Attending On-Campus Staff meets monthly (or as needed). Performance improvement and patient safety issues are among the standing agenda items. Discussions generally include:

- Reports of issues arising from the Neurology Service PIPS Committee Meeting.
- Review of hospital-wide utilization statistics and Neurology Service inpatient and outpatient census and trends.
- Review of additional patient care issues identified by meeting attendees or by other personnel (for example, 4M nursing) prior to meeting.
- Discussion of clinical studies concluded, in process, or proposed.
- Discussion of performance of Residents and Attending Physicians based on ongoing monitoring activities and evaluation sheets.

3. **Staff Appointment / Appraisal Process** (Credentialing)

- **Appointment:** The major categories of Clinical Privileges on the ZSFG Neurology Service include:

- Core Privileges in Adult or Child Neurology
- Special Privileges
- Moderate Sedation
- EEG
- EMG
- Evoked Potentials
- Botulinum Toxin for Movement Disorders, Spasticity, or Refractory Headache
- Critical Care
- CTSI

Physicians are proctored for their first five cases during their initial appointment. The scope of activities proctored is consonant with the clinical privileges requested. Proctoring will include direct observation of faculty performing the activity / procedure for which privileges are performed as well as by ongoing review of cases and patient management through Morning Report and Professor's Rounds. This will be performed by the Chief of Service or an appropriate designee; data will also be monitored from other sources, including hospital and outpatient service notes. Following the proctoring period and based on the review of same, the Chief of Service must verify proficiency in the requested areas prior to granting privileges in those areas and the Credentials Committee of the Medical Staff must approve the application.

Physicians' clinical and teaching performance are periodically evaluated using the following methods:

- Review of charts by PIPS Officer and PIPS Committee and derived from sources described above
- OPPE performed every 12 months, with Neurology Service-specific indicators for either inpatient or outpatient
- Evaluation by residents and medical students (with respect to teaching)

- **Reappointment:**
  - Department of Neurology files include information on current licensure, CPR training status, CME training, DEA status, and other relevant items
  - Files also include documentation of any issues relating to the clinical performance of the individual that have been generated by ongoing PIPS activities of the Department. These are reviewed by the Chief of Service during the reappraisal process.

Appendix D – Job Description: Chief, Neurology Service

Position Summary:

The Chief of Neurology Service directs and coordinated the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also insures that the Service's functions are integrated with those of other clinical department and with ZSFG as a whole.

Reporting Relationships:

The Chief of the Neurology Service reports directly to the Vice Dean and the University of California, San Francisco (UCSF) Department of Neurology Interim Chair (Dr. Nerissa Ko). The Chief is reviewed no 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 Vice Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of the Neurology Service is Board certified in Neurology, 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 the Neurology Service include the following:

Providing the necessary vision and leadership to effectively 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; this includes oversight of inpatient and outpatient Neurology Service activities and the neurodiagnostic and neurophysiology laboratories (including electroencephalography and electromyography laboratories);

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

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

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance standards and priorities, determining the qualifications and competencies of Service personnel, and maintaining appropriate quality control programs; and

Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.
Specific duties and responsibilities include:

- Oversight of the clinical, teaching and clinical research activities of the Neurology Clinical Service
- Reviews and recommends all new appointments, requests for privileges, and reappointments for all Neurology Clinical Service members

- Appointment of other officers of the Neurology Service and committee members
- Oversight of the financial affairs of the Neurology Service
- Attendance and participation in the Medical Executive Committee, Chief of Service Meetings, and other meetings called by the Executive Administrator, and the Chief of Staff
- Participates in the Clinical Practice Group (CPG) and attends the CPG regular meetings and other meetings convened by the Chair of the CPG as needed.
- Execution of disciplinary actions as necessary, as set forth in the ZSFG Bylaws and Rules and Regulations.

Appendix E – ZSFG Neurology Ward and Consult Attending Expectations

ZSFG Ward Attending Expectations 2026-2027

Typical ward attending schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
7:30 AM-8:00 AM		Morning report			Morning report
9:00 AM-11:00 AM	Attending rounds	Attending rounds	Attending rounds	Attending rounds	Attending rounds
12:00 PM-1:00 PM	Conference (3C + Zoom)	Assisting in completing tasks			
1:00 PM-5:00 PM		Assisting in completing tasks		Resident clinic (4M)	Neuroradiology conference (HB 247 + Zoom) [1:30-2:30]

Daily clinical responsibilities

1. The ward attending is expected to be on the ZSFG campus during regular working hours each weekday for clinical, teaching, and supervisory duties. Workspace will be made available for attendings from non-ZSFG sites.
    a. If an attending must leave campus during this time for other professional activities, they are expected to be available by pager and/or cell phone. The attending should be available to return to campus during regular working hours to assist in patient care if needed.
    b. The ward attending serves as secondary attending for consults when the consult attending is in clinic and can staff ED consults being discharged home when schedule allows. This should not significantly delay the patient's discharge from the ED.
2. Attendings must be available each weekday and during assigned weekends to round with the ward resident.
    a. **Weekdays:** Attending rounds are from 9AM-10:45AM M-Th and 9AM-11AM on Friday. Any patient not seen by the end of rounds will be seen by the attending alone (students and rotators also allowed to accompany if not otherwise needed, but the neurology residents should be dismissed to begin the work of the day).
        i. Seeing stable follow-up patients without the residents and then "card flipping" during rounds is acceptable before going to see the new patients and anyone who is unstable as a team. The specific style of rounds can be coordinated between the attending and the Ward Senior resident.
        ii. The last 5 minutes of rounds should be reserved to divide tasks for the day, including the tasks with which the attending can assist (i.e. calling families, running family meetings, calling PCPs or other outpatient providers, assisting with LPs, etc.)
    b. The ward attending is expected to attend multidisciplinary rounds with the junior resident, Utilization Management, Social Work, and PT/OT/SLP. These are currently held in person in H4009 M-Th from 10:45AM-11AM.

c. If there are lower level of care (LLOC) patients on the service with complex discharge needs, the attending has the opportunity to discuss barriers to discharge with UM/SW leadership during Complex Care Rounds on Thursday from 1:25PM-1:35PM via Zoom (call information in Cate's orientation email). The team SW can guide if this conversation is needed during the team's MDR M-Th.
d. If the ward attending is scheduled for Neuro-New Clinic on Friday morning, rounds should occur prior to clinic starting at 9AM (being attentive to morning report from 7:30AM-8:00AM and to restrictions on the time residents are allowed to come in in the morning). The recommendation is for this to occur as work rounds (aka discovery rounds) where the attending joins the residents during their normal pre-rounding process from 8AM-9AM.
e. If the ward resident is scheduled for Neuro-New Clinic on Friday morning, rounds can occur prior to clinic starting (as above) or can occur with the remaining resident in the typical fashion. The specific workflow should be coordinated between the attending and Ward Senior.
f. **Weekends:** See below for further details. It is strongly recommended that rounds with the residents be completed by 11AM on Saturday and Sunday.

3. The ward attending is expected to assist in ensuring **no resident violates duty hour requirements.**
    a. The attending is expected to check in with the Ward Senior at 3PM M-F to discuss updates for the patients, determine what tasks still need to be completed (or assist the resident to triage what work can be deferred to the following day), and assist in completing any necessary tasks to ensure the residents are able to sign out on time. Examples of tasks include, but are not limited to, calling families, calling PCPs or other outpatient providers, writing patient letters or filling out disability paperwork.
    b. The attending and ward residents will receive an email each Wednesday and Thursday morning detailing the number of hours worked by the residents that week (calculated Sunday to Saturday). Residents are not allowed to work >79 hours. The attending should work with the resident to ensure they stay within those requirements. If further coverage is needed, jeopardy will be activated to cover the remaining hours of the week.
    c. To meet duty hour requirements, each Ward resident is given 2 Tuesdays off / month (alternating Ward Senior and Ward Junior). The attending is expected to assist in completion of the necessary tasks for the day. This can include, but is not limited to, writing progress notes for the day (attending only templates have been shared), coordinating follow up appointments with PCPs, family updates, running family meetings or performing LPs. Specific workflow needs for the day should be an ongoing discussion between the resident and attending during the day to ensure the resident signs out on time.
    d. On the day a resident is assigned to swing shift (cross cover and consults between 5-7PM) they are not to come in prior to 7:30AM. Pre-rounding duties may therefore be incomplete prior to rounds. Flexibility in workflows to accommodate this on rounds is encouraged (i.e., seeing patients together that were not seen during pre-rounds, reviewing labs or imaging in the moment on rounds, etc.).
    e. Residents must have at least 8 hours off between shifts. On rare occasions, this may result in a resident needing to come in later than 7:30 am. On such occasions, the resident is expected to notify their attending by email upon leaving the hospital of their expected arrival time the next morning.
    f. The attending running morning report will check in with night float to ensure their work can be completed and that they leave no later than 9AM. The recommendation is for residents to complete the notes for any patient they sent home from the ED followed by

any admission notes (ICU then ward) followed by any inpatient consult notes. Any notes not completed can be shared and completed by the appropriate day resident.

4. Notes / EHR responsibilities
    a. Each patient must be seen daily (7 days a week) and an attending attestation must be written for each resident note. The attestations are templated to optimize billing (see Epic PowerPoint for screen shots of how to access). The attestation must be signed no later than 8AM the day following the attending's evaluation (i.e. if the patient is seen on Monday during rounds, the attestation is required by 8AM Tuesday morning).
    b. All newly admitted patients must have an H&P from the attending in the chart within 24 hours of hospital admission. This occurs in the form of the attending attestation to the resident H&P OR attestation to the initial consultation note (marking clearly in that attestation that that is the H&P and not consultation only note). The H&P attestation is templated to optimize billing (see Epic PowerPoint). If the resident H&P was signed after midnight, no resident progress note is needed the day the patient is first staffed by the attending (ex: if admitted by night float and the H&P signed after midnight on Tuesday, staffed during rounds on Tuesday, no resident progress note is needed for Tuesday). If, however, the H&P is signed before midnight, the resident must write a progress note for the following day (ex: admitted by night float and note signed Monday before midnight, staffed by the attending on rounds Tuesday, attending attests the H&P and the resident progress note for Tuesday). The attestation for the progress note can refer to the H&P attestation (a dot phrase for this that you can use – ".nlrhp") but the progress note must still be attested.
    c. Residents are expected to write a discharge summary on the day of discharge for each patient. This counts as the note for the day and does not require an additional progress note.
    d. The resident notes for patients who were discharged home without being staffed by an attending should be signed by the ward attending on the days they are assigned for morning report. These notes do not require the attestation template, and require only a statement that the patient was not personally interviewed or examined by the attending, that you agree with the recommendations as stated (or adjust those recommendations in the attestation depending on the conversation), and that it is not a billable note. (Feel free to steal the dot phrase created with this wording – ".nlreddc")
    e. On the first day of the rotation, the attending must reassign themselves as the attending for all ward patients (see Epic PowerPoint for screenshots on how to do this). This is essential to ensure Secure Chat messages are appropriately routed.
    f. Each weekday and assigned weekend, the ward attending must check their inbox for orders and PT/OT/SLP documentation to co-sign (see Epic PowerPoint for instructions).
        i. The PT/OT/SLP services will send their initial evaluation notes to you to co-sign. *Do not attest*, just click the "co-sign" button and cancel any charge session that pops up automatically. This serves as confirmation that you authorize their treatment plan but does not trigger billing on our end.
        ii. Each newly admitted patient must have an "admit to inpatient" order OR "admit to observation" order signed within 24 hours of admission. This order will be in your Epic inbox to co-sign. If the patient will be in the hospital for 2 or more midnights, they should be admitted to "inpatient". If in the hospital overnight only, the order should be for "observation" (the residents will know how to change the order type if needed).
5. Clinic: For most weeks, the ward attending will be assigned to staff one half day of resident clinic each week. Typically, this is the Neuro-New Clinic on Thursday from 1PM-5PM, however will

occasionally be the resident continuity clinic on Tuesday 1PM-5PM or the Neuro-New Clinic on Friday from 9AM-12PM (see Cate Freyer's orientation email for assignment).

a. During clinic, the ward attending is expected to staff patients with the residents and NPs (including physically seeing all new patients), sign Epic attestations (see Epic PowerPoint guide for screenshots), and co-sign resident orders/prescriptions as needed.

Weekends, Call and Signout

1. The Ward attending is responsible for staffing all ward patients and all new and active follow-up consult patients each weekend. It is not expected for the attending to be onsite all day to staff new consults/admits in the afternoon.
2. The Ward attending will cover weekend call. Call entails receiving calls from the residents overnight to discuss patient management, logistics, or other questions.
3. Attendings who are covering the weekend will take call from 5 PM on Friday until 7:30 AM (beginning of morning report) on Monday.
4. Weekday night call starts at 5PM and ends at 7:30AM the following day.
5. The attending must sign out the service either verbally or via email to the incoming attending at the end of the rotation and each weekend for which they are not working.

Conference and teaching responsibilities

1. Conferences
    a. Attendings are expected to attend neuroradiology conference every Friday at 1:30pm. These occur both in person and via Zoom.
    b. Attendings are welcome to attend Monday educational conferences and are particularly encouraged to attend the journal club and M&M conferences for the month. These occur in person in 3C as well as over Zoom.
    c. Attendings are welcome to attend 4-Hospital morning report, which occurs once per month from 8AM-9AM (see morning report schedule in Cate Freyer's orientation email for details).
2. Teaching / feedback
    a. Attendings are encouraged to sign up to provide a 1-hour didactic educational session during their half-month rotation, if space is available. This can cover a topic of their choosing, be a formal presentation or chalk talk, and can be a talk (or variation of a talk) they have previously given.
    b. Attendings are primarily responsible for medical student teaching. This includes weekly clinical vignettes with the student rotating on the ward service. The students have access to these vignettes, and you will receive an email from Karl Kanner with the faculty guide for the vignettes. The goal is to review 2-4 with the student / week when the service schedule allows (if service is busy with good patient mix, vignettes can be deferred).
    c. Attendings are also encouraged to give informal chalk talks to students, rotators and residents as time allows.
    d. Attendings are required to perform an observed exam with the students rotating on the ward service. This should be scheduled at the end of week 2 or the beginning of week 3 of the students' rotation block. The goal of this exercise is to provide feedback on exam techniques for the student, both verbally after the observation as well as through a feedback form the student will send through MedHub. Ideally, the student would not be familiar with the patient at the time of the exam, and the patient should speak English if possible.
    e. Attendings will provide verbal feedback to students and residents and evaluate them using MedHub at the end of the half-month rotation (although mid-rotation verbal feedback is also welcomed).

i. Student MedHub evaluations are due within 1 week of the end of their rotation

f. Attendings may also be asked to fill out BBOTs (Brief Bridges Observational Tool) for the students. These are brief feedback forms sent to the attending through MedHub to reflect feedback given on presentations, exam, or other aspects of clinical care. The students are also able to fill these forms out themselves and send to the attending for review.

ZSFG Consult Attending Expectations 2026-2027

Typical consult attending schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
7:30 AM-8:00 AM	Morning report		Morning report		
9:00 AM-11:00 AM	Attending rounds	Attending rounds	Attending rounds	Attending rounds	Attending rounds
12:00 PM-1:00 PM	Conference (3C + Zoom)				
1:00 PM-5:00 PM	Staffing ED consults	Resident clinic (4M)	Staffing ED consults	Staffing ED consults	Neuroradiology conference (HB 247 + Zoom) [1:30-2:30] Staffing ED consults

Daily clinical responsibilities

6. The consult attending is expected to be on the ZSFG campus during regular working hours each weekday for clinical, teaching, and supervisory duties. Workspace will be made available for attendings from non-ZSFG sites.
    a. If an attending must leave campus during this time for other professional activities, they are expected to be available by pager and/or cell phone. The attending should be available to return to campus during regular working hours to staff a patient if needed.
    b. The consult attending serves as a secondary attending when the ward attending is in clinic and can assist in clinical tasks (including, but not limited to, discussing clinical questions or assisting with LPs) as needed.
7. Attendings must be available each weekday to round with the consult resident.
    a. **Weekdays:** Attending rounds are from 9AM-11AM M-F. Any patient not seen by 11AM will be seen by the attending alone (students and rotators also allowed to accompany if not otherwise needed, but the neurology resident should be dismissed to begin the work of the day).
    b. If the attending or resident is scheduled for Neuro-New Clinic on Friday morning, rounds should occur prior to clinic starting at 9AM (being attentive to morning report from 7:30AM-8:00AM and to restrictions on the time residents are allowed to come in in the morning). The recommendation is for this to occur as work rounds (aka discovery rounds) where the attending joins the resident during their normal pre-rounding process from 8AM-9AM.
    c. **Weekends:** the Consult Attending is not routinely assigned to cover weekends. Consult Service attending duties on the weekend will be covered regularly by the Ward Attending.
8. Attendings should make every effort to staff ED consultations throughout the day.
    a. All new ED consults M-F between 8AM-5PM (within reason) who are being discharged home should be seen and staffed by the consult attending prior to discharge. This should

not significantly delay the patient's discharge from the ED. This includes patients seen by the night float resident who remain in the ED the following morning if possible. The resident is not required to join the attending to see the patients, depending on workflow, but should discuss their findings and recommendations with the attending prior to the attending staffing the patient.

b. The consult attending should provide sign out (either verbal or email) to the ward or ICU attending for all consults they staff who are then admitted to the primary neurology service.
c. At the discretion of the consult attending and resident, new inpatient consults (med/surg, ICU, inpatient psych, PES and 4A) seen by the resident after attending rounds can be staffed by the attending the same day or can be staffed the following day during attending rounds.

9. The consult attending is expected to assist in ensuring **no resident violates duty hour requirements.**
    a. The attending is expected to check in with the resident at 3PM M-F to discuss updates for the patients and plan who needs to be seen the following day, determine what tasks still need to be completed (or assist the resident to triage what work can be deferred to the following day), and assist in completing any necessary tasks to ensure the residents are able to sign out on time. This can include, but is not limited to, writing follow up consultation notes or discussing recommendations with teams / patients.
    b. The attending and consult resident will receive an email each Wednesday and Thursday morning detailing the number of hours worked by the resident that week (calculated Sunday to Saturday). Residents are not allowed to work >79 hours. The attending should work with the resident to ensure they stay within those requirements. If further coverage is needed, jeopardy will be activated to cover the remaining hours of the week.
    c. On the day a resident is assigned to swing shift (cross cover and consults between 5-7PM) they are not to come in prior to 7:30AM. Pre-rounding duties may therefore be incomplete prior to rounds. Flexibility in workflows to accommodate this on rounds is encouraged (i.e., seeing patients together that were not seen during pre-rounds, reviewing labs or imaging in the moment on rounds, etc.).
    d. Residents must have at least 8 hours off between shifts. On rare occasions, this may result in a resident needing to come in later than 7:30 am. On such occasions, the resident is expected to notify their attending by email upon leaving the hospital of their expected arrival time the next morning.
    e. The attending running morning report will check in with night float to ensure their work can be completed and that they leave no later than 9AM. The recommendation is for residents to complete the notes for any patient they sent home from the ED followed by any admission notes (ICU then ward) followed by any inpatient consult notes. Any notes not completed can be shared and completed by the appropriate day resident.
10. Notes
    a. All new consults must have an attending attestation within 24 hours of the initial resident note. The attestations are templated to optimize billing (see Epic PowerPoint for screen shots of how to access). The attestation must be signed no later than 8AM the day following the attending's initial evaluation (i.e. if the consultation is first staffed on Monday during rounds, the attestation is required by 8AM Tuesday morning).
    b. All follow-up consults should have a resident note and attending attestation for every day they are seen on rounds. If the resident has not completed the follow-up notes by 3PM, the attending is encouraged to write an attending-only follow-up note for that day. The follow-up attestations and attending-only follow-up notes are templated to optimize

billing (see Epic PowerPoint for screen shots of how to access). The attestation must be signed no later than 8AM the day following the follow-up evaluation.

11. The resident notes for patients who were discharged home without being staffed by an attending should be signed by the consult attending on the days they are assigned for morning report. These notes do not require the attestation template, and require only a statement that the patient was not personally interviewed or examined by the attending, that you agree with the recommendations as stated (or adjust those recommendations in the attestation depending on the conversation), and that it is not a billable note.
12. EHR responsibilities
    a. It is recommended that the attending assign themselves as the consult attending in EPIC on the first day of the rotation (details for how to do this are included in Cate's orientation email). This ensures that any primary team will contact the appropriate person for follow up questions.
    b. Each assigned weekend, the attending must check their inbox for orders and PT/OT/SLP documentation to co-sign (see Epic PowerPoint for instructions).
        i. The PT/OT/SLP services will send their initial evaluation notes to you to co-sign. *Do not attest*, just click the "co-sign" button and cancel any charge session that pops up automatically. This serves as confirmation that you authorize their treatment plan but does not trigger billing on our end.
        ii. Each newly admitted patient must have an "admit to inpatient" order OR "admit to observation" order signed within 24 hours of admission. This order will be in your Epic inbox to co-sign. If the patient will be in the hospital for 2 or more midnights, they should be admitted to "inpatient". If in the hospital overnight only, the order should be for "observation" (the residents will know how to change the order type if needed).
13. Clinic: In most weeks, the consult attending will be assigned to staff one half day of resident clinic each week. Typically, this is the resident continuity clinic on Tuesday 1PM-5PM, however will occasionally be the Neuro-New Clinic on Thursday 1PM-5PM or Friday 9AM-12PM (see Alexandra Brown's schedule for assignment).
    a. During clinic, the consult attending is expected to staff patients with the residents and NPs (including physically seeing all new patients), sign Epic attestations (see Epic PowerPoint guide for screenshots), and co-sign resident orders/prescriptions as needed.

