ZSFG JOINT CONFERENCE COMMITTEE MEETING

March 23, 2026

MEDICAL STAFF Report

Contents:

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on March 23, 2026
March MEC Meetings

SURGERY CLINICAL SERVICE REPORTS: Joseph Cuschieri, MD
The highlights of the Surgery report are as follows:

I. **Mission-** The Division of Surgery at ZSFG is dedicated to delivering exceptional clinical care to all patients in San Francisco and surrounding communities regardless of social or financial status. Its mission also emphasizes providing an outstanding training environment for students and residents, advancing scientific and clinical knowledge through research, and fostering the development of future leaders in surgery.

II. **Scope of the Clinical Service-**Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) is a premier, nationally recognized Level I Trauma Center, known for its exceptional commitment to providing comprehensive, high-quality emergency and trauma care. Renowned for its leadership, expertise, and service to the community. ZSFG's surgical services include a comprehensive range of specialties such as trauma surgery, critical care, emergency general surgery, plastic surgery, vascular surgery, elective general surgery, breast, hepatobiliary, surgical oncology, thoracic, and colorectal surgery. Additional resources include the Vascular Lab, which offers diagnostic services, and the Wraparound Program that provides community support. The department's structure spans multiple divisions led by specialized faculty across all major surgical subspecialties. Clinical work includes both inpatient hospital-based care and ambulatory-based follow-up clinics.

III. **Faculty and Residents-**ZSFG leadership includes Joseph Cuschieri, MD (Chief of Surgery), Adam Oskowitz, MD (Chief of Vascular Surgery), Michael Terry, MD (Chief of Plastic Surgery), Timothy Browder, MD (Trauma Medical Director), Caitlin Collins, MD (Wrap Around Medical Director), Ronald Tesoriero, MD (SICU Medical Director), Sandhya Kumar, MD (Physician Director for Quality Management), Scott Hansen, MD (Medical Director of OASIS Clinic) and Rebecca Plevin, MD (Medical Director of Utilization). Lucy Kornblith, MD was appointed the Elsbach-Richards Endowed Chair of Surgery and Andrew Campbell has been named the recipient of the 2025 Associate for Surgical Education (ASE) distinguished master surgical educator award.

The service maintains a large and diverse training environment supported by multiple divisions and fellowships. Thes faculty members play key roles in clinical leadership, education, and research. Annually over 100 different residents rotate through various services each year. Trainees include ACS/SCC fellows, surgery residents from R1 to R5, plastic surgery fellows and residents, vascular fellow. Medical student training is also robust, with eight third-year students rotating every eight weeks through Surgery 110 and two fourth-year students per month in Surgery 140. The educational structure is supported through daily morning reports, weekly M&M and didactic sessions, monthly trauma reviews and journal clubs, and specialized courses such as ASSET and ATLS, as well as participation in the Bay Area ACS Education Consortium.

IV. **Performance Improvement and Patient Safety (PIPS) initiatives-**The Department of Surgery continues to excel with strong surgical and clinical volumes; however, faculty workload remains high, with significant clinical hours and EMR time contributing to burnout. OR utilization continues to be focus and turnover times remain longer than desired, and efforts continue to improve readiness and workflow. The addition of tenth OR is expected to improve throughput. Quality benchmarks remain strong, with expected trauma mortality and continued evaluation of complications. Significant efforts have reduced pulmonary embolism rates. Multidisciplinary education initiatives have strengthened trauma readiness ahead of the upcoming Level I trauma center reverification. Overall, the department remains resilient, highly performing, and committed to continuous improvement while working to better support faculty workload and well-being.

V. **Research-** ZSFG's Division of Surgery is a leading center for translational and clinical research. ZSFG has been a center of clinical trials related to hemorrhagic shock resuscitation and investigating novel diagnostic for assessing shock and injury. The Division of Surgery at ZSFG has increased research in comprehensive care for injured patients, including the development of a sustained outpatient clinical with comprehensive follow-up, post-discharge outcomes, and incorporation of multidisciplinary care in aspects of mental health and addiction in addition to surgical/medical care. Two major clinical trials have been awarded totaling over 10 million in clinical funding, including the use of vasopressin following hemorrhagic shock (PI: Kornblith, Co-I: Cuschieri), and stem cell administration to decrease risk of acute kidney injury following trauma (PI: Cuschieri, Co-I: Kornblith)

VI. **Financial Report (2025)-**The Department of Surgery reported a significant increase in clinical workload, with RVUs rising compared to the previous year. This growth generated approximately $17 million in charges in 2025; however, due to the existing payer mix, only $4.3 million was recovered. Departmental expenses totaled roughly $3.8 million. Despite this financial constraint, the department continues to prioritize maintenance of its research infrastructure, which remains essential for supporting faculty scholarship and sustaining the institution's Level I Trauma Center status in a competitive funding environment.

VII. **Summary**
Strengths-The Department of Surgery's strengths include nationally recognized, extraordinary faculty who provide exceptional patient care with excellent outcomes. The department is deeply committed to surgical education, offering two primary fellowships in surgical critical care and acute care surgery. Its bright, motivated, resilient, and highly engaged faculty benefit from multiple funding opportunities and diverse career trajectories.

Opportunities for Improvement-The Department of Surgery's service opportunities for improvement are centered on achieving a better balance between service and education, addressing the high census and clinical demands placed on faculty that increase the risk of burnout, and enhancing charge capture, documentation, and overall clarity around billing practices.

VIII. **Surgery Rules and Regulations**-The Committee members expressed deep appreciation to the Surgery Department team for their collaboration, consistent commitment to excellence, delivering high-quality care, responsiveness and partnership. Dr. Cuschieri was acknowledged for his leadership, dedication and exceptional support across multiple disciplines. A motion for the committee to approve the updated Surgery Service Rules and Regulations was made and approved. Approval from the Health Commission is requested for the Surgery Service Rules and Regulations.

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG March 23, 2026
March 2026 MEC Meetings

Clinical Service Report and Rules and Regulations:

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

Credentials Committee:

1. Emergency Department (ED) Standardized Procedures 2026, ED initial and reappointment criteria, and ED summary of changes
2. Revised Anatomic Pathology Privilege List and summary of changes
3. Privilege list and standardized procedure-Insertion and removal of contraceptive implant and summary of changes

Other

1. SFHN Ambulatory Standing Order Protocol (SOP) and summary of changes

UCSF Department of Surgery

Division of Surgery, Zuckerberg San Francisco General

Joseph Cuschieri, MD FACS FSIS
Professor of Surgery and Laboratory Medicine, UCSF
Vice Chair of Surgery, Department of Surgery, UCSF
Chief of Surgery, ZSFG

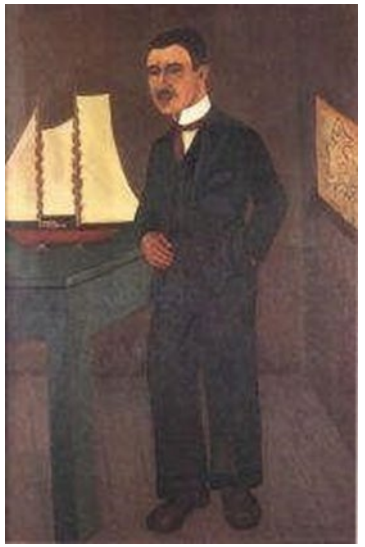
March 2026

ZUCKERBERG SAN FRANCISCO GENERAL
Hospital and Trauma Center

UCSF Department of Surgery

Mission Statement

The surgical faculty at Zuckerberg San Francisco General are dedicated to providing exceptional clinical care to the citizens of San Francisco and the surrounding areas, regardless of their social or financial status.



Our purpose is to deliver an outstanding training environment to students and residents, to make significant advances in scientific knowledge and clinical practice through basic and clinical research, and to produce the next generation of leaders in surgery.

UCSF Department of Surgery

Strengths

UCSF Department of Surgery

Faculty Members

- **Emergency General Surgery and Trama**
  - Marissa Boeck
  - Tasce Bongiovanni
  - **Timothy Browder**
  - **Andre Campbell**
  - **Caitlin Collins**
  - **Joseph Cuschieri**
  - Rochelle Dicker
  - Kent Garber
  - Rachel Koch
  - **Lucy Kornblith**
  - **Rebecca Plevin**
  - **Amanda Samman**
  - **Nichole Starr**
  - **Ronal Tesoriero**

UCSF Department of Surgery

Faculty Members

- **Minimally Invasive Surgery**
  - Sandhya Kumar
- **Surgical Oncology**
  - Adan Alseidi
  - Jasmin Wong
- **Cardiothoracic Surgery**
  - Melissa Coleman
  - Amy Fiedler
- **Colorectal Surgery**
  - Edward Kim

UCSF Department of Surgery

Faculty Members

- Plastic Surgery
  - Scott Hansen
  - Alex Lin
  - Jason Pomerantz
  - **Gloria Sue**
  - **Micheal Terry (Chief)**
  - David Young
- Vascular Surgery
  - **Ahmed Naiem**
  - **Adam Oskowitz (Chief)**
  - **Shant Vartanian**

UCSF Department of Surgery

Clinical data used in the reappointment process

Core Competency	Proposed Metric	Thresholds	Data Source
Patient care	Attributable/ Preventable Mortality	Acceptable – Any 1A or < 2 1B Marginal – 1-2 1B Unacceptable >2 1B, and 1 C or 1D	Epic and M&M
	Complications & related errors	Marginal >1 class 3, any class 4 Unacceptable >1 class 4, any class 5 Uses classification scheme for errors (0-5)	M&M, trauma registry
	Unplanned readmissions	Marginal > 1 STD above mean % for faculty Unacceptable >2 STD above mean % for faculty	Epic and M&M
Medical/Clinical Knowledge	Board Certification/recertification	Meets/fails to meet.	Med Staff Office
	Attendance at Departmental Grand Rounds	Marginal <50% Unacceptable <25%	Department of Surgery Office
Practice-Based Learning and Improvement	Completion of required annual DPH training	Meets/fails to meet	Med Staff Office
	CME	Meets/fails to meet	ACS, surgeon provided
Interpersonal and Communication Skills	Resident Evaluations	Marginal > 1 STD above mean % for faculty Unacceptable >2 STD above mean % for faculty	Department of Surgery Education Office
	UOs about interpersonal and communication skills	Marginal 2-3 valid UOs RE: interpersonal and communication skills Unacceptable >3 valid UOs RE: interpersonal and communication skills	Review by Chief only
Professionalism	UOs about professionalism	Number with thresholds that would need to be developed	Review by Chief only
	Unexcused absences at assigned committee meetings	Marginal <50% Unacceptable <25%	Med Staff office
Systems based Practice	OP notes dictated and signed within 72 hours	NEED THRESHOLDS	Epic
	H&Ps signed within 3 days	<80% Marginal	Epic

UCSF Department of Surgery

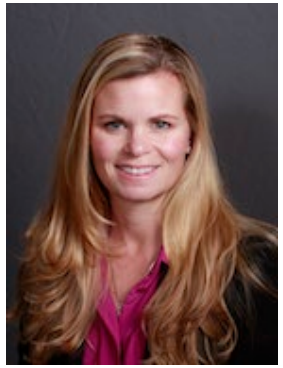
Physician Leadership - UCSF

Vice Chair for Diversity, Equity, and Inclusion

Program Director Surgical Critical Care

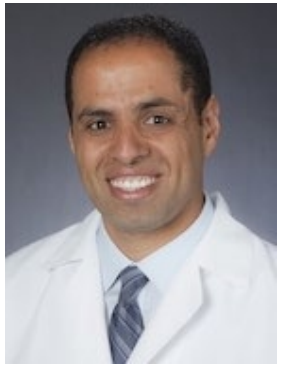
Chief of Surgery, ZSFG

Vice Chair of ACS



Chief Experience Officer

Section Head ACS, UCSF



Associate Dean, SOM

Director of Research, ZSFG

Co-Chair Muriel Steele Society

Director of Gender Equity

Chief of Plastic Surgery, Program Director Plastic Surgery Residency Program

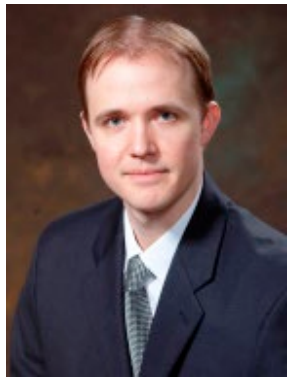
Program Director, Acute Care Surgery

UCSF Department of Surgery

Physician Leadership - ZSFG

Chief of Surgery

Chief of Vascular Surgery



Chief of Plastic Surgery

Associate Medical Director Ambulatory Specialty Care
Medical Director Surgery Clinic

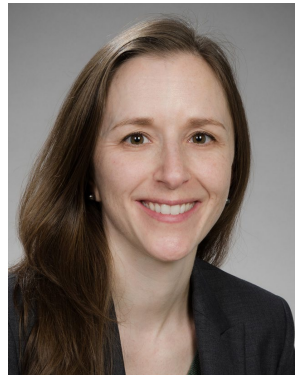
Trauma Medical Director

Wrap Around Medical Director

SICU Medical Director

Physician Director for Quality Management

Medical Director OASIS Clinic



Medical Director Utilization

UCSF Department of Surgery

Hospital Committee Participation

- Multidisciplinary Trauma Peer Review Committee – Browder (Chair), all trauma faculty
- Trauma PIPS – Browder (Co-chair)
- Cancer – Alseidi (Chair)
- Transfusion – Kornblith, Cuschieri
- PIPS – Kumar, Cuschieri
- Risk Management – Cuschieri
- OR – Cuschieri, Browder, Terry
- MEC – Cuschieri
- Disaster – Cuschieri, Browder
- Critical Care – Tesoriero, Cuschieri, Campbell
- GME – Tesoriero
- PEMT – Cuschieri
- Bylaws - Cuschieri
- CPG Board – Cuschieri, Kornblith
- CPG Finance – Cuschieri
- CPG Comp – Kumar, Cuschieri

Physician Leadership – National Roles

- Andre Campbell
  - American College of Surgeons Master Surgical Educators
  - Secretary-Treasurer American College of Surgeons Board of Governors
  - Past-President Society of Black Academic Surgeons
  - ACS COT Lead Reviewer
- Joseph Cuschieri
  - Society of Surgical Critical Care Program Directors, Mentorship Committee (Chair), Awards Committee (Chair)
  - American Association for the Surgery of Trauma
    - Critical Care Committee Chair
    - Manager at Large: Critical Care
    - Scholarship Committee
    - Program Committee
    - Membership Committee
  - American Association for the Surgery of Trauma: Career Mentor
  - Surgical Infection Society
    - Membership Committee
    - Multi-Center Trial Committee
  - NIH DSMB member
  - NIH Career Training Award Committee Member
  - ACS COT VRC Lead Reviewer
- Lucy Kornblith
  - Eastern Association for the Surgery of Trauma Research-Scholarship Committee
  - Association for Academic Surgery Publications Committee
  - Western Trauma Association Social Media Taskforce
  - Eastern Association for the Surgery of Trauma Practice Management Guideline Committee for the use of tranexamic acid in trauma
  - NIH Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV) IV (coagulation) Program Steering, Protocol Development, Mechanistic Studies, and Multi-platform RCT Publications Committees.
  - Association for Academic Surgery, Basic & Translational Science Committee
- Rebecca Plevin
  - EAST Injury Control and Violence Prevention Committee
  - American College of Surgeons Committee on Applicants, District 1
  - Society for Prevention Research Conference: Epidemiology & Etiology Abstract Theme Review Committee – Member
- Ronald Tesoriero
  - Western Trauma Association, Algorithm Committee

UCSF Department of Surgery

Honors/Awards

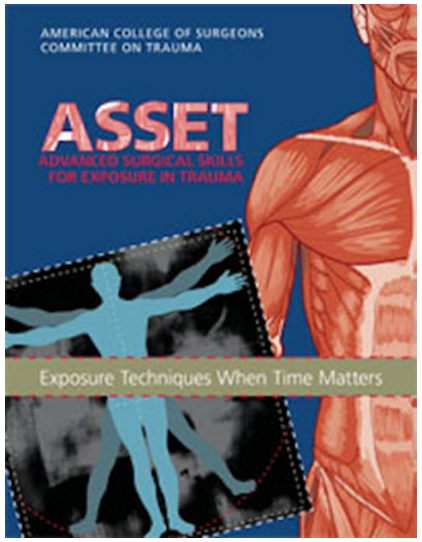
2025 Recipient of ASE
Educator of the Year

Elsbach-Richards
Endowed Chair in Surgery

UCSF Department of Surgery

Education Mission

- The Division of Surgery at ZSFG is dedicated to the dissemination of knowledge and the training of the next generation of surgeons.
- The Surgical Critical Care Fellowship and AAST ACS Trauma Fellowship were both reviewed in the last year, and both were reverified without any deficiency.
- Continued growth in outreach of educational process are occurring with the incorporation of ATLS, Advanced Surgical Skills for Exposure of Trauma (ASSET) and the AAST EGS Course.
  - ASSET was incorporated 3 years ago and has been provided to both EAST Bay and WEST Bay residents
  - AAST EGS Course was held on July 8-9th with experts from throughout the West Coast providing education to Fellows and Residents virtually through the West Coast.



ESTES / AAST

EMERGENCY SURGERY COURSE

DEDICATED TO FURTHERING KNOWLEDGE ON EMERGENCY GENERAL SURGERY

UCSF Department of Surgery

Scope of Clinical Services

- Core Specialty Care
  - Trauma Surgery
  - Critical Care
  - Emergency General Surgery
  - Plastic Surgery
  - Vascular Surgery
- Community Support
  - Wraparound Program

- Surgical Subspecialty Care
  - “Elective” General Surgery
  - Breast
  - Hepatobiliary
  - Surgical Oncology
  - Thoracic
  - Colorectal
- Diagnostic Service
  - Vascular Lab

UCSF Department of Surgery

Service Structure/Education

- Trauma/General Surgery
  - 1 ACS/SCC fellow, 1 R5, 2 R4s, 1 R3, 5 R2, 5-6 R1s
  - From multiple programs
- Plastic Surgery
  - 1 fellow, 1 R4/3, 2 R1s
  - From multiple programs
- Vascular Surgery
  - 1 fellow
- SICU
  - Other ZSFG services with General Surgery residents
- Other rotations: Neurosurgery, Plastics, Gastroenterology

- Annually over 100 different residents rotate through these services

UCSF Department of Surgery

Surgical Education

- ACS fellowship
  - 2 fellows/year
  - Fellowship Director – Ron Tesoriero
- SCC fellowship
  - 2 fellows/year
  - Fellowship Director – Andre Campbell
- Vascular fellowship site
- Plastic Surgery fellowship

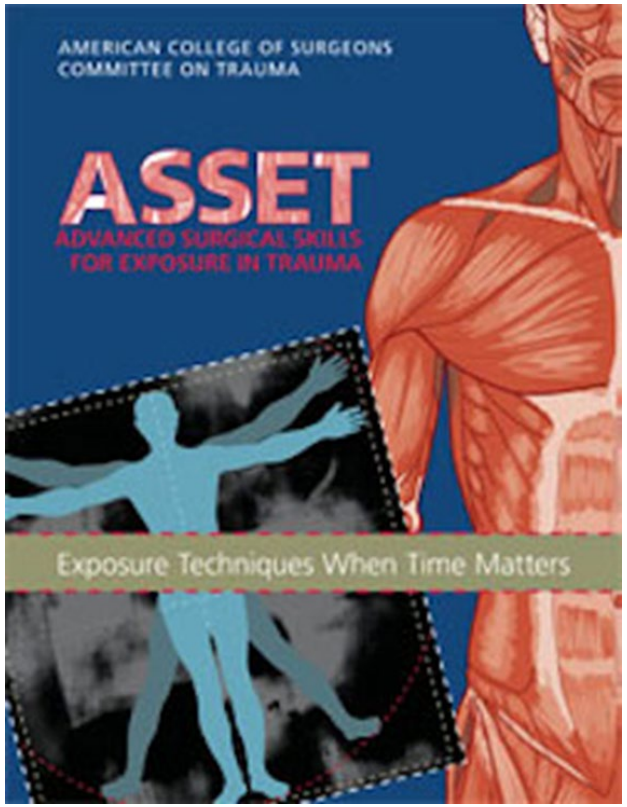
UCSF Department of Surgery

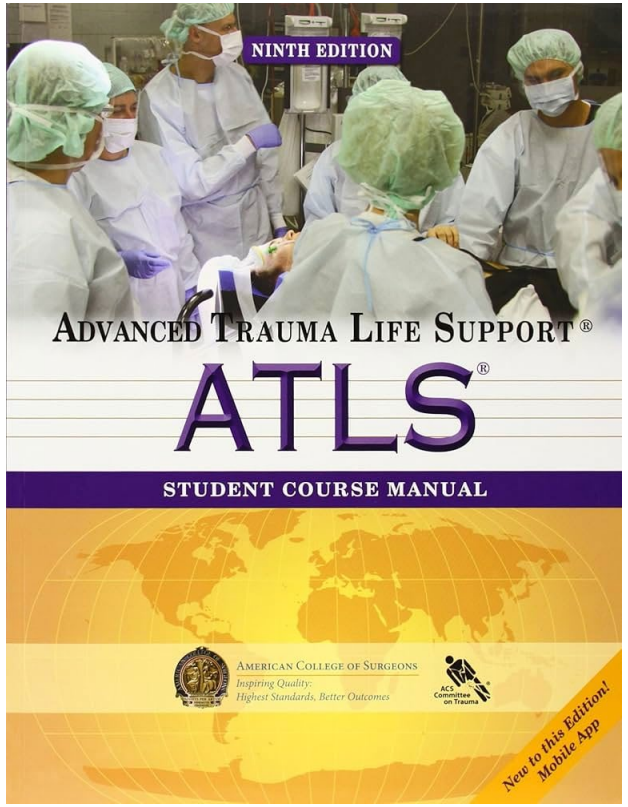
Surgical Education

- Surgery 110
  - Multi-site core surgery rotation
  - Eight 3rd year students per 8 week block @ ZSFG
  - Site director: Andre Campbell
- Surgery 140
  - Up to two 4th year students per month

UCSF Department of Surgery

Surgical Education





Conferences:

- Daily morning report
- Weekly morbidity and mortality conference
- Monthly Trauma Video Review
- Weekly Didactic Conference
- Monthly WIPS
- Monthly Surgical Journal Club
- Monthly Surgical Critical Care Journal Club

Courses:

- **Advanced surgical exposure for trauma (ASSET)**
- **Advanced Trauma Life Support (ATLS)**
- **ATLS Instructor Course**

UCSF Department of Surgery

Bay Area ACS Education Consortium

- Leads:
  - Ronald Tesoriero, MD
  - Cassie Sonntag, MD, MD
- Speakers:
  - Joseph Cuschieri, MD
  - Lucy Kornblith, MD
  - M. Peggy Knudson, MD
  - David Spain, MD
  - Morad Hameed, MD
  - Rochel Dicker, MD

UCSF

UC DAVIS
UNIVERSITY OF CALIFORNIA

UCSF Department of Surgery

Research Mission

Total Grant Funding: $12,310,126.00

- The Division of Surgery at ZSFG is a leading center of translational and clinical research.
  - Translation research in collaboration with investigators within UCSF and across the country has focused on platelet biology, coagulopathy and immune dysfunction following injury and sepsis.
  - ZSFG has been a center of clinic trial work investigating resuscitation from hemorrhagic shock, and investigating novel diagnostics for assessment of shock and injury.
- The Division of Surgery at ZSFG has increased research in the area of comprehensive care for injured patients, including the development of a sustained outpatient clinical with comprehensive follow-up, post-discharge outcomes, and incorporation of multidisciplinary care in aspects of mental health and addiction in addition to surgical/medical care.
- Two major clinical trials have been awarded totaling over 10 million in clinical funding, including the use of vasopressin following hemorrhagic shock (PI: Kornblith, Co-I: Cuschieri), and stem cell administration to decrease risk of acute kidney injury following trauma (PI: Cuschieri, Co-I: Kornblith)

UCSF Department of Surgery


THE WRAPAROUND PROJECT
ZUCKERBERG SAN FRANCISCO GENERAL
HOSPITAL AND TRAUMA CENTER
63
SF
FDC

Weakness

UCSF Department of Surgery

Block Utilization by Service

OR Performed Utilization

Data collected: Fri 1/16 01:07 AM

Utilization Filter: **All Blocks** | Performed Below Target | Performed At or Above Target

Performed Utilization Target (%)

78% Last Month
All Blocks

81% Last Three Months Combined
All Blocks

Block	Last Month ▼	Nov 2025	Oct 2025	Last Three Months Combined	Man Rel % Last Three Months Combined
Ophthalmology	91%	95%	92%	92%	3%
General	85%	81%	90%	86%	1%
Gynecology	85%	80%	81%	82%	2%
Orthopedics	81%	70%	88%	81%	1%
ENT	80%	71%	81%	78%	3%
Urology	75%	92%	89%	86%	6%
Oral Surgery	74%	71%	85%	78%	0%
Plastics	65%	66%	80%	70%	9%
Neurosurgery	58%	83%	54%	63%	4%
Vascular	41%	59%	79%	60%	4%
All Blocks	**78%**	**76%**	**86%**	**81%**	**3%**

UCSF Department of Surgery

OR Room Turnover

	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	QTD	MTD
ZSFG MAIN OR	37	37	37	36	37	38	37	36	36	36	35	36	38	36	36
Anesthesiology	—	—	24	19	18	17	18	14	29	24	17	21	36	19	19
ENT	46	46	43	43	41	41	42	40	43	44	47	46	44	53	53
General	38	43	43	42	44	43	44	43	39	42	39	36	41	47	47
Gynecology	46	48	45	44	46	48	47	40	44	49	44	47	41	46	46
Neurosurgery	—	—	57	47	—	—	—	—	—	—	—	—	—	—	—
Ophthalmology	31	33	34	33	33	33	33	35	31	32	32	31	32	32	32
Oral Surgery	49	38	41	40	40	54	45	54	41	37	43	48	46	45	45
Orthopedics	35	32	26	24	32	31	32	28	35	34	29	28	41	36	36
Pain Management	—	—	23	31	—	26	22	24	30	22	24	27	24	—	—
Plastics	37	47	48	43	44	40	43	39	46	39	37	41	35	34	34
Urology	42	39	40	39	38	45	41	37	38	40	36	38	42	37	37
Vascular	31	44	48	38	43	46	46	36	35	37	43	50	42	37	37

UCSF Department of Surgery

Most Common 9th Room Procedures: Time to OR and LOS

Most Common Procedures	Time to OR (hours)		LOS (days)	
	Pre	Post	Pre	Post
Laparoscopic Cholecystectomy	27	22	4	4
Exploratory Laparotomy	25	19	33	25
Spinal Fusion	26	22	10	10
Debridement of wound	22	19	15	11

*Patients undergoing these procedures outside of the 9th room also had decreased LOS.