Call and Signout

1. The consult attending may take night call as assigned. Call entails receiving calls from the residents overnight to discuss patient management, logistics, or other questions.
2. Weekday night call starts at 5PM and ends at 7:30AM the following day.
3. The attending must sign out the service either verbally or via email to the incoming attending at the end of the rotation and each weekend for which they are not working.

Transfers

1. The consult attending is responsible for screening potential transfers to the neurology service, except in the case of neurologic emergencies. The patient will be staffed on attending rounds, and the consult attending will determine if the patient is appropriate for transfer after staffing the consult. If the patient is stable, the transfer would then occur at 7AM the following morning, with transfer orders being placed by the ward team and the patient staffed on ward rounds. The consult attending should provide sign out (either verbal or email) to the ward attending.

   a. For neurologic emergencies (hemorrhage, status), the transfer request will be triaged through the ICU fellow/attending, and the patient can be transferred immediately once approved.
2. The hospital is currently not transferring patients from other facilities.

Conference and teaching responsibilities

1. Conferences
   a. Attendings are expected to attend neuroradiology conference every Friday at 1:30pm. These occur both in person and via Zoom.
   b. Attendings are welcome to attend Monday educational conferences and are particularly encouraged to attend the journal club and M&M conferences for the month. These occur in person in 3C as well as over Zoom.
   c. Attendings are welcome to attend 4-Hospital morning report, which occurs once per month from 8AM-9AM (see morning report schedule in Cate Freyer's orientation email for details).
2. Teaching / feedback
   a. Attendings are encouraged to sign up to provide a 1-hour didactic educational session during their half-month rotation, if space is available. This can cover a topic of their choosing, be a formal presentation or chalk talk, and can be a talk (or variation of a talk) they have previously given.
   b. Attendings are primarily responsible for medical student teaching. This includes weekly clinical vignettes with the student rotating on the ward service. The students have access to these vignettes, and you will receive an email from Karl Kanner with the faculty guide for the vignettes. The goal is to review 2-4 with the student / week when the service schedule allows (if service is busy with good patient mix, vignettes can be deferred).
   c. Attendings are also encouraged to give informal chalk talks to students, rotators and residents as time allows.
   d. Attendings are required to perform an observed exam with the students rotating on the ward service. This should be scheduled at the end of week 2 or the beginning of week 3 of the students' rotation block. The goal of this exercise is to provide feedback on exam techniques for the student, both verbally after the observation as well as through a feedback form the student will send through MedHub. Ideally, the student would not be familiar with the patient at the time of the exam, and the patient should speak English if possible.
   e. Attendings will provide verbal feedback to students and residents and evaluate them using MedHub at the end of the half-month rotation (although mid-rotation verbal feedback is also welcomed).
      i. Student MedHub evaluations are due within 1 week of the end of their rotation
   f. Attendings may also be asked to fill out BBOTs (Brief Bridges Observational Tool) for the students. These are brief feedback forms sent to the attending through MedHub to reflect feedback given on presentations, exam, or other aspects of clinical care. The students are also able to fill these forms out themselves and send to the attending for review.

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110
August 10, 2026

NEUROLOGY SERVICE

RULES AND REGULATIONS

2026

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110
August 10, 2026

NEUROLOGY SERVICE
RULES AND REGULATIONS

TABLE OF CONTENTS

I. NEUROLOGY SERVICE ORGANIZATON

The Neurology Service is an academic component of the University of California, San Francisco (UCSF). The Service also, therefore, conforms to the UCSF regulations and policies and to the policies of the UCSF Department of Neurology. These affect particularly: staff appointments; resident training; policies and allocations; medical student teaching programs; research programs; and financial oversight. There are no perceived conflicts between the UCSF policies and the policies of Zuckerberg San Francisco General Hospital, but if a conflict should arise that relates to patient care activities, the ZSFG Medical Staff Bylaws and Rules and Regulations of ZSFG and this document will take precedence.

The Neurology Service conforms to the Medical Staff Bylaws and Rules and Regulations of Zuckerberg San Francisco General Hospital (ZSFG). This document is therefore supplementary, defining some of the specific rules and regulations that pertain to the Neurology Service and its activities.

The Rules and Regulations of the Neurology Service define certain principles, standards of practice and other rules of the organization of the Neurology Service and the duties of its members.

A. SCOPE OF SERVICE

The mission of the Neurology Service follows the traditional tripartite goals of an academic medical center: Patient Care, Education, and Research. However, in the immediate setting of patient care and patient interactions (inpatient services, outpatient clinics, telephone contact or consultation, etc.) the Neurology Service patient care mission takes precedence whenever there is a conflict or discrepancy among the three mission components. The policies and approaches to clinical service are outlined more specifically in greater detail in a separate document, *Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).*

B. MEMBERSHIP REQUIREMENTS

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

1. Privileges to practice on the Neurology Service will be commensurate with clinical training (Board Certified/Board Eligible) and documentation of an acceptable standard of clinical practice.
2. Privileges are approved by the Chief of the Neurology Service, subject to the approval of the Credentials Committee of the Medical Staff and approval of the Governing Body.
3. Individual privileges are subject to review and revision at initial appointment, throughout the period of proctoring, at the time of reappointment, at the time judged appropriate by the Chief of the Neurology Service or at any time recommended by two-thirds of the Voting Professional Staff of the Neurology Service.
4. DEA Certification is required; CPR Certification is recommended but not required.

C. ORGANIZATION AND STAFFING OF THE NEUROLOGY SERVICE

The officers of the Neurology Service are:

1. Chief of Service

The qualifications, selection, review and tenure of the Chief of the Neurology Service are in accordance with ZSFG Medical Staff Bylaws and Rules and Regulations.

Responsibilities (See ATTACHMENT D)

- Oversees the clinical, teaching and research activities of the Neurology Service.
- Reviews and recommends all new appointments, requests for privileges, and reappointments for all Neurology Service members.
- Appoints other Neurology Service officers and committee members.
- Manages financial affairs of the Neurology Service.
    - Attends and participates in the Medical Executive Committee, Chief of Service Meetings, and other meetings called by the Executive Administrator, and the Chief of Staff.
    - Participates in the Clinical Practice Group (CPG) and attends the CPG regular meetings and other meetings convened by the Chair of the CPG as needed.
    - Executes disciplinary actions as necessary, as set forth in the ZSFG Bylaws and Rules and Regulations.

2. Director of Performance Improvement and Patient Safety (PIPS)

- Appointment of the Neurology Service Director of PIPS is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
    - The Director of PIPS provides overall leadership and direction of the PIPS Plan and PIPS Committee of the Neurology Service.
    - Represents the Neurology Clinical Service on the ZSFG PIPS Committee.
    - Assists in the reappointment process of the members of the Neurology Clinical Service as it relates to quality improvement, management, and assurance.

3. Director of Neurology Outpatient Services

- Appointment of the Director of Neurology Outpatient Services is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
    - Oversight of the Neurology new patient and follow-up clinics including making the attending clinic schedule
    - Actively work with nursing and hospital leadership regarding optimizing and improving outpatient services
    - Collaborate and coordinate with referring services regarding Neurology outpatient care
    - Oversee e-Referral as it relates to Neurology Outpatient Services
    - Oversee the EMG portion of the Neurodiagnostic Laboratories
    - Coordinate Neurology Resident teaching relevant to the outpatient domain
    - Collaborate with the Neurology Chief of Service regarding overall direction of the outpatient services program

4. Director of Neurology Inpatient Services (aka Neurohospitalist Service)

- Appointment of the Director of Neurology Inpatient Services is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
    - Oversight of the Neurology Ward and Consult Services including making the attending clinic schedule
    - Actively work with nursing and hospital leadership regarding optimizing and improving inpatient services
    - Collaborate and coordinate with referring services regarding Neurology inpatient care

- Coordinate Neurology Resident teaching relevant to the inpatient domain (Ward and Consult Service)
- Collaborate with the Neurology Chief of Service regarding overall direction of the inpatient services program

5. Neurology Medical Student Education Site Director

- Appointment of the Neurology Education Site Director is the prerogative of the Neurology Chief of Service in conjunction with the overall UCSF Department of Neurology medical student clerkship director. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
  - Provide leadership and supervision regarding medical student rotations (including student electives) on the ZSFG Neurology Service
  - Orient new medical students to the rotation (or provide faculty designee to do so)
  - Actively work with the Department of Neurology medical student clerkship director and staff regarding priorities and programs
  - Assigning grades and entering them into the SOM grading portal for students on the Neuro 140 (MS4) elective rotation
  - Coordinate MedHub or other rotation evaluations, providing feedback to faculty, fellows, and residents as appropriate and leading resolution of any issues brought forward
  - Maintain relevant medical student neurology education portals appropriate for the rotation
  - Collaboration with the Chief of Service regarding overall direction for Neurology medical student education at ZSFG

6. Director of Electroencephalography (EEG) Services

- Appointment of the Director of EEG Services is the prerogative of the Neurology Chief of Service. The term of the appointment is open and subject to periodic performance review by the Neurology Chief of Service.
- **Responsibilities**
  - Oversight of the EEG Service including making the attending clinic schedule
  - Actively work with nursing and hospital leadership regarding optimizing and improving inpatient and outpatient EEG services
  - Collaborate and coordinate with referring services regarding EEG services
  - Collaborate with the Neurology Chief of Service regarding overall direction of the inpatient services program

7. Organization of the Neurology Clinical Service

The activities of the Neurology Clinical Service are divided into the following:

a) Inpatient Adult Neurology Ward Service
b) Inpatient Adult Neurology Consultation Service
c) Inpatient Neurocritical Care Service
d) Outpatient Adult Neurology Clinics
e) Neurodiagnostic Laboratories
f) Child Neurology Service

Each of the above activities, including their organization, goals and schedules, are described in greater detail in the supplementary document, *Zuckerberg San Francisco General Hospital Service: Description of Service*, (*Appendix B*), and are briefly outlined below.

Inpatient Adult Neurology Ward Service

The Inpatient Adult Neurology Ward Service provides hospital care for adult patients with neurological diseases and their complications. The purpose of this Service is to provide optimal diagnostic and therapeutic management of patients for whom neurological disease or dysfunction is the predominating reason for hospitalization and the need for acute medical care. This embodies both specialized (care of the neurological condition, itself) and principal (medical care of associated conditions related to the neurological disease, when appropriate) care to this group of patients.

Inpatient Adult Neurology Consultation Service

The Adult Neurology Consultation Service provides specialized consultation to inpatients hospitalized under the care of other services and to emergency department or outpatients requiring urgent consultation in order to assist in providing optimal care of these patients.

Inpatient Neurocritical Care Service

The Inpatient Neurocritical Care Service provides primary hospital care and consultation for patients with acute and subacute neurological problems requiring critical care services. This includes management of acute stroke and is coordinated with the activities of the ZSFG Joint Commission certified Primary Stroke Center.

Outpatient Adult Neurology Clinics

The Outpatient Adult Neurology Clinics provide specialized neurological evaluation, management and consultation for patients suffering neurological dysfunction. It is the outpatient venue for both neurological consultation (advice to other physicians providing care) and principal neurological care (continuous direct care provided by the Clinic neurologist where appropriate).

Neurodiagnostic Laboratories

The Neurodiagnostic Laboratories currently have two components: the Electroencephalography (EEG) Laboratory (which includes Evoked Potentials) and the Electromyography (EMG) Laboratory. Each laboratory provides diagnostic services for both inpatients and outpatients.

Child Neurology Service

The Child Neurology Service provides neurological services for pediatric patients and is organized together with the Pediatrics Service and provides specialized neurological consultation for selected inpatients and outpatients in the pediatric age group (0-17 years).

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

1. Board Certified or Eligible by the American Board of Psychiatry and Neurology in Adult or Child Neurology
2. Current California Licensure
3. Current DEA Certificate

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Neurology Service is in accordance with ZSFG Bylaws, Rules and Regulations.

C. PRACTITIONER PERFORMANCE PROFILES

The Neurology Service Practitioner Performance Profiles are maintained by the Chief of the Neurology Service.

1. Modification of Clinical Services

The process for Modification of Neurology Clinical Services will be through the appropriate review process as required.

2. Staff Status Changes

The process for Staff Status Changes for members of the Neurology Service is in accordance with ZSFG Bylaws, and the Rules and Regulations.

D. AFFILIATED PROFESSIONALS

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

E. STAFF CATEGORIES

The Neurology Clinical Staff fall in the same staff categories that are described in the ZSFG Bylaws, Rules and Regulations.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF NEUROLOGY PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF NEUROLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Neurology Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES and MODIFICATION/CHANGE TO PRIVILEGES

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

The process for modification/change to the privileges for members of the Neurology Service is in accordance with the ZSFG Medical Staff Bylaws and the Rules and Regulations.

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

Monitoring (Proctoring) of individual neurologists shall be the responsibility of the Chief of the Neurology Service (or designee) and the Director of Performance Improvement and Patient Safety (PIPS) for the Neurology Service and is based on observation and review of the care of five patients for each privilege (see Appendix A).

V. EDUCATION

The Chief of the Neurology Service is responsible for Education and Research and is accountable to the Vice Dean and the UCSF Department Chair for the conduct of graduate and undergraduate medical education and UCSF based research programs conducted through the Neurology Service.

The Neurology Service is an important teaching site for the UCSF Neurology Residency Training Program (See Section VI). Surgery Interns destined for the UCSF Neurosurgery Residency Training Program and St. Mary's Internal Medicine Residents serve one-month rotations on the service intermittently through the year. The Service is also a major teaching site for the UCSF School of Medicine, including Brain, Mind, and Behavior apprenticeships (15-20 MS1s per year) and Neurology 110, the Core Neurology Clerkship (45 MS3s per year). Additionally, 2-4 UCSF and extern MS4s complete Neurology 140, the Consultation Elective in Neurology, at ZSFG yearly.

VI. NEUROLOGY SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

The Training of Neurology Residents from UCSF is a major commitment of the Neurology Service. Part of this training involves graduated responsibility as the residents advance in their training. The role and responsibility of house staff at each level of training and their supervision, along with a description of the supervision of medical students is delineated in detail in the document*, Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).* The Neurology Service is intended to be a "Resident-Directed Service" so that whenever appropriate the senior resident on the service will function as the principal coordinator and director of patient triage, evaluation and discharge. Since responsibility is 'graduated' according to the experience, ability and capability of individual house staff, it will be the responsibility of the Attending Physician to judge these qualities and act accordingly; the Chief of Service and other Attending Physicians will assist in this judgment according to their collective experience and the experience within the UCSF Neurology Residency program. Housestaff independently enter all orders, but all DNR orders must be cosigned by an Attending Physician within 24 hours and discharge orders can only be signed by a licensed physician.

The Attending Neurologist in each of the clinical venues is responsible for maintaining the highest quality of patient care, and assumes ultimate responsibility for patient management. This includes assuring that resident-directed activities, and indeed intern and medical student activities, adhere to the highest ethical and professional standards and that they compromise neither patient care nor patient amenities. The supervising Attending Neurologist must appropriately step to the foreground when needed, either for direct patient care or to assure patient understanding and

communication, but also step back when the residents are able to assume this responsibility and perform these duties at the highest level according to their level of training ability and experience. The capacity to adjust in this way, depending upon both the residents' abilities and the patients' needs, will be taken into account when evaluating Neurology Service faculty performance.

Attending Neurologist coverage is available 24 hours a day either in-person or by telephone. Residents are expected to communicate in a timely fashion with the responsible Attending Neurologist in the following circumstances:

1) Patients being considered for admission or transfer to the Neurocritical Care Service.
2) Patients being considered for cooling after cardiac arrest.
3) Patients who die on the Neurocritical Care or Neurology Ward Service without a DNR order.
4) Children seen for neurologic consultation.

Resident evaluation is coordinated through the evaluation process centralized in the Department of Neurology at UCSF. This involves a web-based evaluation system with each Attending Physician filling out a performance assessment at the end of the residents' rotation. This evaluation is discussed with the resident and also the aggregate assessments are reviewed and contribute to the overall performance evaluation of each resident. These are used by the Residency Director and the individual resident's faculty advisor as a basis for assessment of performance and advice regarding improvement. Resident performances are also discussed among Attendings at monthly faculty meetings. Feedback for individual errors or management issues is also discussed at the time of their occurrence by the Attending Physician and by the Chief of Service (or their designee) at Morning Report. All deaths on the Neurology Service are reviewed monthly by the PIPS Director and quarterly by the PIPS Committee, with attention to implications for resident and Attending management issues. Transfers from the Neurology Service are tracked by the Committee quarterly.

VII. NEUROLOGY SERVICE CONSULTATION CRITERIA

Refer to IX.G. below: Attending Physician Responsibilities.

VIII. NEUROLOGY SERVICE DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT

The Neurology Service is committed to the maintenance of the highest standards of practice and dedicated to the continued efforts to improve Neurology Service performance. The PIPS effort is embedded in the day-to-day activities of the Service and in structured activities, including Morning Report, Attending Rounds, Professor's Rounds and the PIPS Committee.

The Chief of Service, or designee (e.g. Director of PIPS), is responsible for ensuring solutions to quality care issues. As necessary, assistance is invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

The goals and objectives of the Neurology Service PIPS Program include, but are not limited to:

1) To ensure appropriate care and safety of all patients receiving care in the Neurology Service. It is understood that this care is provided chiefly in the 4M Clinic and acute medical-surgical areas (wards, ICUs, Emergency Department);
2) To minimize morbidity and mortality, as well as to avoid unnecessary days of inpatient care. Efficiency in delivery of service remains a prime objective.

The Neurology Clinical Service PIPS Program is delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

A. NEUROLOGY CLINICAL SERVICE INDICATORS

Clinical Service Indicators for the Neurology Clinical Service are delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

B. NEUROLOGY CLINICAL SERVICE PRACTITIONER PERFORMANCE PROFILES

Practitioner Performance Profiles for the Neurology Clinical Service are delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

C. MONITORING AND EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Monitoring and Evaluation of Appropriateness of Patient Care Services of the Neurology Clinical Service is delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

D. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

Monitoring and Evaluation of Professional Performance of attending physician and NP providers on the Neurology Clinical Service is accomplished by the Neurology Chief of Service using the Ongoing Provider Performance Evaluation (OPPE) program every year. An annual report of Neurology Service PIPS activities is made to the ZSFG PIPS Committee every year and is delineated in the document, *Zuckerberg San Francisco General Hospital Neurology Service PIPS Plan. (Appendix C).*

E. MEDICAL RECORDS

The members of the Neurology Service are committed to the maintenance of complete, accurate, meaningful and timely medical records in accordance with the ZSFG Bylaws, Rules and Regulations that define the minimal standards for medical records of the Service.

Medical Records shall include complete documentation of patient's clinical information, diagnosis, and current status and management plan in the chart. The details of the formats and responsibilities of each member of the clinical "team" with respect to this documentation are outlined in a separate document, *Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).*

F. INFORMED CONSENT

All decisions for treatment (or withdrawal of treatment) should involve the active participation of the patient or his/her surrogate, and should be made after appropriate discussion of the risks, benefits, and alternatives.

G. ATTENDING PHYSICIAN RESPONSIBILITIES

The responsibilities of each member of the clinical neurology "team" are delineated in detail in the document, *Zuckerberg San Francisco General Hospital Neurology Service: Description of Service (Appendix B).* The Attending Neurologists assigned to the individual components of the Neurology Clinical Service have the ultimate responsibility for patient management. In brief:

1) The Attending Neurologist assigned to the Adult Inpatient Ward Neurology Service will assume overall responsibility for the care of patients admitted to that Service. This entails:
    - Direct evaluation of these patients, initially within the first 24 hours of their admission, and throughout their hospital stay.
    - Supervision of all aspects of their care, including major decisions in management and close supervision of the resident staff.
    - Documentation of this participation in the form of daily notes in the medical record (weekend cross-coverage may be shared with the Attending Neurologists assigned to the Neurology Consultation Service)
    - Availability by pager or telephone 24 hours per day.

2) The Attending Neurologist assigned to the Adult Inpatient Consultation Neurology Service will assume overall responsibility for inpatient consultations. These include:
    - Direct evaluation of inpatients within 24 hours of the request for consultation usually following initial evaluation by the consultant resident.
    - Review of all neurology consultations evaluated by the neurology resident in the Emergency Department not resulting in admission (and hence not covered by the above consideration or not assumed by the Inpatient Service Ward or Neurocritical Care Attending). This may be performed at the time of evaluation or retrospectively, the following day, depending upon the complexity and acuity of the problem. This may also take place at Morning Report, with the faculty member staffing Morning Report serving as the designee of the Neurology Consultation Service Attending for purposes of case review.
    - Assure that the advice of the Neurology Service is accurate, appropriate, and well founded, and that this is communicated in a clear and timely manner.
    - Availability by pager or telephone 24 hours per day.

3) The Attending Neurologist assigned to the Neurocritical Care Service will assume overall responsibility for the care of patients admitted to that Service. This entails:
    - Direct evaluation of these patients, initially within the first 24 hours of their admission, and throughout their hospital stay.
    - Supervision of all aspects of their care, including major decisions in management and close supervision of the resident staff.
    - Documentation of this participation in the form of daily notes in the medical record.
    - Assure that the advice of the Neurology Service is accurate, appropriate, and well founded, and that this is communicated in a clear and timely manner.
    - Supervise any neurocritical care procedures performed, depending on the level of experience, training, and expertise of the fellow or resident performing the procedure
    - Availability by pager or telephone 24 hours per day.

4) The Attending Neurologist assigned to the Child Neurology Service will assume the overall responsibility of all neurology consultations involving patients in the pediatric age group in conjunction with the Child Neurology Fellow based at Benioff UCSF Children's Hospital. This includes:
    - Staffing of Child Neurology Outpatient Clinic on the ZSFG campus
    - Direct evaluation of inpatients as deemed appropriate by the requesting service and if available and on campus.
    - The adult Neurocritical Care Service Attending may participate in the care of children with critical neurological emergencies admitted to ZSFG (e.g. neurotrauma)

- The adult Neurology Consult Service may staff inpatient consults for children ages 17 years and older
- Other neurological consultations will be directed from the ZSFG Pediatrics Service to the Child Neurology Fellow on call for UCSF Benioff Children's Hospital

5) The Attending Neurologists assigned to supervision of the Neurology Clinic will assume ultimate responsibility for the patients evaluated and cared for in the Neurology Clinic. The degree of direct supervision of outpatient evaluation will depend upon the:
   - Training level, individual experience, and proven ability of the resident staff also caring for the patient, as well as
   - The complexity and difficulty of the patient problem.
   - This will range from complete and thorough evaluation by the Attending in cases where students are first evaluating patients to a brief review of the findings and plan in the case of advanced residents.
   - The Attending Neurologists in the Clinic will also serve to assure the efficient and timely triage and evaluation of patients and the highest standards and courtesy and professionalism in the clinic.

6) The Attending Neurologist assigned to either perform and interpret EMG's or interpret EEG's and Evoked Potentials will have received appropriate subspecialty training (Board Eligibility or Certification) and will assure that these are performed in a timely manner commensurate with optimal clinical care and that interpretations are made and conveyed to the referring physician in useful form, usually within one to two (1 to 2) days of their performance, depending upon the reason for the test. If privileged to do so, an attending neuromuscular neurologist may also perform botulinum toxin injections in patients for whom this is indicated.

X. MEETING REQUIREMENTS

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

All Neurology Service faculty holding a 50% or greater appointment at ZSFG will be expected to serve on ZSFG Medical Staff committees. A minimum service of one committee per 50% appointment (e.g. 100% faculty will serve on at least two medical staff committees) will be expected.

The Neurology Service will maintain the following committees and regular meetings:
1. The Neurology Service faculty meeting will occur monthly or as needed.
2. The Neurology Service PIPS committee will meet quarterly, or as needed. The composition of this committee is discussed in the ZSFG Neurology Service PIPS Plan.

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. ADDITIONAL NEUROLOGY CLINICAL SERVICE SPECIFIC INFORMATION

Orientation of Medical Staff is the responsibility of the Chief of the Neurology Service or designee. Risk Management compliance is in accordance with the ZSFG Bylaws, Rules and Regulations.

XII. VOTING CRITERIA

Members of the Neurology Clinical Service professional staff for purposes of voting on rules, regulations, and policies shall be those members whose principal clinical activities (>50%) are performed at ZSFG and who are geographically located principally on the ZSFG campus. This group shall be referred to as the *Voting Professional Staff of the Neurology Clinical Service.* Special exception will be made for individuals providing subspecialty expertise critical to the Neurology Service's overall mission (e.g., Child Neurology) who are approved by a two-thirds (2/3rds) majority of the Voting Professional Staff of the Neurology Clinical Services.

XIII. ADOPTION AND ADMENDMENT

The Neurology Service Rules and Regulations will be adopted and revised by a majority of all Active members of the Neurology Service bi-annually.

Appendix A - Zuckerberg San Francisco General Hospital Neurology Privilege Form

Privilege	Status	Approved

Neuro NEUROLOGY 2017

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

CORE PRIVILEGES

18.10 ADULT NEUROLOGY

Work up, diagnose, and treat patients on the Neurology Service and consult on patients with neurological problems in the inpatient setting and emergency department. Work up, diagnose, treat, and consult on adult patients (age 17 and older) with neurological problems in the clinics. Core privileges include lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology).

PROCTORING: Review of 5 cases REAPPOINTMENT: Review of 3 cases

18.20 CHILD NEUROLOGY

Work up, diagnose, treat, and consult on pediatric patients (under age 18 and those patients up to age 30 with neurologic conditions that typically present during childhood) with neurological problems in the inpatient and outpatient settings. Core privileges include lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases REAPPOINTMENT: Review of 3 cases

SPECIAL PRIVILEGES

18.30 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 Neurology 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

18.40 EEG

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with EEG privileges.

REAPPOINTMENT: Review of 3 cases.

18.50 EMG

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with EMG privileges.

REAPPOINTMENT: Review of 3 cases.

18.60 EVOKED POTENTIALS

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with evoked potential privileges.

REAPPOINTMENT: Review of 3 cases.

18.70 BOTULINUM TOXIN FOR MOVEMENT DISORDERS, SPASTICITY OR REFRACTORY HEADACHE

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology) and training in administration of botulinum toxin for the above indications.

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with botulinum toxin privileges.

REAPPOINTMENT: Review of 3 cases.

18.80 CRITICAL CARE

Evaluation and management of critically ill patients, including management of airway, ventilation, hemodynamics, sedation, and analgesia. Staffing of Stroke/Neurocritical Care Follow-Up Clinic and consults outside the ICU that require a neurointensivist.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology) or American Board of Emergency Medicine and eligible or certified in Neurocritical Care by the American Board of Psychiatry and Neurology or United Council for Neurologic Subspecialties.

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with Critical Care Privileges

REAPPOINTMENT: Review of 3 cases

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

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

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

PROCTORING: All OPPE metrics acceptable REAPPOINTMENT: All OPPE metrics acceptable

_____ _____

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

APPROVED BY

_____ _____

Division Chief Date

_____ _____

Service Chief Date

Appendix B - Zuckerberg San Francisco General Hospital Neurology Clinical Service:

Description of Service

(Maintained in the Department of Neurology)

This document describes the Neurology Service at Zuckerberg San Francisco General Hospital, including its mission, the organization of its clinical services, the duties and regulations regarding various personnel and the schedule of activities. It serves as a supplement to the document, *Rules and Regulations, Neurology Service, Zuckerberg San Francisco General Hospital.*

The Neurology Service at Zuckerberg San Francisco General Hospital is divided into several principal components that contribute to fulfilling its clinical mission. These include the **Adult Inpatient Neurology Ward Service, Adult Inpatient Neurology Consultation Service, Neurocritical Care Service,** and **Neurology Outpatient Clinics**. The service also oversees the **Neurodiagnostic Laboratories**, including the electroencephalography (EEG), electromyography (EMG) laboratories (in combination with the Hospital) and cooperates with the Pediatric Service in providing **Child Neurology Service** specialty care. These are complementary components that contribute to the continuity of patient care and the continuity and breadth of education, as well as provide a platform for clinical research.

These activities are driven by a strong commitment to the overall service mission of Zuckerberg San Francisco General Hospital and by the association with and commitment to the University of California, San Francisco and particularly its Department of Neurology. The Neurology Service believes that specialized neurological care is an essential component of the patient care services at ZSFG. Likewise, the Neurology Service at ZSFG is an important component of the UCSF Neurology Department and both enhances the academic activities of the Department and benefits from the programs, leadership and resources of the 'parent' Department. This document focuses on the clinical services and emphasizes the organization and hierarchical responsibilities of physician members of 'team' in relation to the component activities. It also explains the weekly schedules for the three inpatient services that are included at the end of this document.

Mission of the Neurology Service

The mission of the Service follows the traditional tripartite goals of an Academic Medical Center: patient care, education and research.

Patient Care. This is the principal focus of day-to-day activity of the Service and the component of our mission that underlies the Service's very existence. The Service's objective is to provide exemplary patient care and clinical service to the patient community served by ZSFG within the limits of available resources. This is the ***first priority*** of all activities related to patients. The

Service aims to provide timely, knowledgeable and humane service to all individuals within the framework of the institution.

Education. ZSFG is a major postgraduate and medical student teaching venue in the UCSF system. The major educational emphasis of the Service, and one that lies at its very core, relates to the UCSF Neurology Residency Training Program. The Neurology Resident rotations at ZSFG are among the most important of the three years of this specialty training. This importance is based on the nature and traditions of this Institution and to the patient populations served. In turn, the Resident Trainees provide critical service to the Hospital and to these patients. The supervision of residents is aimed at allowing *graduated responsibility* based both upon the years of training and upon the individual capabilities of the trainee, while at the same time providing the safeguards of appropriate Attending Staff supervision. This training is effected principally through experience and instruction at the bedside and organized formally through the various inpatient teaching and work rounds and individual review of patients in the outpatient setting.

Medical student teaching, particularly at the third year level, is also an important activity that receives major attention of the Service. Customarily 4-5 students rotate monthly on the Service as part of their mandatory neurology clerkship. They rotate among the inpatient Ward, Consultation, and Neurocritical Care services. Fourth year students may also elect rotation on the Inpatient Consultation and Neurocritical Care Services. Teaching of students involves bedside rounds as well as group didactic sessions centering on ‘case vignettes; designed to broaden their familiarity with the full spectrum of neurological disease.

Research. The ZSFG Neurology Service considers the development of Clinical and Translational Research directed at elucidating and ameliorating the diseases afflicting the patients cared for at ZSFG to be critically important and a central aspect of its mission. There is a direct connection with the UCSF Brain and Spinal Injury Center at ZSFG. There are now ongoing clinical research studies in HIV-AIDS, stroke, and traumatic brain injury.

Without vigorous and strong commitment to each of the three components of the mission, the Neurology Service would lose its identity and *raison d’etre*, at least in its current form. Each of these components contributes directly (e g. shared personnel and resources) and indirectly (e.g. quality of personnel and intellectual rigor) to the strength of the other. None can be sacrificed or compromised without important impact on the other.

The following section describes each component of the Clinical Service.

Inpatient Adult Neurology Ward Service

The Inpatient Neurology Ward Service provides specialized care for patients with neurological Diseases and their complications. Its purpose is to admit and care for patients in which the need for neurological diagnosis and treatment is preeminent and for those who have received principal care from the Service when they develop other complications requiring hospitalization. The physician and physician-in-training personnel centrally contributing to the Service include: the General Inpatient Ward Attending Neurologist, the Senior neurology

Resident, the Junior Neurology Resident, PGY1(s) when present, and the third-year Medical Students spending their required Neurology Clerkship on the Service. Other personnel are also critical to the operation of the Service, including particularly the Neuroimaging unit of the Department of Radiology, the nurses on the various units, the Social Worker assigned to the Service, and the Neurorehabilitation 'team' from Physical, Occupational and Speech Therapy; these components will not be discussed further here, however, except as they relate to the schedule and expectations of the Service. The following describes some of the expectations and responsibilities of each of the aforementioned physician and physician-in-training team members.

Ward Service Attending Neurologist – The general Ward Service Attending Neurologist is ultimately responsible for care of patients on the Service except for those housed in the Intensive Care Unit (ICU). This involves both supervisory and direct patient evaluation and management. With respect to the latter, the following rules should be followed, with rare exceptions:

- S/he will directly evaluate and provide an admission note on all new patients within 24 hours of admission and earlier if indicated by the type or complexity of the illness.

- S/he will directly evaluate and provide a progress note on all patients ***daily***. This will generally be done in the context of daily Attending Work Rounds made with the Neurology Residents. Weekend cross-coverage may be shared with the Inpatient Neurology Consult Attending.

- S/he will oversee the entire staff but generally confer with and communicate with the Senior Resident in directing the Service. S/he will directly participate in all decisions regarding invasive diagnostic studies, therapy and life support.

- Since the Service is committed to functioning as an academic teaching service, the Attending Physician needs to make judgments and adjustments with respect to when s/he needs to assume the primary physician role and when s/he can delegate this role to the resident staff. This will depend on the individual capabilities of the resident and on the complexity and nature of the patients' illnesses. At all times the Attending must be sufficiently familiar with the details of the patients' management to assure that optimal care is being administered. The latter includes not only the accuracy of diagnosis and the appropriateness of therapies, but also the manner and thoroughness of communication with families and other personnel involved in the patients' overall care. The Attending must set and assure the standard with respect to professionalism and highest ethical and personal interactions.

- The Ward attending physician also plays an overall role in coordinating the educational experience of the MS3 students rotating on the various ZSFG neurology services. Case vignettes (standardized and provided by the Department of Neurology medical clerkship director) should be discussed with the entire group of rotating MS3 students at least once each week.

Ward Service Senior Neurology Resident – This resident directly manages the Ward Service and serves as the overall "Practice Group Leader" for all the Neurology residents rotating at ZSFG at a given time. This resident importantly oversees the details of day-to-day decisions regarding triage and admission, as well as diagnosis and therapy. S/he rounds daily with the Attending Neurologist on Ward Attending Work Rounds and participates in Resident Work Rounds. S/he directs patient-related decisions in consultation with the Attending Physicians as needed. S/he also plays a major role in teach Medical Students the fundamental aspects of neurology, including the neurological examination and basic care of those with neurological impairment. The formal duties thus include:

- Directly supervising care of all patients on the Ward Service. This requires direct evaluation of each patient and ongoing monitoring of all diagnostic studies, therapy and patient status.
- Overseeing the quality and timeliness of chart documentation by the Junior Resident and adding a formulation, clarification summary note on complex admissions or during the course of a complex course of illness.
- Assuring the timely completion of discharge notes, including sharing this duty with the Junior Resident.
- Reporting to, consulting with, and rounding with the Attending Neurologists daily.
- Assisting and filling in for the Junior Resident during the daytime when they are absent or too busy to provide timely coverage of patients on the Service, or consultation on other services including the Emergency Department.
- Attending Morning Report.
- Planning the biweekly Professor's Rounds, including case selection and organization.
- Planning the on-call and other house staff scheduling (after the first few months, this may be delegated to the Junior Resident).
- Participating in Outpatient Clinics.
- Overseeing Resident Work Rounds during the week.
- Coordinating rounding schedules and resident responsibilities for the weekend days.

Ward Service Junior Neurology Resident – Although not the neurologist of record (since this is the Attending Physician), the Junior Resident serves as *the neurology Ward team member who is the primary interface* with the patient (and family, associates, etc.). S/he provides documentation of the patient's illness, manages and schedules tests, and deals with the logistics of care with the assistance of the PGY1 (when available). This resident will usually carry the 'Ward Service Pager' (**415-327-WARD**) during the day.

- Rounds each weekday on all patients on the service, and on weekends assigned, overseeing evaluation and care during these rounds. After the initial months of the new academic year, the Junior Resident can 'run' these rounds at the discretion of the Senior Resident.
- Provides a full admission note emphasizing neurologic aspects of diagnosis, formulation, planned evaluations and therapies.

- Provides independent daily progress notes summarizing the patient's status (including disposition), analysis and formulation of diagnosis and plan. The junior Ward resident also reviews, amends, and co-signs medical student notes.
- Presents patients to the Attending or Professor on Rounds if the students are not available for this duty. Additionally, presents and demonstrates the salient neurological findings and discusses diagnosis and rationale of the plan at the bi-weekly "Professor's Rounds" Clinical Case Conference.
- Attends Morning Report.
- Participates in Outpatient Clinics

Student Clerks – The primary responsibility of medical students relates to their education. However, because the Service adheres to the general philosophy that their *active* participation in the patient care team is an important vehicle for education, the students will also participate in the care activities. These include:

- Rounding daily on all patients on the Service.
- Assisting in patient care by: evaluating assigned patients on admission, following those patients daily, performing (under direct supervision) lumbar punctures and similar procedures on these patients, contributing daily notes summarizing results of diagnostic studies, patient status and changes in therapies and plans (not to substitute for the Resident notes), and contributing a recent review of the literature as a further guide to those caring for the patient. The students should also summarize the Attending Round evaluation of patients, including the principal new findings revealed by the history and examination and the diagnostic opinion and plan provided by the Attending Neurologist.

Neurology Inpatient Consultation Services

The Neurology Inpatient Consultation Services are divided into two components: an Adult Neurology Consultation Service and a Child Neurology Consultation Service. Together they provide specialized neurological consultation for the other inpatient services, the Emergency Department and, when needed, outpatient clinics of ZSFG. They are staffed by an Attending Neurologist assigned to each Service who assumes ultimate responsibility for the performance of the Services and the care delivered, and a Junior Resident who is the focus of the activities of both components. A student subPGY1 and MS3 student clerks may also be assigned to the Service to assist in these tasks.

Rules of Consultation Service – In order to provide optimal service for the care of patients and assistance to the primary physicians caring for patients requiring neurological expertise, there are expectations requiring the timeliness, level of expertise, and communication of this service. These are embodied in the following guidelines:

- All requested *routine consultations* will be seen by the consulting resident on the day of the request unless the requesting physician directly stipulates that a delay of up to 48 hours is acceptable. This means that consultations not seen by the daytime coverage will

be evaluated by the resident on duty at night. SubPGY1 students may evaluate these patients, first, but the resident will still see them on the same day.

- All *urgent consultations* will be seen by the consulting resident within two hours of request and emergency consultations seen even more rapidly. Exceptions may relate to conflicts among urgent patients; these should be explicitly triaged by the consultation resident in agreement with the requesting physician or seen by another resident (e.g. Ward resident) if needed.
- *Acute Stroke Activations* represent an important exception to the expected time of evaluation. *Acute Stroke Activations* (also referred to as "Stroke Codes") are formal emergency activation in the hospital which specify the location of the relevant patient. Neurology residents are expected to respond in person immediately (physical presence within 5 minutes), and in the rare case in which they are performing a procedure (e.g. lumbar puncture) that cannot be safely immediately interrupted, then they are to call the hospital location (usually ED) in order to notify of the delay.
- All adult inpatients should be presented to and evaluated by the Attending Adult Neurologist within 24 hours of the requested consultation. Difficult or urgent patients should be discussed by telephone or directly evaluated more rapidly. Exceptions include Emergency Department consultations in which patients are discharged; these cases should be discussed before discharge or retrospectively the next day, depending upon the complexity of the problem. Patients evaluated on Saturday may be reviewed and evaluated by the Attending on Monday if they are not complex and such review is not urgent.
- In the case of patients seen in the Emergency Department or outpatient clinics during daytime hours who clearly require admission to the Neurology Ward or Neurocritical Care Service, the Consultation Resident should serve as a triage officer. This entails entering a brief note, seeing that emergency management is begun and that appropriate laboratory studies are ordered, and then turning the patient over to the Inpatient Service team for definitive admission evaluation (and admission note) and care. The exception to this policy will be when the inpatient resident team is not immediately available due to other patient care responsibilities; Attending Rounds are not a sufficient reason for the Inpatient Resident Staff to defer this task.
- The conclusions and recommendations of the Consultation Service should be clearly and rapidly communicated to the physicians of the primary service caring for the patient. This principally involves inclusion of the consultation note in the chart with designation of who has reviewed the case. For non-routine consultations and at times for routine consultations as well, the resident is also responsible for more active communication to the physicians requesting the consult. This entails direct telephone contact and discussion or, under certain circumstances, faxing of a copy of the Consultation Note or e-mail communication. In some cases, the Attending Physician will undertake telephone communication.
- All contact and communication with other services, as well as with nursing and other personnel should be conducted with the highest level of professionalism and courtesy. Residents must recognize that there is no such thing as an "inappropriate" request for consultation or assistance. If assistance is requested, it is needed.

The responsibilities and expectations of the members of the team are outlined as follows:

Attending Adult Neurologist – The Attending Adult Neurologist is responsible for the overall quality of the Consultation Service. This physician must review all patients consulted. With the exceptions enumerated above (discharged ED patients) this entails direct evaluation of the patients in a timely (within 24 hours) manner. More urgent consultations are discussed by telephone or directly seen within a shorter time frame depending upon the complexity or urgency of the problem. In the case of those patients directly evaluated, a note reflecting the evaluation and describing any additions or corrections of the resident's evaluation (or students and resident's notes) as well as a clear set of recommendations should be placed in the chart. In brief, the Attending:

- Oversees all aspects of the Consultation Service, assuring the quality of its evaluations, recommendations and service delivery.
- Evaluates and provides a note on all patients within 24 hours of the request. This note should clearly articulate the problem and recommendations and also invite further questions and discussion if needed.
- Reviews in detail all patients seen by the resident but not available for direct evaluation (e.g. ED patients). A designee such as the Neurology attending supervising Morning Report may serve this function.