UCSF Department of Surgery

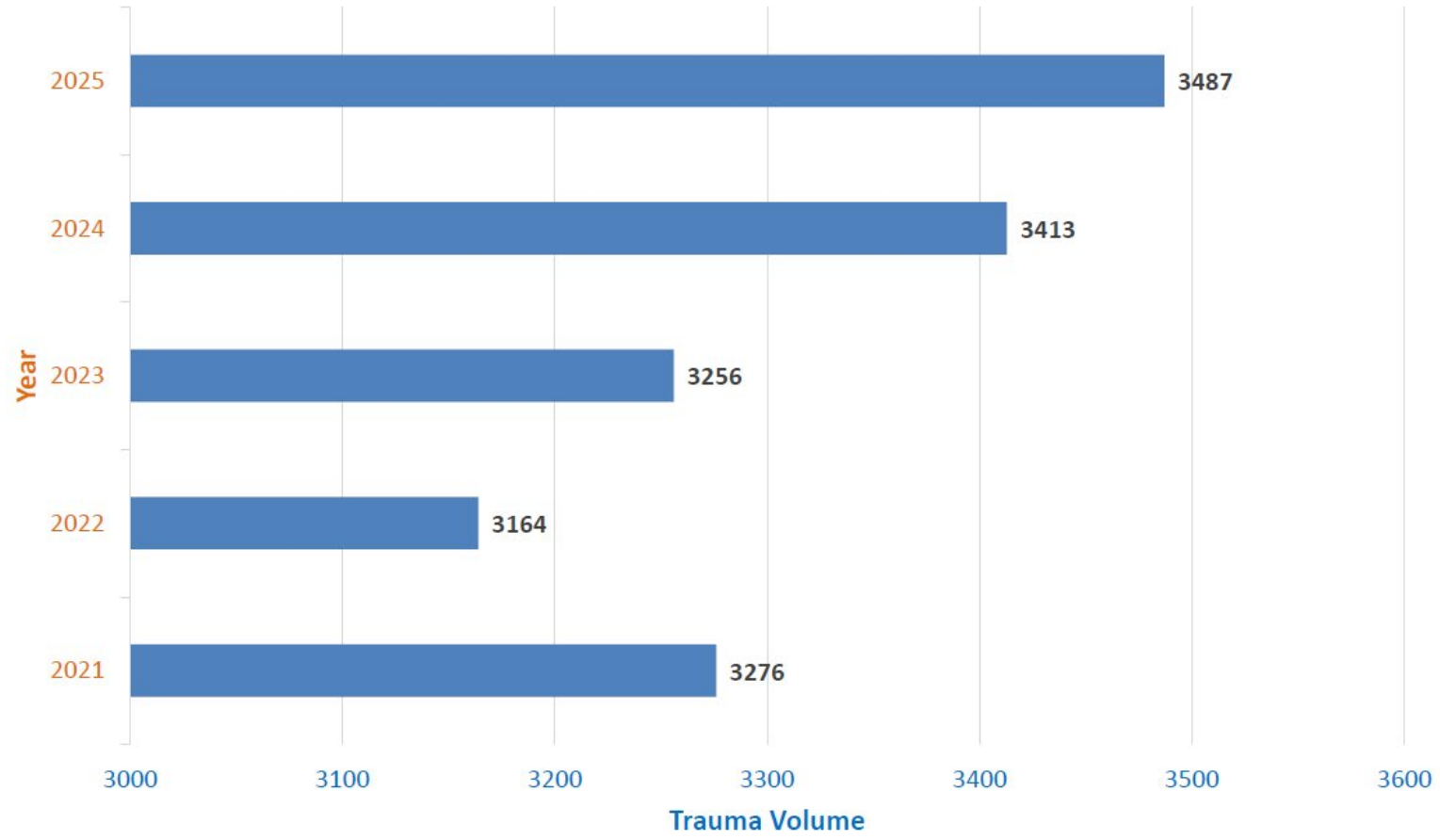
Trauma Statistics

	2024 Total	JAN 25	FEB 25	MAR 25	APR 25	MAY 25	JUN 25	JUL 25	AUG 25	SEP 25	OCT 25	NOV 25*	DEC 25*	2025 YTD*	JAN 26*
All Patients	**3414**	297	235	251	263	269	299	319	302	322	341	291	298	**3487**	299
TTA Admitted	**1377**	104	91	90	97	95	98	137	115	125	128	86	117	**1283**	115
ED D/C	**1132**	86	70	74	69	92	108	91	92	105	107	103	75	**1072**	90
Non- TTA Admitted	**905**	107	74	87	97	82	93	91	95	92	106	102	106	**1132**	94
DIRECT ADMIT	**0**	0	0	0	0	0	0	0	0	0	0	0	0	**0**	0
Activation Level															
Shock Trauma Alerts	**119**	5	2	5	3	8	7	15	9	19	13	7	7	**100**	9
900 Activations	**726**	50	48	51	48	54	50	55	57	70	72	34	65	**654**	57
911 Activations	**1769**	133	110	111	117	131	146	167	144	153	160	152	125	**1649**	142
Upgrade															
Upgrade: 911 to 900	**97**	3	12	10	6	7	8	5	13	7	13	7	5	**96**	6
Upgrade: NON to TTA	**217**	18	16	13	14	23	15	29	25	20	13	15	30	**231**	20
Age															
AGE > 65	**969**	109	85	79	89	75	102	102	96	98	112	87	115	**1149**	98
AGE =< 14	**104**	11	7	6	9	10	13	10	6	11	6	10	13	**112**	8
Pediatric Admission by ED Dispo															
ICU	**11**	2	1	1	0	0	1	0	0	0	0	0	0	**5**	0
OR	**7**	0	0	0	0	0	0	0	0	1	0	0	0	**1**	0
TELEMETRY	**2**	1	0	0	0	0	0	0	0	0	0	0	0	**1**	0
FLOOR	**34**	2	1	1	4	4	2	6	1	2	1	4	5	**33**	3
Admitted Patient ISS Score															
ISS 1-9	**1128**	118	85	101	107	92	103	116	114	113	118	105	64	**1236**	1
ISS 10-15	**597**	39	43	42	47	43	50	57	55	54	57	46	31	**564**	0
ISS 16-24	**295**	34	17	22	21	22	23	32	19	25	27	24	10	**276**	0
ISS >= 25	**215**	18	15	10	13	14	13	16	18	19	26	7	12	**181**	0

**incomplete data*

UCSF Department of Surgery

Annual Trauma Volume

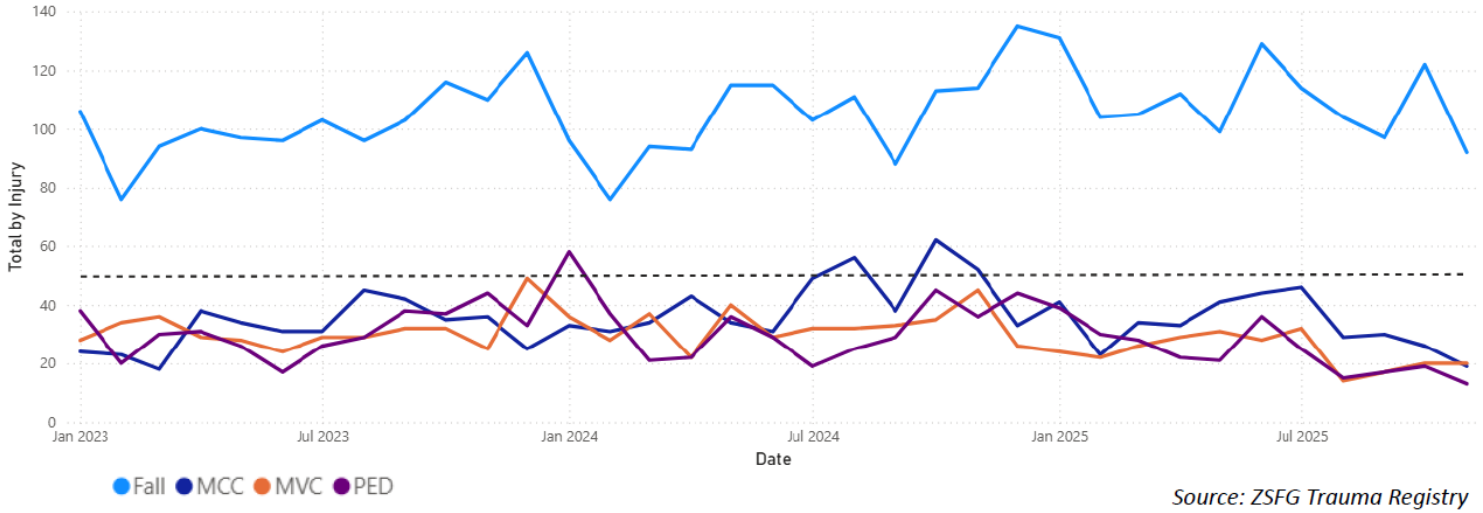


UCSF Department of Surgery

Mechanism of Injury

- **Top 3 MOI**
  - #1 Falls
  - #2 MCC
  - #3 MVC/PED

MOI	2023	2024	2025	Total
Fall	1223	1253	1209	**3685**
MCC	382	496	366	**1244**
PED	369	401	265	**1035**
MVC	375	395	263	**1033**



Source: ZSFG Trauma Registry

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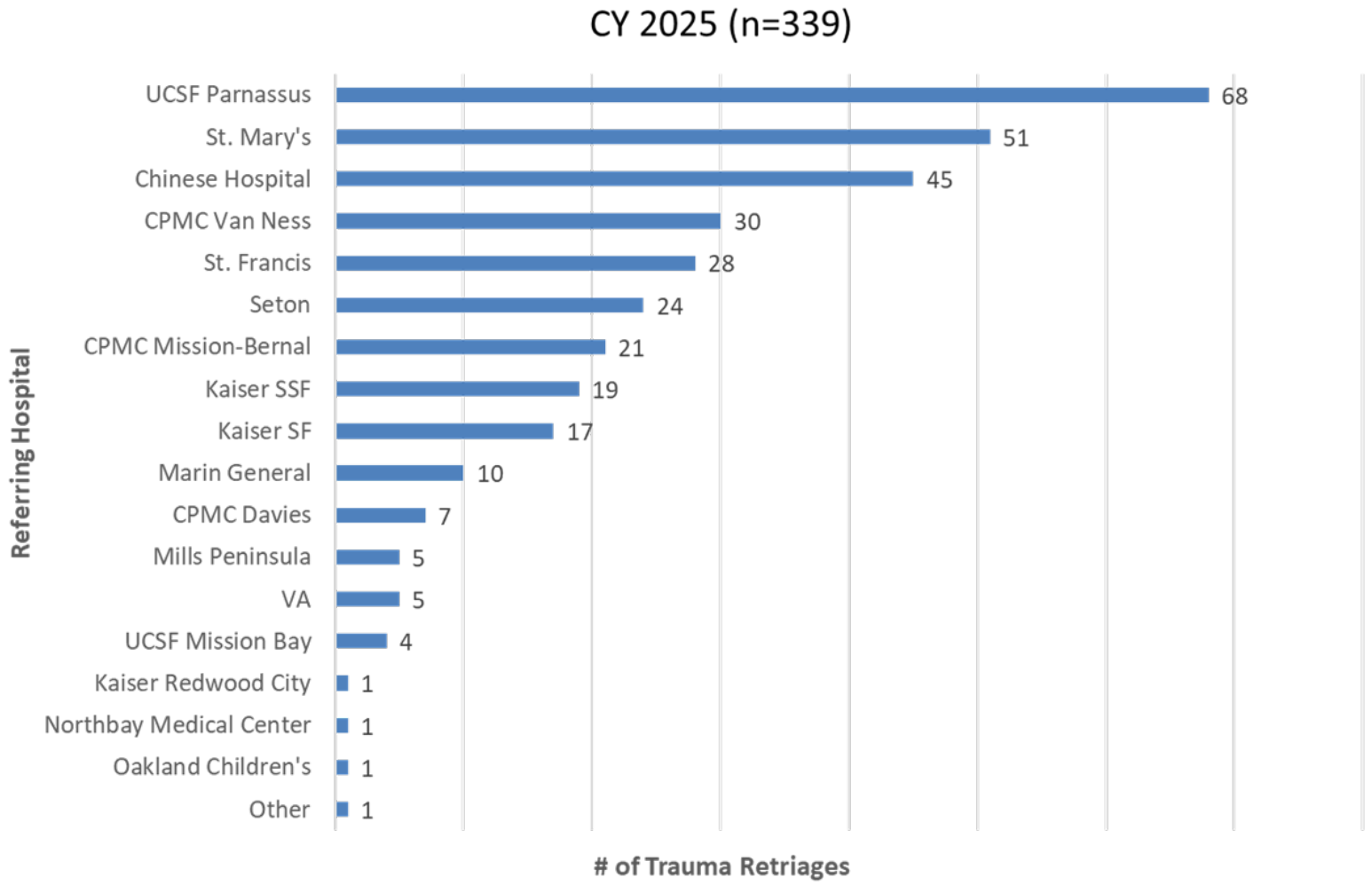
Trauma Re-triage to ZSFG



Source: ZSFG Trauma Registry

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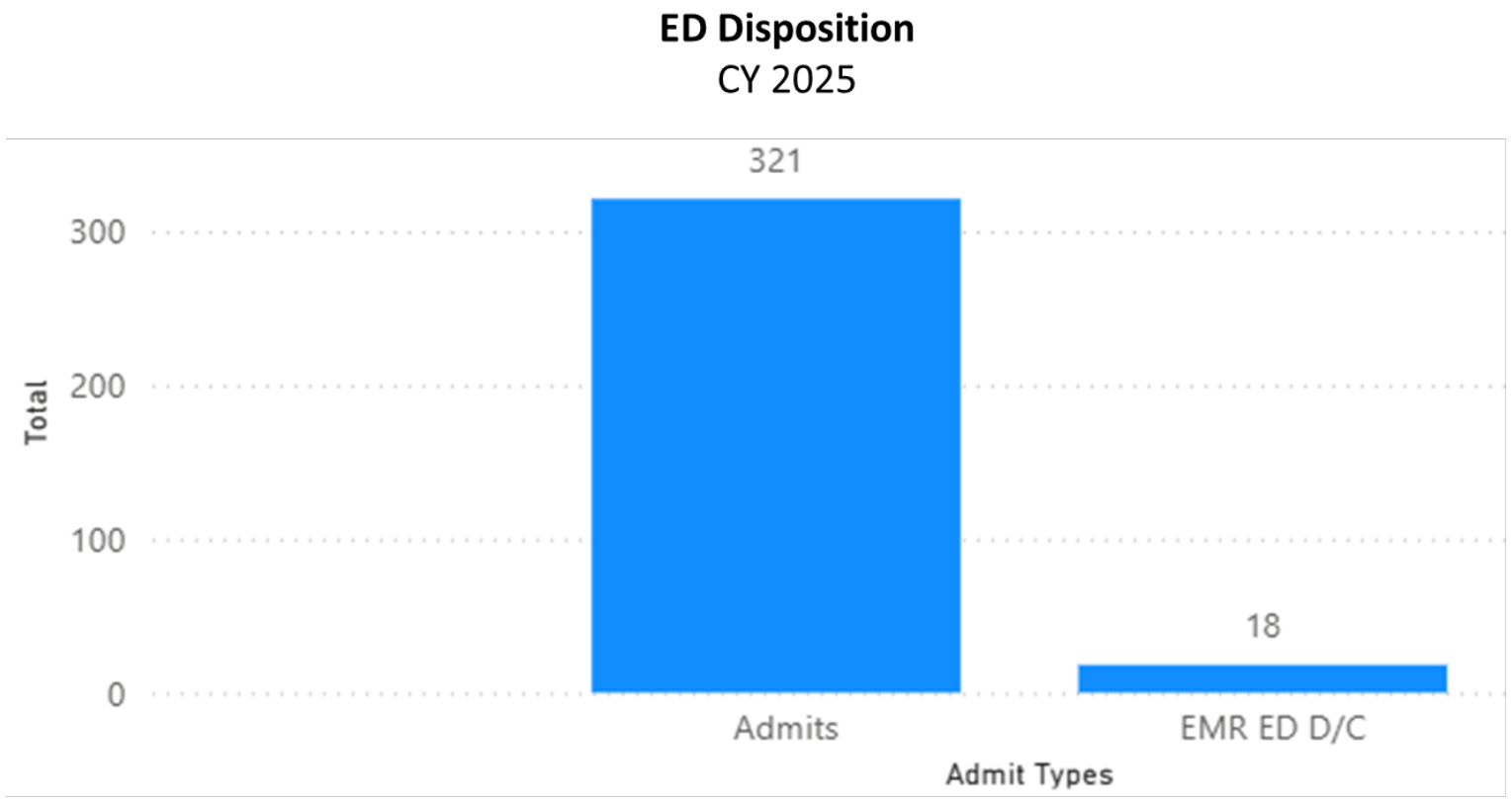
Trauma Re-triage Disposition



95% Admissions
5% ED Discharges

Source: ZSFG Trauma Registry

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Opportunities

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Division of Surgery Process Improvement

- Physician Leadership:
  - Dr. Sandhya Kumar (General Surgery)
  - Dr. Joseph Cuschieri (Trauma and General Surgery)
- Data/Program manager:
  - Jeremy Ho (General Surgery)
  - Juliann Sussman (Trauma)
- Trauma Program Metrics
- Clinic Metrics
  - TNAA
- Operative Metrics
  - Elective (Inguinal hernia)
  - Urgent (Appendectomy, Cholecystectomy)

UCSF University of California San Francisco

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

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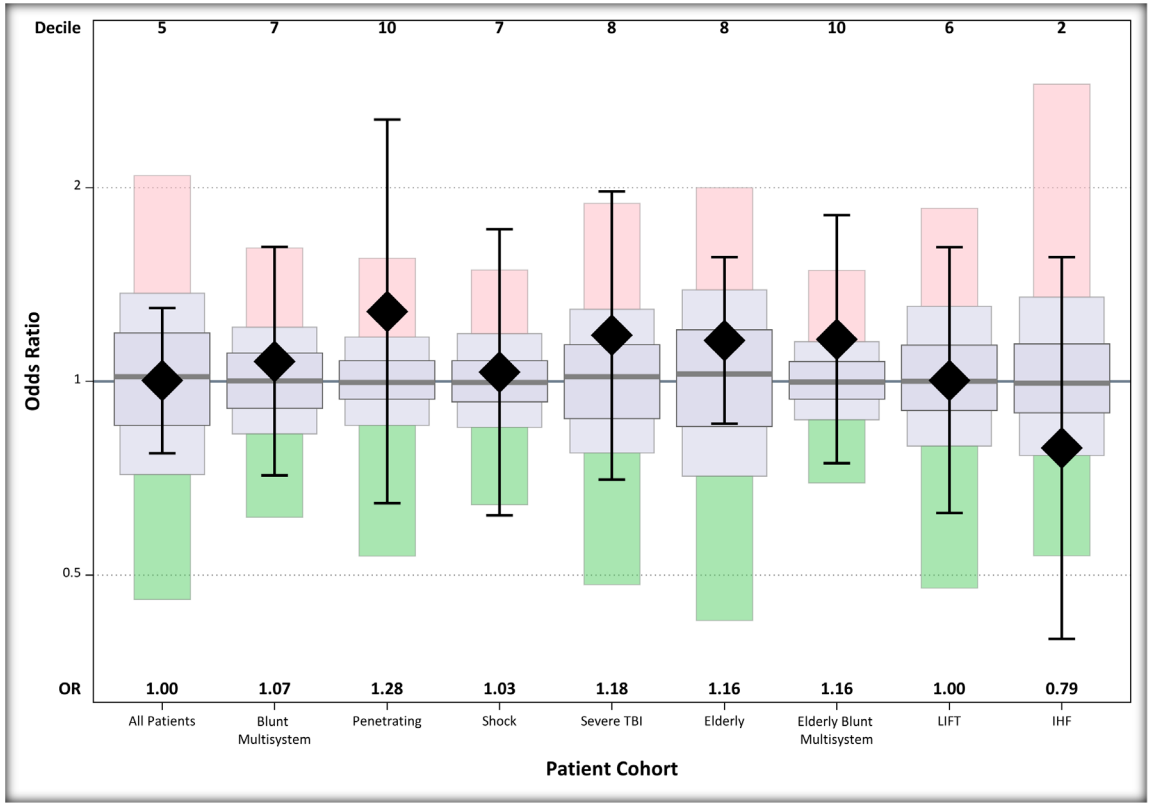
Clinical and Operational Report

UCSF Department of Surgery

TQIP Risk Adjusted Mortality



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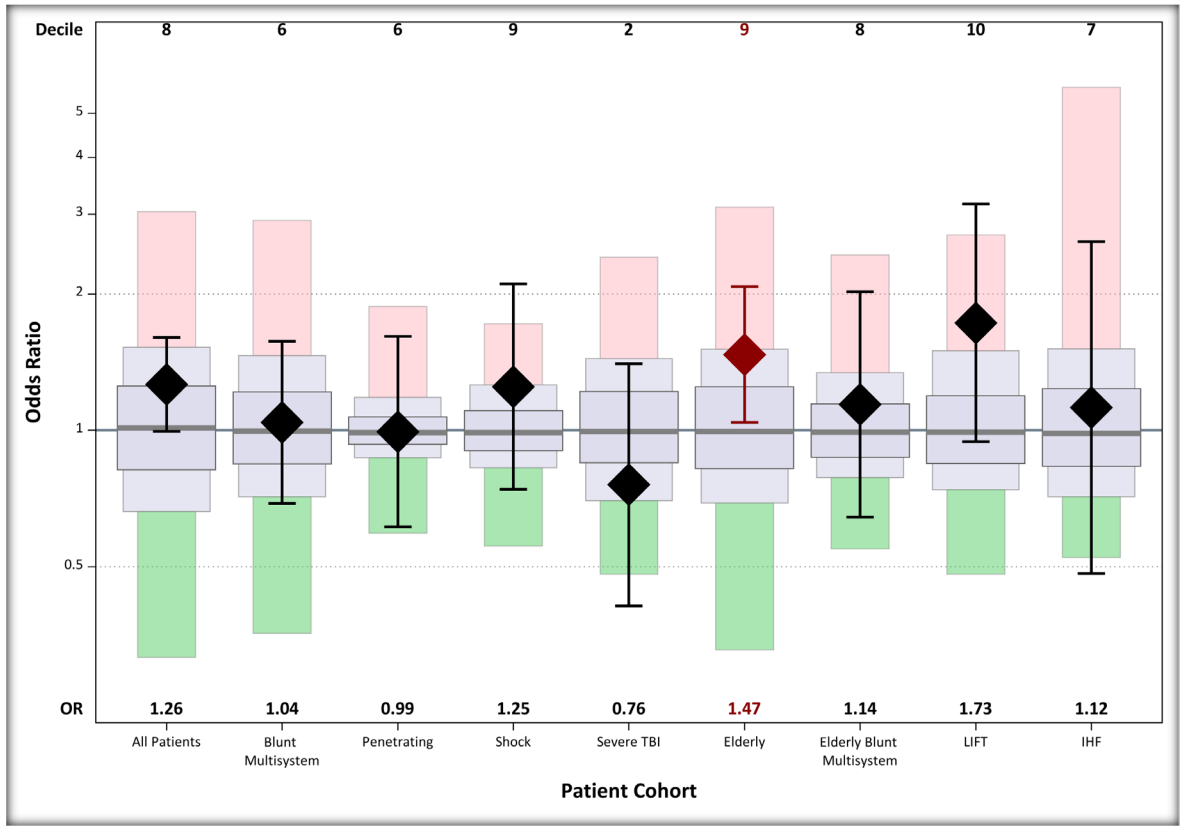
TQIP Risk Adjucted Hospital Events by Cohort



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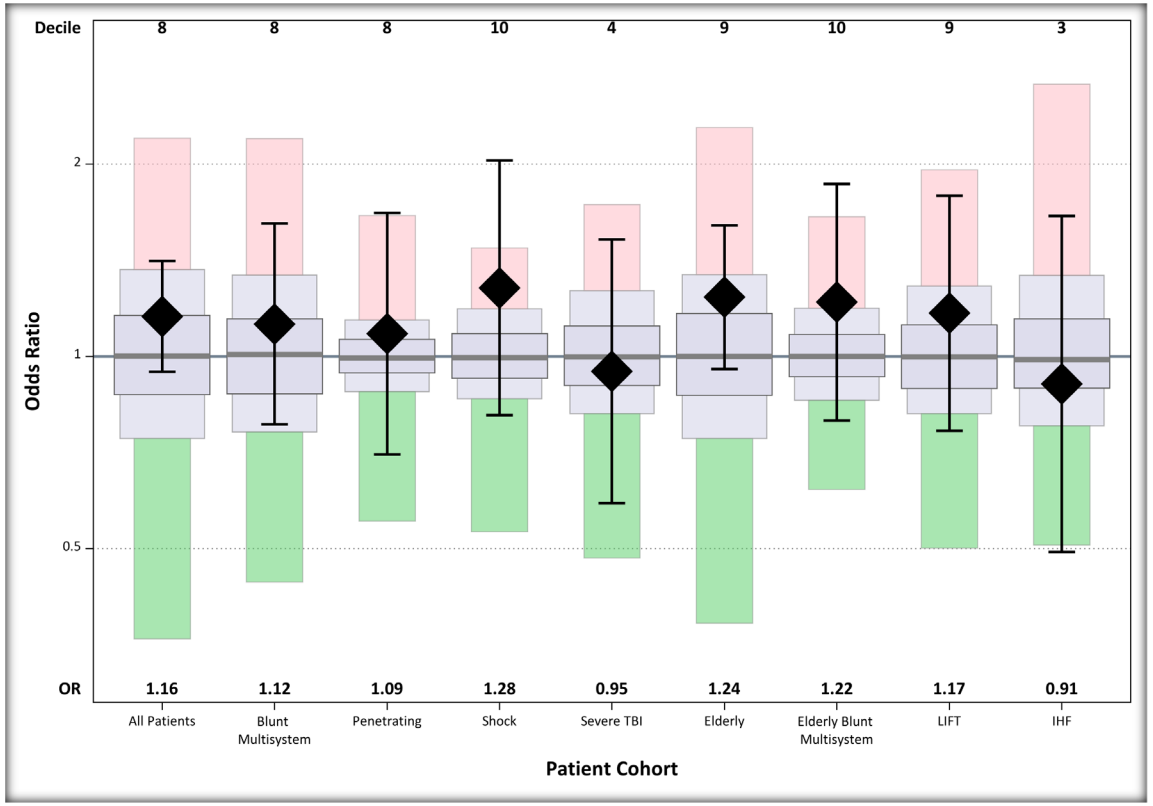
TQIP Risk Hospital Events and Death



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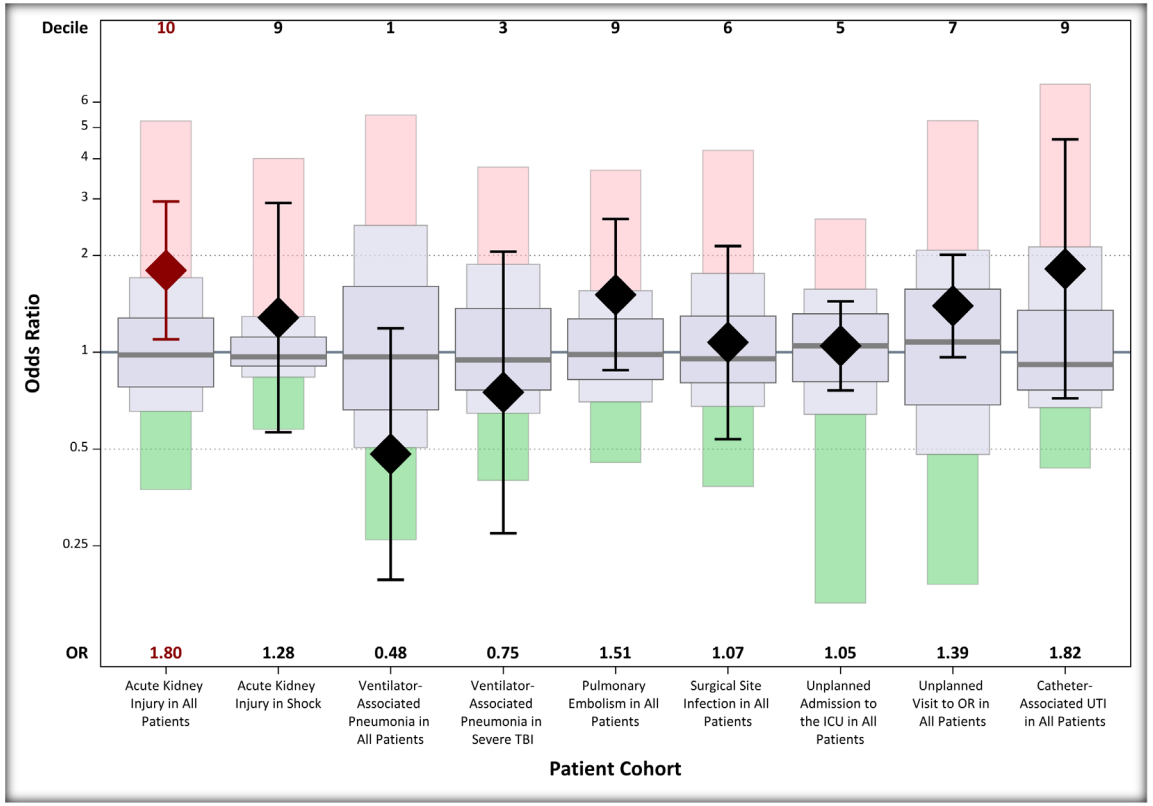
TQIP Risk-Adjusted Specific Hospital Events



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TQIP Risk-Adjusted Specific Hospital Events

		Odds Ratio									
Hospital Event	Cohort	Spring 2021	Fall 2021	Spring 2022	Fall 2022	Spring 2023	Fall 2023	Spring 2024	Fall 2024	Spring 2025	Fall 2025
Acute Kidney Injury	All Patients*	1.46	1.22	0.88	1.03	1.12	0.64	0.46	1.09	1.45	1.80
Acute Kidney Injury	Shock*	0.85	0.77	0.88	1.14	1.26	0.99	0.79	0.96	0.98	1.28
Ventilator-Associated Pneumonia	All Patients*	0.33	0.55	1.89	1.60	1.87	2.26	2.35	2.25	1.85	0.48
Ventilator-Associated Pneumonia	Severe TBI	0.39	0.43	1.62	1.66	0.98	1.35	1.73	2.23	1.58	0.75
Pulmonary Embolism	All Patients*	2.74	2.37	1.93	1.30	1.69	2.33	2.54	2.05	1.73	1.51
Surgical Site Infection	All Patients*	1.84	2.08	1.55	1.19	1.42	0.99	1.79	2.58	1.24	1.07
Unplanned Admission to the ICU	All Patients*	1.32	1.20	0.99	1.03	1.04	0.83	0.97	1.02	0.99	1.05
Unplanned Visit to OR	All Patients*	1.11	0.77	0.89	0.92	0.79	0.81	1.07	0.94	0.93	1.39
Catheter-Associated UTI	All Patients*	3.45	2.22	1.48	1.26	1.32	2.86	3.79	1.66	3.17	1.82

* For all reports prior to Fall 2025, the IHF cohort patients were explicitly excluded from other cohorts. Beginning in Fall 2025, IHF cohort patients are no longer explicitly excluded from other cohorts. Odds Ratios are reflective of models built on this expanded cohort. Reported ORs prior to Fall 2025 remain unchanged.

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Trauma Program: Orthopedic Care

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

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

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

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

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

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

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Trauma Program: Neurosurgical and Spine Care

Table 30: Cerebral Monitoring Method for Severe TBI Patients

	Cerebral Monitoring	External Ventricular Drain	Intraparenchymal Oxygen Monitor	Jugular Venous Bulb	Other Pressure Monitoring Device
Group	N	N (%)	N (%)	N (%)	N (%)
All Hospitals	5,279	2,665 (50.5)	253 (4.8)	47 (0.9)	3,151 (59.7)
Your Hospital	18	17 (94.4)	7 (38.9)	0 (0.0)	18 (100.0)
Note: Multiple methods are possible for an individual patient					

Table 31: Craniotomy by Cohort

		Patients	Craniotomy	Time to Craniotomy (hours)	Unknown Time to Craniotomy
Cohort[1]	Group	N	N (%)	Median (IQR)	N (%)
Severe TBI	All Hospitals	26,906	5,278 (19.6)	2.45 (1.7-6.1)	19 (0.4)
	Your Hospital	49	18 (36.7)	2.28 (1.93-3.22)	0 (0.0)
Epidural Hematoma	All Hospitals	1,387	604 (43.5)	2.68 (1.83-6.02)	3 (0.5)
	Your Hospital	15	5 (33.3)	2.37 (2.33-8.22)	0 (0.0)
[1] Epidural Hematoma is a separate cohort from Severe TBI - please see the References document to learn how Epidural Hematoma is defined					

Table 33: Spinal Decompression/Stabilization for Patients with Spinal Cord Injury

	Spinal Cord Injury	Spinal Decompression/ Stabilization	Time to Spinal Decompression/ Stabilization (hours)	Time to Spinal Decompression/ Stabilization more than 24 hours	Unknown Time to Spinal Decompression/ Stabilization
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	14,784	10,270 (69.5)	21.83 (9.93-47.6)	4,746 (46.3)	15 (0.1)
Your Hospital	59	44 (74.6)	8.58 (4.76-15.16)	8 (18.2)	0 (0.0)

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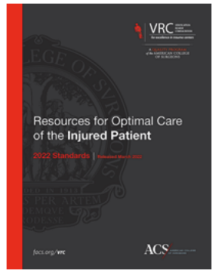
ACS COT Trauma Re-verification July 2026

THE COMMITTEE ON TRAUMA

VERIFIED TRAUMA CENTER

ACS COT releases new 2022 trauma center standards



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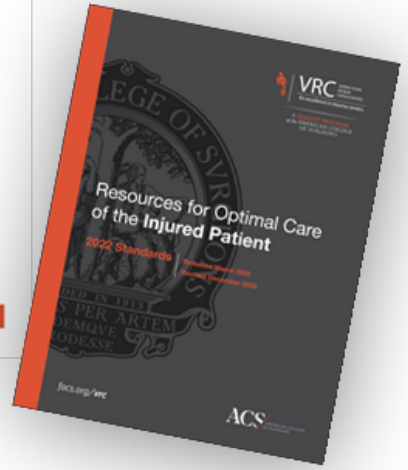
5.4 Trauma Surgeon Response to Highest Level of Activation—Type I

900

Definition and Requirements

For the highest level of activation, at least 80 percent of the time, the trauma surgeon must be at the patient's bedside within 15 minutes (Level I or II trauma centers) or 30 minutes (Level III trauma centers) of patient arrival.



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8.2 Nursing Trauma Orientation and Education—TYPE II

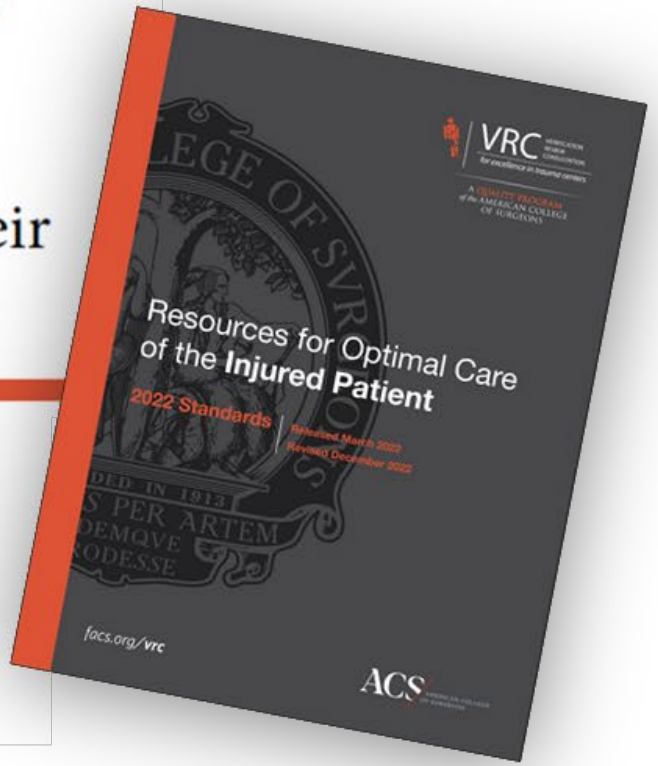
Definition and Requirements

All trauma centers must provide trauma orientation to new nursing staff caring for trauma patients.

Nurses must participate in trauma CE corresponding to their scope of practice and patient population served.

Examples of orientation may include:

- Center-developed educational program that integrates PIPS-identified issues
- Education specific to patient population served



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*T*uesday's *T*en-Minute *T*rauma *T*opics

- Trauma attending / fellow facetime with ED staff in a non-urgent environment
- Opportunity for ED staff to ask questions directly of attendings + provide staff with 10 mins of trauma specific education

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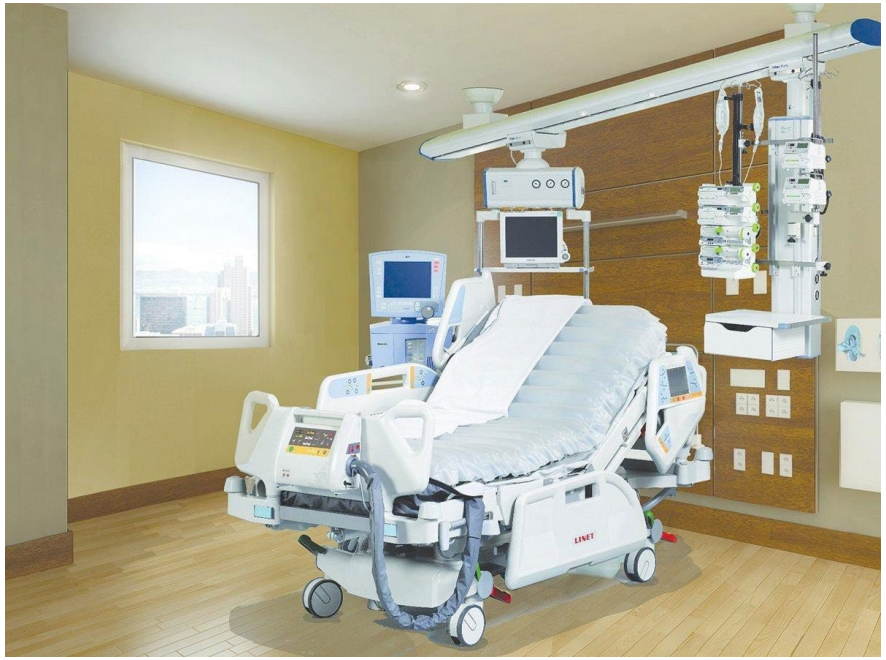
UCSF Health

UCSF Health Hyde and Stanyan Hospitals & Clinics



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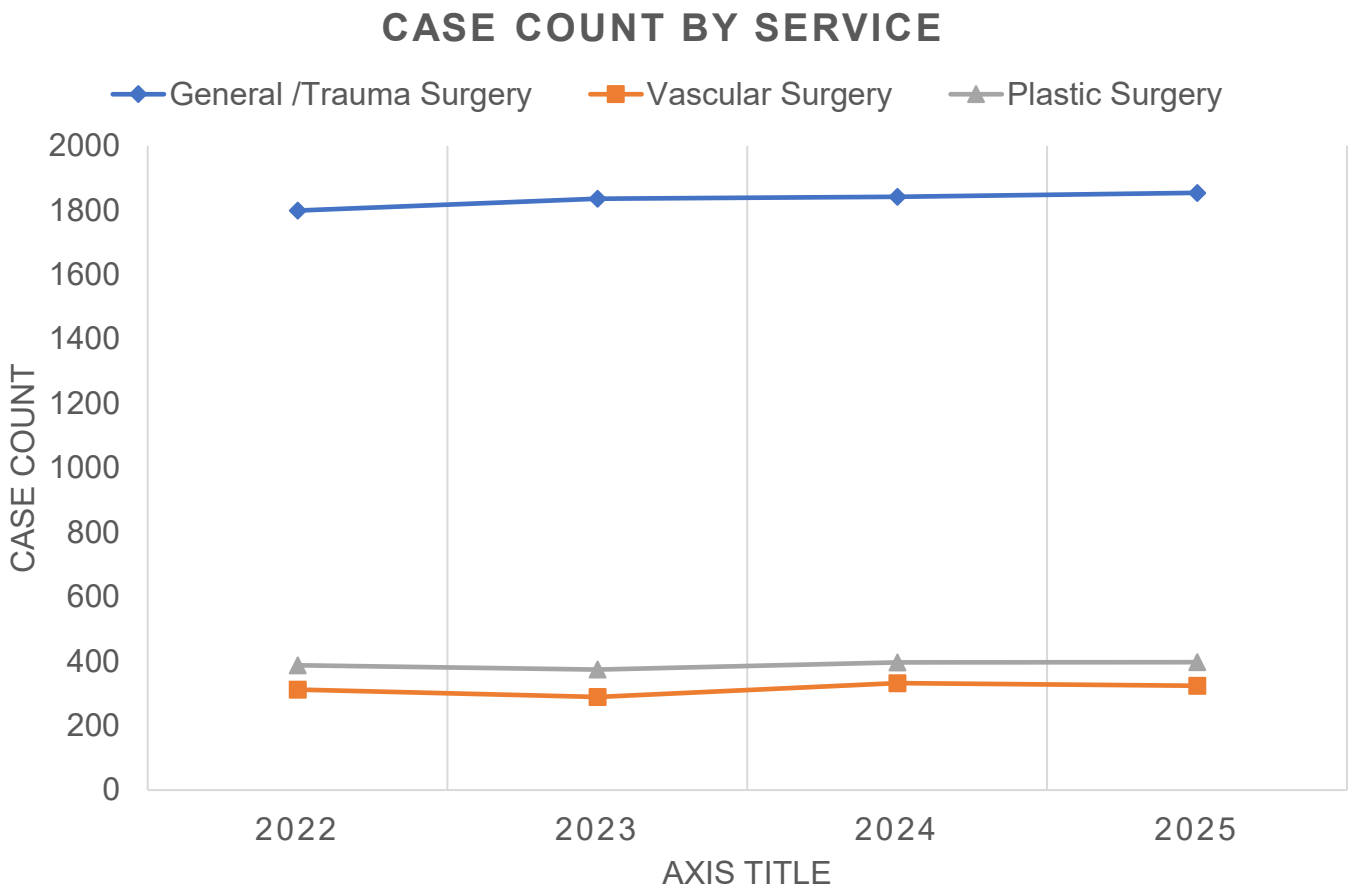
ZSGH Department of Surgery OR Cases



Surgery Cases	2022	2023	2024	2025	Total
General /Trauma Surgery	1799	1836	1842	1854	7331
Vascular Surgery	312	289	332	324	1257
Plastic Surgery	387	374	396	397	1554

% Change Year Over Year	2022-2023	2023-2024	2024-2025
General /Trauma Surgery	2.06%	0.33%	0.65%
Vascular Surgery	-7.37%	14.88%	-2.41%
Plastic Surgery	-3.36%	5.88%	0.25%

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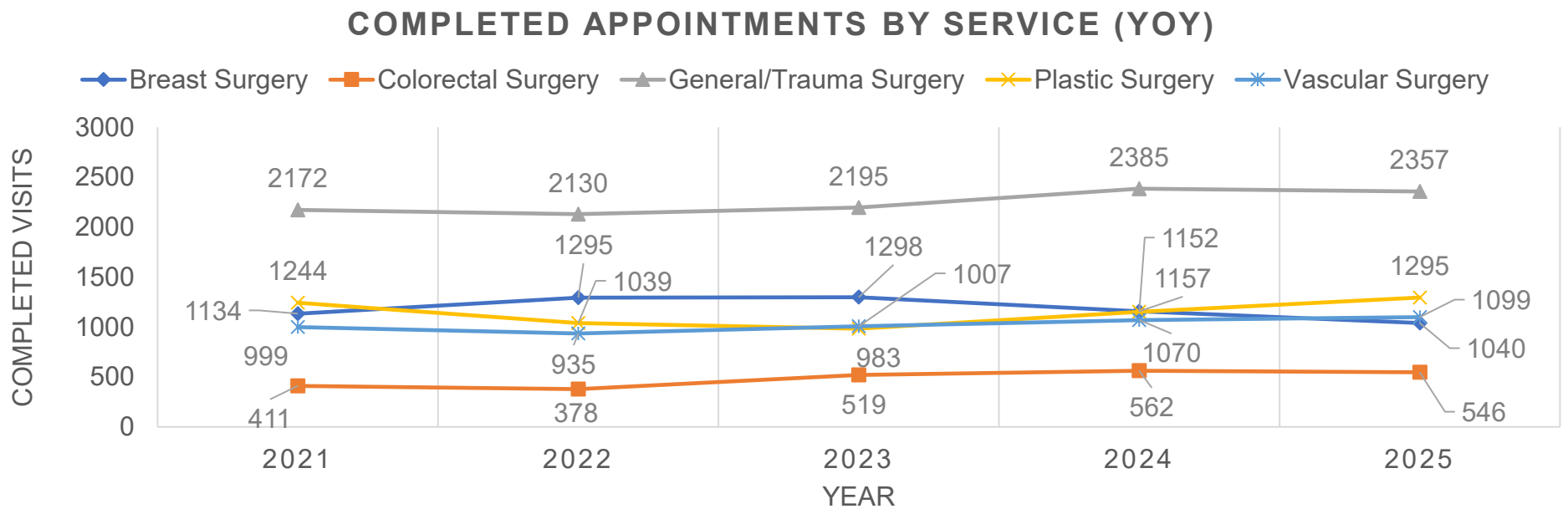
***Data updated to the end of February 2026**

ZSGH Outpatient Appointments



Completed Appointments	2021	2022	2023	2024	2025	Total
Breast Surgery	1134	1295	1298	1157	1040	5924
Colorectal Surgery	411	378	519	562	546	2416
General/Trauma Surgery	2172	2130	2195	2385	2357	11239
Plastic Surgery	1244	1039	983	1152	1295	5713
Vascular Surgery	999	935	1007	1070	1099	5110

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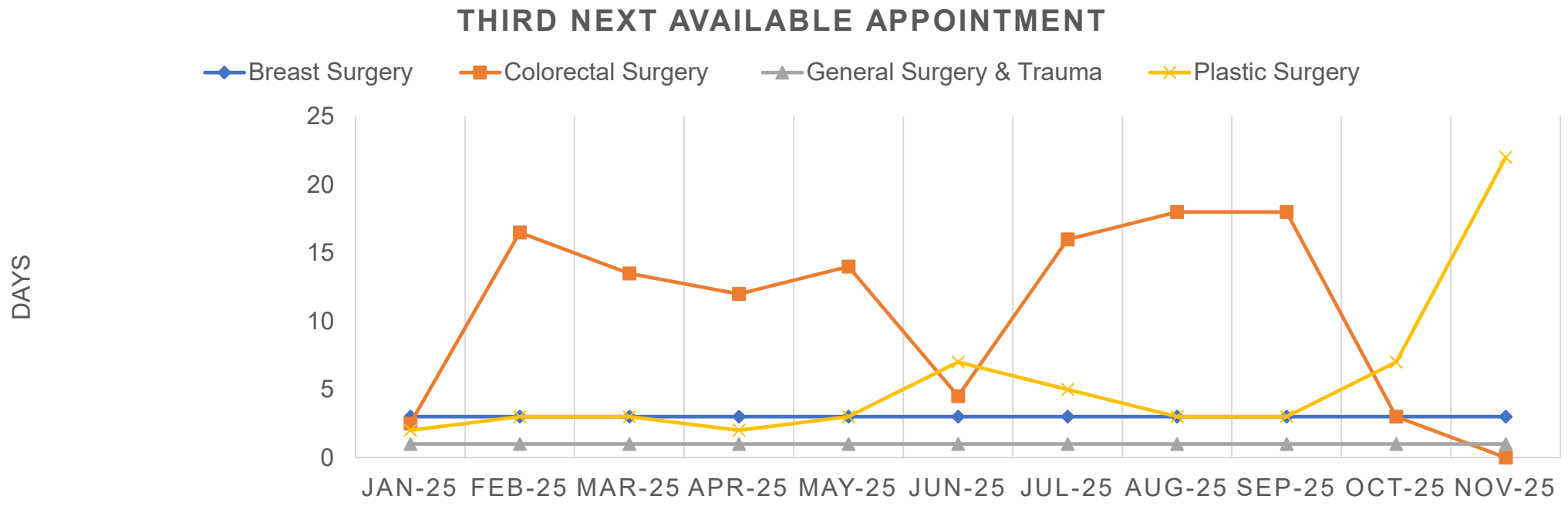
*Data updated to the end of February 2026

ZSGH TNAA



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Breast Surgery	3	3	3	3	3	3	3	3	3	3	3
Colorectal Surgery	2.5	16.5	13.5	12	14	4.5	16	18	18	3	0
General Surgery & Trauma	1	1	1	1	1	1	1	1	1	1	1
Plastic Surgery	2	3	3	2	3	7	5	3	3	7	22

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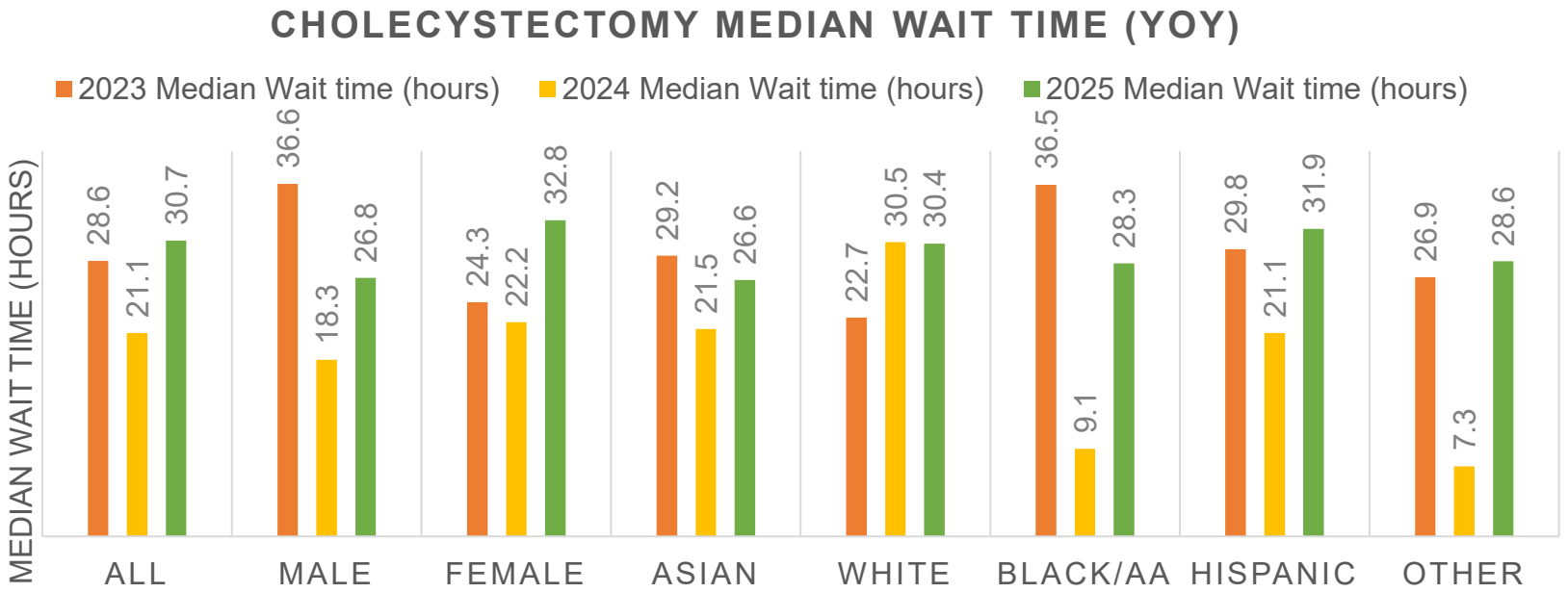
***Data updated to the end of February 2026**

ZSGH DOS Cholecystectomy



Year	% of patients with wait time <36hrs	% patients with wait tim <24 hrs
2022	64%	49%
2023	58%	51%
2024	75%	62%
2025	66%	50%

Cholecystectomy Cases	Total Cases	Gender		Race				
		Male	Female	Asian	White	Black/AA	Hispanic	Other
2023 Cases	161	54	107	24	12	4	113	9
Median Wait time (hours)	28.6	36.6	24.3	29.15	22.7	36.5	29.8	26.9
2024 Cases	158	33	41	12	4	3	62	3
Median Wait time (hours)	21.12	18.33	22.23	21.52	30.54	9.08	21.1	7.28
2025 Cases	180	63	117	25	7	9	127	12
Median Wait time (hours)	30.7	26.83	32.81	26.61	30.38	28.34	31.92	28.56

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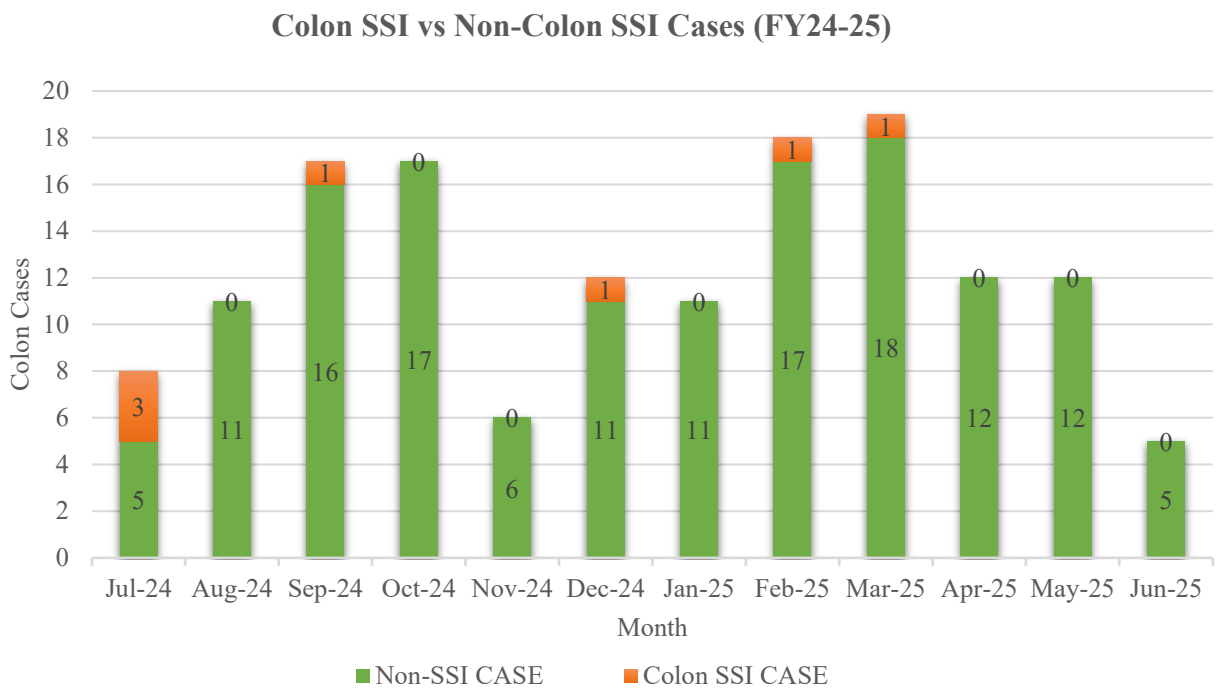
*Data updated to the end of February 2026

ZSGH Department of Surgery Colon SSI



All SSI Model	Total operations	# SSI	Predicted #	SIR
FY17-18	64	10	3.9	2.59
FY18-19	66	10	4.2	2.36
FY19-20	83	13	7.4	1.76
FY20-21	114	13	10.2	1.28
FY21-22	142	12	11.9	1.01
FY22-23	151	12	12.3	0.96
FY23-24	149	11	10.5	1.05
FY24-25	148	7	6.76	1.04

Complex SSI Model	Procedure Count	SSI Count	Predicted #	SIR
FY24-25	148	7	6.76	1.04
Emergent SIR	68	5	3.33	1.50
Trauma SIR	18	2	1.49	1.34
Non-trauma Emergent SIR	50	3	1.84	1.62

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*Data updated through fiscal year 2024-2025. SIR model 2015.