Attending Child Neurologist – The practice and standards for the Attending Child Neurologists are the same as for the Attending Adult Neurologist as just described with the exception that when emergency consultation is needed and the Attending Child Neurologist is not directly available, the ZSFG Pediatrics Service will contact the Child Neurology Fellow on call at UCSF Benioff Children's Hospital by telephone for advice. If bedside immediate evaluation is deemed necessary (such as in the case of a critically ill child), an adult neurologist may initiate the Attending duties (Consult Attending if child age $\geq$ 17, Neurocritical Care Attending if child is admitted to the hospital and is critically ill) until the Child Neurology Attending or Fellow is available.

Neurology Consultation Resident – This individual serves as the focus of the Service, triaging all Consultations and evaluating all patients seen during the daytime hours as well as following up on all patients evaluated by the covering residents during night or weekend hours. This resident is the primary interface of the Neurology Service with other services in the Hospital. S/he is therefore expected to provide courteous, friendly and willing service at all times. Their evaluation of patients should address the broad spectrum of patient needs conveyed by the individuals caring for these patients. This resident will be responsible for the Consultation pager **(415-327-NERV)** carrying it during the daytime and passing it on to the night or weekend call resident. Among the specific responsibilities are the following:

- Evaluation of consultations in the various venues (inpatient wards, ED and outpatient clinics) following the time guidelines above.
- Providing an initial note at the time of the initial evaluation (designated, "will present to the Service Attending" or the like before evaluation by the Attending) in the medical

record, and providing follow-up notes as indicated (usually at least every other day, depending upon the patient's condition and the availability of results of diagnostic studies and the effects of therapeutic intervention). If patients are no longer to be followed by the Service, an *explicit* note in the chart should say this and invite re-consultation as needed.
- Supervising student sub-PGY1 and MS3 clerks on the Service and directly evaluating any patients seen by these individuals *before* they are presented to the Attending Neurologist. This requires an **independent note** by the resident documenting her/his examination and finds.
- Communication with the primary service as outlined above.
- Attending Morning Report.

Student Clerk – The primary responsibility of medical students relates to their education. However, because the Service adheres to the general philosophy that their *active* participation in the patient care team is an important vehicle for education, the students will also participate in the care activities. These include:

- Rounding daily with the Consult Service.
- Assisting in patient care by: evaluating assigned patients and following those patients as appropriate. The students should also summarize the Attending Round evaluation of patients, including the principal new findings revealed by the history and examination and the diagnostic opinion and plan provided by the Attending Neurologist.

Inpatient Neurocritical Care Service

The Neurocritical Care Service provides primary and consultative coverage for patients with critical neurological conditions. These include patients with acute stroke, neurotrauma, seizures, and neuromuscular conditions. Additionally patients on other clinical services, including neurosurgery, trauma surgery, medical intensive care, and cardiology, who have critical neurological issues are seen. The Neurocritical Care Service provides faculty coverage for acute stroke intervention as part of the Primary Stroke Center and comprehensive stroke center services.

Neurocritical Care Attending – The Neurocritical Care Attending will assume supervision of care for patients on the Neurology Service while they are in the ICU.

S/he will directly evaluate and provide an admission note on all new patients within 24 hours of admission to the ICU and earlier in indicated by the type or complexity of the illness. S/he will directly evaluate and complete a progress note on all patients ***daily***.

- S/he will generally confer with and communicate with the Neurology Neurocritical Care resident in supervising this component of the Service. S/he will directly participate in all decision regarding invasive diagnostic studies, therapy and life support.

- Since the Service is committed to functioning as an academic teaching service, the Neurocritical Care Attending Physician needs to make judgments and adjustments with respect to when s/he needs to assume the primary physician role and when s/he can delegate this role to the resident staff. This will depend on the individual capabilities of the resident and on the complexity and nature of the patients' illnesses. However, all major decisions and procedures will be reviewed by the Neurocritical Care Attending. At all times, the Neurocritical Care Attending must be sufficiently familiar with the details of the patients' management to assure that optimal care is being administered. The latter includes not only the accuracy of diagnosis and the appropriateness of therapies, but also the manner and thoroughness of communication with families and other personnel involved in the patients' overall care. The Attending must set and assure the standards with respect to professionalism and highest ethical and personal interactions.
- The Neurocritical Care Attending will staff the weekly Stroke Clinic.
- The Neurocritical Care Attending will be available by pager and telephone 24 hours a day.

Neurocritical Care Fellow- As ZSFG is a principle teaching institution for the UCSF Neurocritical Care fellowship, the Neurocritical Care Fellow will serve the function as team leader for morning work rounds. The fellow will also serve as the primary contact for the Neurology Consult resident regarding acute stroke and neurocritical care cases.

Neurocritical Care Neurology Resident- The Neurology resident rotating on the Neurocritical Care Service will be responsible for daily rounding and notes on all patients on the Neurocritical Care Service. This resident will be responsible for ordering or recommending tests and treatments for service patients. Additionally, the resident will

- Serve as the primary conduit for communication with families of patients on the Neurology Service in the ICU.
- Serve as the primary conduit for communication with other clinical services seeking neurocritical care consultation
- Provide basic teaching to the student clerk on the service

Student Clerk – The primary responsibility of medical students relates to their education. However, because the Service adheres to the general philosophy that their *active* participation in the patient care team is an important vehicle for education, the students will also participate in the care activities. These include:

- Rounding daily with the Neurocritical Care Service.
- Assisting in patient care by: evaluating assigned patients and following those patients as appropriate. The students should also summarize the Attending Round evaluation of patients, including the principal new findings revealed by the history and examination and the diagnostic opinion and plan provided by the Attending Neurologist.

Neurology Resident In-house Night Coverage

Resident Night Coverage – Neurology overnight in-house coverage is provided seven days a week by a Night Resident who serves from approximately 7 PM through Morning Report the next day. This night coverage system was instituted in response to changes in housestaff duty hours. The overnight resident will handle all consultations and oversee the care of the Ward and Neurocritical Care patients during this period. S/he will also be available by telephone as a resource for advice and consultation by the SFHN. S/he will carry all service pagers during this time. All admission and consultations will be 'checked out' with the daytime resident staff before or during Morning Report or in a sign-out session on the weekends. Cases requiring attending or fellow input will be discussed by telephone or by direct presentation to the Attending or Neurocritical Care Fellow/Attending on call.

Neurology Outpatient Clinics

As Neurology evolves increasingly to an outpatient specialty, the importance of this activity will continue to increase, both with respect to service delivery and teaching. The outpatient clinic activity of the Adult Service now uses the 4M Clinics facility and includes three regular weekly sessions: two General New Patient clinics (Thursday afternoon and Friday morning) and one follow-up clinic (Tuesday afternoon). There are also four subspecialty clinics: a weekly Stroke Clinic, a monthly Geriatics-Neuro Clinic, a monthly Neuroimmunology Clinic which is imbedded into a new patient clinic, and a monthly Epilepsy Clinic. The Child Neurology Clinic meets Friday mornings in the Pediatric area.

Because the allotted time (including room and nurse availability) for the principal Neurology Clinics is constrained, it is critical that the clinics start on time and that patient flow is maintained so that they can end on time as well. Attendings, Residents and Students are therefore expected to arrive on time. The Clinics have become important teaching vehicles for students, expanding their range and volume of experience. This must continue, yet not unduly inconvenience patients nor impede patient 'throughput.' Much of the patient care in the clinics is performed by Residents for similar reasons, along with economic considerations. The following outlines some of the responsibilities of the personnel in the Adult Neurology Clinics.

Attending Neurologists – Usually three Attendings are assigned to each New Patient clinic session and two or three to the Follow-up clinic session. Their duties include: overseeing residents and any nurse practitioners, applying the principles of graduated responsibility described earlier; and direct evaluation of patients as needed to facilitate patient flow. Their activities in this context include:

- Directing the Clinic. One of the Attending Neurologists in each clinic will assume the role of director for that session. Associated duties include triaging (when each patient is to be seen, by whom, and into which room); assigning patients based on their complexity

and suitability for teaching is an important duty. These activities are important to increase the efficiency of the session and require someone to maintain an overview for the day.

- Evaluating patients seen by Residents. The requirement for Attending supervision varies according to the experience and capability of the individual residents, as well as the problem of the patient. Hence, the supervision requirements range from careful and thorough assessment of new patients seen by PGY1s or beginning first-year Neurology Residents to brief review of the findings and plan of Senior Residents seeing patients in follow-up. The Attending Physician is responsible for knowing the patient flow and assignments and providing judgment regarding the supervisory needs of the patients being seen.
- Direct evaluation of patients. Because of the need to maintain patient flow and the limited value of some patients as 'teaching cases,' the Attending Neurologist assigned to Clinic often needs to join directly in the effort to evaluate patients not seen by the Residents or NPs. In these instances, the Attending will assume full responsibility for care of these patients or triage for resident follow-up.

Neurology Residents – The Neurology residents providing Outpatient Service to ZSFG do this as part of an independent outpatient rotation, as well as during their inpatient rotation at the Hospital and during other rotations when they participate in their Continuity Clinic here.

- Adult Neurology New Patient Clinics: Neurology residents on the dedicated outpatient rotation at ZSFG as well as mixed outpatient rotations across the UCSF-staffed hospitals staff the adult Neurology New Patient Clinics. The Neurology Residents assigned to the ZSFG Ward and Consult services also participate in a limited role in the ZSFG Adult Neurology New Patient Clinics, usually once weekly. At the early Junior level, the resident's patients will usually be reviewed in some detail with the Attending, while at the Senior level the review is much less detailed. Since this is a graduated process, the judgment of how much supervision is needed should be determined by the Attending Physician. It is imperative that the Residents arrive in the clinic on time and that they begin seeing patients as soon as they are available. Results of evaluations should be conveyed to the referring physicians by computerized note, fax, e-mail or telephone.
- Adult Neurology Follow-up Clinics: Each UCSF Neurology Resident maintains a continuity clinic at ZSFG and they generally staff this clinic once monthly during the time slot for the Adult Neurology Follow-up Clinics. The residents should consider the clinic as a *time assignment* rather than strictly on the basis of patients scheduled. In general, they will see only those patients that they have been following long-term. However, if they are not fully booked with follow-up patients, they will be assigned to evaluate either patients that are new to them, but who were seen in new patient clinic by a provider who does not have a follow-up clinic, or follow-up patients who need to be seen before the availability of their 'continuity' neurologist permits. Assignment will be made by the Attending Physician supervising the clinic session.
- Child Neurology Clinic: these clinics are staffed by Child Neurology fellows and attendings as designated.

Neurodiagnostic Laboratory

The Neurodiagnostic Laboratory represents a joint enterprise with ZSFG in which the Neurology Service provides the professional expertise in overseeing and interpreting test results and the Hospital provides the facilities, equipment and technical support. This document considers only the aspects supplied by the Neurology Service – the "professional component."

The Laboratory is organized into two sections operating separately except for aspects of scheduling and support: EEG, and EMG.

EEG – the EEG Laboratory is an important resource for patient care with its value relating principally, although not exclusively, to the diagnosis of seizure disorders and toxic-metabolic brain disease. The EEG's are interpreted by one of the Neurology Attendings who provides special expertise in EEG and epilepsy. It is important that this is done on a timely basis. Networking arrangements allow digital EEG records to be transmitted. The scheduling and responsibility for the timeliness of service is assumed by the Clinic clerks, in conjunction with the technician. In addition to the high-level specialized expertise, the requirements of the Laboratory include:

- Timely interpretation of records. Interpretation of routine records should be within 72 hours and interpretation of urgent records within 12 hours. If requested, these reports can be available to the referring physician immediately after reading by voice, fax or computer entry into the medical record. The office can be contacted for an earlier reading.
- While it is desirable that scheduling of routine testing occurs within one week of request, current resources do not allow this. Exceptions for both inpatients and outpatients will be triaged by the Senior Neurology Resident.
- Emergency EEG's are occasionally performed by the Neurology Residents after hours. This extra service will vary with the training of the resident on call, the medical need and the concomitant workload with the decision being made by the resident, after evaluating the patient, in consultation with the Consult Attending.

EMG – The EMG Laboratory likewise provides a needed on-site facility for evaluation of nerve and muscle disorders. Since the EMG examination is more akin to a physician consultation than to a simple (mechanized) laboratory test, the professional staff is rate-limiting for this facility. The Director of this Laboratory will assure not only the quality of the Service, but its timeliness, in order to assure high standards of care for the Hospital and Neurology Services at ZSFG. The goals of the laboratory are to provide timely and quality service similar to that of EEG, including:

- Availability of the unit for scheduling routine studies as soon as possible, and for acute needs (e.g. for diagnosis of myasthenia gravis or inpatient studies) within two days of request. Unfortunately, due to other responsibilities, the availability of the present Director is limited and, hence, there are unwanted delays in scheduling studies. Urgent studies are performed upon request, however.
- Reports should be available to the referring physician immediately after reading by voice, fax or computer entry into the medical record. The office can be contacted for an earlier reading.

Conferences and Rounds

The formal aspects of the teaching and patient care activities of the Service are structured in a series of conferences and rounds. Some of these are included in the schedule that follows in this document. The structure and purpose are discussed here.

House Staff Work Rounds – This is a critical aspect of patient care. These are the daily morning work rounds on the various services and involve the residents and students assigned to the specific services. During these rounds all inpatients on the Neurology Ward Service are evaluated by direct examination and chart (including laboratory results) review, and the plans for diagnosis and treatment are discussed, reviewed and assigned for implementation. These begin first thing in the morning, usually at 7:00 A.M. (Monday through Friday). On Neurocritical Care Work Rounds, patients on the Neurosurgery Service are seen beginning at 7:00 A.M. each weekday, with other patients on the Neurocritical Care Service to follow. Neurology Consult work rounds are usually done prior to Morning Report by the Inpatient Neurology Consultation Resident. Residents from the various services then meet at Morning Report.

Morning Report – This is held each weekday and is attended by the neurology Residents assigned to ZSFG inpatient Neurology services and the night coverage Resident. The primary purpose of this exercise relates to Quality Management of the Service, with teaching an important secondary goal. All new inpatients seen by any of the adult inpatient services (Ward, Consultation, Neurocritical Care) will be briefly (beginning with a concise one minute synopsis) presented to the Chief of Service or their designee, and those presenting diagnostic or therapeutic difficulty will be highlighted for further discussion. This includes patients seen in the ED and sent home. Similarly, any active or unsettled diagnostic or therapeutic issues with patients admitted or initially consulted earlier will be discussed. The Attending neurologists rotating on the inpatient services are encouraged but not required to attend Morning Report. The objective of this exercise is to provide a consistent and uniform level of care and oversight for the Neurology Service through this common reporting mechanism. This also facilitates subspecialty consultation and entry of patients into clinical research protocols.

Consult Attending Rounds – These are held daily and are a mixture of patient care (first priority) and teaching rounds. Teaching is at the Resident level and directed to issues of diagnosis and practical management. The timing of these rounds will vary with the Attending's schedule of other activities but generally will begin either early in the morning or in the afternoon, allowing all patients to be evaluated by the Attending within 24 hours of the consultation. Problem or

difficult diagnosis/management patients will be staffed outside of this schedule. When the regular Attending assigned to this rotation for the month cannot be available, another Neurologist needs to be available to substitute.

Ward Attending Rounds – During these rounds the Attending Neurologist reviews (visiting each patient and reviewing their diagnostic studies and progress generally) the Service with the Senior resident (and/or Junior resident if available) and completes the Attending notes. These notes are generally brief and relate to overall diagnostic and care summary issues; they are supplementary, but not a substitute for the more detailed Resident notes. These are almost exclusively patient care rounds with some supplementary teaching if time allows. These rounds are generally done immediately after Morning Report each weekday and in the mornings on weekends.

Neurocritical Care Attending Rounds – These are held daily. Patients are presented to the Neurocritical Care Attending by the student or resident primarily responsible for the patient. Diagnostic and treatment plans are reviewed and updated. These rounds also serve an important teaching function and may be supplemented by didactic teaching and medical literature review when appropriate.

Professor's Rounds – This conference is held on Tuesday mornings, usually biweekly. One or two cases are presented to a visiting professor. They will generally be chosen from the inpatient and outpatient services because: 1) they represent interesting examples of diagnoses that are worthy of sharing with others, or 2) represent difficult diagnostic or management problems. The Senior Resident on the Ward Service will be responsible for organizing the cases and seeing that the patients and other material (neuroimages, electrophysiology) are available for review. For the Case Conferences, the Junior Resident will generally present the case (succinctly) and demonstrate the relevant (but not extraneous) findings; the Junior or Senior Resident will also present a brief review of the problem related to the major issues exemplified by the patient. Participation by physicians and consultants from other services is encouraged.

Neuroimaging Conference – This is presented by Neuroradiology in combination with Neurology and Neurosurgery every Friday. A list of cases to be presented is submitted by the Junior Ward Resident the afternoon before the conferences; late additions may be added on to the conference. Additionally, on other days pertinent neuroimages will be reviewed with the Neuroradiology staff on an *ad hoc* basis.

Resident Neurology Didactic Conference – This is a weekly conference, usually at noon on Mondays, during which a faculty member provides an educational lecture on a specific topic directed at residents and students. As part of this, once a month there is a journal club in which a specific article of interest is reviewed and once a month there is a Neurology M&M session in which the Senior Ward resident reviews one or more cases for quality improvement purposes.

Appendix C - ZSFG Neurology Clinical Service Performance Improvement & Patient Safety Plan

Organization and Responsibility:

1. **Department Chairperson:** Nerissa Ko, M.D., Professor and Interim Chair, UCSF Department of Neurology, has delegated responsibility for the ZSFG Neurology **Performance Improvement and Patient Safety (PIPS)** Program to J. Claude Hemphill, M.D.,M.A.S., Professor of Neurology, Chief of Neurology at ZSFG.

2. **Performance Improvement and Patient Safety (PIPS) Coordinator:** Liz Hamid, M.D., Assistant Professor of Neurology

3. **Performance Improvement and Patient Safety Committee:**
Liz Hamid, M.D., Associate Professor of Neurology, Neurology PIPS Coordinator; J. Claude Hemphill, III, M.D.,M.A.S., Professor of Neurology, Chief of Neurology at ZSFG; Cate Freyer, MBA, Neurology Service Division Manager*;* Sara Cole, RN, ZSFG Stroke Program

4. **Performance Improvement and Patient Safety (PIPS) Plan:**
The ZSFG Neurology Performance Improvement and Patient Safety Plan is reviewed every second year by the Neurology Chief of Service

Departmental Review and Evaluation:

1. The Neurology Service PIPS Committee meets quarterly, with the following regular agenda items:
- Review of all deaths on the Neurology Service. The PIPS Officer reviews the charts of each of these patients monthly and summarizes each case for the Committee.
- Review of sentinel events, and stroke quality measures.
- Discussion of patient care issues generated from Morning Report, Professor's Rounds, and Monthly M&M Conference
- Selected PIPS issues, including ongoing projects. These are determined by the Committee on an ongoing basis. Emphasis is on high-risk or high-volume issues or where possible problems or inefficiencies have been identified by attending staff, residents, nursing, patients or other individuals. These reviews are limited to issues that can be adequately researched using available resources. Special review is considered for issues related to the Primary Stroke Center.

2. **Staff Meeting:** The ZSFG Neurology Service Attending On-Campus Staff meets monthly (or as needed). Performance improvement and patient safety issues are among the standing agenda items. Discussions generally include:

- Reports of issues arising from the Neurology Service PIPS Committee Meeting.
- Review of hospital-wide utilization statistics and Neurology Service inpatient and outpatient census and trends.
- Review of additional patient care issues identified by meeting attendees or by other personnel (for example, 4M nursing) prior to meeting.
- Discussion of clinical studies concluded, in process, or proposed.
- Discussion of performance of Residents and Attending Physicians based on ongoing monitoring activities and evaluation sheets.

3. **Staff Appointment / Appraisal Process** (Credentialing)

- **Appointment:** The major categories of Clinical Privileges on the ZSFG Neurology Service include:

- Core Privileges in Adult or Child Neurology
- Special Privileges
- Moderate Sedation
- EEG
- EMG
- Evoked Potentials
- Botulinum Toxin for Movement Disorders, Spasticity, or Refractory Headache
- Critical Care
- CTSI

Physicians are proctored for their first five cases during their initial appointment. The scope of activities proctored is consonant with the clinical privileges requested. Proctoring will include direct observation of faculty performing the activity / procedure for which privileges are performed as well as by ongoing review of cases and patient management through Morning Report and Professor's Rounds. This will be performed by the Chief of Service or an appropriate designee; data will also be monitored from other sources, including hospital and outpatient service notes. Following the proctoring period and based on the review of same, the Chief of Service must verify proficiency in the requested areas prior to granting privileges in those areas and the Credentials Committee of the Medical Staff must approve the application.