Intervention: Drop-In Clinic Pilot

- **Inclusion**: PEH + 3M clinic referral from:
  - **Aug '24**: Ward 86 (POP-UP), DPH WPIC, ZSFG Surgery
  - **Dec '24**: Social Medicine, SF Community Health Center Street Medicine
  - **May '25**: ZSFG Family Health Center, Mission Neighborhood Health Center
  - **Aug '25**: ZSFG Bridge Clinic
  - **Jan '26**: DPH clinics with drop-in pilots: Tom Waddell Urban Health Center, PC South East Health Center, Potrero Hill Health Center

Thursdays 8am-12pm 3M

Feb 2026: WPIC clinician-driven telehealth drop-in pilot launched

Anticipated Impact:

- ↓ Reduced emergency care
- ↑ Rates of scheduled care
- ↑ Positive post-operative & post-injury outcomes
- ↑ Patient satisfaction

Pilot drop-in clinic has ~0-3 patients per week with limited referral base

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Drop-In Pilot

- **19** months of pilot
- Accept referrals from **11** different referring teams currently
- **N=41** patients evaluated via drop-in mechanism
- **N=14** underwent surgery

Characteristic	N (%)
Total	41 (100%)
Men	35 (85%)
Age (median, IQR)	50 (42, 56)
Primary Concern	
Hernia (Inguinal, umbilical, ventral)	32 (78%)
Skin Condition (Abscess, Lipoma)	3 (7%)
Colorectal (Condyloma, Colostomy, Fistula)	4 (10%)
Post-Operative/Post-Trauma Follow Up	2 (5%)
Outcome	
Operation completed – all hernias	14 (34%)
Undergoing work-up	15 (36%)
No follow-up needed	12 (29%)

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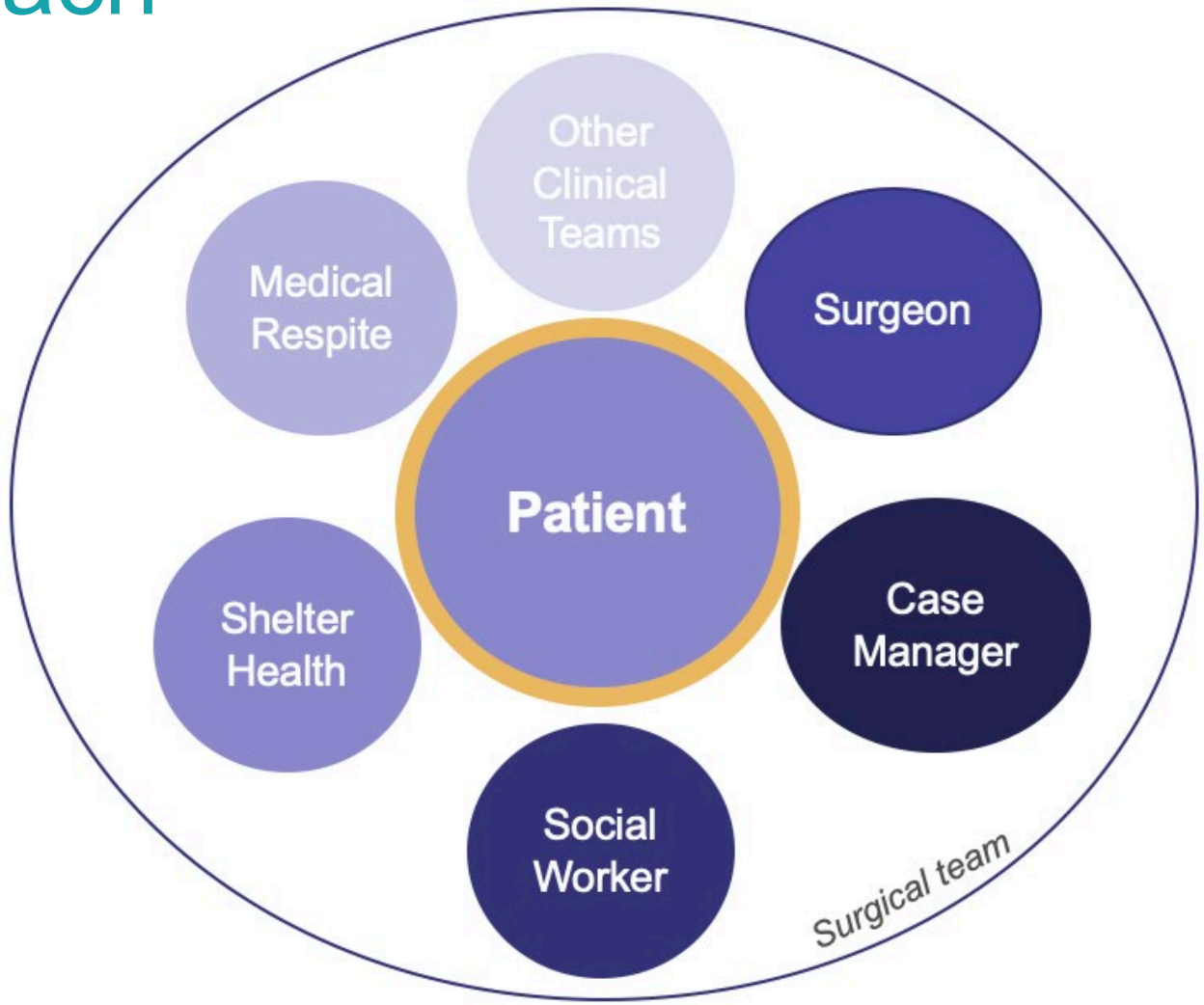
Project Reach



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Threats

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ZSFG

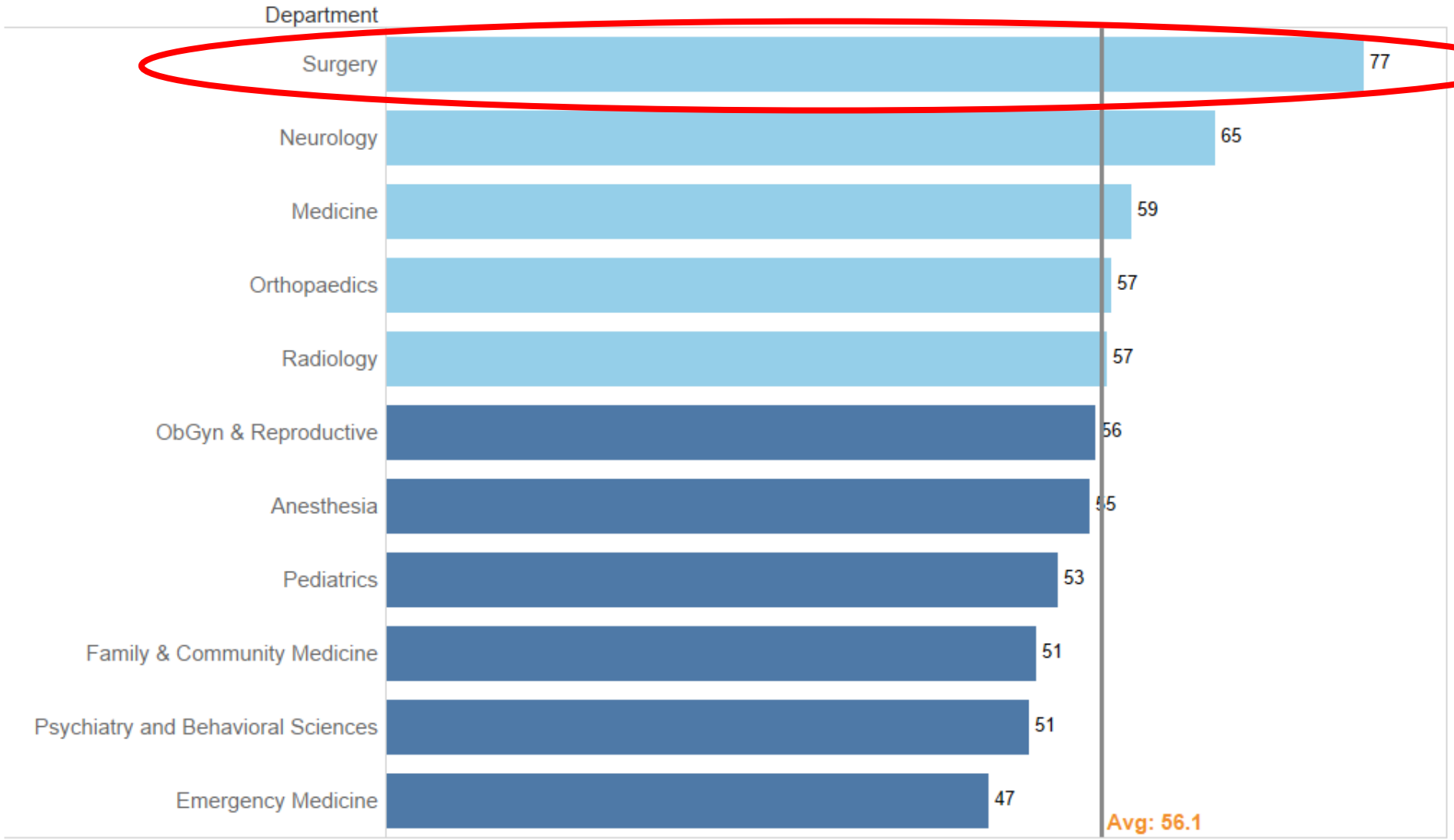
FY24 Team I can rely on other people

I can rely on other people on my clinical team to do their jobs well.

ZSFG

FY24 Hours Worked

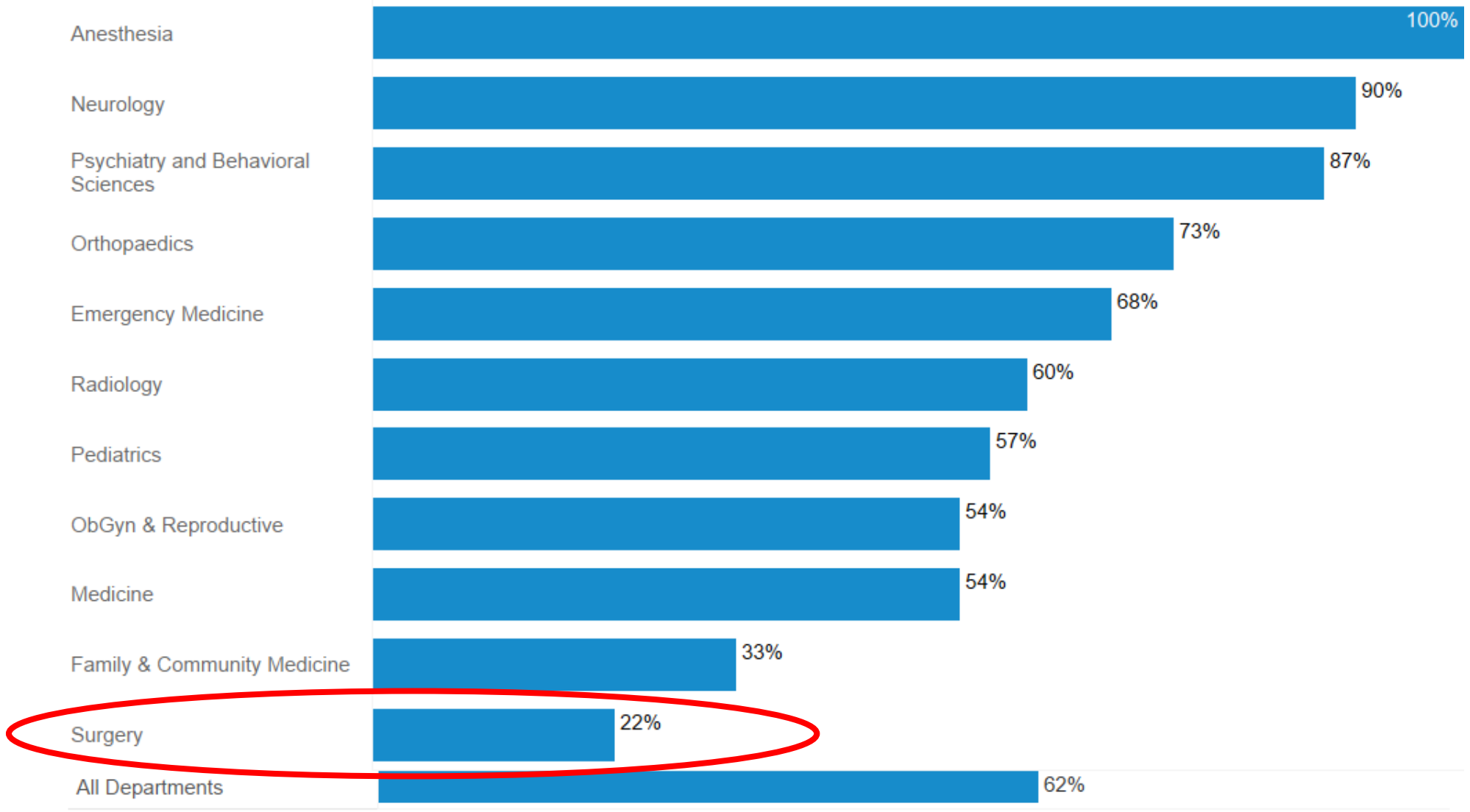
On average, how many hours do you work each week (including on-site call and working from home such as charting, work-related emails, writing, academic work, etc.)? If you work more than 100 hours, please select 100.



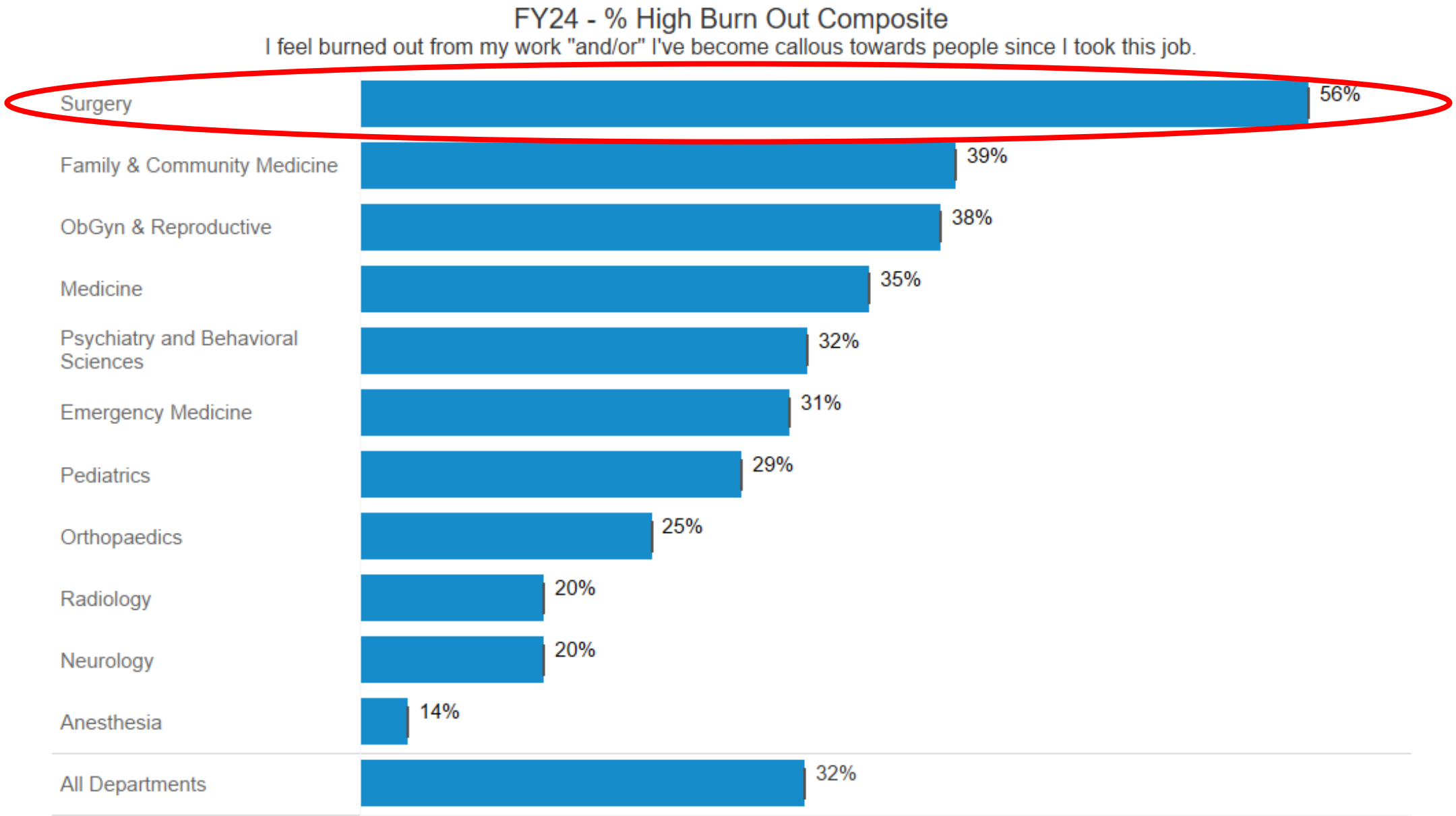
ZSFG

FY24 After Hours EMR

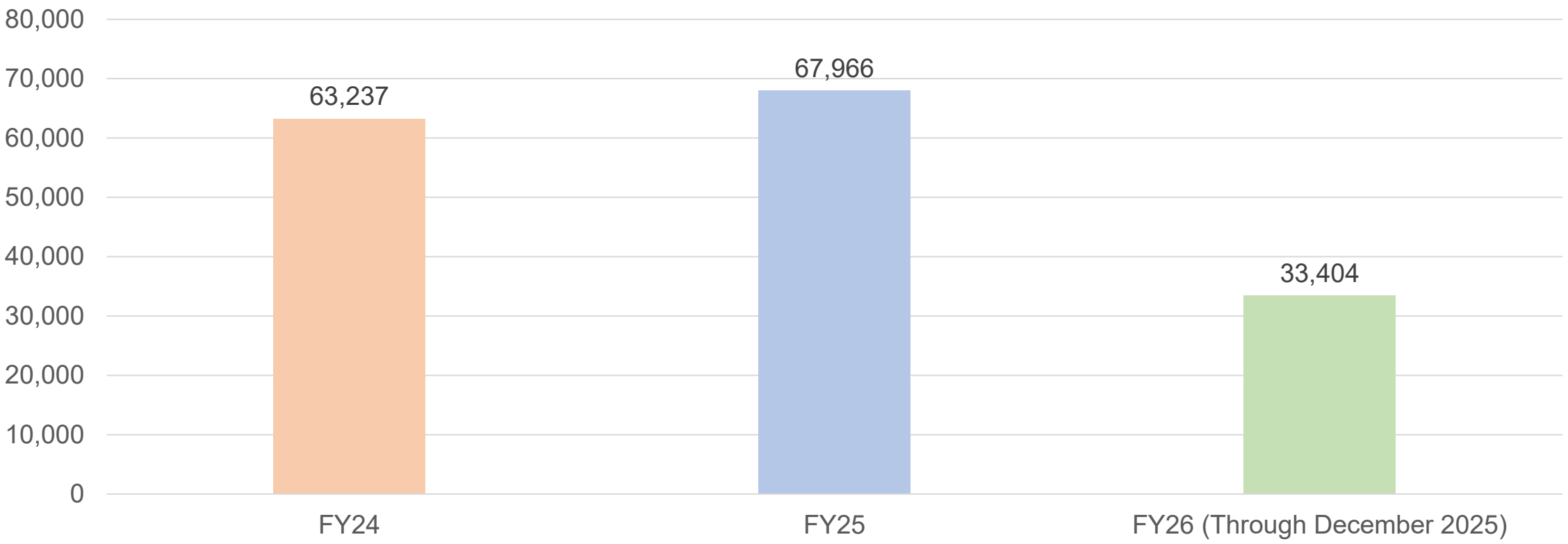
The amount of time I spend on the medical record at home or outside of clinical hours:
'Minimal / None/Modest/Satisfactory'



ZSFG

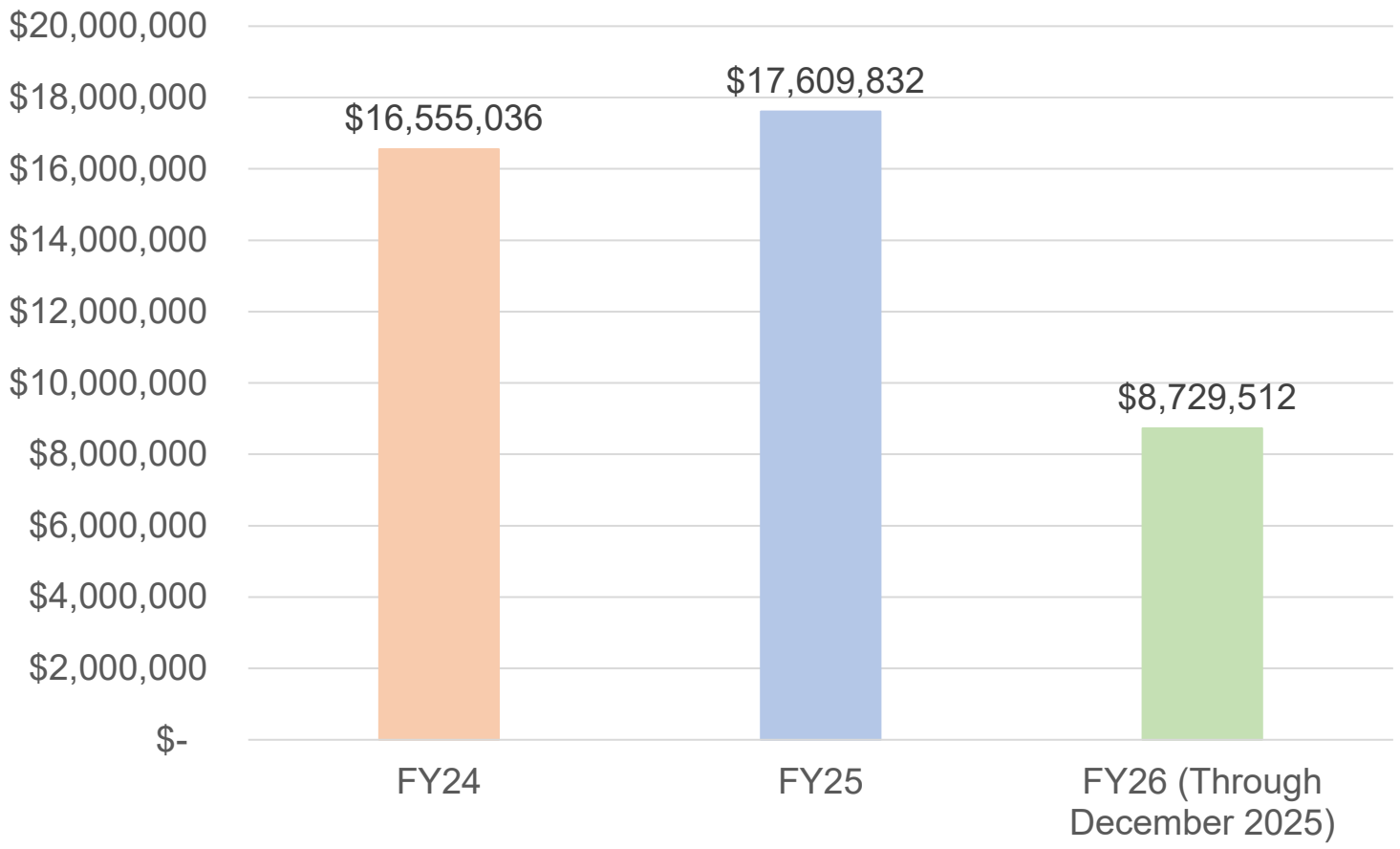

FY24 - % High Burn Out Composite
I feel burned out from my work "and/or" I've become callous towards people since I took this job.
Surgery
56%
Family & Community Medicine
39%
ObGyn & Reproductive
38%
Medicine
35%
Psychiatry and Behavioral Sciences
32%
Emergency Medicine
31%
Pediatrics
29%
Orthopaedics
25%
Radiology
20%
Neurology
20%
Anesthesia
14%
All Departments
32%

ZSFG Department of Surgery wRVUs



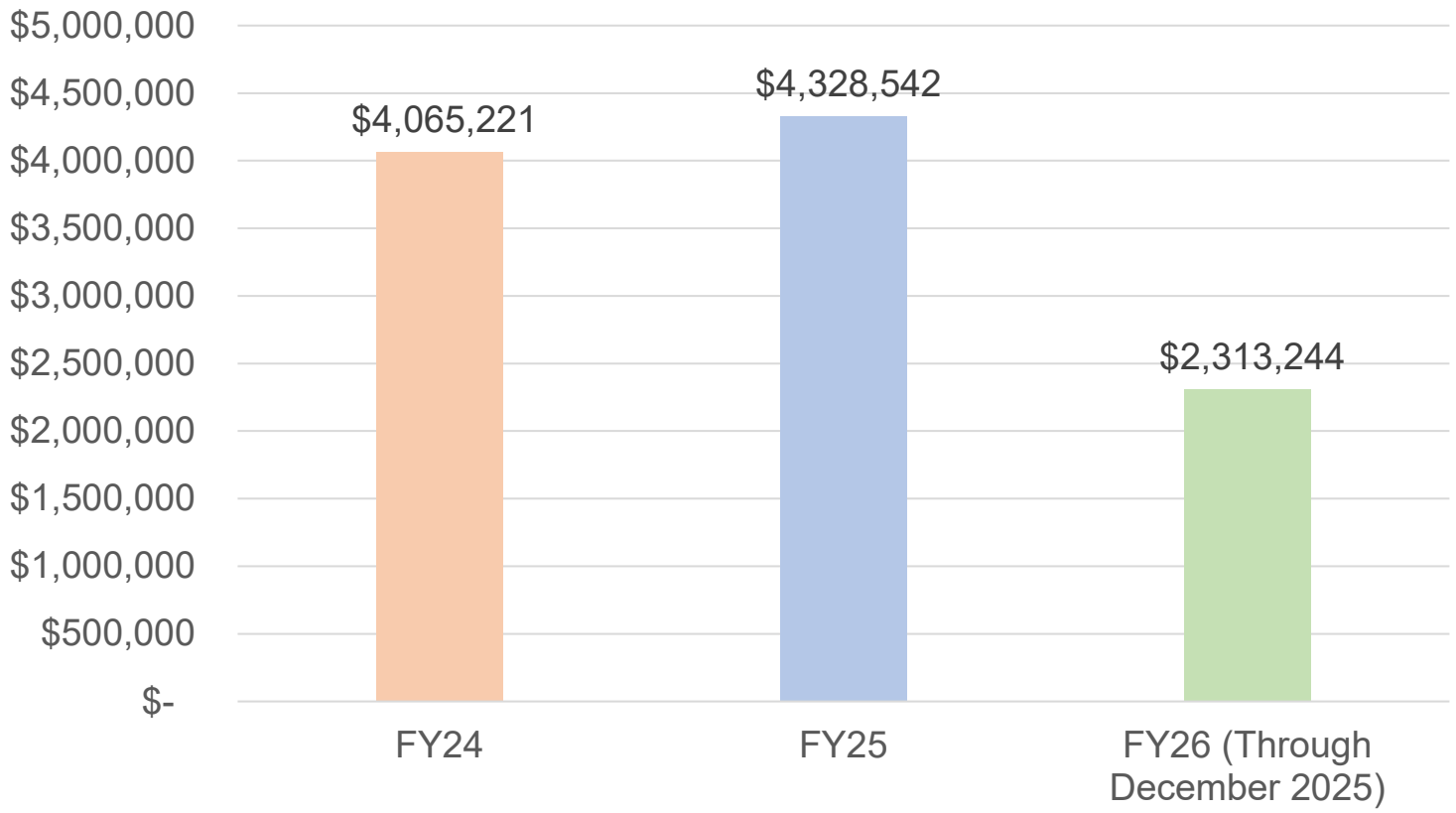
UCSF Department of Surgery

ZSFG Department of Surgery Charges



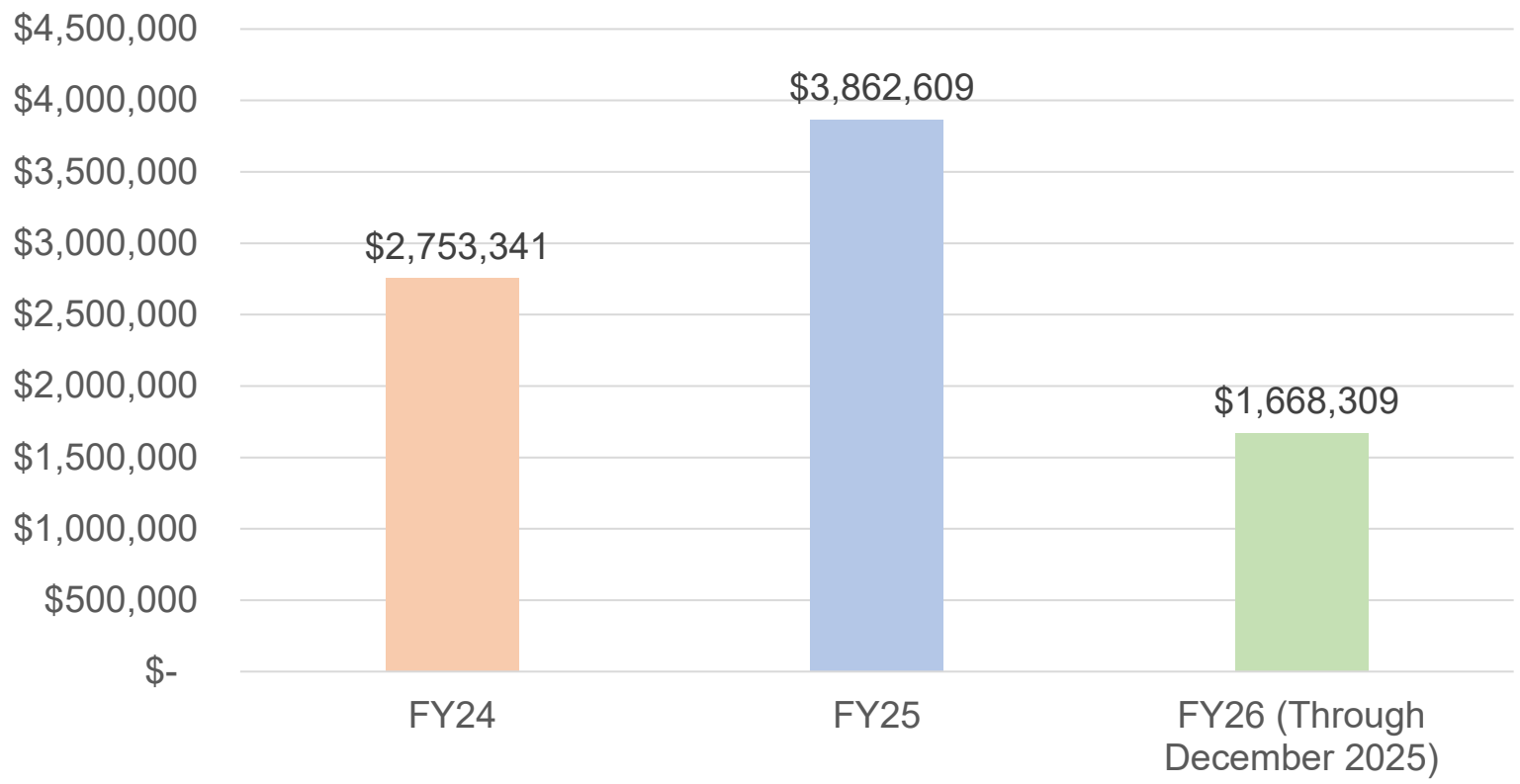
UCSF Department of Surgery

ZSFG Department of Surgery Payments



UCSF Department of Surgery

ZSFG Department of Surgery Expenses



UCSF Department of Surgery

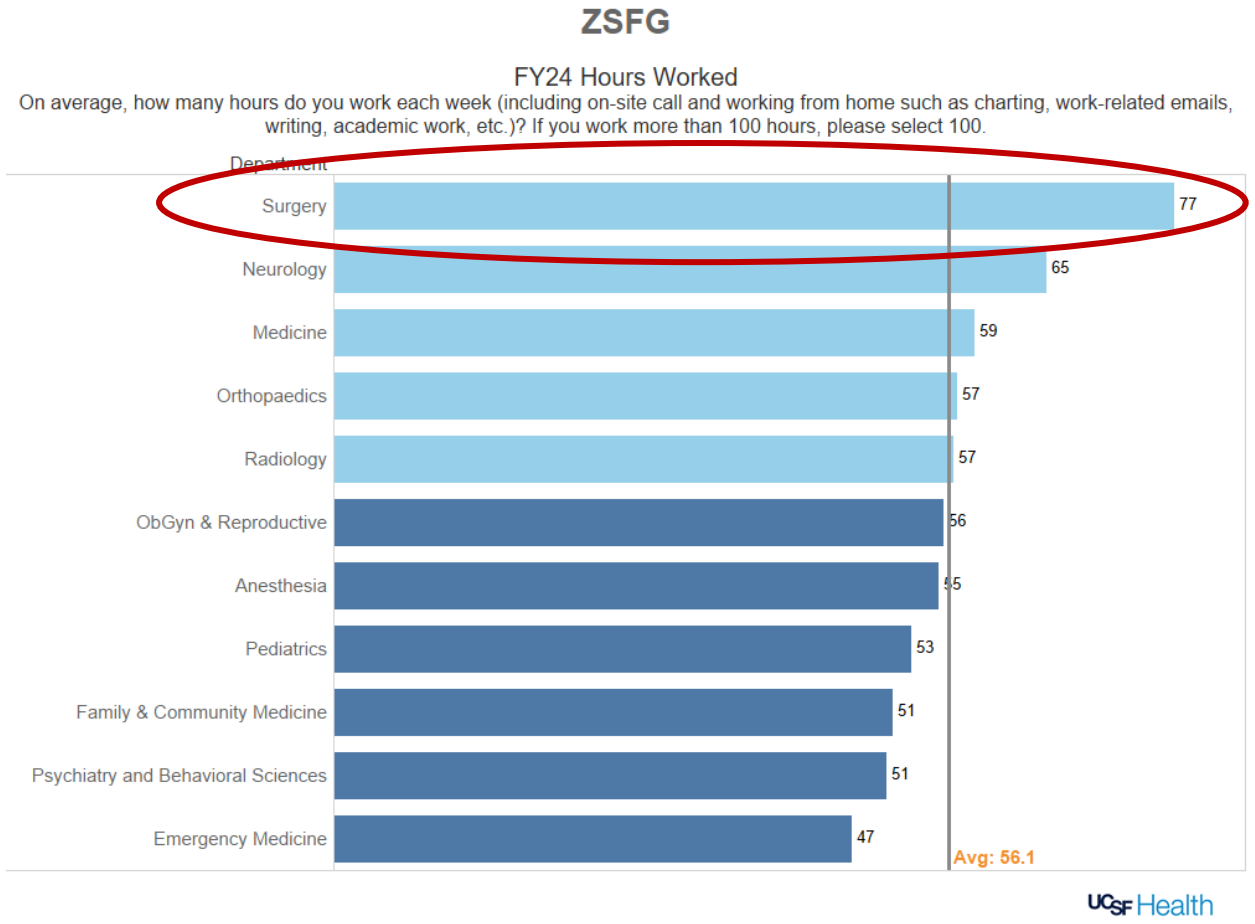
Summary

UCSF Department of Surgery

Divisional Summary

- **Strengths**
  - Nationally recognized extraordinary faculty providing exceptional patient care with excellent outcomes.
  - Dedication to surgical education with two primary fellowships in surgical critical care and acute care surgery.
  - Bright, motivated, resilient and engaged faculty with multiple funding opportunities and career trajectories

- **Opportunities for improvement**
  - Service vs education balance
  - High census and clinical needs of faculty and risk of burnout
  - Improve charge capture, documentation, and clarity around billing



UCSF Health

UCSF Department of Surgery

City and County of San Francisco

Department of Public Health

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

Daniel Lurie
Mayor

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	*ZSFG Clinical Service Rules and Regulations*
Clinical Service :	*Surgery*
Date of last approval:	*2024*
Summary of R&R updates:	*Defined Vascular Surgery Service as separate from Trauma/General Surgery. Defined Acute Care Surgery as a emergency general surgery/trauma/critical care to be more consistent with national change in service nomenclature.*
Update #1:	*Vascular Surgery is a distinct service separate from general surgery.*
Update #2:	*Morbidity and Mortality Conference occurs weekly*
Update #3:	*Minor grammar changes throughout document.*
Update #4:	
Update #5:	

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS

~~2024~~2026

Updated January 2018

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS (Continued)

I. SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

1. The Surgery Service consists of the following surgical specialties: elective ~~general~~ surgery (consisting of general surgery, minimally invasive surgery, surgical oncology and colorectal surgery); acute care surgery (consisting of emergency general surgery, ~~;~~ trauma, and surgical critical care); plastic surgery, vascular surgery, and thoracic surgery, ~~colorectal surgery, minimally invasive surgery, surgical oncology and surgical critical care~~.

2. The Trauma and General Surgery Service will care for all patients admitted to the hospital for acute traumatic problems, and all patients admitted through the Emergency Medicine Service for acute or emergent non-traumatic general surgical problems. Subspeciality ~~for the~~ surgical ~~specialties listed above~~care will be provided by either Plastic or Vascular surgery services as appropriate.

3. The Trauma and General Surgery Service will also consist of all patients who present through the Surgical Clinic with non-urgent surgical problems including those admitted for any of the surgical subspecialties listed above (excluding plastic surgery and vascular surgery).

4. The Plastic Surgery Service will care for all patients who need reconstructive surgery, both emergently and electively.

5. The Vascular Surgery Service will care for all patients who need vascular reconstruction, both emergently and electively.

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION AND STAFFING OF THE SURGERY CLINICAL SERVICE

1. The Organization of Surgery Clinical Services Officers is as follows: (Note: See also attached Organizational Chart)*

Chief of Service

Chief of Plastic Surgery
Trauma Medical Director
~~Associate Trauma Medical Director~~
Surgical Director of the Surgical Intensive Care Unit
Chief of Vascular Surgery
Chief of Thoracic Surgery

Medical Director of the Soft Tissue Infection Clinic (OASIS)
Director of Surgery Clinic

A. Chief of Service

1) Appointment and Review
Appointment and review of the Chief of Service will occur by the process specified in the Medical Staff Bylaws.

2) Responsibilities
The Chief of Service is responsible for the overall direction of the clinical, teaching and research activities for the Surgery Service including:

(a) Review and recommendation of all new appointments, request for privileges and reappointments.
(b) Appointment of the other officers of the Surgery Service and service on committees.
(c) Financial affairs of the Surgery Service.
(d) Attendance at the Medical Executive Committee, the Dean's Meetings and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.
(e) Disciplinary actions as necessary, as set forth in these rules and regulations in the Bylaws and Rules and Regulations of the Medical Staff.

2. Attending Physician Clinical Responsibilities

A. Overall direction of clinical care is the responsibility of the attending staff of the Surgery Service. To perform that responsibility, close supervision of house-staff and Nurse Practitioners, and active participation in the care of each patient on the ~~in-patient~~inpatient service or those seen in the outpatient setting is required.

B. Specific Duties

1) Trauma /General Surgery Service Attending:
Core surgery faculty members are assigned each week to be the attending of record for the service. The service attending makes rounds with the resident team, writes daily progress notes in EPIC, responds to major trauma activations in the emergency department, and sees all emergent and non-emergency consults from other services as needed. The Service Attending also oversees all operations performed on consult and service patients (emergent and non-emergent) during the daytime weekday shift. The service attending will be immediately available during their daytime shift unless specific arrangements are made for a back-up surgeon to cover. Any purely elective surgery will not be scheduled by the Service attending

unless specific cross coverage arrangements are made in advance. Clinic responsibilities for the service attending are minimized.

2) In addition to the Trauma/General Surgery Weekly Service Attending, there is an on-call attending for trauma/emergency surgery that is immediately available to cover the night call (generally 5~~6~~ PM to 7 AM). This on-call surgeon responds to major trauma activations during their shift and conducts or supervises all trauma and emergency general surgery operations during that time. A ~~back-up~~backup trauma/general surgeon is also assigned for each shift (day and night) and is promptly available should the on-call surgeon request assistance.

3) All attending surgeons ~~that~~ who are assigned clinic time are expected to be present for the evaluation of new and follow-up patients scheduled into their elective clinic. Patients in need of surgery will be evaluated by the attending surgeon ~~and consent~~, and consent will be obtained by the surgeon prior to formal scheduling in the operating room. The surgeon of record will perform or directly supervise the conduct of all elective surgical procedures in the operating room.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Surgery Clinical Service will be in accordance with ZSFG Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations. Reappointment to the staff is dependent on continuing demonstration of competence.

C. ONGOING PROFESSIONAL PERFORMANCE EVALUATION (OPPE)

The quality assurance information specific to Surgery Service Practitioners will be maintained by the Chief of Surgery and/or their designee and will be used to monitor and report on ongoing professional performance evaluations (Surgery OPPE, Appendix F) and in the data summary sheets provided by the Service Chief at the time of reappointment or re-credentialing.

The process for Staff Status Change for members of the Surgery Services will be in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

D. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals through the Surgery Clinical Service will be in accordance with ZSFG Bylaws, Rules and Regulations, as well as with these Clinical Service Rules and Regulations (see Attachment A).

E. STAFF CATEGORIES

Surgery Clinical Service staff fall into the same staff categories that are described in Article III – *Categories of the Medical Staff* of the ZSFG Bylaws, Rules and Regulations, as well as with these Clinical Service Rules and Regulations.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Surgery Clinical Service Privilege Request Form shall be reviewed annually at the time of reappointment to the medical staff.

C. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

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

Privileges to practice on the Surgery Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice. The specifics of the process and the privileges which will be assigned are described in detail in the **DELINEATION OF PRIVILEGES, SURGERY SERVICE, ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL, ATTACHMENT A.**

Privileges are delineated by consensus of the active medical staff members of the Surgery Service, and are approved by the Chief of Surgery, subject to the approval of the Credentials Committee of the medical staff.

Individuals' privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, and at the time as judged necessary by the Chief of Service.

Note: Completion of medical records including dictation of operative notes within two weeks of the date of operation is a medical staff requirement and individuals who are consistently delinquent may have their privileges suspended.

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

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

IV. PROCTORING AND MONITORING REQUIREMENTS

A. REQUIREMENTS

Proctoring requirements for the Surgery Clinical Service shall be the responsibility of the Chief of the Service.
All requirements and details of proctoring will be delineated in the document.

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION OF MEDICAL STAFF

The Surgery Clinical Services offers weekly educational activities/teaching conferences as follows:

ZSFG Trauma Service Morning Report	Monday-Friday 0630-0730
UCSF Surgery Grand Rounds	Wednesday 0700-0900
ZSFG Surgery Mortality and Morbidity Conference	Every ~~1st and 3rd~~ Tuesday 1700-1800*
Trauma Multidisciplinary Peer Review (faculty only)*	Monthly - every 4th Wednesday 3-5pm
~~ZSFG Surgical Case Conferences/ Grand Rounds~~	~~Every 4th Tuesday 1700-1800*~~
GI Radiology Conference	Monday1200-1300
Trauma Video Resuscitation Conference	2nd Tuesday 1700-1600
Tumor Board	Thursday 0800-090

Note: Attendance at 50% of ZSFG Surgery Grand Rounds /~~Case Conference~~ Mobidity and Mortality Conferenceis an expectation for all full-time surgery faculty. Persistent non-compliance may be reported to the medical staff office as part of OPPE.
*>50% attendance at ~~TMPR~~ Trauma Multidisciplinary Peer Review is a privileging requirement for core trauma panel members~~,~~ ; failure of this requirement will require suspension of trauma privileges.

VI. SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

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

1. ROLE, RESPONSIBILITY, AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF (Refer to CHN Website for Housestaff Competencies link.)

A. The Trauma and General Surgery Service, the Vascular Surgery, and the Plastic Surgery Services will be overseen by a Chief Resident and/or Surgical Critical Care/Vascular Fellow in each respective discipline. The Chief Resident in collaboration with senior residents will supervise the junior house staff in all aspects of patient care including the admission history and physical exams, ordering of laboratory and radiologic investigations, house staff rounds on all hospitalized patients, and house staff patient evaluation in the outpatient clinics. All residents are under the supervision of the attending surgeon assigned to the Trauma and General Surgery Service, Vascular Surgery or Plastic Surgery Service, or to the attending surgeons working in the outpatient surgical clinic area. In addition, all residents are directly supervised for all critical portions of the procedure by the attending surgeons in the operating room, except for minor procedures such as incision and drainage of abscesses, and consistent with the ACGME rules of indirect supervision.

B. All surgical residents are assigned specific duties appropriate to their level of training and expertise. These duties are outlined in detail in Attachment C.4. The surgical curriculum for house staff at the University of California, San Francisco is designed to ensure that the basic fund of knowledge and technical skill for the performance of these duties are taught to the residents under the direct supervision of the faculty. Specific house staff competencies are detailed in Appendix B.

2. RESIDENT EVALUATION PROCESS

The surgical attending staff meet regularly to perform individual evaluation of the residents and interns assigned to the surgical service at ZSFG. This evaluation includes all the components considered essential for progression to the next level of training, including professionalism, technical abilities, communication skills, and system-based and practice-based learning. These evaluations are provided ~~on-line~~online and made available to the UCSF Surgical Residency Director (or Director from a surgical or medical sub-specialty as appropriate) as well as to the residents themselves for their own self-evaluation. Each resident is given an exit interview by a surgery attending prior to leaving the rotation.

A. Mortality and Morbidity Conference includes discussion of all deaths and important complications with an emphasis on identification of opportunities for changes to systems of care or clinical practice that will improve care. This will be tracked within ~~the either the Surgical or Trauma QI Program dependent~~either the Surgical or Trauma QI Program, depending on the service line of the complication.

3. ABILITY TO WRITE PATIENT CARE ORDERS

House staff members may write patient care orders, except as specified by ZSFG policy (for example: DNR or Chemotherapy Agents). The supervising attending surgeon has ultimate responsibility for orders written by the surgical house staff ~~on~~ for the patients under their supervision.

VII. SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

Non-emergent, non-urgent surgical consultations are requested through eReferral, by submitting a consultation request form, or by telephone request tendered through a member of the surgical faculty, Fellow, or senior resident. Emergency consultations are requested through contact ~~of~~ with the on-call attending, service attending, or on-call senior resident. Emergency consultations are staffed by ~~the either the service or~~ either the service or the on-call attending surgeon. A record of such consultations will be provided by either the senior resident staff or directly by the attending.

VIII. DISCIPLINARY ACTION

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

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

A. GOALS AND OBJECTIVES

The Chief of Service, or designee, will be responsible for ensuring solutions to surgical performance improvement~~,~~ and patient safety. As necessary, assistance will be invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization (eg: Executive Committee; OR Committee, Risk Management etc) to:

1. Ensure appropriate care and safety of all patients receiving care in the department. It is understood that this care is provided chiefly in the emergency room, the operating room, the ICU, the surgical wards, and the surgical clinics.

2. Maximize the safety of patients receiving surgical care.

3. Minimize morbidity and mortality of surgical patients and to avoid unnecessary days of inpatient care.

4. Improve efficiency in the delivery of service.

B. RESPONSIBILITY

1. The Chief of Surgery has overall responsibility for the conduct of the Surgical Performance, Improvement and Patient Safety (PIPS) program. The Chief of Surgery may delegate portions of this responsibility to the Trauma Medical Director~~,~~, or the Director of the OASIS Outpatient Clinic.

C. REPORTING

Performance improvement/patient safety and utilization management activity records will be maintained by the clinical service. Minutes will be sent to the Medical Staff Services Department.

D. CLINICAL INDICATORS

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

F. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

G. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

H. MEDICAL RECORDS

The members of the Surgery Service are committed to the maintenance of complete, accurate, and timely medical records. These requirements are set forth in the ZSFG Bylaws and Rules and Regulations, which define the minimum standards for Medical Record completion.

1. Operative Records

   Dictated operative reports are required for all major and minor operative procedures performed in the operating suite, whether inpatient or outpatient. Operations or procedures performed in the surgical or OASIS clinics will generally be capable of being performed under local anesthesia and ~~minor in~~ of minor extent. A dictated operative note will not be required for these procedures, but they must be documented in the medical chart by an operative procedure note.

   Dictated operative reports should, contain the following elements (minimum):

   a. Pre-operative diagnosis
   b. Post-operative diagnosis
   c. Operative procedure(s) performed
   d. Surgeon(s)
   e. Narrative description of the operation
   f. Major findings
   g. Complications
   h. Estimated blood loss
   i. Specimens

2. Discharge Summaries

   Dictated discharge summaries will be completed on all patients hospitalized for more than 48 hours, and for those trauma patients surviving less than 48 hours. Patients hospitalized less than 48 hours may have a handwritten or dictated discharge summary at the discretion of the treating resident or attending physician. Dictated discharge summaries will contain a succinct description of the reasons for hospitalization, the course of treatment, complications of treatment, condition on discharge, and plans for post-hospitalization care.

   As noted above, consistently delinquent operative or medical records may result in temporary or permanent loss of privileges as outlined in the Medical Staff Bylaws.

I. INFORMED CONSENT

1. All decisions for operative treatment should involve the active participation of the patient or their surrogate and should be made after appropriate discussions of the details of the procedure and expectations

for the procedure, and attendant alternatives, risks, benefits, and complications.

2. Documentation of "Informed Consent" on medical ~~staff approved~~staff-approved forms is required for the following:
    a. All surgical procedures performed in the operating room, procedure rooms, ICU, or wards.
    b. All procedures performed in the clinic unless specifically included on the list of procedures that do not require consent.
    c. All procedures involving laser therapy.