Physicians' clinical and teaching performance are periodically evaluated using the following methods:

- Review of charts by PIPS Officer and PIPS Committee and derived from sources described above
- OPPE performed every 12 months, with Neurology Service-specific indicators for either inpatient or outpatient
- Evaluation by residents and medical students (with respect to teaching)

- **Reappointment:**
  - Department of Neurology files include information on current licensure, CPR training status, CME training, DEA status, and other relevant items
  - Files also include documentation of any issues relating to the clinical performance of the individual that have been generated by ongoing PIPS activities of the Department. These are reviewed by the Chief of Service during the reappraisal process.

Appendix D – Job Description: Chief, Neurology Service

Position Summary:

The Chief of Neurology Service directs and coordinated the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also insures that the Service's functions are integrated with those of other clinical department and with ZSFG as a whole.

Reporting Relationships:

The Chief of the Neurology Service reports directly to the Vice Dean and the University of California, San Francisco (UCSF) Department of Neurology Interim Chair (Dr. Nerissa Ko). The Chief is reviewed no 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 Vice Dean, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these persons and groups and with other clinical departments.

Position Qualifications:

The Chief of the Neurology Service is Board certified in Neurology, 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 the Neurology Service include the following:

Providing the necessary vision and leadership to effectively 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; this includes oversight of inpatient and outpatient Neurology Service activities and the neurodiagnostic and neurophysiology laboratories (including electroencephalography and electromyography laboratories);

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

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

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance standards and priorities, determining the qualifications and competencies of Service personnel, and maintaining appropriate quality control programs; and

Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.
Specific duties and responsibilities include:

- Oversight of the clinical, teaching and clinical research activities of the Neurology Clinical Service
- Reviews and recommends all new appointments, requests for privileges, and reappointments for all Neurology Clinical Service members

- Appointment of other officers of the Neurology Service and committee members
- Oversight of the financial affairs of the Neurology Service
- Attendance and participation in the Medical Executive Committee, Chief of Service Meetings, and other meetings called by the Executive Administrator, and the Chief of Staff
- Participates in the Clinical Practice Group (CPG) and attends the CPG regular meetings and other meetings convened by the Chair of the CPG as needed.
- Execution of disciplinary actions as necessary, as set forth in the ZSFG Bylaws and Rules and Regulations.

Appendix E – ZSFG Neurology Ward and Consult Attending Expectations

ZSFG Ward Attending Expectations 2026-2027

Typical ward attending schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
7:30 AM-8:00 AM		Morning report			Morning report
9:00 AM-11:00 AM	Attending rounds	Attending rounds	Attending rounds	Attending rounds	Attending rounds
12:00 PM-1:00 PM	Conference (3C + Zoom)	Assisting in completing tasks			
1:00 PM-5:00 PM		Assisting in completing tasks		Resident clinic (4M)	Neuroradiology conference (HB 247 + Zoom) [1:30-2:30]

Daily clinical responsibilities

1. The ward attending is expected to be on the ZSFG campus during regular working hours each weekday for clinical, teaching, and supervisory duties. Workspace will be made available for attendings from non-ZSFG sites.
    a. If an attending must leave campus during this time for other professional activities, they are expected to be available by pager and/or cell phone. The attending should be available to return to campus during regular working hours to assist in patient care if needed.
    b. The ward attending serves as secondary attending for consults when the consult attending is in clinic and can staff ED consults being discharged home when schedule allows. This should not significantly delay the patient's discharge from the ED.
2. Attendings must be available each weekday and during assigned weekends to round with the ward resident.
    a. **Weekdays:** Attending rounds are from 9AM-10:45AM M-Th and 9AM-11AM on Friday. Any patient not seen by the end of rounds will be seen by the attending alone (students and rotators also allowed to accompany if not otherwise needed, but the neurology residents should be dismissed to begin the work of the day).
        i. Seeing stable follow-up patients without the residents and then "card flipping" during rounds is acceptable before going to see the new patients and anyone who is unstable as a team. The specific style of rounds can be coordinated between the attending and the Ward Senior resident.
        ii. The last 5 minutes of rounds should be reserved to divide tasks for the day, including the tasks with which the attending can assist (i.e. calling families, running family meetings, calling PCPs or other outpatient providers, assisting with LPs, etc.)
    b. The ward attending is expected to attend multidisciplinary rounds with the junior resident, Utilization Management, Social Work, and PT/OT/SLP. These are currently held in person in H4009 M-Th from 10:45AM-11AM.

c. If there are lower level of care (LLOC) patients on the service with complex discharge needs, the attending has the opportunity to discuss barriers to discharge with UM/SW leadership during Complex Care Rounds on Thursday from 1:25PM-1:35PM via Zoom (call information in Cate's orientation email). The team SW can guide if this conversation is needed during the team's MDR M-Th.
d. If the ward attending is scheduled for Neuro-New Clinic on Friday morning, rounds should occur prior to clinic starting at 9AM (being attentive to morning report from 7:30AM-8:00AM and to restrictions on the time residents are allowed to come in in the morning). The recommendation is for this to occur as work rounds (aka discovery rounds) where the attending joins the residents during their normal pre-rounding process from 8AM-9AM.
e. If the ward resident is scheduled for Neuro-New Clinic on Friday morning, rounds can occur prior to clinic starting (as above) or can occur with the remaining resident in the typical fashion. The specific workflow should be coordinated between the attending and Ward Senior.
f. **Weekends:** See below for further details. It is strongly recommended that rounds with the residents be completed by 11AM on Saturday and Sunday.

3. The ward attending is expected to assist in ensuring **no resident violates duty hour requirements.**
    a. The attending is expected to check in with the Ward Senior at 3PM M-F to discuss updates for the patients, determine what tasks still need to be completed (or assist the resident to triage what work can be deferred to the following day), and assist in completing any necessary tasks to ensure the residents are able to sign out on time. Examples of tasks include, but are not limited to, calling families, calling PCPs or other outpatient providers, writing patient letters or filling out disability paperwork.
    b. The attending and ward residents will receive an email each Wednesday and Thursday morning detailing the number of hours worked by the residents that week (calculated Sunday to Saturday). Residents are not allowed to work >79 hours. The attending should work with the resident to ensure they stay within those requirements. If further coverage is needed, jeopardy will be activated to cover the remaining hours of the week.
    c. To meet duty hour requirements, each Ward resident is given 2 Tuesdays off / month (alternating Ward Senior and Ward Junior). The attending is expected to assist in completion of the necessary tasks for the day. This can include, but is not limited to, writing progress notes for the day (attending only templates have been shared), coordinating follow up appointments with PCPs, family updates, running family meetings or performing LPs. Specific workflow needs for the day should be an ongoing discussion between the resident and attending during the day to ensure the resident signs out on time.
    d. On the day a resident is assigned to swing shift (cross cover and consults between 5-7PM) they are not to come in prior to 7:30AM. Pre-rounding duties may therefore be incomplete prior to rounds. Flexibility in workflows to accommodate this on rounds is encouraged (i.e., seeing patients together that were not seen during pre-rounds, reviewing labs or imaging in the moment on rounds, etc.).
    e. Residents must have at least 8 hours off between shifts. On rare occasions, this may result in a resident needing to come in later than 7:30 am. On such occasions, the resident is expected to notify their attending by email upon leaving the hospital of their expected arrival time the next morning.
    f. The attending running morning report will check in with night float to ensure their work can be completed and that they leave no later than 9AM. The recommendation is for residents to complete the notes for any patient they sent home from the ED followed by

any admission notes (ICU then ward) followed by any inpatient consult notes. Any notes not completed can be shared and completed by the appropriate day resident.

4. Notes / EHR responsibilities
    a. Each patient must be seen daily (7 days a week) and an attending attestation must be written for each resident note. The attestations are templated to optimize billing (see Epic PowerPoint for screen shots of how to access). The attestation must be signed no later than 8AM the day following the attending's evaluation (i.e. if the patient is seen on Monday during rounds, the attestation is required by 8AM Tuesday morning).
    b. All newly admitted patients must have an H&P from the attending in the chart within 24 hours of hospital admission. This occurs in the form of the attending attestation to the resident H&P OR attestation to the initial consultation note (marking clearly in that attestation that that is the H&P and not consultation only note). The H&P attestation is templated to optimize billing (see Epic PowerPoint). If the resident H&P was signed after midnight, no resident progress note is needed the day the patient is first staffed by the attending (ex: if admitted by night float and the H&P signed after midnight on Tuesday, staffed during rounds on Tuesday, no resident progress note is needed for Tuesday). If, however, the H&P is signed before midnight, the resident must write a progress note for the following day (ex: admitted by night float and note signed Monday before midnight, staffed by the attending on rounds Tuesday, attending attests the H&P and the resident progress note for Tuesday). The attestation for the progress note can refer to the H&P attestation (a dot phrase for this that you can use – ".nlrhp") but the progress note must still be attested.
    c. Residents are expected to write a discharge summary on the day of discharge for each patient. This counts as the note for the day and does not require an additional progress note.
    d. The resident notes for patients who were discharged home without being staffed by an attending should be signed by the ward attending on the days they are assigned for morning report. These notes do not require the attestation template, and require only a statement that the patient was not personally interviewed or examined by the attending, that you agree with the recommendations as stated (or adjust those recommendations in the attestation depending on the conversation), and that it is not a billable note. (Feel free to steal the dot phrase created with this wording – ".nlreddc")
    e. On the first day of the rotation, the attending must reassign themselves as the attending for all ward patients (see Epic PowerPoint for screenshots on how to do this). This is essential to ensure Secure Chat messages are appropriately routed.
    f. Each weekday and assigned weekend, the ward attending must check their inbox for orders and PT/OT/SLP documentation to co-sign (see Epic PowerPoint for instructions).
        i. The PT/OT/SLP services will send their initial evaluation notes to you to co-sign. *Do not attest*, just click the "co-sign" button and cancel any charge session that pops up automatically. This serves as confirmation that you authorize their treatment plan but does not trigger billing on our end.
        ii. Each newly admitted patient must have an "admit to inpatient" order OR "admit to observation" order signed within 24 hours of admission. This order will be in your Epic inbox to co-sign. If the patient will be in the hospital for 2 or more midnights, they should be admitted to "inpatient". If in the hospital overnight only, the order should be for "observation" (the residents will know how to change the order type if needed).
5. Clinic: For most weeks, the ward attending will be assigned to staff one half day of resident clinic each week. Typically, this is the Neuro-New Clinic on Thursday from 1PM-5PM, however will

occasionally be the resident continuity clinic on Tuesday 1PM-5PM or the Neuro-New Clinic on Friday from 9AM-12PM (see Cate Freyer's orientation email for assignment).

a. During clinic, the ward attending is expected to staff patients with the residents and NPs (including physically seeing all new patients), sign Epic attestations (see Epic PowerPoint guide for screenshots), and co-sign resident orders/prescriptions as needed.

Weekends, Call and Signout

1. The Ward attending is responsible for staffing all ward patients and all new and active follow-up consult patients each weekend. It is not expected for the attending to be onsite all day to staff new consults/admits in the afternoon.
2. The Ward attending will cover weekend call. Call entails receiving calls from the residents overnight to discuss patient management, logistics, or other questions.
3. Attendings who are covering the weekend will take call from 5 PM on Friday until 7:30 AM (beginning of morning report) on Monday.
4. Weekday night call starts at 5PM and ends at 7:30AM the following day.
5. The attending must sign out the service either verbally or via email to the incoming attending at the end of the rotation and each weekend for which they are not working.

Conference and teaching responsibilities

1. Conferences
    a. Attendings are expected to attend neuroradiology conference every Friday at 1:30pm. These occur both in person and via Zoom.
    b. Attendings are welcome to attend Monday educational conferences and are particularly encouraged to attend the journal club and M&M conferences for the month. These occur in person in 3C as well as over Zoom.
    c. Attendings are welcome to attend 4-Hospital morning report, which occurs once per month from 8AM-9AM (see morning report schedule in Cate Freyer's orientation email for details).
2. Teaching / feedback
    a. Attendings are encouraged to sign up to provide a 1-hour didactic educational session during their half-month rotation, if space is available. This can cover a topic of their choosing, be a formal presentation or chalk talk, and can be a talk (or variation of a talk) they have previously given.
    b. Attendings are primarily responsible for medical student teaching. This includes weekly clinical vignettes with the student rotating on the ward service. The students have access to these vignettes, and you will receive an email from Karl Kanner with the faculty guide for the vignettes. The goal is to review 2-4 with the student / week when the service schedule allows (if service is busy with good patient mix, vignettes can be deferred).
    c. Attendings are also encouraged to give informal chalk talks to students, rotators and residents as time allows.
    d. Attendings are required to perform an observed exam with the students rotating on the ward service. This should be scheduled at the end of week 2 or the beginning of week 3 of the students' rotation block. The goal of this exercise is to provide feedback on exam techniques for the student, both verbally after the observation as well as through a feedback form the student will send through MedHub. Ideally, the student would not be familiar with the patient at the time of the exam, and the patient should speak English if possible.
    e. Attendings will provide verbal feedback to students and residents and evaluate them using MedHub at the end of the half-month rotation (although mid-rotation verbal feedback is also welcomed).

i. Student MedHub evaluations are due within 1 week of the end of their rotation

f. Attendings may also be asked to fill out BBOTs (Brief Bridges Observational Tool) for the students. These are brief feedback forms sent to the attending through MedHub to reflect feedback given on presentations, exam, or other aspects of clinical care. The students are also able to fill these forms out themselves and send to the attending for review.

ZSFG Consult Attending Expectations 2026-2027

Typical consult attending schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
7:30 AM-8:00 AM	Morning report		Morning report		
9:00 AM-11:00 AM	Attending rounds	Attending rounds	Attending rounds	Attending rounds	Attending rounds
12:00 PM-1:00 PM	Conference (3C + Zoom)				
1:00 PM-5:00 PM	Staffing ED consults	Resident clinic (4M)	Staffing ED consults	Staffing ED consults	Neuroradiology conference (HB 247 + Zoom) [1:30-2:30] Staffing ED consults

Daily clinical responsibilities

6. The consult attending is expected to be on the ZSFG campus during regular working hours each weekday for clinical, teaching, and supervisory duties. Workspace will be made available for attendings from non-ZSFG sites.
    a. If an attending must leave campus during this time for other professional activities, they are expected to be available by pager and/or cell phone. The attending should be available to return to campus during regular working hours to staff a patient if needed.
    b. The consult attending serves as a secondary attending when the ward attending is in clinic and can assist in clinical tasks (including, but not limited to, discussing clinical questions or assisting with LPs) as needed.
7. Attendings must be available each weekday to round with the consult resident.
    a. **Weekdays:** Attending rounds are from 9AM-11AM M-F. Any patient not seen by 11AM will be seen by the attending alone (students and rotators also allowed to accompany if not otherwise needed, but the neurology resident should be dismissed to begin the work of the day).
    b. If the attending or resident is scheduled for Neuro-New Clinic on Friday morning, rounds should occur prior to clinic starting at 9AM (being attentive to morning report from 7:30AM-8:00AM and to restrictions on the time residents are allowed to come in in the morning). The recommendation is for this to occur as work rounds (aka discovery rounds) where the attending joins the resident during their normal pre-rounding process from 8AM-9AM.
    c. **Weekends:** the Consult Attending is not routinely assigned to cover weekends. Consult Service attending duties on the weekend will be covered regularly by the Ward Attending.
8. Attendings should make every effort to staff ED consultations throughout the day.
    a. All new ED consults M-F between 8AM-5PM (within reason) who are being discharged home should be seen and staffed by the consult attending prior to discharge. This should

not significantly delay the patient's discharge from the ED. This includes patients seen by the night float resident who remain in the ED the following morning if possible. The resident is not required to join the attending to see the patients, depending on workflow, but should discuss their findings and recommendations with the attending prior to the attending staffing the patient.

b. The consult attending should provide sign out (either verbal or email) to the ward or ICU attending for all consults they staff who are then admitted to the primary neurology service.
c. At the discretion of the consult attending and resident, new inpatient consults (med/surg, ICU, inpatient psych, PES and 4A) seen by the resident after attending rounds can be staffed by the attending the same day or can be staffed the following day during attending rounds.

9. The consult attending is expected to assist in ensuring **no resident violates duty hour requirements.**
    a. The attending is expected to check in with the resident at 3PM M-F to discuss updates for the patients and plan who needs to be seen the following day, determine what tasks still need to be completed (or assist the resident to triage what work can be deferred to the following day), and assist in completing any necessary tasks to ensure the residents are able to sign out on time. This can include, but is not limited to, writing follow up consultation notes or discussing recommendations with teams / patients.
    b. The attending and consult resident will receive an email each Wednesday and Thursday morning detailing the number of hours worked by the resident that week (calculated Sunday to Saturday). Residents are not allowed to work >79 hours. The attending should work with the resident to ensure they stay within those requirements. If further coverage is needed, jeopardy will be activated to cover the remaining hours of the week.
    c. On the day a resident is assigned to swing shift (cross cover and consults between 5-7PM) they are not to come in prior to 7:30AM. Pre-rounding duties may therefore be incomplete prior to rounds. Flexibility in workflows to accommodate this on rounds is encouraged (i.e., seeing patients together that were not seen during pre-rounds, reviewing labs or imaging in the moment on rounds, etc.).
    d. Residents must have at least 8 hours off between shifts. On rare occasions, this may result in a resident needing to come in later than 7:30 am. On such occasions, the resident is expected to notify their attending by email upon leaving the hospital of their expected arrival time the next morning.
    e. The attending running morning report will check in with night float to ensure their work can be completed and that they leave no later than 9AM. The recommendation is for residents to complete the notes for any patient they sent home from the ED followed by any admission notes (ICU then ward) followed by any inpatient consult notes. Any notes not completed can be shared and completed by the appropriate day resident.
10. Notes
    a. All new consults must have an attending attestation within 24 hours of the initial resident note. The attestations are templated to optimize billing (see Epic PowerPoint for screen shots of how to access). The attestation must be signed no later than 8AM the day following the attending's initial evaluation (i.e. if the consultation is first staffed on Monday during rounds, the attestation is required by 8AM Tuesday morning).
    b. All follow-up consults should have a resident note and attending attestation for every day they are seen on rounds. If the resident has not completed the follow-up notes by 3PM, the attending is encouraged to write an attending-only follow-up note for that day. The follow-up attestations and attending-only follow-up notes are templated to optimize

billing (see Epic PowerPoint for screen shots of how to access). The attestation must be signed no later than 8AM the day following the follow-up evaluation.

11. The resident notes for patients who were discharged home without being staffed by an attending should be signed by the consult attending on the days they are assigned for morning report. These notes do not require the attestation template, and require only a statement that the patient was not personally interviewed or examined by the attending, that you agree with the recommendations as stated (or adjust those recommendations in the attestation depending on the conversation), and that it is not a billable note.
12. EHR responsibilities
    a. It is recommended that the attending assign themselves as the consult attending in EPIC on the first day of the rotation (details for how to do this are included in Cate's orientation email). This ensures that any primary team will contact the appropriate person for follow up questions.
    b. Each assigned weekend, the attending must check their inbox for orders and PT/OT/SLP documentation to co-sign (see Epic PowerPoint for instructions).
        i. The PT/OT/SLP services will send their initial evaluation notes to you to co-sign. *Do not attest*, just click the "co-sign" button and cancel any charge session that pops up automatically. This serves as confirmation that you authorize their treatment plan but does not trigger billing on our end.
        ii. Each newly admitted patient must have an "admit to inpatient" order OR "admit to observation" order signed within 24 hours of admission. This order will be in your Epic inbox to co-sign. If the patient will be in the hospital for 2 or more midnights, they should be admitted to "inpatient". If in the hospital overnight only, the order should be for "observation" (the residents will know how to change the order type if needed).
13. Clinic: In most weeks, the consult attending will be assigned to staff one half day of resident clinic each week. Typically, this is the resident continuity clinic on Tuesday 1PM-5PM, however will occasionally be the Neuro-New Clinic on Thursday 1PM-5PM or Friday 9AM-12PM (see Alexandra Brown's schedule for assignment).
    a. During clinic, the consult attending is expected to staff patients with the residents and NPs (including physically seeing all new patients), sign Epic attestations (see Epic PowerPoint guide for screenshots), and co-sign resident orders/prescriptions as needed.

Call and Signout

1. The consult attending may take night call as assigned. Call entails receiving calls from the residents overnight to discuss patient management, logistics, or other questions.
2. Weekday night call starts at 5PM and ends at 7:30AM the following day.
3. The attending must sign out the service either verbally or via email to the incoming attending at the end of the rotation and each weekend for which they are not working.