3. Documentation of patient consent will be provided by a properly signed and completed ZSFG Operative Consent Form.
4. The operating surgeon will also provide a Preoperative Note in the progress notes section of the ~~patient chart (typically on~~ patient's chart (typically on a pre- and post-operative note form). This note should include elements outlined in I.1. above.

X. MEETING REQUIREMENTS

A. MEETING CRITERIA

In accordance with ZSFG Medical Staff Bylaws, all Active members of the ZSFG medical staff are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, and the annual Medical Staff Meeting. This information will be located in the provider files.

Clinical Services (faculty) meetings are conducted at ~~least twice monthly for the purpose of discussing clinical service needs, financial monitoring, educational and research agendas~~monthly for the purpose of discussing clinical service needs, financial monitoring, educational and research agendas, and other business as appropriate.

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.

B. COMMITTEES

Members of the Department of Surgery either Chair or participate in the following ZSFG committees

1. Multidisciplinary Trauma Peer Review Committee (TMD serves as Chair)
2. Hospital PIPS
3. Risk management
4. MEC (Chief and Trauma Director are ex officio members)
5. Disaster (Trauma Medical Director)
6. Operating Room (Chief is ex officio member & co-chair)
7. Transfusion
8. Critical Care
9. PEMT

10. CPG
11. Credentials
12. Cancer
13. Others as needed

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. OPERATIONAL

All house staff will receive~~,~~ and are required to review~~,~~ the online orientation module, “Surgical Resident Orientation to the Operating Room" (see Attachment C.5). All new faculty members will be oriented by the Chief of Surgery and have meetings scheduled to meet other key physician and nursing colleagues to assist in orientation to the hospital. The Chief of Surgery will be responsible for ensuring that 24-hour a day, 365 day-a-year attending and resident surgeon coverage is available for the hospital.

B. SCHEDULES

~~Full time~~Full-time faculty must submit their requests for time off to the Chief of Surgery at least two months ahead of time. ~~Full time faculty must note on their schedule request reasons for days off (i.e. personal, reason for work-related business.)~~Full-time faculty must note on their schedule the reasons for days off (i.e., personal, work-related business).

All approved schedule requests will be kept on file with the scheduling administrative assistant. She/he will coordinate with the 3M and ISIS clinics and the OR regarding ~~out of office~~out-of-office faculty schedule blocking. Absence from clinic and release of OR time will not be accommodated (except in case of an emergency or illness) if the notification is shorter than 6 weeks in advance.

Once the trauma/service calendars are completed, it is up to the individual attending surgeon to find coverage should they wish to trade dates. In the event of an illness, the back-up surgeon will be ~~call~~ called to provide in-house coverage until the schedule can be rearranged.

C. CLINICAL

The evaluation and documentation of patients admitted to the hospital are discussed in section IX D and IX E.

D. RISK MANAGEMENT

The Chief of Service will ensure that hospital policies regarding leaving against medical advice, restraints, informed consent, DNR, universal precautions, and the use of interpreters are followed by members of the Surgery Service.

XII. ADOPTION AND AMENDMENT

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

Surgery Privileges

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

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

Surg SURGERY 2010

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.

38.00 CORE PRIVILEGES/GENERAL SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures
REAPPOINTMENT: 20 operative procedures in the previous two years

Preoperative, operative and post-operative care of patients Surgery of the alimentary tract, abdomen, breast, skin and soft tissues, and endocrine system. Privilege includes care of general surgical and trauma patients in the Intensive Care Unit, non-surgical or surgical management in the surgical clinic or emergency department, and comprehensive management of enteral and parenteral nutrition. Surgical procedures are:

38.01 ABDOMEN, PERITONEUM
- A. Insertion Peritoneal Dialysis Catheter
- B. Open or Laparoscopic Exploratory Laparotomy
- C. Open Drainage Abdominal Abscess
- D. Open Repair of Inguinal, Femoral, and Ventral Hernia
- E. Laparoscopic Repair of Inguinal, Femoral, and Ventral Hernia
- F. Repair Miscellaneous Hernias

38.02 ESOPHAGUS
- A. Laparoscopic Anti-Reflux Procedure
- B. Open Anti-Reflux Procedure or Repair of Paraesophageal Hernia

38.03 LIVER, BILIARY TRACT, PANCREAS
- A. Open or Laparoscopic Cholecystectomy With or Without Cholangiography
- B. Cholecystostomy
- C. Open Common Bile Duct Exploration, Repair Acute Common Bile Duct Injury
- D. Choledochoscopy
- E. Choledochoenteric Anastomosis
- F. Operation for Gallbladder Cancer (when found incidentally)
- G. Hepatic Biopsy, Wedge Resection of Liver, Drainage Liver Abscess
- H. Distal Pancreatectomy or Pancreatic Debridement for Necrosis
- I. Intraoperative Pancreatic Ultrasound
- J. Drainage Pancreatic Pseudocyst

38.04 STOMACH and INTESTINES
- A. Percutaneous Endoscopic Gastrostomy
- B. Partial/Total Gastrectomy
- C. Truncal Vagotomy and Drainage, Repair Duodenal Perforation, Open Gastrostomy
- D. Open or Laparoscopic Appendectomy

Privileges for Zuckerberg **San Francisco General Hospital**

Requested	Approved	
		E. Open Partial Colectomy, Colostomy, Colostomy Closure
		F. Subtotal Colectomy with Ileorectal Anastomosis/Ileostomy
		G. Laparoscopic Partial Colectomy
		H. Hemorrhoidectomy, Lateral Internal Sphincterotomy, Banding for Internal Hemorrhoids
		I. Drainage Anorectal Abscess, Pilonidal Cystectomy, anal Fistulotomy/Seton Placement
		38.05 ENDOCRINE SYSTEM
		A. Partial or Total Thyroidectomy and Parathyroidectomy
		B. Open Adrenalectomy
		38.06 ENDOSCOPY
		A. Esophagogastroduodenoscopy
		B. Proctoscopy
		C. Colonoscopy with or without Biopsy/Polypectomy
		38.07 HEMIC and LYMPHATIC SYSTEMS
		A. Open splenectomy
		B. Lymph Node Biopsy or Excision
		C. Bone marrow Biopsy and Aspiration
		38.08 SKIN and SOFT TISSUES
		A. Excisional/Incisional Resection and/or Repair of Lesions of Skin and Subcutaneous Tissues.
		B. Excision, Biopsy, Incision of Soft Tissue Lesion of Muscular or Fascial Areas
		C. Incision, Drainage, Debridement for Soft Tissue Infections
		D. Wide Local Excision Melanoma
		E. Split-thickness and Full-thickness Skin Grafts
		F. Burn Debridement
		G. Repair of Wounds and Complex Lacerations and Traumatic Injuries
		H. Repair Tendons
		I. Digital Nerve Block
		J. Fasciotomy
		K. Placement of Negative Pressure Dressing Devices
		38.09 CARDIOVASCULAR SYSTEM
		A. Venous Insufficiency and Operation for Varicose Veins
		B. Sclerotherapy, Peripheral Vein
		C. Insertion of Vena Caval Filter
		D. Percutaneous Vascular Access
		E. Creation or Rrevision of Arteriovenous Graft/Fistula
		F. Embolectomy/Thrombectomy Artery
		G. Major Extremity Amputations (above or below knee, foot, transmetatarsal, toe)
		38.10 THORAX
		A. Chest Tube Placement
		B. Exploratory Thoracotomy, Pericardial Window for Diagnosis/Drainage
		38.11 TRACHEA and BRONCHI
		A. Tracheostomy and Cricothyroidotomy
		38.20 SPECIAL PRIVILEGES

Privileges for Zuckerberg San Francisco General Hospital

Requested	Approved	
		38.21 COMPLEX UPPER ABDOMINAL SURGERY
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or American Board of Cardiothoracic Surgery, or a member of the Clinical Service prior to 10/17/00
		PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures.
		REAPPOINTMENT: 10 operative procedures in the previous 2 years.
		Preoperative, operative and post-operative care of patients with complex benign or malignant conditions of the esophagus, liver, and pancreas:
		A. Total esophagectomy, esophagogastrectomy
		B. Open Heller myotomy, Collis gastroplasty, resection of perforated esophagus
		C. Cricopharyngeal myotomy with excision Zenker's diverticulum
		D. Laparoscopic repair of paraesophageal hernia or Heller myotomy
		E. Open liver segmentectomy/lobectomy
		F. Laparoscopic liver segmentectomy/lobectomy
		G. Portal-systemic shunt
		H. Operation for gallbladder or bile duct cancer (planned)
		I. Excision choledochal cyst
		J. Pancreaticoduodenectomy, ampulary resection, or total pancreatectomy
		K. , Frey procedure, Beger procedure
		38.22 COMPREHENSIVE CARE OF BREAST DISEASE
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00.
		PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.
		REAPPOINTMENT: 20 operative procedures in the previous 2 years.
		Preoperative, operative and post-operative care of patients with complex benign or malignant conditions (excluding soft tissue infections) of the breast:
		A. Aspiration of breast cyst
		B. Duct excision
		C. Breast biopsy with or without needle localization
		D. Lumpectomy, partial, simple mastectomy, modified radical, radical mastectomy
		E. Sentinel lymph node biopsy, axillary lymph node dissection
		F. Stereotactic breast biopsy
		38.23 COMPLEX COLO-RECTAL SURGERY
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or American Board of Colorectal Surgery, or a member of the Clinical Service prior to 10/17/00.
		PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures.
		REAPPOINTMENT: 10 operative procedures in the previous 2 years.
		Preoperative, operative and post-operative care of patients with complex benign or malignant conditions of the colon and rectum:
		A. Total proctocolectomy, ileoanal pull-through, ileal-pouch procedures

Privileges for Zuckerberg **San Francisco General Hospital**

Requested Approved

B. Repair complex anorectal fistulae
C. Excision of anal cancer, transanal resection for tumor
D. Perineal operation for rectal prolapse
E. Stapled hemorrhoidectomy
F. Open or laparoscopic transabdominal operation for rectal prolapse
G. Abdominoperineal resection
H. Pelvic exenteration for rectal cancer

38.24 COMPLEX VASCULAR SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or Board Certification or eligibility in Vascular Surgery, or a member of the Clinical Service prior to 10/17/00.

PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures.

REAPPOINTMENT: 10 operative procedures in the previous 2 years.

Preoperative, operative and post-operative care of patients with complicated vascular disease:

A. Aorto-iliac, ilio-femoral, aorto-femoral bypass
B. Femoral-femoral, femoral-popliteal, axillo-femoral bypass
C. Profunda endarterectomy, other endarterectomy
D. Infrapopliteal bypass, composite leg bypass graft, revise/re-do lower extremity bypass
E. Thoracic outlet decompression, vertebral artery operation, arm bypass, or endarterectomy
F. Celiac/SMA/renal endarterectomy/bypass
G. Elective repair aorto/iliac/femoral/popiteal aneurysm
H. Repair thoracoabdominal aortic aneurysm
I. Carotid endarterectomy, reoperative carotid surgery, excise carotid body tumor
J. Angioscopy
K. Balloon angioplasty, transcatheter stent
L. Endovascular repair other aneurysm, other endovascular graft
M. Endovascular thrombolysis
N. Pseudoaneurysm repair/injection
O. Excise infected vascular graft, repair graft-enteric fistula
P. Sympathectomy
Q. Venous embolectomy/thrombectomy, venous reconstruction
R. Repair arteriovenous malformation

38.25 COMPREHENSIVE PEDIATRIC SURGERY

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

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

A. Excision of retroperitoneal or pelvic tumor, including Wilms' tumor and neuroblastoma
B. Repair of complex chest and abdominal wall defect
C. Repair omphalocele or gastroschisis
D. Repair of esophageal atresia, stenosis or tracheo-esophageal fistula
E. Definitive surgery for Hirschsprung's Disease
F. Operation for rectal duplication
G. Repair of imperforate anus, including secondary operations

Privileges for Zuckerberg San Francisco General Hospital

Requested	Approved	
		H. Operative reduction intussusception
		I. Pyloromyotomy
		J. Correction of congenital vaginal/penile anomalies, exploration and management of intersex
		K. Excision cystic hygroma, lymphangioma, hemangioma
		L. Excision of hemangiomas and lymphangiomas
		M. Repair of pectus excavatum, pectus carinatum and other thoracic deformities
		N. Excision intrathoracic tumor, cyst or other lesion, including mediastinum
		O. Segmental pulmonary resection, lobectomy, pneumonectomy
		P. Repair exstrophy of cloaca or vesicointestinal fissure, repair of cloacal anomaly
		Q. Nephrectomy, partial or complete for trauma or benign and malignant cyst or tumor
		R. Repair hypospadias or epispadias, meatotomy
		S. Nissen fundoplication
		38.26 SURGICAL CRITICAL CARE
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery in Surgical Critical Care, or a member of the Clinical Service prior to 10/17/00.
		PROCTORING: Review of 10 cases
		REAPPOINTMENT: Provision of surgical critical care to a minimum of 20 patients and at least 10 hours of critical care related CME in the previous 2 years
		Critical care of patients hospitalized in Intensive Care Units, including (but not limited to) comprehensive management of mechanical ventilation, nutrition, cardiovascular support, diagnosis and management of infections, management of shock, critical care of neurologic and neurosurgical patients, critical care of burn patients. Performance of invasive critical care procedures:
		A. pulmonary artery catheter placement
		B. Endotracheal intubation, airway management
		C. Thoracentesis, paracentesis
		D. Patient controlled analgesia and epidural analgesia
		E. Cardiac pacing (external and transvenous), defibrillation and cardioversion.
		38.27 PLASTIC SURGERY
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery.
		PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures
		REAPPOINTMENT: 40 operative procedures in the previous two years
		Functional and aesthetic management of congenital acquired and traumatic defects of the face, neck, body, and extremities, excluding microsurgery and replantation of limbs and parts
		A. Incision and Drainage of abscess
		B. Flexor/extensor tendon repair, tenolysis, drainage of tendon sheath
		C. Local skin/ muscle rotational flap, skin tissue rearrangement
		D. Repair nailbed injury
		E. Release a-1 pulley, pulley reconstruction

Privileges for Zuckerberg San Francisco General Hospital

Requested	Approved	
		F. Fasciotomy
		G. Separation of digit syndactyly, excision of supranumery digit
		H. Carpal/cubital tunnel release
		I. Completion amputation of digit
		J. ORIF/CRPP radius, ulnar, carpal, metacarpal, phalangeal fractures
		K. Removal of foreign body
		L. Placement of tissue expander
		M. Breast reconstruction with TRAM, free perforator flap
		N. Breast capsulotomy/capsulectomy
		O. Breast reconstruction with saline implant, removal saline implants
		P. Nipple reconstruction
		Q. ORIF mandibulomaxillary/ZMC/nasal/nasoethmoid/orbital floor fracture
		R. Full thickness (FTSG) or split thickness skin graft (STSG)
		S. Abdominal wall reconstruction, components separation, mesh placement
		T. Debridement, skin and subcutaneous tissue, muscle and bone
		U. Placement of negative pressure dressing devices
		38.28 MICROSURGERY AND REPLANTATION OF LIMBS AND PARTS
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery, or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with successful completion of a Fellowship in Microsurgery, or a member of the Clinical Service prior to 10/17/00.
		PROCTORING: 2 observed operative procedures and 5 retrospective review of operative procedures
		REAPPOINTMENT: 5 operative procedures in the previous two years
		A. Use of operating microscope, repair blood vessel/ nerve, digit replantation
		B. Free myo/skin flap microvascular anastomosis
		38.29 LASER SURGERY
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Appropriate training, viewing of the laser safety video prepared by the ZSFG Laser Safety Committee, and baseline eye examination.
		PROCTORING: 2 observed procedures
		REAPPOINTMENT: 2 cases in the previous two years; and viewing of the laser safety video prepared by the ZSFG Laser Safety Committee and documentation of eye exam within the previous 6 months
		A. Removal of congenital and acquired lesions (tattoos, hemangiomas, pigmented lesions)
		38.30 LAPAROSCOPIC GENERAL SURGERY
		PREREQUISITES: Currently Board Admissible, Board Certified or Re-certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Demonstration of competence in Laparoscopic Surgery and completion of a surgical residency/fellowship that incorporates structured experience in laparoscopic surgery. For those without formal training during residency or fellowship in laparoscopic procedures, the minimum requirements are: observation of a minimum of five (5) cases and successful completion of twenty-five (25) cases.
		PROCTORING: 2 observed operative procedures
		REAPPOINTMENT: 5 operative procedures in the previous two years

Privileges for San Francisco General Hospital

Requested	Approved	
		A. Laparoscopic repair of paraesophageal hernia or Heller myotomy
		B. Laparoscopic liver segmentectomy/lobectomy
		C. Laparoscopic procedures for morbid obesity
		D. Laparoscopic or lap-assisted colectomy
		E. Laparoscopic assisted pancreatectomy
		F. Laparoscopic splenectomy
		G. Laparoscopic adrenalectomy
		H. Other advanced laparoscopic procedures NOS
		38.31 BRONCHOSCOPY AND FOREIGN BODY REMOVAL
		PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Surgery or American Board of Thoracic Surgery, or a member of the Clinical Service prior to 10/17/00.
		PROCTORING: 1 observed operative procedure
		REAPPOINTMENT: 2 cases in the previous two years
		38.32 ACUTE TRAUMA CARE
		PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Current ATLS certification (provider). Availability, clinical performance and continuing medical education consistent with current standards for general surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons.
		PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures
		REAPPOINTMENT: 5 operative procedures in the previous two years. 32 hours of trauma-related CME in previous 2 years.
		On-call trauma coverage for the initial resuscitation and comprehensive management of the acutely injured patient. Includes acute operative management of thoracic and vascular injuries, and initial surgical critical care of the trauma patient:
		A. Repair/resection for renal, ureteral, or bladder trauma
		B. Placement of intracranial pressure monitor
		C. Reduction and stabilization of maxillofacial fracture
		D. Repair of tendon or nerve
		E. Open reduction/ debridement of open/closed fracture, closed reduction of fracture

Privileges for Zuckerberg **San Francisco General Hospital**

Requested Approved

38.33 PERCUTANEOUS DILITATIONAL TRACHEOSTOMY WITH BRONCHOSCOPIC ASSISTANCE

Privilege shall be performed either in the Operating Room or in the ICU. All procedures will be performed with bronchoscopic guidance.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Documentation of two successfully performed procedures supervised by an experienced practitioner or documentation of two previous successful procedures during residency or fellowship.

PROCTORING: 1 observed operative procedure

REAPPOINTMENT: 1 operative procedure in the previous two years

38.34 SURGICAL ULTRASOUND

Examination for the detection of peritoneal or pericardial fluid

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery. Successful completion of a basic ultrasound course approved by the American College of Surgeons and successful completion of the advanced module for trauma and acute care imaging course.

PROCTORING: Interpretation of 25 exams

REAPPOINTMENT: Interpretation of 25 ultrasounds and 3 hours of Category I CME in ultrasonography in the previous two years

38.35 MODERATE SEDATION

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department

PROCTORING: Review of 5 cases

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

38.36 NON-TRAUMA THORACIC SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Cardiothoracic Surgery, or currently Board Admissible, Board Certified, or Recertified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00, or successful completion of a structured experience in thoracic surgery including the successful completion of twenty-five (25) cases.

PROCTORING: 2 operative cases

REAPPOINTMENT: 2 operative cases in the previous two years

A. Pulmonary lobectomy, pneumonectomy, wedge lung resection

B. Pleurodesis, open drainage of empyema

C. Excision mediastinal tumor

D. Transthoracic repair diaphragmatic hernia

E. Repair aortic arch injury, dissection, or thoracic aortic aneurysm or dissection

F. Pericardiectomy

G. ORIF rib fractures

Privileges for Zuckerberg **San Francisco General Hospital**

Requested Approved

38.37 THORACOSCOPIC SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or American Board of Cardiothoracic Surgery, or a member of the clinical service prior to 10/17/00, or completion of a surgical residency/fellowship that incorporates a structured experience in thoracoscopic surgery. Competence should be documented by instructors. For those without formal training during residency or fellowship in thoracoscopic procedures, the minimum requirements are observation of three thoracoscopic surgical procedures performed by a surgeon experienced in the performance of such procedures; and either training in thoracoscopic surgery by a surgeon experienced in thoracoscopic surgery with proctored assistance by a surgeon experienced in either thoracoscopic procedures or laparoscopic techniques, or completion of a University sponsored or academic society (Joint Committee) recognized didactic course with clinical and hands-on laboratory practice in three animals

PROCTORING: 2 observed operative procedures

REAPPOINTMENT: 1 operative procedure in the previous two years

A. Thoracoscopy with or without biopsy

B. Thoracoscopic pleurodesis, evacuation hematoma or empyema

C. Thoracoscopic Heller myotomy

38.38 CARDIOPULMONARY BYPASS

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified by the American Board of Cardiothoracic Surgery, or a member of the Clinical Service prior to 10/17/00.

PROCTORING: 2 observed operative procedures

REAPPOINTMENT: 2 operative procedures in the previous two years

38.39 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery and current X-Ray/Fluoroscopy Certificate, or a member of the Clinical Service prior to 10/17/00.

PROCTORING: Presentation of valid California Fluoroscopy certificate;

REAPPOINTMENT: Presentation of valid California Fluoroscopy certificate

38.40 COMPLEX CRANIOFACIAL SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery

PROCTORING: 2 observed operative procedures

REAPPOINTMENT: 2 cases in the previous two years

A. Closed reduction and Mandibulomaxillary (MMF) fixation of mandible fracture

B. Open reduction and internal fixation of mandible fracture

C. Open reduction and internal fixation of zygoma fracture

D. Open reduction and internal fixation of orbital floor fracture

E. Open reduction and internal fixation of orbital wall fracture

F. Open reduction and internal fixation of zygomaticomaxillary (ZMC) complex fracture

G. Open reduction and internal fixation of noso-orbital ethmoid fracture

H. Open reduction and internal fixation of Le Fort I fracture

I. Open reduction and internal fixation of Le Fort II fracture

J. Open reduction and internal fixation of Le Fort III fracture

K. Cleft lip repair

L. Cleft palate repair

M. Resection of arteriovenous malformation

N. Complex tissue rearrangement, scalp

Printed 1/8/2018

Requested Approved

38.45 COMPLEX HAND SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery, or the American Board of Surgery with successful completion of a fellowship in Hand Surgery

PROCTORING: 1 observed operative procedures

REAPPOINTMENT: 2 cases in the previous two years

- A. Incision/drainage abscess, finger or hand
- B. Palmar fasciotomy Dupuytren's contracture
- C. Palmar fasciectomy Dupuytren's contrature
- D. Closed capsulotomy
- E. Open capsulotomy
- F. Exicision Bone cysts
- G. Excision bone tumors
- H. Bone Grafts, hands or fingers
- I. Arthrodeisis, hand or finger joints
- J. Tenolysis
- K. Tenorrhaphy
- L. Tendon Transfer
- M. Free Tendon graft, from arm or leg
- N. Arthroplasty with implant
- O. Ligament repair or reconstruction
- P. Reconstruction Hand Deformities
- Q. Amputation, finger, hand or forearm
- R. Fractures/dislocations
- S. Carpal tunnel release
- T. Nerve tranpositions
- U. Nerve repair, primary
- V. Nerve repair, secondary with nerve graft
- W. Removal of foreign bodies
- X. Replantation of fingers and/or hand
- Y. Wrist arthoscopy
- Z. Carpal bone fractures
- A1. Wrist Fractures

38.55 WAIVED TESTING

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

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

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

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

- A. Fecal Occult Blood Testing (Hemoccult®)
- B. Vaginal pH Testing (pH Paper)
- C. Urine Chemstrip® Testing
- D. Urine Pregnancy Test (SP® Brand Rapid Test)

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

I hereby request clinical privileges as indicated above.

Applicant date

FOR DEPARTMENTAL USE:

Proctors have been assigned for the newly granted privileges.
Proctoring requirements have been satisfied.

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

CPR certification is required.
CPR certification is not required.

APPROVED BY:

Division Chief date

Service Chief date

SURGERY 2022
(07/2022 MEC & JCC)

38.00 General Surgery- CORE (pt. 1)

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

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

Breast

- Incision and drainage of abscess/cysts
- Excisional biopsy

Skin, Soft Tissue, Musculoskeletal

- Excisional/incisional resection of skin and subcutaneous tissues
- Biopsy of skin and soft tissue lesions, including excisional biopsy
- Debridement of skin and soft tissue
- Hidradenectomy
- Debridement of burn wounds
- Split thickness skin graft
- Full thickness skin graft
- Lymph node biopsy
- Fasciotomy
- Placement of negative pressure dressing devices
- Other emergency procedures not otherwise specified

Head and Neck

- Open Or Percutaneous Tracheostomy
- Cricothyroidotomy
- Biopsy of neck mass
- Biopsy of thyroid nodule/mass
- Other emergency procedures not otherwise specified
- Temporal artery biopsy

Abdomen – Peritoneum

- Exploratory Laparotomy
- Diagnostic Laparoscopy
- Drainage Abdominal Abscess
- Open Repair Inguinal/Femoral Hernia
- Open Repair Ventral Hernia
- Laparoscopic Repair Ventral Hernia
- Insertion Peritoneal Dialysis Catheter
- Other emergency procedures not otherwise specified
- Open repair of diaphragmatic hernia

38.00 General Surgery- CORE (pt. 2) ___

Abdomen - Liver, Biliary, Pancreas, Spleen

- Open cholecystectomy
- Laparoscopy cholecystectomy
- Cholangiogram
- Open Common Bile Duct Exploration
- Choledoscopy
- Repair Common Bile Duct Injury
- Choledochoenteric Anastomosis
- Operation For Gallbladder Cancer (When Found Incidentally)
- Hepatic Biopsy
- Partial Hepatectomy
- Drainage Liver Abscess
- Distal Pancreatectomy
- Pancreatic Debridement
- Drainage of pancreatic Pseudocyst
- Splenectomy
- Other emergency procedures not otherwise specified

Abdomen - GI tract

- Repair/Resection Of Perforated Esophagus
- Partial/Total Gastrectomy
- Open or Laparoscopic Gastrostomy/Jejunostomy
- Repair Duodenal Perforation
- Truncal Vagotomy
- Open or Laparoscopic Enterostomy/Enterectomy
- Open or Laparoscopic Colostomy/Colectomy
- Hemorrhoidectomy
- Banding for Internal Hemorrhoids
- Lateral Internal Sphincterotomy
- Drainage Anorectal Abscess
- Pilonidal Cystectomy
- Anal Fistulotomy/Seton Placement
- Other emergency procedures not otherwise specified

Endoscopy

- Diagnostic Esophagogastroduodenoscopy
- Diagnostic Sigmoidoscopy
- Diagnostic Colonoscopy

38.05 General Surgery - Special Privileges ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or experience or Subspecialty Board Certification.

PROCTORING: INITIAL - 2 observed operative procedures and 10 retrospective reviews per Category of operative procedures.

REAPPOINTMENT - 2 operative procedures per Category in the previous 2 years. For those procedures that are rarely performed and, as such, there is no frequency or volume of cases required, each case will be reviewed and for each privilege a running evaluation of all cases will be performed after each case

A. Skin, Soft Tissue, Musculoskeletal ___

1 Wide Local Excision Melanoma ___

2 Sentinel lymph node biopsy ___

3 Axillary, femoral, or cervical lymph node dissection ___

B. Head and Neck ___

1 Cricopharyngeal Myotomy ___

2 Excision Zenker'S Diverticulum ___

3 Excision thyroglossal duct cyst ___

4 Glossectomy ___

C. Abdomen – Peritoneum ___

1 Laparoscopic Repair Inguinal Hernia ___

2 Laparoscopic Repair Femoral Hernia ___

3 Laparoscopic repair of hiatal or other diaphragmatic hernia ___

D. Abdomen - Liver, Biliary, Pancreas, Spleen ___

1 Laparoscopic Common Bile Duct Exploration ___

2 Intraoperative Ultrasound ___

3 Operation for Gallbladder or Bile Duct Cancer ___

4 Elective Liver Segmentectomy/Lobectomy ___

5 Elective Pancreaticoduodenectomy ___

6 Elective Ampullary Resection ___

7 Elective Pancreatectomy ___

8 Longitudinal Pancreaticojejunostomy, Frey Procedure, Beger Procedure ___

E. Abdomen - GI tract ___

1 Total Esophagectomy ___

2 Esophagogastrectomy ___

3 Laparoscopic Anti-Reflux Procedure ___

4 Open Anti-Reflux Procedure ___

5 Laparoscopic Bariatric Procedure ___

6 Laparoscopic Heller Myotomy ___

F. Endoscopy ___

1 Percutaneous Endoscopic Gastrostomy ___

2 Therapeutic Esophagogastroduodenoscopy ___

3 Esophagogastroduodenoscopy with biopsy ___

4 Therapeutic Colonoscopy ___

5 Colonoscopic Biopsy/Polypectomy ___

6 ERCP ___

G. Endocrine ___

1 Thyroidectomy ___

2 Parathyroidectomy ___

3 Open Or Laparoscopic Adrenalectomy ___

4 Pancreatic Enucleation ___

38.10 Breast - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or experience or Subspecialty Board Certification.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Biopsy breast lesion
- Duct Excision
- Lumpectomy with or without wire liocalization and/or Magseed
- Partial or Simple Mastectomy
- Modified Radical or Radical Mastectomy
- Sentinel lymph node biopsy
- Axillary Lymph Node Dissection
- Stereotactic Breast Biopsy

38.15 Colorectal - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Colon and Rectal Surgery.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.. .

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Stapled Hemorrhoidectomy
- Repair Complex Anorectal Fistulae
- Complex Anal Sphincter Reconstruction
- Excision Of Anal Cancer
- Transanal Resection For Tumor
- Total Proctocolectomy, Ileoanal Pull-Through, Ileal-Pouch Procedures
- Abdominoperineal Resection
- Pelvic Exenteration For Rectal Cancer
- Complex Recto-Vaginal Fistula/Rectocele Repairs
- Open Or Laparoscopic Operation For Rectal Prolapse
- Perineal Repair Rectal Prolapse

38.20 Trauma - Core (pt. 1) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.. .

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

Skin, Soft Tissue, Musculoskeletal

- Exploration and Repair of Wounds and Complex Lacerations/Traumatic Injuries
- Repair Tendons
- Major Extremity Amputations
- Hip Disarticulation
- Forequarter Amputation
- Girdlestone Procedure
- Other emergency procedures not otherwise specified

Head and Neck

1. Emergency Neck Exploration
2. Thyroidectomy/Parathyroidectomy for Trauma
3. Repair/Resection of Cervical Tracheal Injury
4. Repair/Resection of Cervical Esophageal Injury
5. Esophagostomy
6. Pharyngostomy
7. Other emergency procedures not otherwise specified

GU tract

1. Nephrectomy
2. Renorrhaphy
3. Adrenalectomy
4. Ureteral resection/repair
5. Ureteral reimplantation
6. Repair of bladder
7. Cystotomy/Cystectomy
8. Placement of supra-pubic tube
9. Urethral resection/repair
10. Orchiectomy
11. Scrotal exploration
12. Hysterectomy
13. Oopherectomy
14. Salpyngectomy
15. Cesearan section for trauma
16. Other emergency procedures not otherwise specified

38.20 Trauma - Core (pt. 2) ___

Thoracic

- Emergency sternotomy
- Emergency thoracotomy
- Tube thoracostomy
- Thoracentesis
- Bronchoscopy, flexible
- Pericardial window, diagnostic or therapeutic
- Repair of cardiac injury
- Emergency repair of tracheal/bronchial injury
- Emergency pulmonary resection
- Evacuation of hemothorax, open
- Evacuation of hemothorax, thoracoscopic
- Repair of diaphragm via thoracic approach, open
- Emergency repair of chest wall defects
- Emergency esophageal repair/resection
- Other emergency procedures not otherwise specified

Vascular

- Emergency vascular control of hemorrhage
- Emergency arterial ligation, repair and/or bypass, all sites
- Emergency venous ligation, repair and/or bypass, all sites
- Angiography
- Venography
- Percutaneous central venous line placement
- Venous cutdown for vascular access
- Placement of tunneled or implanted venous access devices
- Porto-systemic shunt
- Placement and Management of Resusciative Balloon Occlusion of the Aorta (REBOA)
- Other emergency procedures not otherwise specified

38.25 Plastic Surgery - Core ___

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

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Incision and Drainage of Abscess
- Flexor/Extensor Tendon Repair, Tenolysis, Drainage of Tendon Sheath
- Local Skin/ Muscle Rotational Flap, Skin Tissue Rearrangement
- Repair Nailbed Injury
- Release A-1 Pulley, Pulley Reconstruction
- Fasciotomy
- Separation of Digit Syndactyly, Excision of Supranumery Digit
- Carpal/Cubital Tunnel Release
- Completion Amputation Of Digit
- ORIF/CRPP Radius, Ulnar, Carpal, Metacarpal, Phalangeal Fractures
- Removal of Foreign Body
- Placement of Tissue Expander
- Breast Reconstruction With TRAM, Free Perforator Flap
- Breast Capsulotomy/Capsulectomy
- Breast Reconstruction with Saline/Silicone Implant, Removal Saline/Silicone Implants
- Nipple Reconstruction
- ORIF Mandibulomaxillary/ZMC/Nasal/Nasoethmoid/Orbital Floor Fracture
- Full Thickness (FTSP) Or Split Thickness Skin Graft (STSG)
- Abdominal Wall Reconstruction, Components Separation, Mesh Placement
- Lower Extremity Reconstruction with local or free flap
- Head and Neck Reconstruction with local or free flap
- Trunk reconstruction with local or free flap
- Debridement, Skin and Subcutaneous Tissue, Muscle and Bone
- Placement of Negative Pressure Dressing Devices

38.30 Plastic Surgery - Special Privileges ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic Surgery with documented additional training and/or experience or Subspecialty Board Certification.

PROCTORING: INITIAL - 2 observed operative procedures and 10 retrospective reviews per Category of operative procedures.

REAPPOINTMENT - 2 operative procedures per Category in the previous 2 years. For those procedures that are rarely performed and, as such, there is no frequency or volume of cases required, each case will be reviewed and for each privilege a running evaluation of all cases will be performed after each case

A. Microvascular ___

1 Use Of Operating Microscope, Repair Blood Vessel/ Nerve, Digit ___

2 Replantation ___

3 Free Myo/Skin Flap Microvascular Anastamosis ___

B. Hand ___

1 Incision/Drainage Abscess, Finger or Hand ___

2 Palmar Fasciotomy Dupuytren's Contracture ___

3 Palmar Fasciectomy Dupuytren's Contracture ___

4 Closed Capsulotomy ___

5 Open Capsulotomy ___

6 Excision Bone Cysts ___

7 Excision Bone Tumors ___

8 Bone Grafts, Wrist, Hands or Fingers ___

9 Arthrodesis, Wrist, Hand or Finger Joints ___

10 Tenolysis ___

11 Tenorrhaphy ___

12 Tendon Transfer ___

13 Free Tendon Graft, From Arm or Leg ___

14 Arthroplasty with Implant ___

15 Ligament Repair Or Reconstruction ___

16 Reconstruction Hand Deformities ___

17 Amputation, Finger, Hand or Forearm ___

18 Fractures/Dislocations ___

19 Carpal/Cubital Tunnel Release ___

20 Brachial Plexus exploration ___

21 Neurolysis ___

22 Nerve Transfer ___

23 Nerve Tranpositions ___

24 Nerve Repair, Primary ___

25 Nerve Repair, Secondary with Nerve Graft ___

26 Removal of Foreign Bodies ___

27 Replantation of Fingers and/or Hand ___

28 Wrist Arthroscopy ___

29 Carpal Bone Fractures ___

30 Wrist Fractures ___

C. Craniofacial ___

1 Closed Reduction and Mandibulomaxillary (MMF) Fixation of Mandible Fracture ___

2 Open Reduction and Internal Fixation of Mandible Fracture ___

3 Open Reduction and Internal Fixation of Zygoma Fracture ___

4 Open Reduction and Internal Fixation of Orbital Floor Fracture ___

5 Open Reduction and Internal Fixation of Orbital Wall Fracture ___

6 Open Reduction and Internal Fixation of Zygomaticomaxillary (ZMC) ___

7 Complex Fracture ___

8 Open Reduction and Internal Fixation of Noso-Orbital Ethmoid Fracture ___

9 Open Reduction and Internal Fixation of Le Fort I Fracture ___

10 Open Reduction and Internal Fixation of Le Fort II Fracture ___

11 Open Reduction and Internal Fixation of Le Fort III Fracture ___

12 Cleft Lip Repair ___

13 Cleft Palate Repair ___

14 Resection of Arteriovenous Malformation ___

15 Complex Tissue Rearrangement, Scalp ___

D. Gender Affirming Surgery ___

1 Feminizing Mammoplasty, primary ___

2 Feminizing Mammoplasty, revision ___

3 Masculinizing Chest Surgery, primary ___

4 Masculinizing Chest Surgery, revision ___

5 Vaginoplasty, penile inversion ___

6 Vaginoplasty, colon or peritoneum ___

7 Phalloplasty, microvascular ___

8 Phalloplasty, non-microvascular ___

38.31 Plastic Surgery - Laser Surgery ___

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

PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at ZSFG

REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at ZSFG

- Removal of Congenital and Acquired Lesions (Tattoos, Hemangiomas, Pigmented Lesions)

38.32 Acute Trauma Care ___

SCOPE: On-call trauma coverage for the initial resuscitation and comprehensive management of the acutely injured patient. Includes acute operative management of thoracic and vascular injuries, and initial surgical critical care of the trauma patient.

CRITERIA:
1. Completion of ACGME-approved residency with ABS Board certification/eligibility in General Surgery.
2. Current ATLS certification (provider)
3. Clinical performance and commitment consistent with standards for general surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons.

_____

Trauma Medical Director **Date**

38.35 Thoracic Surgery - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Thoracic Surgery.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Bronchoscopy
- Open Decortication and/or Pleurectomy
- Thoracoscopic Decortication and/or Pleurectomy
- Thoracotomy for empyema
- Thoracoscopy for empyema
- Repair/resection trachea/bronchus, elective
- Elective thoracotomy for pulmonary resection
- Elective thoracoscopy for pulmonary resection
- Repair of diaphragm via thoracic approach
- Elective repair of chest wall defects/deformities
- Elective thymectomy
- Open Reduction and Internal Fixation Rib Fractures
- Insertion of venous cannula for veno-venous ECMO, open or percutaneous
- Insertion of arterial cannula for veno-arterial ECMO, open or percutaneous.
- Insertion of permanent pacemaker

38.40 Thoracic Surgery - Special Privileges ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Thoracic Surgery.

PROCTORING: INITIAL - 2 observed operative procedures and 10 retrospective reviews of operative procedures.

REAPPOINTMENT - 2 operative procedures in the previous 2 years. For those procedures that are rarely performed and, as such, there is no frequency or volume of cases required, each case will be reviewed and for each privilege a running evaluation of all cases will be performed after each case

1. Cardiopulmonary bypass

38.45 Vascular Surgery - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery in Vascular Surgery.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Angiography
- Venography
- Endarterectomy or thrombectomy of the lower extremity, upper extremity, abdominal, thoracic or cervical vessels (arterial or venous)
- Surgical bypass of the lower extremity, upper extremity, abdominal, thoracic or cervical vessels (arterial or venous)
- Open repair of aneurysms (excluding vessels in the pericardium and intracranial)
- Endovascular repair of the aorta, including the arch, thoracic and abdominal aorta
- Thoracic outlet decompression with rib resection and neurolysis
- Injection and ablation procedures of pseudoaneurysms and venous structures
- Creation or revision of arteriovenous fistula and grafts, open or percutaneous
- Percutaneous vascular access and placement of indwelling vascular catheters (arterial or venous)
- Endovascular treatment of the lower extremity, upper extremity, abdominal, thoracic or cervical vessels (arterial or venous, excluding vessels in pericardium and intracranial), including angioplasty, stent deployment, atherectomy, intravascular ultrasound, thrombectomy and thrombolysis.
- Excision, resection or biopsy of artery, vein or graft
- Amputation of the lower extremity
- Debridement of skin, subcutaneous, fascia, muscle, bone
- Tube thoracostomy
- Fasciotomy, upper and lower extremity
- Placement and Management of Resusciative Balloon Occlusion of the Aorta (REBOA)

38.50 Critical Care - Core ___

PREREQUISITES: PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery in Surgical Critical Care.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core procedures in the previous two years of a sampling of the procedures listed below.

- Placement of percutaneous central lines
- Placement of arterial lines
- Intubation
- Bronchoscopy
- Placement tube thoracostomy
- Thoracentesis
- Pericardiocentesis
- Paracentesis
- Lumbar puncture
- Insertion of transvenous pacemaker
- Pulmonary artery catheter insertion
- Emergency cricothyroidotomy
- Cardioversion
- Defibrillation
- Placement of esophageal balloon for hemostasis
- Bedside ultrasonography
- Patient Controlled Analgesia

38.55 Cardiothoracic Pre-Operative Evaluation - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Thoracic Surgery.

PROCTORING: INITIAL – 2 retrospective reviews of cases of a sampling of the procedures listed below.

REAPPOINTMENT - 2 retrospective reviews of cases of a sampling of the procedures listed below.

- Evaluate and make recommendations for potential Cardiac Surgery of inpatient and outpatient.

38.65 Waived Testing ___

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

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

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

- Fecal Occult Blood Testing (Hemoccult®)
- Vagnal Ph Testing (Ph Paper)
- Urine Chemstrip® Testing
- Urine Pregnancy Test (Sp® Brand Rapid Test)

38.70 Diagnostic Radiology - Fluoroscopy ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery and current X-Ray/Fluoroscopy Certificate, or a member.

PROCTORING and REAPPOINTMENT: Presentation of valid California Fluoroscopy certificate

38.80 Procedural Sedation ___

PREREQUISITES:
The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.08 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 Emergency Medicine 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

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____
CTSI Medical Director Date

APPROVED BY

Division Chief Date

Service Chief Date

Appendix A. OR Block Time

MONDAY:

4.0 OR's available –, Plastic Surgery (Terry), General Surgery, Vascular (1st and 3rd Mondays), Emergency General Surgery

TUESDAY:

2.5 OR's available Breast Surgery (Wong), Surgical Oncology (Alseidi), Plastic Surgery (Terry)

WEDNESDAY:

2.5 OR available Surgery (~~Tesoriero, Sammann~~), Plastic Surgery (Soo), Emergency General Surgery

THURSDAY:

3.5 OR's available – Surgery (~~Mackersie, Campbell, Cuschieri, Plevin~~), Plastic Surgery (Young, Hansen, Terry)

FRIDAY:

1.5 OR's available – Vascular (Vartanian, Oskowitz), Emergency General Surgery

APPENDIX B: SURGERY HOUSE STAFF COMPETENCIES

Refer to CHN Intranet site, House Staff Competencies link.

APPENDIX C – ADDITIONAL CLINICAL SERVICE SPECIFIC ATTACHMENTS

1. **ATTACHMENT C1: AFFILIATED PROFESSIONALS**
2. **ATTACHMENT C2: SURGERY CLINICAL SERVICE PROCTORING PLAN**
3. **ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN**
4. **ATTACHMENT C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL**
5. **ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY**
6. **ATTACHMENT D: JOB DESCRIPTIONS**

APPENDIX C ATTACHMENT C1: AFFILIATED PROFESSIONALS

(TRAUMA NURSE PRACTITIONER BINDER KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX C: ATTACHMENT C2 - SURGERY CLINICAL SERVICE PROCTORING PLAN

SURGERY CLINCIAL SERVICE
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL PROCTORING PLAN

I. REQUIREMENTS

A Proctoring will be required who request surgical privileges within the Surgery Clinical Service at Zuckerberg San Francisco General Hospital. The proctoring ~~which is carried out~~, which is carried out, will be specific to the area in which privileges are requested.

C Applicants for surgical privileges at ZSFG who are accredited on the active staff at UCSF campus hospitals and UCSF affiliated hospitals (SFVAMC, CPC, Kaiser SF), have faculty appointments in the UCSF Department of Surgery, and perform the majority of their surgery at a UCSF campus hospital or UCSF affiliated hospital will be assumed to have been adequately proctored and will not be required to have direct observation on their cases in the operating room. Unless the Chief of Surgery determines that there is a reason for intraoperative proctoring.

D Proctoring will consist of these activities:

1. Intraoperative Observation
   Direct intraoperative observation of applicants will be carried out by one of the assigned proctors for ~~a sufficient number of~~enough cases in each category of privileges to assure competence in the technical and operative aspects of surgery.

2. Complication Review
   All deaths and complications occurring in patients treated by the applicant during the provisional year of staff appointment will be tabulated, and the conclusions of the surgery D&C conference regarding the specific complication will be reviewed.

E. The proctor appointed for the applicant and the Chief of Surgery will meet periodically to review the above areas, and determine when to discontinue monitoring in areas D.1. and D.2., based on the number of cases and competence demonstrated. At any point in the proctoring process, if the proctor and the Chief of Surgery feel that the applicant is not qualified in a specific area, they may revoke provisional privileges in that area and shall notify the applicant and the Credentials Committee in writing of this action.

F Anyone performing general surgery can be placed under observation at any time when it is deemed indicated by (1) the Chief of Service, (2) the Credentials Committee, (3) the Medical Executive Committee, or (4) the Operating Room Committee. The duration of observation shall be at the discretion of the Chief of Service, and a report shall be made at the end of this time to the requesting committee.

II. APPOINTMENT AND RESPONSIBILITITES OF PROCTORS

A. Any member of the Department of Surgery, who is a member of the Active Staff, or member of the Courtesy Staff with a UCSF faculty appointment, may be appointed as a proctor. The proctor must be experienced in the areas being evaluated, but need not have the same Board Certification or subspecialty certification as the applicant.

B. One or more proctors will be appointed by the Chief of Surgery for each applicant. The Chief of Surgery may participate as a proctor or may independently evaluate any aspect of patient care performed by the applicant.

C. The applicant will notify one of the proctors of all cases scheduled during the proctoring period, so that they may arrange to be present during surgery, until the requirements of Section I, D.1. above, have been satisfied. The applicant may schedule surgery at his or her discretion and it will be the responsibility of the proctor to attend if he wishes.

D. A proctoring form for each operative observation will be completed by the proctor and submitted to and maintained by the Chief of Surgery. These will be kept in the applicant's clinical service credentials file and will be confidential as legally defined within hospital surgical Performance, Improvement and Patient Safety process.

APPENDIX C: ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

APPENDIX C: ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY

1. **The Faculty clinic absentee** window is set at 6 weeks. In the event that the physician will not be available after the 6 week window has passed for a non-emergent reason:

    a. When a faculty absentee form is filled out, the clinic staff is responsible for informing the faculty member and the Department Assigned Administrative Assistant of receipt of the absentee date/time via email.
    b. The Attending has to directly inform the clinic nursing director, and the chief of surgery in writing including the reason for missing clinic. A specific reason (academic, out of town, site visit commitment) must be given.
        i. Action plan as understood by clinic staff will be communicated back to faculty member and Department Assigned Administrative Assistant via email to include
            1. Date of expected absence
            2. Plan for alternative coverage/rescheduling
        ii. Faculty must make every attempt at obtaining coverage – either from another attending assigned to that clinic or by having another attending cover the patient load, OR
        iii. As an alternative, patients can be rescheduled to one of the two back flow clinics on Monday or Thursday PM for the following week. This will be first come first serve.
2. **Faculty timeliness**:
    a. Service expectations are that the patients are roomed and ready to be seen by 9 AM/1 PM so that clinic can start immediately. The service expects the attending to be on time for clinic and if not the clinic will call the attending by 9:15 or 1:15. If no response from the attending they are to call the Chief of Service or designee.
3. **Attending surgeons will be automatically excused from clinic when they are covering the service or are assigned to the ICU.** This includes the ICU service at UCSF Moffit ,VAMC and UCSF Mission Bay
    a. Faculty who need to see patients should use Monday afternoon overflow clinic time during the following week.
4. **Clinic Room Assignment:**
    a. NP's will use the room in the back of the clinic to complete H&P's.
    b. MEA's have been proposed to help staff the rooms and will be assigned to specific rooms to help with patient throughput.
    c.
5. **H&P's:** If the day of surgery is within 30 days of the last clinic visit, an interim H&P update is completed by the surgical attending or resident in the pre-operative area. In the event that surgery is > 30 days from the last clinic visit, a full H&P is to be completed by a member of the surgical team.
6. **Block time in the OR:**
    a. OR blocks may only be released by the attending assigned to that block. This should be done as soon as the attending knows she/he will be unavailable (on service; out of town etc). In general, these blocks should be released two months ahead of time. Once the OR time has been released, the clinic OR calendar will clearly state that the time has been released. Once released it cannot be reclaimed.
        i. Other attendings may not schedule surgeries on a block day that is not theirs unless it has been released.
        ii. See appendix A for OR block schedule.

7. **Scheduling templates:**
    a. Each Faculty will be assigned a template designed by attending with an expectation that they will see between 5-10 new patients per week in general surgery and a similar number of ~~followups~~follow-ups. However, some attendings are only part-time and may see fewer patients.

~~8. **Additional Scheduling Notes:**~~
    ~~a. Patients who fail to show up for their H&P's two weeks prior to surgery will be cancelled from the scheduled surgery. The clinic staff will immediately communicate with the faculty member about this cancellation so that another patient on the "blue list" can be placed in this slot. If that faculty member is not able to be reached, that slot will be opened up for inpatient overflow or other elective cases.~~

SURGERY CLINICAL SERVICE

PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

I. ORGANIZATION

The Surgery Clinical Service at Zuckerberg San Francisco General Hospital, under the umbrella of the hospital-wide Surgical Performance, Improvement, and Patient Safety Committee, operates a quality management program within the Surgery Clinical Service with multiple facets. These activities, to be described below, are carried out under the direction of the Chief of Surgery. They, in turn, report to the ZSFG Surgical Performance, Improvement, and Patient Safety Management Committee.

II. PURPOSE

The overall purpose of the Surgical Performance, Improvement, and Patient Safety Committee is to (1) continuously monitor feedback and (2) ultimately improve the quality of patient care delivered by the Surgery Clinical Service. Monitoring exists for both surgical and resident staff, in addition to system monitoring for the Trauma Service. The intent of this monitoring is to identify and correct specific individual and system problems.

III. SCOPE

The services, which are included within this program, are the ~~Trauma~~ Acute Care Surgery Service (which include General Surgery, Emergency General Surgery, Trauma, and Surgical Critical Care), Vascular Surgery ~~Thoracic Surgery and Vascular Surgery),~~ and Plastic Surgery Services. Oversight of the Vascular and Plastic Surgery Surgical Performance, Improvement and Patient Safety program is delegated to the Chief of the Division of Vascular Surgery and Plastic Surgery, repectively. ~~Oversight of the other service is by the Chief of Surgery.~~ Orthopedics, Neurosurgery, Urology, Otolaryngology (ENT), and Ophthalmology are not included within the Surgery Clinical Service and are responsible for the independent operation of their programs.

IV. IDENTIFICATION OF PROBLEMS

Three general methods are used to identify and correct problems that occur within a busy teaching hospital environment. These are as follows:

A. Routine Surveillance

The activities grouped under this heading are carried out as continuous activities for monitoring and ensuring the quality of care, and providing optimal teaching to students and residents.

1. Daily Attending Ward Rounds
   Ward rounds are made by surgical attendings with senior or chief residents on every service and every patient is seen and evaluated daily. Diagnostic and treatment plans, and clinical course are reviewed. A daily progress note is generated by each attending on every patient and filed in the electronic medical record.

2. Daily Trauma Nurse Clinical Rounds
   An experienced Emergency/Trauma Nurse (most often the Trauma Program Coordinator or Trauma Case Manager) rounds daily with the Trauma Service Residents and collects data concurrently regarding diagnosis and treatment

of trauma patients. Specific patient complications, as well as system problems (E.g., missed triage, delay in trauma team activation, etc.) are tabulated and reported back to the Trauma Director. Patient complications are also reported by the resident staff at a weekly Service meeting. Data collected by the Trauma Program Coordinator is entered into the computerized Trauma Registry and analyzed for discrepancies in predicted vs. observed outcome as described below.

3. Surgical Mortality and Morbidity Conference
This conference is held weekly~~biweekly~~ and all available Surgery Clinical Service attendings and residents attend. Weekly statistics are reviewed, and all deaths and complications are reported and discussed. All deaths and complications are then entered in the computerized departmental registry and are categorized as preventable, possibly preventable, non-preventable, or systems problem according to the responsible attending and resident for later compilation and analysis. In addition, complications or deaths are assigned a Severity Index (SI) rating on a ~~5 point~~5-point scale as follows:
   SI-1: minor inconvenience. (Examples: superficial surgical site infection, pneumonia, UTI, uncomplicated missed injury)
   SI-2: moderate severity, slight prolongation hospital stay. (Examples: DVT requiring Coumadin, deep SSI requiring percutaneous drainage, iatrogenic pneumothorax)
   SI-3: complication associated with prolonged stay, need for readmission or additional procedures or interventions. (Examples: wound dehiscence, respiratory arrest, pulmonary embolus, post-operative bleeding requiring reoperation.)
   SI-4: Complication requiring major intervention, associated with prolonged morbidity or inconvenience. (Examples: Enteroatmospheric fistula, reoperation requiring ostomy, multiple additional procedures or admissions)
   SI-5: ~~Long term~~Long-term or permanent morbidity, disability, or death.(Examples: Death, major amputation, permanent brain injury).