Transfers

1. The consult attending is responsible for screening potential transfers to the neurology service, except in the case of neurologic emergencies. The patient will be staffed on attending rounds, and the consult attending will determine if the patient is appropriate for transfer after staffing the consult. If the patient is stable, the transfer would then occur at 7AM the following morning, with transfer orders being placed by the ward team and the patient staffed on ward rounds. The consult attending should provide sign out (either verbal or email) to the ward attending.

   a. For neurologic emergencies (hemorrhage, status), the transfer request will be triaged through the ICU fellow/attending, and the patient can be transferred immediately once approved.
2. The hospital is currently not transferring patients from other facilities.

Conference and teaching responsibilities

1. Conferences
   a. Attendings are expected to attend neuroradiology conference every Friday at 1:30pm. These occur both in person and via Zoom.
   b. Attendings are welcome to attend Monday educational conferences and are particularly encouraged to attend the journal club and M&M conferences for the month. These occur in person in 3C as well as over Zoom.
   c. Attendings are welcome to attend 4-Hospital morning report, which occurs once per month from 8AM-9AM (see morning report schedule in Cate Freyer's orientation email for details).
2. Teaching / feedback
   a. Attendings are encouraged to sign up to provide a 1-hour didactic educational session during their half-month rotation, if space is available. This can cover a topic of their choosing, be a formal presentation or chalk talk, and can be a talk (or variation of a talk) they have previously given.
   b. Attendings are primarily responsible for medical student teaching. This includes weekly clinical vignettes with the student rotating on the ward service. The students have access to these vignettes, and you will receive an email from Karl Kanner with the faculty guide for the vignettes. The goal is to review 2-4 with the student / week when the service schedule allows (if service is busy with good patient mix, vignettes can be deferred).
   c. Attendings are also encouraged to give informal chalk talks to students, rotators and residents as time allows.
   d. Attendings are required to perform an observed exam with the students rotating on the ward service. This should be scheduled at the end of week 2 or the beginning of week 3 of the students' rotation block. The goal of this exercise is to provide feedback on exam techniques for the student, both verbally after the observation as well as through a feedback form the student will send through MedHub. Ideally, the student would not be familiar with the patient at the time of the exam, and the patient should speak English if possible.
   e. Attendings will provide verbal feedback to students and residents and evaluate them using MedHub at the end of the half-month rotation (although mid-rotation verbal feedback is also welcomed).
      i. Student MedHub evaluations are due within 1 week of the end of their rotation
   f. Attendings may also be asked to fill out BBOTs (Brief Bridges Observational Tool) for the students. These are brief feedback forms sent to the attending through MedHub to reflect feedback given on presentations, exam, or other aspects of clinical care. The students are also able to fill these forms out themselves and send to the attending for review.

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Neurology 2022

Provider Name:

Privilege	Status	Approved

Neuro NEUROLOGY 2022

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

CORE PRIVILEGES

18.10 ADULT NEUROLOGY ___
Work up, diagnose, and treat patients on the Neurology Service and consult on patients with neurological problems in the inpatient setting and emergency department. Work up, diagnose, treat, and consult on adult patients (age 17 and older) with neurological problems in the clinics. Core privileges include lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology).

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

18.20 CHILD NEUROLOGY ___
Work up, diagnose, treat, and consult on pediatric patients (under age 18 and those patients up to age 30 with neurologic conditions that typically present during childhood) with neurological problems in the inpatient and outpatient settings. Core privileges include lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

SPECIAL PRIVILEGES

18.30 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 Neurology 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

18.40 EEG ___

Delineation Of Privileges

Neurology 2022

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with EEG privileges.

REAPPOINTMENT: Review of 3 cases.

18.50 EMG ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with EMG privileges.

REAPPOINTMENT: Review of 3 cases.

18.60 EVOKED POTENTIALS ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology).

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with evoked potential privileges.

REAPPOINTMENT: Review of 3 cases.

18.70 BOTULINUM TOXIN FOR MOVEMENT DISORDERS, SPASTICITY OR REFRACTORY HEADACHE ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology) and training in administration of botulinum toxin for the above indications.

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with botulinum toxin privileges.

REAPPOINTMENT: Review of 3 cases.

18.80 CRITICAL CARE ___
Evaluation and management of critically ill patients, including management of airway, ventilation, hemodynamics, sedation, and analgesia. Staffing of Stroke/Neurocritical Care Follow-Up Clinic and consults outside the ICU that require a neurointensivist.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Psychiatry and Neurology (Neurology or Neurology with Special Qualification in Child Neurology) or American Board of Emergency Medicine and eligible or certified in Neurocritical Care by the American Board of Psychiatry and Neurology or the United Council for Neurologic Subspecialties.

PROCTORING: Review of 5 cases by an assigned Neurology Service Staff Member with Critical Care Privileges

REAPPOINTMENT: Review of 3 cases

90.00 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH ___
Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

Delineation Of Privileges

Neurology 2022

Provider Name:

Privilege	Status	Approved

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

APPROVED BY

_____ _____

Service Chief Date

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

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

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:	
Standardized Procedure Title:	Licensed Acupuncturists (LAcs) in the San Francisco Health Network
Department:	Primary Care
Dept Chief:	Tiffany Kenison, MD
SP Author(s):	Folashade Wolfe-Modupe, MD; Candice Turchin, LAc; Sunny Pak, MD
Update #1:	Regulatory clarification (Title 16)
Reason/Explanation for Revision:	The 2026 SP adds prominent regulatory clarification on the first page stating that Licensed Acupuncturists do *not* fall under Title 16 CCR 1474 and instead are governed under Title 16, **Division 13.7**. This changes the Governing Body from Board of Registered Nursing and Medical Board of California to California Acupuncture Board
Update #2:	Expanded referral pathways
Reason/Explanation for Revision:	The 2026 SP introduces the option for patients to self-refer for acupuncture services in SFHN, whereas the 2023 SP referenced provider-based referrals only. This is from the Business and Professions Code Section 4926 under the Acupuncture Licensure Act, which states:

	"Acupuncture should be subject to regulation and control as a primary health care profession.
Update #3:	Revised supervision and evaluator qualifications
Reason/Explanation for Revision:	This separates the supervision into two roles: 1) Clinical Supervisor, who can be a Licensed Acupuncturist, such as the Lead Acupuncturist, privileged by the ZSFG Medical Staff Office to provide acupuncture services, with a minimal of 5 years of acupuncture practice in California. 2) Supervisor of Record, who hold administrative oversight within a matrix management structure. This supervisor does not need to be practicing acupuncture.
Update #4:	Revision to proctoring and biennial reappointment requirements
Reason/Explanation for Revision:	More clearly state direct observation of 5 patients and chart review of 5 different patients for proctoring, and review of 3 cases every two years.
Update #5:	Expanded practice settings
Reason/Explanation for Revision:	The 2026 SP expands permissible practice locations to include **specialty and ambulatory care centers**, beyond the primary care and inpatient settings listed in the 2023 SP.
Update #6:	Added therapies and expanded clinical indications
Reason/Explanation for Revision:	New therapeutic modalities, such as **gua sha,** (with brief definition added) and expanded clinical indications, to clearly state to include substance use and chronic pain, broadening described practice activities.
Update #7:	Standardization and clarification of documentation and exam language
Reason/Explanation for Revision:	Improved clarity and consistency of physical exam terminology, including transitioning to *"pulse examination, palpation, and tongue observation",* to address reviewer's comment.

*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 chang to **" San Francisco Health Network"** • CHN change to **"SFHN"**
Qualified Provider	Insert the following after every use of words "qualified provider:" who has completed proctoring and subsequently maintained their eligibility for performing the procedure. *Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure*. (Credentials Committee, 11/2023)
Prerequisites	Onsite training no longer to be listed as a prerequisite. Instead, the training to be completed once procedure is approved for the provider and then before the provider initiates proctoring. Update protocols to reflect this change (Credentials Committee, 11/2023)

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

STANDARDIZED PROCEDURE: Licensed Acupuncturists (LAcs)

Title: Licensed Acupuncturists (LAcs) in the San Francisco Health Network

I. Policy Statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, Licensed Acupuncturists, and Administrators and must conform to the code of regulations set forth by the California Acupuncture Board. Licensed Acupuncturists do not fall under Title 16 CCR Section 1474

Licensed acupuncturists are governed by the **California Acupuncture Board** under **Title 16, Division 13.7** of the California Code of Regulations.

B. All standardized procedures are to be kept electronically and in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in each clinic utilizing the services of a LAc, and on file in the Medical Staff Office.

II. Functions To Be Performed

A. Definitions:

In accordance with California Codes Section 4927d, “Acupuncture” means the stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping, and moxibustion,

A licensed Acupuncturist (LAc) is a licensed health professional with at minimum a master’s degree in Acupuncture and Oriental Medicine

(conferred by a school either accredited by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) or approved directly by the California Acupuncture Board) who evaluates and treats patients according to the principles of Traditional Oriental Medicine, using these techniques.

An acupuncturist licensed in the State of California is also authorized to perform or prescribe therapies and techniques in accordance with California Codes Section 4937. Portions of this code encompassing the scope of practice permitted on SFHN premises include the following: an acupuncturist may perform or prescribe the use of acupuncture, electro acupuncture, moxibustion, cupping, oriental massage, acupressure, breathing techniques, energy work (qi gong, teyi, etc), meditation, exercise, diet and nutrition, heat, cold, and magnets to promote, maintain, and restore health; and provide patient education on herbal and non-herbal dietary supplements.

To be performed within the SFHN by a LAc, these activities require standardized procedures. These standardized procedures include guidelines stating specific situations requiring the Licensed Acupuncturist to seek physician consultation.

B. Functions:

Licensed Acupuncturists (LAcs) who are not physicians will evaluate patients according to the principles of traditional acupuncture and provide acupuncture treatment to SFHN patients with stable medical conditions according to standardized procedures. Administration of acupuncture is based on laws and regulations by the State of California Acupuncture Board.

III. Circumstances under which An LAc may perform function

A. Setting
The Licensed Acupuncturist (LAc) may perform the following standardized procedure function in any San Francisco Health Network health care delivery facilityunder supervision per section C below.

B. Requirement for referral
This standardized procedure describes the care LAc will provide to SFHN patients. In SFHN, patients may be referred to acupuncture by primary care provider, other provider, or self-refer.

C. Supervision:

1. Overall Accountability:
   Each Licensed Acupuncturist (LAc) shall be responsible and accountable to two designated supervisory roles:
   a. **Clinical Supervisor**: The Clinical Supervisor, who may serve as the Lead Acupuncturist, shall be a Licensed Acupuncturist privileged by the ZSFG Medical Staff Office to provide acupuncture services within the setting in which the LAc practices (e.g., Community Primary Care or a designated hospital-based service). The Clinical Supervisor shall provide direct oversight of clinical activities, ensure adherence to professional standards of acupuncture practice, and support the LAc's ongoing clinical development. In accordance with California Code of Regulations, Title 16, Section 1399.421, only a Licensed Acupuncturist may directly supervise the professional scope of practice of another Licensed Acupuncturist.
   b. **Supervisor of Record**: The Supervisor of Record, who may serve as the Director of Acupuncture or the Director of Integrative Medicine, shall hold administrative oversight within the matrix management structure. The Supervisor of Record shall be responsible for the LAc's overall job performance, including the performance appraisal process (conducted in consultation with the Clinical Supervisor), and for addressing matters related to discipline or other employment actions.

   Both the Clinical Supervisor and the Supervisor of Record are ultimately accountable to the Chief of the respective service.

2. A qualified consulting physician will be available to the LAc at all times and in person if needed.

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

   a. Immediately for any urgent or emergent condition arising which requires prompt medical attention;
   b. Immediately for acute decompensation or deterioration of patient status;
   c. Immediately for problems requiring hospital admission or potential hospital admission

d. Promptly for any complication arising from acupuncture treatment
e. In a timely manner when symptoms for which the patient was referred fail to improve within a reasonable time frame
f. In a timely manner at the request of the patient, acupuncturist or referring physician.

IV. Prerequisites - Requirements for the Licensed Acupuncturists

A. Basic Training and Education

1. Minimum of a Master's degree in Acupuncture and Oriental Medicine (conferred by a school either accredited by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) or approved directly by the California Acupuncture Board) who evaluates and treats patients according to principles of Traditional Oriental Medicine, using these techniques.

2. The LAc shall maintain a current and valid license issued by the State of California Acupuncture Board of the Department of Consumer Affairs in accordance with California Codes Section 4938.

3. The LAc must have documentation of completion of a clean needle technique course

4. The LAc must be currently credentialed by ZSFG on behalf of the SFHN

5. Copies of licensure and certification must be on file in the Medical Staff Office.

6. Receipt of or filed application for a CHN number

V. Evaluation

A. Evaluation of LAc competence in performance of standardized procedures

1. Initial: at the conclusion of the standardized procedure training, the Licensed acupuncturist evaluator will assess the LAcs ability to practice, the quality and consistency of their documentation and delivery of therapeutic modalities.

a. Clinical Practice
- Length of proctoring period will be 20 clinical hours, at least 5 hours directly supervised. The evaluator will be a peer or supervising licensed acupuncturist who has a minimum of 5

years of practice in the state of California and is a member of the ZSFG Medical Staff.

- The method of evaluation in clinical practice will utilize feedback from consulting providers and the review of direct observation and chart review on 5 different patients. Documentation will be reviewed and signed off by a peer or supervising licensed acupuncturist who has a mimimum of 5 years of practice in the state of California and reported to the medical director of each involved clinic or to the Chief of each involved in-patient service.

2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by a peer or supervising licensed acupuncturist who has a minimum of 5 years of practice in the state of California, at appropriate intervals.

3. Biennial Reappointment: The supervising licensed acupuncturist or designated same discipline peer will utilize feedback from colleagues and consulting providers and the review of at least five charts in order to evaluate the licensed acupuncturists clinical competence, the quality and consistency of their documentation and their delivery of therapeutic modalities. At least 5 cases must be documented for each biennial period

VI. Development and Approval of Standardized Procedure

A. Method of Development

- **Acupuncturist Regulations**: Licensed acupuncturists are governed by the **California Acupuncture Board** under **Title 16, Division 13.7** of the California Code of Regulations. L.Ac do not fall under Title 16 CCR Section 1474

B. Approval

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

C. Review Schedule

The standardized procedure will be reviewed every three years and as practice changes by the acupuncture supervisor and the Chiefs of Services in which LAcs are practicing.

D. Revisions

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

Procedure #1: Acupuncture Evaluation and Therapies

A. DEFINITION

In accordance with California Codes Section 4927d, “Acupuncture” means the stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electro acupuncture, cupping and moxibustion.

An acupuncturist treating patients of the ZSFG Medical Center, primary care health centers, or ZSFG inpatient services is not authorized to order laboratory or other diagnostic studies but may recommend such tests to be considered by the patient’s physician.

1. Location to be performed: SFHN primary care centers, specialty and ambulatory care centers, or in-patient services.

2. Performance of procedure:

    a. Indications: Physical or mental symptoms that are acute or chronic in nature, or symptoms which are intractable, or for which the patient prefers the addition of acupuncture care; this may include issues of mental health, substance use, chronic pain, as well as physiologic imbalance.
    b. Precautions: Psychiatrically and medically unstable individuals are eligible to receive these services at the discretion of the LAc and the referring provider.
    c. Contraindications: None

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B. DATA BASE

1. Subjective Data
    a. Historical information relative to the presenting illness (presenting symptoms or condition) including review of medical records as appropriate.
    b. Status of relevant symptoms e.g. present/absent, acute/chronic and quality.
    c. Past health history, family history, occupational history, personal/social history, review of symptoms.

2. Objective Data
    a. Physical examination according to acupuncture physical examination standards of practice, which include, but are not limited to pulse examination, palpation, and tongue observation.

C. DIAGNOSIS

The LAc will diagnose within the system of traditional oriental medicine; the LAc will not diagnose medical conditions within the context of western biomedical science.

D. PLAN

1. Therapeutic Treatment Plan
   a. Prior to the first therapeutic session, the patient will complete an initial intake form. The LAc will review the form to identify primary goals for the session, and potential precautions for acupuncture therapy. If potential concerns are identified, the LAc will discuss these issues with the acupuncture supervisor, or referring provider prior to commencing therapy.
   b. The LAc may perform or prescribe the use of acupuncture, electro acupuncture, moxibustion, cupping, gua sha, (a form of Instrument-Assisted Soft Tissue Mobilization (IASTM), that involves applying unidirectional, press-stroking friction to lubricated skin with a smooth-edged instrument to stimulate microcirculation and induce a therapeutic, controlled inflammatory response in subcutaneous and myofascial tissues) oriental massage, acupressure, breathing techniques, meditation, energy work (qi gong, teyi, etc.), exercise, diet and nutrition, heat, cold and magnets to promote, maintain and restore health; and provide patient education on herbal and non-herbal dietary supplements.
   c. The LAc will follow all infection control procedures, will perform clean needle technique and will store and utilize materials and accessories according to appropriate Environment of Care policy and procedures.
   d. Patient consent obtained before procedure is performed and obtained according to hospital policy. Written consent will be obtained prior to the first treatment provided to each patient.

2. Patient conditions requiring Attending Consultation
   a. Please refer to consultation section III C. 3

3. Patient and Family Education
   In verbal and/or written format, the LAc will explain the therapeutic modalities and appropriate follow up to the patient and family (when appropriate)

4. Follow-up and Referral

Performed in accordance with the standard of practice.

E. RECORD KEEPING

A. The LAc will document patient care therapies in the medical record within 72 hours of the patient visit in accordance with hospital and health center regulations.
B. Documentation of encounter will include:
    1. Patient subjective report (e.g. chief complaint)
    2. Patient history as reported during patient interview
    3. Physical examination according to acupuncture physical examination standards of practice, which may include, but are not limited to pulse examination, palpation, and tongue observation.
    4. Diagnosis according to acupuncture principles and scope of practice
    5. Assessment and treatment plan in accordance with California Code Section 4937 and this document
    6. A consent form signed by the patient authorizing acupuncture treatment for their first session of acupuncture
    7. Type of acupuncture provided during session
    8. Documentation of any complications associated with a procedure should such occur
    9. Follow up recommendations

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: 1. Current and valid license issued by the State of California Acupuncture Board of the Department of Consumer Affairs in accordance California Code Section 4938
Proctoring Period: 1. Direct observation of 5 patients and chart review of 5 different patients
Reappointment Competency Documentation: 1. Review of a minimum number of 3 cases needed every two years.

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

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

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:	
Standardized Procedure Title:	Medical Emergency Response Team (MERT)
Department:	Intensive Care Unit
Dept Chief:	Antonio Gomez, MD
SP Author(s):	Allison Preston
Update #1:	Specifying IM route for naloxone administration in addition to IV route.
Reason/Explanation for Revision:	To allow for emergent administration when IV access is not available.
Update #2:	Substituting Plasma-Lyte IV fluid for Normal Saline in Protocol #6: Assessment and Management of Severe Sepsis and Protocol #7: Assessment and Management of GI Bleeding.
Reason/Explanation for Revision:	To align with national guidelines and hospital sepsis pathway.

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below. See also CA BRN Standardized Procedure Guidelines

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

2025

Zuckerberg San Francisco General Hospital and Trauma Center

COMMITTEE ON INTERDISCIPLINARY PRACTICE

STANDARDIZED PROCEDURE- REGISTERED NURSE

TITLE: Medical Emergency Response Team (MERT) Registered Nurse

1. Purpose of Policy

   To expedite patient care by initiating evidence-based interventions by Registered Nurses based on patient complaint and acuity. These medical staff approved procedures are intended to be a guide for Medical Emergency Response Team (MERT) RNs to initiate basic interventions in the hospital.

2. Policy Statement

   A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Registered Nurses, Pharmacists, Physician Assistants, Physicians and administrators and other affiliated staff and must conform to the Nurse Practice Act, Business and Professions Code Section 2725 and all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

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

2. Functions to be performed

   The Registered Nurse based upon the nursing process determines the need for a standardized procedure. The RN provides 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 RN to seek provider consultation.

3. Circumstances under Which RN May Perform Function

   A. Setting
   The MERT Registered Nurse may perform the following standardized procedure functions on the ZSFG campus consistent with their experience and training.

B. Scope of Supervision Required:
   1. The RN is responsible and accountable to the Critical Care Nursing and Medical Directors.
   2. Overlapping functions are to be performed in areas which allow for a consulting provider to be available, at all times, to the RN, by phone or in person, including but not limited to the clinical area.
   3. Provider consultation is to be specified in the protocols and under the following circumstances:

      a.Acute decompensation of patient situation.
      b.Upon the request of the registered nurse, patient or provider.
      c. Unexplained historical, physical or laboratory findings.
      d. Uncommon, unfamiliar, unstable, and complex patient condition.
      e. An adverse response to respiratory treatment, or a lack of therapeutic response.

4. Protocols to be used in practice area:

   Protocol #1 Assessment and Management of Adult Patient with Generalized Medical Illness and Abnormal Vital Signs
   Protocol #2 Assessment and Management of Altered Mental Status
   Protocol #3 Assessment and Management of Seizure
   Protocol #4 Assessment and Management of Shortness of Breath
   Protocol #5 Assessment and Management of Chest Pain
   Protocol #6 Assessment and Management of Severe Sepsis
   Protocol #7 Assessment and Management of Gastrointestinal Bleeding
   Protocol #8 Assessment and Management of Anaphylaxis
   Protocol #9 Assessment and Management of Opioid-induced respiratory depression

5. Requirements for the Registered Nurse

A. Experience and Education
   1. Active California Registered Nurse license.
   2. Current Basic Life Support certification from an approved American Heart Association provider.
   3. Current Advanced Cardiac Life Support certification from an approved American Heart Association provider.

B. Special Training
   1. Minimum of 2 years critical care experience
   2. Successful completion of clinical orientation/training (24 hours preceptorship) requirements, including standardized procedures specific training

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

1. Initial:
   At the conclusion of the standardized procedure training, the Nurse Manager, Medical Director, or designated provider will assess the RN's ability to perform the procedure:

   Clinical Practice:
   Successful completion of the RN orientation program (24 hours)
   Successful completion of a review of accuracy and completeness of documentation for actual patient cases by MERT Team Lead (minimum of five the first year, then two thereafter).

2. Annual:
   Nurse Manager, Medical Director, or designated provider will evaluate the RN's competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation or chart review may be used. The standardized procedures will be reviewed as a portion of the required MERT annual education..

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

6. Development and Approval of Standardized Procedures

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

B. Approval
   All standardized procedures must be approved by the CIDP, Credentials Committee, Medical Executive Committee, and the Joint Conference Committee prior to use.

C. Review Schedule
   The standardized procedure will be reviewed every three years or as practice changes, by the registered nurses, nurse managers and medical directors.

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

Protocol #1: Assessment and Management of Adult Patient with Generalized Medical Illness and Abnormal Vital Signs

A. Definition: This protocol covers the initial assessment and management of adult patients with generalized medical illness and abnormal vital signs seen by Registered Nurses (RN) on the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

Indications

- Any concern about a patient's clinical condition
- Change in vital signs 20% from baseline
- Change in mental status
- Acute change in oxygenation requirements
- Chest pain unrelieved by chest pain protocol
- Shortness of breath
- SpO2 <92% despite oxygen

B. Data Base

1. Subjective Data

- Signs and symptoms generalized medical illness
- Sequence of preceding events
- Actions that relieve symptoms
- Pertinent past medical history, current medications and allergies
- Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to generalized medical illness
- Level of consciousness (may use Glasgow Coma Scale)
- Measure vital signs q 30 minutes and prn
- Attach cardiac monitor, assess rhythm and monitor for dysrhythmias
- Place on pulse oximetry and measure SpO2

3. Diagnosis
    a. Consistent with subjective and objective findings
    b. Assessment of status and disease process

4. Plan

1. Administer supplemental oxygen if SpO_2 <92%, maintain patent airway

2. Stat EKG for HR >20% from baseline or dysrhythmia, show provider when completed

3. Ensure adequate IV/IO access and IV/IO patency

4. Obtain stat POCT fingerstick glucose

5. If POCT glucose <70 mg/dl administer D50 25 grams (1 ampule) IV, notify provider, and recheck POCT glucose in 1 hour

6. If POCT glucose >180, notify provider

7. Consider sending urinalysis

8. Patient education and counseling appropriate to disease process

9. Consultation with provider upon provider's arrival to MERT activation, or:
    - Any new concern about a patient's clinical condition
    - Vital signs remain 20% from baseline
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Chest pain unrelieved by chest pain protocol
    - Shortness of breath
    - Pulse oximetry <92% despite titration of oxygen therapy
    - Assess skin condition: color, temperature, moisture and capillary refill

Protocol #2: Assessment and Management of Altered Mental Status

A. Definition: This protocol covers the initial assessment and management of patients with altered mental status seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

Indications

- Altered mental status
- History of seizure disorders, IDDM, trauma, infection, psychiatric disorders, stroke, or
- Decrease, cessation, or overdose of alcohol or drug intake

B. Data Base

1. Subjective Data

- Signs and symptoms of altered mental status
- Sequence of preceding events
- Duration of episode
- Actions that relieve symptoms
- Pertinent past medical history, current medications and allergies
- Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms (headache, dizziness, chest pain, palpitations)
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to altered mental status and/or syncope
- Level of consciousness (may use Glasgow Coma Scale) and pupillary response
- Assess for airway patency, insert oral or nasal airway as needed
- Measure vital signs every 30 minutes and prn
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Place on pulse oximetry and measure SpO_2
- Assess skin condition: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings

b. Assessment of status and disease process

D. Plan

1. Administer supplemental oxygen if SpO_2 <92%, maintain patent airway

2. Stat chest Xray and ABG (VBG if unable to obtain ABG) if O2 sat<92% despite oxygen therapy or if patient exhibits signs or symptoms of respiratory distress

3. Stat EKG for HR >20% from baseline or dysrhythmia, show provider when completed

4. Ensure adequate IV/IO access and IV/IO patency

5. Obtain stat POCT fingerstick glucose

6. If POCT glucose <70 mg/dl administer D50 25 grams (1 ampule) IV, , notify provider, and recheck POCT glucose in 1 hour

7. If POCT glucose >180, notify provider

8. Consider sending urinalysis and urine toxicology, split and hold the sample for urine culture, if not recently done

9. Consider sending CBC, comprehensive metabolic panel, magnesium, phosphorus and ionized calcium

10. Patient education and counseling appropriate to disease process

11. Consultation with provider upon provider's arrival to MERT activation, or:
    - Any new concern about a patient's clinical condition
    - Vital signs remain 20% from baseline
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Chest pain unrelieved by chest pain protocol
    - Shortness of breath
    - Pulse oximetry <92% despite titration of oxygen therapy

Protocol #3: Assessment and Management of Active Seizure

A. Definition: This protocol covers the initial assessment and management of patients with a seizure seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) or the Intensive Care Unit (ICU).

Indications

- Witnessed or suspected seizure

B. Data Base

1. Subjective Data

- Signs and symptoms of seizure
- Description of onset and duration of event
- Sequence of preceding events
- Actions that relieve symptoms
- Pertinent past medical history, current medications and allergies
- Characteristics of any pain (PQRST); location, quality, and intensity (1-10) and associated symptoms
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to seizure
- Level of consciousness (may use Glasgow Coma Scale) and pupillary response
- Assess for and maintain airway patency, insert oral or nasal airway as needed
- Measure vital signs every 30 minutes and prn
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Place on pulse oximetry and measure SpO_2
- Assess skin condition: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings
b. Assessment of status and disease process

D. Plan

1. Stat EKG for HR > 20% from baseline or dysrhythmia, show provider when completed

2. Ensure adequate IV/IO access and IV/IO patency

3. Obtain stat POCT fingerstick glucose

4. If POCT glucose <70 mg/dl administer D50 25 grams (1 ampule) IV, notify provider and recheck POCT glucose in 1 hour

5. If POCT glucose >180, notify provider

6. Consider sending urinalysis and urine toxicology

7. Consider sending CBC and comprehensive metabolic panel, , magnesium, phosphorus and ionized calcium

8. Initiate seizure precautions.

9. Patient education and counseling appropriate to disease process

10. Consultation with provider upon provider's arrival to MERT activation, or:
    - Any new concern about a patient's clinical condition
    - Vital signs remain 20% from baseline
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Chest pain unrelieved by chest pain protocol
    - Shortness of breath
    - Pulse oximetry <92% despite titration of oxygen therapy

Protocol #4: Assessment and Management of Shortness of Breath

A. Definition: This protocol covers the initial assessment and management of patients with shortness of breath seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Room (ED) or the Intensive Care Unit (ICU).

Indications

- Chief complaint of shortness of breath
- Shortness of breath with confirmed wheezing and history of asthma/COPD
- RR>24, or
- RA SpO2<94%

B. Data Base

1. Subjective Data

- Signs and symptoms of shortness of breath
- Assess for signs and symptoms of asthma/COPD
- Review pertinent past medical history, hospitalizations for respiratory disease, current medications and allergies
- Characteristics of shortness of breath (PQRST) and associated symptoms (cough, fever, chills)
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to respiratory disease
- Auscultate lung sounds bilaterally
- Note respiratory rate, depth, and work of breathing
- Note stridor or audible wheezing and notify physician/ordering provider/RT
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Measure vital signs every 30 minutes x2
- Place on pulse oximetry and measure SpO_2
- Assess skin condition: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings
b. Assessment of status and disease process

D. Plan

1. Administer supplemental oxygen if SpO2<92%, maintain patent airway

2. Stat chest Xray and ABG (VBG if unable to obtain ABG) if O2 Sat <92% despite oxygen therapy or if patient exhibits signs or symptoms of respiratory distress

3. Stat EKG for HR>20% from baseline or dysrhythmia, show provider when completed

4. Ensure adequate IV/IO access and IV/IO patency

5. If wheezes are present, administer nebulized duoneb (combination albuterol sulfate 2.5 mg and ipratroprium bromide 0.5 mg per 3 mg saline) x 3 doses every hour prn

6. NPO until evaluated by provider

7. Patient education and counseling appropriate to disease process

8. Consultation with provider upon provider's arrival to MERT activation, or:
    - Any new concern about a patient's clinical condition
    - Vital signs remain 20% from baseline
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Chest pain unrelieved by chest pain protocol
    - Shortness of breath
    - Pulse oximetry <92% despite titration of oxygen therapy

Protocol #5: Assessment and Management of Chest Pain

A. Definition: This protocol covers the initial assessment and management of patients with suspected ischemic chest discomfort seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

Indications

- Suspected ischemic chest discomfort

Exclusions

- Acute chest trauma

B. Data Base

1. Subjective Data

Review history and signs and symptoms suggestive of ischemia

- Retrosternal chest discomfort
- Pain spreading to shoulders, neck, arms, or jaw, or pain in back
- Associated lightheadedness, fainting, diaphoresis, or nausea
- Shortness of breath
- Global feeling of distress, anxiety, or impending doom
- Pertinent past medical history, current medications and allergies
- Characteristics of pain (PQRST); location, quality, and intensity (1-10)
- Any treatments used prior to arrival
- Duration and onset of chest pain

2. Objective Data

- Perform focused physical exam relevant to chest pain/cardiac disease
- Level of consciousness (may use Glasgow Coma Scale)
- Measure vital signs every 30 minutes x2
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Place on pulse oximetry and measure SpO_2
- Skin assessment: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings
b. Assessment of status and disease process

D. Plan

1. Administer supplemental oxygen if SpO_2 <94%, maintain patent airway

2. Stat EKG, show provider when completed

3. Ensure adequate IV/IO access and IV/IO patency

4. Consider sending stat CBC, comprehensive metabolic panel, magnesium, phosphorus, and calcium coagulation labs.

5. Patient education and counseling appropriate to disease process

6. Consultation with provider upon provider's arrival to MERT activation, or:
    - Any new concern about a patient's clinical condition
    - Vital signs remain 20% from baseline
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Chest pain unrelieved by chest pain protocol
    - Shortness of breath
    - Pulse oximetry <90% despite oxygen

Protocol #6: Assessment and Management of Severe Sepsis

A. Definition: This protocol covers the initial assessment and management of patients with suspected severe sepsis seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and the Intensive Care Unit (ICU).

Indications

- Confirmed or suspected infection with two ***OR*** more of the following SIRS criteria:
- Heart Rate > 90
- Respiratory Rate > 20 (or $PaCO_2$ <32)
- Temperature ≥ 38 º C (100.4 º F)
- Temperature ≤ 36 º C (96.8 º F)
- WBC > 12 or < 4 or > 10% bands (if available)

Exclusions

- None

B. Data Base

1. Subjective Data

- Signs and symptoms suggestive of infection
- Review pertinent past medical history, current medications and allergies
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to infection
- Level of consciousness (may use Glasgow Coma Scale)
- Measure vital signs every 30 minutes x2
- Attach cardiac monitor, assess rhythm, and monitor for arrhythmias
- Place on pulse oximetry and measure SpO_2
- Skin assessment: color, temperature, moisture, and capillary refill

C. Diagnosis

1. Consistent with subjective and objective findings
2. Assessment of status and disease process

D. Plan

1. Administer supplemental oxygen if SpO_2 <92%, maintain patent airway

2. Obtain ABG (VBG if unable to obtain ABG)

3. Stat chest Xray if O2 sats<92% despite oxygen therapy or if patient exhibits signs or symptoms of respiratory distress

4. Consider sending stat CBC, comprehensive metabolic panel, magnesium, phosphorus, ionized calcium and lactate

5. Send blood cultures x2, urine culture and sputum culture if not already pending

6. If SBP<90, initiatePlasma-Lyte IV fluid bolus, 30mL/kg, over 60 minutes

6. Stat EKG for HR >20% from baseline or dysrhythmia, show provider when completed

8. Ensure adequate IV/IO access and IV/IO patency

9. Patient education and counseling appropriate to disease process

11. Consultation with provider upon provider's arrival to MERT activation, or:
    - Any new concern about a patient's clinical condition
    - Vital signs remain 20% from baseline
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Chest pain unrelieved by chest pain protocol
    - Shortness of breath
    - Pulse oximetry <92% despite oxygen

Protocol #7: Assessment and Management of Gastrointestinal Bleeding

A. Definition: This protocol covers the initial assessment and management of patients with gastrointestinal (GI) bleeding seen by Registered Nurses (RN) of the Medical Emergency Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Department (ED) and Intensive Care Unit (ICU).

Indications

- Blood or coffee-ground emesis
- Melena
- Rectal bleeding (more than spotting on tissue), and vital sign abnormality suggesting hemodynamic instability (HR >100 or SBP < 90)

B. Data Base

1. Subjective Data

- Signs and symptoms suggestive of GI bleeding
- Amount, type, and frequency of blood in emesis or stools and other associated symptoms (abdominal pain, fatigue, syncope)
- Pertinent past medical history, including history of ulcer, coagulopathies, esophageal varices, CHF or renal failure; current medications and allergies
- Characteristics of any pain (PQRST); location, quality, and intensity (1-10)
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to gastrointestinal disorders
- Level of consciousness (may use Glasgow Coma Scale)
- Measure vital signs every 30 minutes
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Place on pulse oximetry and measure SpO_2
- Skin signs: color, temperature, moisture, and capillary refill; petechiae, purpura, or ecchymosis

C. Diagnosis

a. Consistent with subjective and objective findings
b. Assessment of status and disease process

D. Plan

1. Administer supplemental oxygen if SpO_2 <92%, maintain patent airway

2. Ensure adequate IV/IO access and IV/IO patency (2 large bore IVs)

3. Consider sending stat CBC, comprehensive metabolic panel, magnesium, phosphorus, ionized calcium, and lactate. Send type and screen or type and cross if not available

4. Hold anticoagulant drips and medications until evaluated by a provider

5. NPO until evaluated by a provider

6. Patient education and counseling appropriate to disease process

7. If SBP <90 initiate 1000 mL Plasma-Lyte IV bolus over 60 minutes

8. Consultation with provider upon provider's arrival to MERT activation, or:
    - Any new concern about a patient's clinical condition
    - Vital signs remain 20% from baseline
    - New or worsening change in mental status
    - Acute change in oxygenation requirements
    - Chest pain unrelieved by chest pain protocol
    - Shortness of breath
    - Pulse oximetry <92% despite oxygen
    - Massive hematemesis bleeding with potential airway compromise

Protocol #8: Assessment and Management of Anaphylaxis

A. Definition: This protocol covers the initial assessment and management of patients experiencing anaphylaxis as seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Room (ED) or the Intensive Care Unit (ICU).

Indications: Likely allergen exposure plus >/= 2 systems involved:

- Respiratory (stridor, wheezing, dysnpea, hypoxemia)
- Cardiovascular (hypotension)
- Skin/mucosa (rash, pruritus, erythema, swelling of face, lips, tongue, or uvula)
- Gastrointestinal (persistent cramping pain or vomiting)

B. Data Base

1. Subjective Data

- Signs and symptoms of anaphylaxis
- Review pertinent past medical history, current medications and allergies
- Sequence of preceding events
- Any treatments used prior to arrival

2. Objective Data

- Perform focused physical exam relevant to anaphylaxis
- Assess for airway patency
- Measure vital signs every 2 minutes
- Place on pulse oximetry and monitor SpO2
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias
- Assess skin condition: color, temperature, moisture, and capillary refill

C. Diagnosis

1.Consistent with subjective and objective findings
2.Assessment of status and disease process

D. Plan

3. Consider activation of STAT Airway or Code Blue if immediate support is needed prior to primary team arrival.

4. Administer supplemental oxygen if SpO2<92%, maintain patent airway.

5. Administer 0.3mg IM epinephrine.

6. Ensure adequate IV/IO access and IV/IO patency.

5. NPO until evaluated by provider

6. Patient education and counseling appropriate to disease process

7. Consultation with provider upon provider's arrival to Code Blue Activation.

Protocol #9: Assessment and Management of Opioid-induced respiratory depression

A. Definition: This protocol covers the initial assessment and management of patients experiencing opioid-induced respiratory depression as seen by Registered Nurses (RN) of the Medical Rapid Response Team (MERT) on the ZSFG Hospital Campus outside of the Emergency Room (ED) or the Intensive Care Unit (ICU).

Indications

- Respiratory depression (respiratory rate < 8 breaths/min or oxygen saturation < 90% on RA)
- Unresponsiveness or decreased level of consciousness (i.e. not arousable to voice or pain, GCS <8)

B. Data Base

1. Subjective Data

- Signs and symptoms of opioid-induced respiratory depression
- Assess for signs and symptoms of respiratory depression
- Review pertinent past medical history, hospitalizations for respiratory disease, current medications and allergies
- Any treatments used prior to arrival

2. Objective Data

Perform focused physical exam relevant to respiratory depression

- Assess for and maintain airway patency, insert oral or nasal airway as needed.
- Note respiratory rate, depth, and work of breathing.
- Level of consciousness (may use Glasgow Coma Scale) and pupillary response.
- Attach cardiac monitor, assess rhythm, and monitor for dysrhythmias.
- Measure vital signs every 2 minutes until baseline level of consciousness regained.
- Place on pulse oximetry and measure SpO_2
- Assess skin condition: color, temperature, moisture, and capillary refill

C. Diagnosis

a. Consistent with subjective and objective findings
b. Assessment of status and disease process

D. Plan

1. Consider activation of STAT Airway or Code Blue if immediate support is needed prior to primary team arrival.

2. Administer supplemental oxygen if SpO2<92%, maintain patent airway

3. Ensure adequate IV/IO access and IV/IO patency.

4. Administer 0.4 mg IV/IM naloxone.

5. Patient education and counseling appropriate to disease process

6. Consultation with provider upon provider's arrival to MERT Activation.

MERT RN SP Author: Allison Preston RN, Christina Bloom RN	
Medical Director MERT: Antonio Gomez MD	
Approval Body	Date Approved
CIDP	11/5/25
NEC	11/19/25
Medical Executive Committee	January 2026
Joint Conference Committee	1/26/26

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Certified Nurse-Midwife, Obstetrics And Gynecology 2026

Provider Name:

Privilege	Approved	Approved
NURSE-MIDWIFERY 2026		
FOR ALL PRIVILEGES Complication rates and department quality indicators will be monitored semiannually. Reference "ZSFG CNM Guidelines for Care" document for delineation of CNM-OBGyn MD collaboration, co-management, and transfer of care when patient's condition and/or treatment falls outside of the CNM's independent scope as required by California law.		
CORE PRIVILEGES	___	___
OUTPATIENT NURSE-MIDWIFERY CARE	___	___
PREREQUISITES: Current certification as a nurse-midwife by the American Midwifery Certification Board. Active nurse-midwife and nurse-midwife furnishing certificate in California. PROCTORING: Documentation review of 5 cases REAPPOINTMENT: 50 clinic visits in the previous 2 years		
a. Prenatal Care Visits. If indicated by patients' needs, site may also include the patient's home, a community location, or another safe, private location.	___	___
b. Treatment Of Medical Complications Of Pregnancy Including, But Not Limited To: Hypertensive Disorders, Gestational Diabetes Mellitus, Anemia, Thyroid Disease, Sexually Transmitted Disease, Pulmonary Disease, Infectious Disease.	___	___
c. Preventive Health Visits: Postpartum and Family Planning		
d. Problem Oriented Visits: Postpartum and Family Planning		
BIRTH CENTER TRIAGE AND INPATIENT NURSE-MIDWIFERY CARE		
PREREQUISITES: Current certification as a nurse-midwife by the American Midwifery Certification Board. Active nurse-midwife and nurse-midwife furnishing certificate in California. Current Basic Life Support (BLS) certification by the American Heart Association and Neonatal Resuscitation Program (NRP) certification by the American Academy of Pediatrics. PROCTORING: observation and documentation review of 5 cases, each of which includes at least one of the below procedures with at least two including normal cephalic vaginal delivery and at least two including laceration repair REAPPOINTMENT: 15 cases in the previous two years		
a. Routine Triage and Inpatient Antepartum, Intrapartum, And Postpartum Care	___	___
b. Evaluation, Diagnosis, and Treatment of Medical Conditions Complicating Pregnancy and Postpartum	___	___
c. Management Of Spontaneous, Augmented, and Induced Labor, Including Amniotomy	___	___
d. Fetal Assessment, Antepartum and Intrapartum	___	___
e. Internal Fetal and Uterine Monitoring, Including Amnioinfusion	___	___
f. Normal Cephalic Vaginal Delivery and Placental Delivery, Including Vaginal Birth After Cesarean	___	___
g. Resuscitation of the Newborn, When Indicated and Pending Arrival of Pediatric Team		
h. Episiotomy and Repair of 1st And 2nd Degree Laceration, Including Administration of Local Anesthesia, When Indicated	___	___
i. Discharge of inpatients		

Delineation Of Privileges

Certified Nurse-Midwife, Obstetrics And Gynecology 2026

Provider Name:

Privilege	Approved	Approved
WAIVED TESTING PRIVILEGES Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges providers satisfy competency expectations for waived testing by The Joint Commission.	___	___
PREREQUISITES: Board Certified by American Midwifery Certification Board. Current nurse-midwife certification in California. PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege. REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.		
	___	___
a. Vaginal Ph Testing (Ph Paper)	___	___
b. Urine Chemstrip® Testing	___	___

SPECIAL PRIVILEGES	___	___
INSERTION OF INTRAUTERINE CONTRACEPTIVE (IUC) WITH PARACERVICAL AND INTRAUTERINE BLOCK WHEN INDICATED PROCTORING: Established Experience (defined by documentation of greater than 5 cases in the past 2 years): 2 observations of insertion, intrauterine block, and paracervical block and associated documentation reviews Without Established Experience (as above and after onsite training, as needed): 3 observations of insertion, intrauterine block, and paracervical block and associated documentation reviews REAPPOINTMENT: 1 documentation review in the past 2 years		
INSERTION OF POST-PLACENTAL INTRAUTERINE CONTRACEPTIVE (IUC) PROCTORING: Established Experience (defined by documentation of greater than 5 cases in the past 2 years): 2 observations and associated documentation reviews Without Established Experience (as above and after onsite training, as needed): 3 observations and associated documentation reviews REAPPOINTMENT: Documentation review of 1 case in the past 2 years		

Delineation Of Privileges

Certified Nurse-Midwife, Obstetrics And Gynecology 2026

Provider Name:

Privilege	Approved	Approved
INSERTION OF CONTRACEPTIVE IMPLANT PREREQUISITES: Completion of required Nexplanon training course PROCTORING: Established Experience (defined by documentation of greater than 5 cases in the past 2 years): 1 observation and associated documentation review Without Established Experience (as above and after onsite training, as needed): 2 observations and associated documentation reviews REAPPOINTMENT: Documentation review of 1 case in the past 2 years		
LIMITED OBSTETRIC ULTRASOUND FOR SINGLETON PREGNANCIES IN FIRST TRIMESTER <14 Weeks Gestational Age a. Localization Of Intrauterine Pregnancy (Diagnose IUP) b. Evaluation Of Fetal Viability And Heart Rate c. Estimation Of Gestational Age PREREQUISITES: Completion of an 8-hour limited obstetric ultrasound training course; OR Recent (within 5 years), documented experience in limited obstetric ultrasound at gestational age <14 weeks (including ≥ 25 ultrasound exams.) PROCTORING: Observation and associated documentation review of 5 ultrasound exams (<14 weeks gestation). For clinicians whose prerequisite was training, not documented experience, 10 observed, consecutive exams and review of associated documentation as well as an additional 10 retrospective documentation reviews. REAPPOINTMENT: Documentation review of 4 ultrasound exams (<14 weeks gestation) in the previous two years	___	___
LIMITED OBSTETRIC ULTRASOUND FOR SINGLETON PREGNANCIES IN THIRD TRIMESTER Evaluation of: a. Fetal cardiac activity b. Fetal presentation c. Amniotic fluid volume PREREQUISITES: Completion of an 8-hour limited obstetric ultrasound training course; OR Recent (within 5 years), documented experience in limited obstetric ultrasound in the third trimester (including ≥ 25 ultrasound exams). PROCTORING: Observation and associated documentation review of 5 ultrasound exams (third trimester). For clinicians whose prerequisite was training, not documented experience, the proctoring will be consecutive. REAPPOINTMENT: Documentation review of 2 ultrasound exams (third trimester) in the previous two years	___	___

Delineation Of Privileges

Certified Nurse-Midwife, Obstetrics And Gynecology 2026

Provider Name:

Privilege	Approved	Approved
PROCEDURAL SEDATION Procedural sedation privilege is required for those who will work in 6G/Women's Options Center. PREREQUISITES: The CNM must have completed the ZSFG procedural sedation test as evidenced by a satisfactory score on the examination. Current certification in nurse-midwifery by the American Midwifery Certification Board. Active nurse-midwife and nurse-midwife furnishing certificate in California. Current Basic Life Support (BLS) certification by the American Heart Association PROCTORING: Documentation review of 5 cases. REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and current Basic Life Support (BLS) certification by the American Heart Association	___	___
6G/OPTIONS CENTER-FIRST TRIMESTER ASPIRATION ABORTION Training- As described in Section 2725.4 of CA Business and Professions Code, training by any of the following (1-5): (1) A board-approved nurse-midwifery program or in a course offered by an accredited nurse-midwifery program. (2) A course offered by a Board-approved continuing education provider that reflects evidence-based curriculum and training guidelines or a course approved for Category I continuing medical education. (3) A course offered by a state or national health care professional or accreditation organization. (4) Training based on the competency-based training protocols established by the Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development, now known as the Department of Health Care Access and Information. (5) Training and evaluation of clinical competency, performed at a clinic or hospital, on performing abortion by aspiration techniques that is provided by any of the following who have performed the procedure themselves: MD, CNM, NP, or PA. Completion of training on site related to unit workflow, documentation and protocols. Observation of 5 procedures performed by a provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure PROCTORING: 30 observed procedures and associated documentation reviews REAPPOINTMENT: 10 procedures every two years 3 documentation reviews every 2 years Independent performance of this procedure requires procedural sedation privilege.	___	___

Delineation Of Privileges

Certified Nurse-Midwife, Obstetrics And Gynecology 2026

Provider Name:

Privilege	Approved	Approved
6G/OPTIONS CENTER-PRE-OPERATIVE EVALUATION/DILATOR PLACEMENT FOR SECOND TRIMESTER ABORTION Training in paracervical blocks, mechanical dilation and osmotic dilator placement. One-on-one, directly supervised on-the-job training in mechanical dilation and dilator insertion. PROCTORING: 5 observed procedures with 3 associated documentation reviews. REAPPOINTMENT: 5 procedures every two years. 2 documentation reviews every 2 years.		
CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings. PREREQUISITES: Current certification in nurse-midwifery by the American Midwifery Certification Board. Active nurse-midwife and nurse-midwife furnishing certificate in California. Approval of the Director of the CTSI (below) is required for all applicants. PROCTORING: All OPPE metrics acceptable REAPPOINTMENT: All OPPE metrics acceptable	___	___
_____ _____ CTSI Medical Director Date		
I hereby request clinical privileges as indicated above. _____ _____ Applicant Date		
APPROVED BY _____ _____ Division Chief Date _____ _____ Service Chief Date		

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

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

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP: 5/6/26	
Person completing this form:	
Standardized Procedure Title:	Urology
Department:	
Dept Chief:	
SP Author(s):	David Bayne
Update #1:	Formatting updated
Reason/Explanation for Revision:	○ Mostly formatting changes after authors David Bayne & Christi Butler updated 11/3/25 ○ Vagn asked about dipstick use - clarified frequency is rare, but they are done sometimes before BCG to screen for UTIs
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 chang to **“ San Francisco Health Network”** • CHN change to **“SFHN”**
Qualified Provider	Insert the following after every use of words “qualified provider:” who has completed proctoring and subsequently maintained their eligibility for performing the procedure. *Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure*. (Credentials Committee, 11/2023)
Prerequisites	Onsite training no longer to be listed as a prerequisite. Instead, the training to be completed once procedure is approved for the provider and then before the provider initiates proctoring. Update protocols to reflect this change (Credentials Committee, 11/2023)

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2026

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

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Urology Department

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 Title16, CCR Section 1474.*

B. *All standardized procedures are kept in the Department of Urology, in the 3M Urology Clinic, and electronically 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.

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

The NP/ PA conduct(s) physical exams, diagnoses and treats illness, order(s) and interpret(s) tests, counsel(s) on preventative health care, assist(s) in surgery, perform(s) invasive procedures and furnish(es) medications/issue(s) drug orders as established by state law.

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

A. Setting
   1) Location of practice is outpatient clinics, inpatient units, operating room, ICU, and emergency department.

B. Supervision

   1. Overall Accountability:
      The NP/PA is responsible and accountable to: Chief of Urology or other designated supervising physicians as *applicable.*
   2. A consulting physician, who may include attendings and fellows, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
      a. Acute decompensation of patient situation
      b. Problem that is not resolved after reasonable trial of therapies.
      c. Unexplained historical, physical, or laboratory findings.
      d. Upon request of patient, affiliated staff, or physician.

e. Problem requiring hospital admission or potential hospital admission.
f. Acute, severe respiratory distress.
g. An adverse response to respiratory treatment, or a lack of therapeutic response.
h. When consultants from any other service are used

IV. Scope of Practice – Protocols

1. Protocol #1: Health Care Management: Acute/Urgent Care
2. Protocol #2: Furnishing Medications and Drug Orders
3. Protocol #3: Discharge of Inpatients
4. Protocol #4: eConsult Review
5. Protocol #5: Procedure: Suprapubic Catheter Change
6. Protocol #6: Procedure: Coude Catheter Placement
7. Protocol #7: Procedure: Intravesical instillation of BCG
8. Protocol #8: Procedure: Ordering Blood Transfusions
9. Protocol #9. Procedure: Waived Testing

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

B. Specialty Training
1. No previous specialty area experience expected for this

position.

VI. Evaluation

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

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

a. Clinical Practice

- Length of proctoring period will be: three months which can be shortened or lengthened as appropriate. Please note numbers as noted in each protocol.
- The evaluator will be Medical Director, Chief of Service, and/or designated supervising physicians or peer as applicable.
- The methods of evaluation in clinical practice will be those needed to demonstrate clinical competence as noted in each protocol.
- Number of observations and chart reviews needed to cover core protocols (#1-3) is 3. One case may be representative of multiple core protocols.

2. 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 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 Director, designated physician must evaluate the NP /PA's clinical competence as noted in each protocol including one chart review for each core protocol (1-3), one case may be representative of multiple core protocols

5. Physician Assistants:

a. Physician Assistants have 3 (three) forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are: 1) Examination of the patient by Supervising Physician the same day as care is given

by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

VII. *Development and Approval of Standardized Procedure*

A. Method of Development

1. Standardized procedures are developed collaboratively by 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 – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent urologic problems, which include but are not limited to common acute urologic problems, uncommon, unstable, or complex conditions within outpatient clinics, inpatient units, and the emergency department.

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 ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of 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. Any Problem requiring hospital admission or potential

hospital admission.

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling.
   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 regarding patient health status and diagnosis.

E. RECORD KEEPING

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

Protocol #2: 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), and 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 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 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 medical record, or in the Medication Administration Record (MAR). The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, route, 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. 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 medical record as appropriate The medical record of any patient cared for by a PA for whom the supervising physician and surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.

Protocol #3: Discharge of Inpatients

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

B. DATA BASE
1. Subjective Data
    a. Review: heath history and current health status

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

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

D. PLAN
1. Treatment
    a. Review treatment plan with patient and/or family.
    b. Initiation or adjustment of medications per Furnishing/Drug Orders protocol.
    c. Assure that appropriate follow-up arrangements (appointments/studies) have been made.

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.

3. Education
    a. Review inpatient course and what will need follow-up.
    b. Provide instructions on:
        - follow-up clinic appointments

- outpatient laboratory/diagnostic tests
- discharge medications
- signs and symptoms of possible complications

4. Follow-up
   a. Follow-up appointments
   b. Copies of relevant paperwork will be provided to patient.

E. RECORD KEEPING

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

Protocol #4**:** eConsult Review

A. DEFINITION

eConsult review is defined as the review of new outpatient consultation requests via the online eConsult system. 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 be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
    b. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
    c. 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 Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.

3. Proctoring: A review of at least 20 eConsult consultation decisions will be performed by the Chief of Service or designee concurrently for the first six months. Before performing eConsults independently, providers will have 1) six months experience with patients in the specific specialty area provided at ZSFG or elsewhere and 2) successfully complete proctoring.

4. Ongoing reappointment: Review of 5 consultations every 2 years

B. DATA BASE

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 Chief of Service will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.
   b. All data provided via the eConsult consultation 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 Review

   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 eConsult, the consulting scheduler is responsible for notifying the patient.

E. RECORD KEEPING

All information contained within the electronic referral 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 consultation request will be printed and the provider recommendations will be written on the print out. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into EPIC and forwarded to the scheduler.

Protocol #5: Procedure: Suprapubic Catheter Change

A. DEFINITION
Changing of an existing suprapubic catheter

1) Location to be performed: inpatient wards, outpatient clinics, Emergency Department.

2) Performance of procedure:
   i. Indications: Patient with an existing suprapubic catheter needing change (e.g. regular scheduled change, catheter is not draining well, catheter fell out, active urinary tract infection)
   ii. Precautions: none
   iii. Contraindications: patient is acutely ill (febrile within 24 hours and/or hemodynamically unstable); patient had the initial suprapubic catheter placed within 2 weeks.

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 ZSFG 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. 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.)
   f. Difficulty removing or replacing the suprapubic tube

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for the next suprapubic catheter change or for the ongoing management of active urologic conditions.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care: a. Completion of training on site b. State the number of procedures provider must observe being done by a qualified provider: 3
Proctoring Period: a. Actual number of performances needed to be directly observed: 2 b. State who can do the proctoring: any urology attending
Reappointment Competency Documentation: a. Minimum number of procedures that must be completed in two years: 2 b. Is direct observation of procedure needed? no c. Who will be the evaluator?Any urology attending d. Chart reviews needed: 2

Protocol #6: Procedure: Coude Catheter Placement

A. DEFINITION
Placement of a Coude-tip catheter

1. Location to be performed: inpatient wards, outpatient clinics, operating room, emergency department.
2. Performance of procedure:
   i. Indications: male patient requiring a catheter placement with known prostatic hypertrophy, or inability to place a regular Foley catheter
   ii. Precautions: tip of coude catheter should be pointed upwards on insertion
   iii. Contraindications: none

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (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 ZSFG 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. 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.)
   f. No urine drainage and/or unable to irrigate the coude catheter after placement

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care: a. Completion of training on site b. State the number of procedures provider must observe being done by a qualified provider: 2
Proctoring Period: a. Actual number of performances needed to be directly observed: 2 b. State who can do the proctoring: any urology attending
Reappointment Competency Documentation: a. Minimum number of procedures that must be completed in two years: 2

b. Is direct observation of procedure needed? no
c. Who will be the evaluator? Any urology attending
d. Chart reviews needed: 2

Protocol #7: Procedure: Intravesical instillation of Bacillus Calmette–Guérin (BCG)

A. DEFINITION

Placement of a foley catheter, instillation of BCG (standard dose) into the bladder through the foley catheter, foley catheter removal

1. Location to be performed: outpatient clinic

2. Performance of procedure:
   i. Indications*:* patient with certain types of bladder cancer who meet criteria for and agree to have intravesical BCG treatment based on the established algorithm. Patient needs to have a negative urinalysis done in clinic (POCT) prior to each instillation
   ii. Precautions: person administering the medication should use droplet contact precautions
   iii. Contraindications: immunosuppressed individuals, active tuberculosis, hematuria, urinary tract infection, traumatic foley catheter insertion, febrile illness, hemodynamic instability, prior BCG sepsis

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 ZSFG 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. 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.
   f. Difficulty placing foley catheter

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care: a. Completion of training on site b. State the number of procedures provider must observe being done by a qualified provider: 3
Proctoring Period: a. Actual number of performances needed to be directly observed: 3 b. State who can do the proctoring: any urology attending
Reappointment Competency Documentation: a. Minimum number of procedures that must be completed in two years or state number of procedures annually: 2 b. Is direct observation of procedure needed? no c. Who will be the evaluator? Any urology attending d. Chart reviews needed: 2

Protocol #8: ORDERING TRANSFUSIONS

A. DEFINITION

Ordering the administration of whole blood or blood components i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate.

NOTE: Transfusion orders generally consist of at least two parts: the blood component order directed to Blood Bank staff, e.g. "Type and cross 2 units of RBC", and the order to administer the ordered components usually intended for nursing staff, e.g. "transfuse 2 RBC units at the patient's next outpatient visit on (date). These orders may be written at the same time or sequentially.

1. Location to be performed: Inpatient, outpatient setting.

2. Performance of procedure:
   a. Indications
      1. Anemia
      2. Thrombocytopenia or platelet dysfunction
      3. Coagulation factor or other plasma protein deficiencies <u>not</u> appropriately correctable by other means.
   b. Precautions
      1. Blood and blood components must be given according to ZSFG guidelines.
      2. <u>Emergency</u> 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
      Absolute: none
      Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenia purpura (TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.

B. DATA BASE
   1. Subjective Data
      a. History and review of symptoms relevant to the presenting complaint and reason for transfusion.
      b. Transfusion history, including prior reactions, minor red cell

antibodies and allergies.

2. Objective Data
   a. Physical exam relevant to the decision to transfuse.
   b. Laboratory evaluation.
   c. All Point of Care Testing (POCT) will be performed according to 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

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

4. Follow-up
   As appropriate for patients condition and reason transfusions were given.

E. RECORD KEEPING
Patient visit, consent forms, and other transfusion-specific documents including completed transfusion report form will be included in the medical record and other patient data bases, as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Successful completion of the 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 2 transfusion every 2 years and review of 2 medical records every 2 years. c. Review of any report from the Transfusion Committee. d. Evaluator will be the medical director or other designated physician.

Protocol #9: 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: outpatient clinics

2) The following non-instrument based waived tests are currently performed at ZSFG:
   a. SP® Brand Urine Pregnancy
      Indication: Assist with the diagnosis of pregnancy.
   b. 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 ZSFG 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
   c Actions to be taken (follow-up or confirmatory testing, Attending consultation, referrals) based on defined test results.
   d Documentation or logging of tests performed

C. DIAGNOSIS

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

D. PLAN

1. Testing

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

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

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

2. Test Results requiring Attending Consultation

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

3. Education

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

4. Follow-up

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

E. RECORD KEEPING

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,
Proctoring: Successful completion of Halogen quizzes for each of the waived tests the practitioner is performing at ZSFG, 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% every two years.

Approval Dates:

Committee on Interdisciplinary Practice (CIDP)	5/6/26
Credentials Committee	
Medical Executive Committee	
ZSFG Joint Conference Committee (JCC)	

Zuckerberg San Francisco General Hospital and Trauma Center
STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

PROVIDER NAME: _____ Major site: _____

CLINICAL SERVICE: UROLOGY Other sites: _____

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
CORE				
HCM: Acute/Urgent Care	3 months in length. 3 direct observations and chart reviews. One case may represent multiple protocols.	3 chart reviews (1 for each core protocol) every 2 years. One reviewed case may represent multiple protocols.		
Furnishing Medications/Drug Orders	3 months in length. 3 chart reviews, representing both inpatient and outpatient medication orders. One case may represent multiple protocols.	5 chart reviews every 2 years. One reviewed case may represent multiple protocols.		
Discharge of Inpatients	3 months in length. 3 direct observations and chart reviews. One case may represent multiple protocols.	5 chart reviews every 2 years. One reviewed case may represent multiple protocols.		
SPECIAL				
Suprapubic Catheter Change	Completion of 3 procedures under direct observation.	2 procedures and 2 chart reviews every 2 years.		
Coude Catheter Placement	Completion of 2 procedures under direct observation.	2 procedures and 2 chart reviews every 2 years.		
Intravesical Instillation of BCG	Completion of 3 procedures under direct observation.	2 procedures and 2 chart review every 2 years.		
eConsult	Review of 20 consultations during first 6 months.	Review of 5 eReferrals every 2 years.		
Ordering Blood Transfusions	Read and Sign SFGH Policy and Procedure 2.3. Read Blood Transfusion section of the Laboratory Manual. Review of 1 transfusion order with	Complete review of the 2 education modules and pass with a score of 80% every 2 years. Perform 2 transfusions and 2 medical record		

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
	review of medical record.	reviews every 2 years. Review any reports from the Hospital Transfusion Committee.		
Waived Testing a. Fecal Occult Blood b. Vaginal pH testing c. Urine Pregnancy d. Urine Dipstick	Completion of Halogen quizzes for each test and receive a passing score of 80%.	Completion of Halogen quizzes for each test and receive a passing score of 80% every 2 years.		

_____ _____

Chief of Urology Date

* Clinical data relevant to privileges, or performance evaluation of standardized procedures, is available for review in the provider's file located in our Clinical Service office.