4. Monitoring of Incomplete Charts and Undictated Operative Notes
All surgical charts of discharged patients from the preceding week are prepared by Medical Records weekly and are reviewed by the Surgery Clinical Service residents and attendings. All incomplete entries, unsigned medical student notes or orders, or absent discharge summaries are completed.

   An independent system is used for the completion of operative notes. The Medical Records Department notified the Chief of Surgery weekly with a written list of all incomplete operative notes. The Chief of Surgery directly contacts the responsible individual to ensure the timely completion of the dictation.

B. Exception Reporting
The second method of identification of problems is via the reporting or unusual or unexpected occurrences. These problems are then individually investigated and evaluated and are referred to the Chief of Service or Trauma Director/Trauma QA Committee for resolution.

1. Unusual Occurrence Report
   Incident reports are completed by the nursing staff according to a set of defined indicators (e.g., drug reaction, patient complaint, unexpected return to the operating room, post-operative bleeding, etc) and these are channeled to the Chief of Surgery when any surgical patient or surgical staff is involved with the incident. These are individually investigated and either resolved or referred to the most appropriate body for resolution.

2. Interdepartmental Incidents
   System problems arising on surgical units between Services, etc. not requiring specific Unusual Occurrence Reports, are reported back to the Trauma Program Coordinator by faculty, residents, or nursing/ancillary personnel. This reporting system is in addition to routine surveillance made by the Trauma Program Coordinator as described previously. Specific problems are then forwarded to either the Chief of Surgery or the Trauma Director/Trauma PIPS Committee for discussion/resolution.

C. Use of Clinical Indicators

With the advent of the clinical registry of all surgical patients, it has become possible to greatly expand the scope of this activity and identify attending-specific information related to patient outcomes. This activity is steadily evolving as more information is accumulated in the registry. The following are indicators currently in place.

1. Surgical Site Infections (General and Plastic Surgery)
   Overall wound infection rates are monitored by the Infection Control Committee and reported to the Chief of Surgery. These are attending specifics and may be discussed at the weekly Morbidity and Mortality Conference.

2. Attending Specific Compilation of Deaths and Complications (General Surgery)
   Aggregate compilation of deaths and complications on a quarterly basis for each attending surgeon ~~are compiled~~is compiled and reviewed by the departmental staff quarterly, in order to allow inter-attending comparison of rates.

3. Trauma Attending Presence at 900 Trauma Activations
   ~~Expectation of ACS Trauma Center Verification is that a surgical attending will respond to highest level trauma activations within 15 minutes of the patient's arrival in the ED, monitored by the Trauma Medical Director as part of~~ The expectation of the ACS Trauma Center Verification is that a surgical attending will respond to the highest level trauma activations within 15 minutes of the patient's arrival in the ED, monitored by the Trauma Medical Director as part of the trauma PIPS process.

4. Unexplained Return to the Operating Room
   Information reported at M&M conference will be compiled to determine surgeon specific rates.

V. PROBLEM RESOLUTION

Resolution of problems identified by the above mechanisms occurs on multiple levels, as seems most appropriate to the individual circumstances. The principal methods are the following:

A. Individual Discussion

Minor problems related to individual behavior, administrative problems, and interpersonal or communication problems are best dealt with on an individual level. This is done by the Attending Surgeon on a given service in the process of daily contact and patient surveillance described above. Unusual problems are brought to the attention of the Chief of Surgery, who discusses the problem(s) with the individual(s) involved~~,~~ when they are in the Surgery Clinical Service. Similar problems involving nursing personnel are dealt with by the Trauma Nurse Coordinator either through the Head Nurse of the Unit involved~~,~~ or the individual nurse.

B. Group Discussion/Education –Surgery M&M Conference

The most common mechanism for evaluating and correcting problems in a teaching environment is through the constant education of the trainees involved in the process. This is accomplished as a significant part of the weekly Mortality and Morbidity Conference, in which the problems are identified~~,~~ and then discussed in detail as to methods of avoidance or prevention. Expected standards of care, standards of monitoring, priority setting, methods of assessment, etc., are communicated to all levels of resident staffs.

C. Trauma Surgical Performance, Improvement, and Patient Safety Committee

This conference is attended by representatives from all clinical services involved in the care of the trauma patient, as well as from nursing, and interdepartmental issues, policy changes, pre-hospital care issues, and more global institutional issues are addressed at this committee. The primary function of the Trauma PIPS Committee is to formulate and implement policy in response to system problems that arise and are identified by the methods described above. The clinical indicators specific to trauma patients are also reported back to this Committee. ~~Trauma PIPS meeting is conducted by the Trauma Director~~The Trauma PIPS meeting is conducted by the Trauma Director, who also sits on the Hospital Trauma PIPS Committee as a surgical representative.

APPENDIX C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL

(KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX D: JOB DESCRIPTIONS

CHIEF OF SURGERY CLINICAL SERVICE JOB DESCRIPTION

Chief of Surgery Clinical Service

Position Summary:

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

Reporting Relationships:

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

Position Qualifications:

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

Major Responsibilities:

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

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

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

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

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of

service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs.

Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.

TRAUMA PROGRAM MEDICAL DIRECTOR

General Description:

The trauma medical director is a general surgeon, appointed by the Hospital through the Executive Administrator, to lead the multidisciplinary activities of the Trauma Program. The role of the TMD will be to work with service Chiefs and hospital administration in order to organize, manage, and develop the Trauma Program, and to seek to improve the Trauma Center in terms of quality, volume, scope of services, and cost-effectiveness of trauma care.

Qualifications:

- Current ABMS board certification in General Surgery.
- Fellow in good standing of the American College of Surgeons (ACS).
- Member in good standing of active medical staff, ZSFG.
- Advanced competency and special interest in trauma care and surgical critical care.
- Active involvement in clinical trauma care and surgical critical care.
- Active involvement in regional or national trauma education.
- Active involvement/participation in regional & national trauma organizations.
- Active involvement and demonstrated proficiency in trauma-related research.
- Demonstrated leadership skills & established history of positive collegial relationships with professional and ancillary staff in an acute care environment.
- Minimum of three years of prior experience in an established designated trauma center or system.
- Demonstrated leadership in peer-review committee functions for 'sentinel' or 'critical' case review.
- Demonstrated commitment to the underlying principles of Trauma Performance Improvement, Trauma Program requirements by the ACS Committee on Trauma, and Title 22, and the process of trauma program verification and designation.

Appointment, reappointment, review, termination

- Appointed by the ZSFG Executive Administrator, in collaboration with the Chief of Surgery.
- Requires approval of Department Chair-.
- Requires approval of the majority of the MEC Chiefs of Services.
- ~~Term~~ The term of appointment is three years.
- TMD performance review conducted every three years by the MEC. More often at the direction of the ZSFG Executive Administrator.
- The TMD may be removed by the Chief of Surgery, the Department Chair, or the ZSFG Executive Administrator in conjunction with a majority of MEC Chiefs of Service.

Responsibilities:

1) General Administrative Responsibilities and reporting relationships

- Directs the multidisciplinary functions of the trauma program.
- Provides the medical liaison between trauma team members and hospital administration.
- Responsible for ensuring that the quality of trauma patient care provided at ZSFG is commensurate with the institution's designation as a Level 1 center and as the sole provider of trauma services to the City & County of San Francisco.

- Takes action to correct deficiencies in coverage, response, or competence in the provision of trauma care by members of the trauma panel and trauma team.
- Regularly provides reports on Trauma Program performance to the MEC, including topics and issues related to policy, operations, staffing, quality improvement, and compliance with the Trauma Performance Agreement.
- Helps develop institutional policies, procedures and protocols, as needed, to improve the quality and cost-effectiveness of trauma care.
- Acts to further develop and promote the ZSFG trauma program as a regional resource.
- Acts as the principal clinical supervisor for the Trauma Program Nurse Practitioners.
- Reports directly to the ZSFG Executive Administrator.
- Collaborates with other Hospital Administrators, Chief of Staff, and Chiefs of Service.
- Monitors compliance with trauma performance agreement.
- Participates in CHN strategic planning.

2) Performance Improvement (PI) program

- Ensures that appropriate peer review is conducted for all types of adverse or potentially adverse ~~event~~events.
- Chairs Multidisciplinary Peer Review Committee.
- Helps develop clinical practice guidelines.
- Monitors as needed and makes recommendations regarding trauma-related hospital privileges and credentials for members of the trauma team.
- Monitors, as needed, facility standards to ensure that they are commensurate with Level 1 Center function.
- Reports matters of critical importance related to trauma patient care, as needed, directly to other administrative agencies or officers within the Department of Public Health or related CCSF agencies (e.g. SFPD, SFFD).

3) Trauma Center designation & verification

- Interacts with SF EMSA in reviewing Trauma Center performance consistent with the requirements in Title 22.
- Works with SF EMSA in revising, as needed, the CCSF Trauma Plan.
- Directs planning and preparation for ACS-COT Trauma Center site surveys and any additional site surveys that the local EMSA may require.

4) Trauma Registry

- Maintains ~~control / oversight~~control/oversight of Trauma Registry in conjunction w/ hospital administration.
- Responsible for overseeing timely updates of same.
- Establishes guidelines for use of ZSFG Trauma Registry data outside the Trauma Program.
- Reviews and approves written requests for registry data use by individuals or departments.

5) Credentialing / privileges

- Reviews, as needed, the performance and qualifications of Trauma Surgeons & members of the trauma team providing trauma care at ZSFG.
- Adds/removes trauma surgeons from trauma panel, subject to the approval by TEC.
- Acts to restrict or suspend trauma-related privileges, as necessary and for just cause, in conjunction with the TEC, for any member of the trauma team.

- Recommends and/or approves recommendation, as indicated, for trauma privileges for members of the trauma team.

6) Pre-hospital care

- Involved in review/development of pre-hospital policies, practices, and procedures.
- Meets regularly ~~w~~with~~/~~ EMSA director, paramedic medical director & paramedics, as needed for purposes of: 1) City disaster planning, 2) Trauma triage, 3) Title 22 compliance, 4) Trauma system performance improvement, 5) Pre-hospital performance improvement.

7) Prevention

- Identifies a member of the trauma team or trauma panel who acts to coordinate injury prevention at ZSFG.
- Monitors and acts to promote/enhance injury prevention activities at ZSFG.
- Acts as a liaison and/or consultant for the Dept. of Public Health for purposes of organizing and promoting injury prevention programs and activities.

8) Patient & Community relations (outreach)

- Helps support & develop trauma patient/family satisfaction projects.
- Develops strategic relationships with referring hospitals & physicians for purposes of improving trauma care and facilitating any requested transfers.
- Supports and helps to provide provider educational offerings within the region.
- Participates in regional trauma audit committees as needed.
- Helps to develop and provide trauma consulting services, as needed, to surrounding communities.

9) Trauma Education / training / research

- Actively supports and participates trauma-related research and educational programs including those for medical students, residency programs, and post-graduate education.
- Participates in regional trauma audit committees as needed.
- Is actively involved in ATLS, Stop the Bleed and ASSET courses.

10) Participation at regional & national level (per ACS)

- Participates in local, regional, and national trauma-related activities and organizations.
- Participates in the trauma activities of the American College of Surgeons Committee on Trauma.

11) Managerial / Financial

- Works with trauma business mgr. & senior administrator to effect improvement in LOS, cost effectiveness as needed
- Implements policy/practice changes to help improve cost effectiveness.
- Ensures establishment of appropriate call schedules for all specialties.
- Assists TP manager in developing/meeting budgetary goals.

INTENSIVE CARE UNIT MEDICAL DIRECTORS
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
JOB DESCRIPTION

The Medical Directors are physician leaders in critical care responsible for coordinating clinical care, clinical operations, and education and training in alignment with Zuckerberg San Francisco General Hospital's mission, vision, values and goals. The unit Medical Directors report to the ZSFG Critical Care Medical Director (CCMD) and work closely with the mangers of nursing and other allied healthcare professions to implement strategies for optimizing patient care and operational efficiency.

MISSION STATEMENT

The Medical Directors are committed leaders in continuous clinical innovation, quality improvement, and excellence in medical education.

QUALIFICATIONS

Board-certified in a relevant specialty as well as Critical Care Medicine
Credentialed ZSFG physician or eligible for such credentialing
Excited and inspired by the opportunity to make changes and improve systems
Strong commitment to the mission statement and responsibilities of the position
Outstanding professional credibility and personal integrity
Exceptional clinical skills
Demonstrated ability for teamwork and collaborative problem-solving using an analytical and systematic approach
Excellent verbal and written communication skills
Ability to provide leadership to physicians and other health care professionals

DUTIES AND RESPONSIBILITIES

XIII. Reporting Relationships

- Although the Medical Directors are full-time UCSF faculty members with an appointment within an academic department, in this position, they report directly to the ZSFG Critical Care Medical Director
- The Medical Directors work in close partnership with the other ICU Medical Directors and the ZSFG Critical Care Medical Director
- The Medical Directors work collaboratively with the ICU faculty and inter-disciplinary ICU care team

Performance Improvement and Patient Safety

- Develop and implement clinical protocols and quality improvement projects
- Review potential ICU-wide projects in the Critical Care Directors meetings
- Monitor the performance of the various protocols and analyze the results for further improvement
- Review relevant clinical quality data and performance measures and share findings to the ZSFG Critical Care Medical Director monthly
- Review and address major adverse events, near-misses, and patient safety vulnerabilities and coordinate Morbidity & Mortality Conferences

Clinical Operations

- Ensure adequate critical care physician staffing of intensive care units
- Coordinate call schedules for ICU faculty, fellows, and residents
- Assist the ZSFG Critical Care Medicine Director in optimizing patient flow in all ICU beds, coordinating with the Emergency Department, inpatient units, Operating Room, and Post-Anesthesia Care Unit
- Assist ZSFG Critical Care Medical Director in standardization and analysis of compliance in documentation, billing practices, and financial analysis of ICU operations
- Work with ICU nursing and hospital leadership to assure compliance with all regulatory requirements

Leadership and Communication

- Meet monthly with the ICU nurse manager and other healthcare professional leaders in the ICU to ensure close collaboration, coordination, and clear communication
- Meet monthly with the ZSFG Critical Care Medical Director and other ICU Medical Directors to standardize and coordinate care among all critical care units
- Participate in scheduled unit-specific ICU faculty meetings
- Participate in quarterly combined ICU faculty meetings
- Attend Quarterly ICU multi-disciplinary Grand Rounds
- Host and coordinate one ICU multi-disciplinary Grand Rounds per academic year
- Co-lead annual ICU faculty retreat
- Initiate and lead recurring multi-disciplinary Quality Improvement reviews in partnership with other services (ED, Trauma Surgery, Anesthesia, Family Medicine, Medicine, Otolaryngology, etc.)

Supervision of ICU Faculty

- Review clinical and teaching performance of individual Attendings and provide regular feedback, including compliance with protocols, promptness on rounds, and completion of teaching evaluations
- Ensure participation in quality improvement initiatives and adherence to standardized practices
- Set expectations and ensure Attending adherence to professional behavior standards at all times
- Ensure satisfactory Attending participation at various ICU faculty meetings and Grand Rounds

Medical Education (as applicable to the individual units)

- Resident and Fellow scheduling
- Serve as Medical Student Clerkship Director
- Coordinate Resident and Student evaluations
- Coordinate Journal Club, didactic teaching sessions, and other educational activities

Some duties above may be delegated with the understanding that the Medical Director is responsible for ensuring all tasks are completed.

Committees

All Medical Directors serve on a minimum of two Medical Staff committees, assigned upon mutual agreement with the ZSFG Critical Care Medical Director, including, but not limited to:

- Critical Care Committee
- Procedural Sedation Subcommittee of Pharmacy & Therapeutics Committee
- Trauma Peer Review Committee
- Performance Improvement and Patient Safety Committee
- Donor Committee
- Code Blue Committee
- Ethics Committee

Time Commitment

The Medical Director positions are 0.2 FTE commitment for each for the Medical and Surgical ICUs. When there are Co-Directors, duties are divided evenly and the expected effort is 0.1 FTE each. Division of responsibility is negotiated between the Co-Directors with the ZSFG Critical Care Medical Director and specific duties are clearly delineated.

Term of Appointment

The term of appointment as ICU Medical Director is one year subject to annual renewal based on satisfactory performance of the physician in this role and the needs of ZSFG. There is an initial evaluation after the first 6 months of appointment and annually thereafter. Review is performed jointly by the ZSFG Critical Care Medical Director and Chief Medical Officer. Consideration of non-renewal of appointment will be discussed in advance with the faculty member's Service Chief.

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS

2026

Updated January 2018

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS (Continued)

I. SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

1. The Surgery Service consists of the following surgical specialties: elective surgery (consisting of general surgery, minimally invasive surgery, surgical oncology and colorectal surgery); acute care surgery (consisting of emergency general surgery, trauma, and surgical critical care); plastic surgery, vascular surgery, and thoracic surgery, .

2. The Trauma and General Surgery Service will care for all patients admitted to the hospital for acute traumatic problems, and all patients admitted through the Emergency Medicine Service for acute or emergent non-traumatic general surgical problems. Subspeciality surgical care will be provided by either Plastic or Vascular surgery services as appropriate.

3. The Trauma and General Surgery Service will also consist of all patients who present through the Surgical Clinic with non-urgent surgical problems including those admitted for any of the surgical subspecialties listed above (excluding plastic surgery and vascular surgery).

4. The Plastic Surgery Service will care for all patients who need reconstructive surgery, both emergently and electively.

5. The Vascular Surgery Service will care for all patients who need vascular reconstruction, both emergently and electively.

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION AND STAFFING OF THE SURGERY CLINICAL SERVICE

1. The Organization of Surgery Clinical Services Officers is as follows: (Note: See also attached Organizational Chart)*

Chief of Service

Chief of Plastic Surgery
Trauma Medical Director

Surgical Director of the Surgical Intensive Care Unit
Chief of Vascular Surgery
Chief of Thoracic Surgery

Medical Director of the Soft Tissue Infection Clinic (OASIS)
Director of Surgery Clinic

A. Chief of Service

1) Appointment and Review

Appointment and review of the Chief of Service will occur by the process specified in the Medical Staff Bylaws.

2) Responsibilities

The Chief of Service is responsible for the overall direction of the clinical, teaching and research activities for the Surgery Service including:

(a) Review and recommendation of all new appointments, request for privileges and reappointments.

(b) Appointment of the other officers of the Surgery Service and service on committees.

(c) Financial affairs of the Surgery Service.

(d) Attendance at the Medical Executive Committee, the Dean's Meetings and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.

(e) Disciplinary actions as necessary, as set forth in these rules and regulations in the Bylaws and Rules and Regulations of the Medical Staff.

2. Attending Physician Clinical Responsibilities

A. Overall direction of clinical care is the responsibility of the attending staff of the Surgery Service. To perform that responsibility, close supervision of house-staff and Nurse Practitioners, and active participation in the care of each patient on the inpatient service or those seen in the outpatient setting is required.

B. Specific Duties

1) Trauma /General Surgery Service Attending:

Core surgery faculty members are assigned each week to be the attending of record for the service. The service attending makes rounds with the resident team, writes daily progress notes in EPIC, responds to major trauma activations in the emergency department, and sees all emergent and non-emergency consults from other services as needed. The Service Attending also oversees all operations performed on consult and service patients (emergent and non-emergent) during the daytime weekday shift. The service attending will be immediately available during their daytime shift unless specific arrangements are made for a back-up surgeon to cover. Any purely elective surgery will not be scheduled by the Service attending unless specific cross coverage arrangements are made in advance. Clinic responsibilities for the service attending are minimized.

2) In addition to the Trauma/General Surgery Weekly Service Attending, there is an on-call attending for trauma/emergency surgery that is immediately available to cover the night call (generally 5 PM to 7 AM). This on-call surgeon responds to major trauma activations during their shift and conducts or supervises all trauma and emergency general surgery operations during that time. A backup trauma/general surgeon is also assigned for each shift (day and night) and is promptly available should the on-call surgeon request assistance.

3) All attending surgeons who are assigned clinic time are expected to be present for the evaluation of new and follow-up patients scheduled into their elective clinic. Patients in need of surgery will be evaluated by the attending surgeon, and consent will be obtained by the surgeon prior to formal scheduling in the operating room. The surgeon of record will perform or directly supervise the conduct of all elective surgical procedures in the operating room.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Surgery Clinical Service will be in accordance with ZSFG Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations. Reappointment to the staff is dependent on continuing demonstration of competence.

C. ONGOING PROFESSIONAL PERFORMANCE EVALUATION (OPPE)

The quality assurance information specific to Surgery Service Practitioners will be maintained by the Chief of Surgery and/or their designee and will be used to monitor and report on ongoing professional performance evaluations (Surgery OPPE, Appendix F) and in the data summary sheets provided by the Service Chief at the time of reappointment or re-credentialing.

The process for Staff Status Change for members of the Surgery Services will be in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

D. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals through the Surgery Clinical Service will be in accordance with ZSFG Bylaws, Rules and Regulations, as well as with these Clinical Service Rules and Regulations (see Attachment A).

E. STAFF CATEGORIES

Surgery Clinical Service staff fall into the same staff categories that are described in Article III – *Categories of the Medical Staff* of the ZSFG Bylaws, Rules and Regulations, as well as with these Clinical Service Rules and Regulations.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Surgery Clinical Service Privilege Request Form shall be reviewed annually at the time of reappointment to the medical staff.

C. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

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

Privileges to practice on the Surgery Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice. The specifics of the process and the privileges which will be assigned are described in detail in the **DELINEATION OF PRIVILEGES, SURGERY SERVICE, ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL, ATTACHMENT A.**

Privileges are delineated by consensus of the active medical staff members of the Surgery Service, and are approved by the Chief of Surgery, subject to the approval of the Credentials Committee of the medical staff.

Individuals' privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, and at the time as judged necessary by the Chief of Service.

Note: Completion of medical records including dictation of operative notes within two weeks of the date of operation is a medical staff requirement and individuals who are consistently delinquent may have their privileges suspended.

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

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

IV. PROCTORING AND MONITORING REQUIREMENTS

A. REQUIREMENTS

Proctoring requirements for the Surgery Clinical Service shall be the responsibility of the Chief of the Service.
All requirements and details of proctoring will be delineated in the document.

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION OF MEDICAL STAFF

The Surgery Clinical Services offers weekly educational activities/teaching conferences as follows:

ZSFG Trauma Service Morning Report	Monday-Friday 0630-0730
UCSF Surgery Grand Rounds	Wednesday 0700-0900
ZSFG Surgery Mortality and Morbidity Conference	Every Tuesday 1700-1800*
Trauma Multidisciplinary Peer Review (faculty only)*	Monthly - every 4th Wednesday 3-5pm
GI Radiology Conference	Monday1200-1300
Trauma Video Resuscitation Conference	2nd Tuesday 1700-1600
Tumor Board	Thursday 0800-090

Note: Attendance at 50% of ZSFG Surgery Grand Rounds /Mobidity and Mortality Conferenceis an expectation for all full-time surgery faculty. Persistent non-compliance may be reported to the medical staff office as part of OPPE.
*>50% attendance at Trauma Multidisciplinary Peer Review is a privileging requirement for core trauma panel members; failure of this requirement will require suspension of trauma privileges.

VI. SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

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

1. ROLE, RESPONSIBILITY, AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF (Refer to CHN Website for Housestaff Competencies link.)

A. The Trauma and General Surgery Service, the Vascular Surgery, and the Plastic Surgery Services will be overseen by a Chief Resident and/or Surgical Critical Care/Vascular Fellow in each respective discipline. The Chief Resident in collaboration with senior residents will supervise the junior house staff in all aspects of patient care including the admission history and physical exams, ordering of laboratory and radiologic investigations, house staff rounds on all hospitalized patients, and house staff patient evaluation in the outpatient clinics. All residents are under the supervision of the attending surgeon assigned to the Trauma and General Surgery Service, Vascular Surgery or Plastic Surgery Service, or to the attending surgeons working in the outpatient surgical clinic area. In addition, all residents are directly supervised for all critical portions of the procedure by the attending surgeons in the operating room, except for minor procedures such as incision and drainage of abscesses, and consistent with the ACGME rules of indirect supervision.

B. All surgical residents are assigned specific duties appropriate to their level of training and expertise. These duties are outlined in detail in Attachment C.4. The surgical curriculum for house staff at the University of California, San Francisco is designed to ensure that the basic fund of knowledge and technical skill for the performance of these duties are taught to the residents under the direct supervision of the faculty. Specific house staff competencies are detailed in Appendix B.

2. RESIDENT EVALUATION PROCESS

The surgical attending staff meet regularly to perform individual evaluation of the residents and interns assigned to the surgical service at ZSFG. This evaluation includes all the components considered essential for progression to the next level of training, including professionalism, technical abilities, communication skills, and system-based and practice-based learning. These evaluations are provided online and made available to the UCSF Surgical Residency Director (or Director from a surgical or medical sub-specialty as appropriate) as well as to the residents themselves for their own self-evaluation. Each resident is given an exit interview by a surgery attending prior to leaving the rotation.

A. Mortality and Morbidity Conference includes discussion of all deaths and important complications with an emphasis on identification of opportunities for changes to systems of care or clinical practice that will improve care. This will be tracked within either the Surgical or Trauma QI Program, depending on the service line of the complication.

3. ABILITY TO WRITE PATIENT CARE ORDERS

House staff members may write patient care orders, except as specified by ZSFG policy (for example: DNR or Chemotherapy Agents). The supervising attending surgeon has ultimate responsibility for orders written by the surgical house staff for the patients under their supervision.

VII. SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

Non-emergent, non-urgent surgical consultations are requested through eReferral, by submitting a consultation request form, or by telephone request tendered through a member of the surgical faculty, Fellow, or senior resident. Emergency consultations are requested through contact with the on-call attending, service attending, or on-call senior resident. Emergency consultations are staffed by either the service or the on-call attending surgeon. A record of such consultations will be provided by either the senior resident staff or directly by the attending.

VIII. DISCIPLINARY ACTION

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

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

A. GOALS AND OBJECTIVES

The Chief of Service, or designee, will be responsible for ensuring solutions to surgical performance improvement and patient safety. As necessary, assistance will be invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization (eg: Executive Committee; OR Committee, Risk Management etc) to:

1. Ensure appropriate care and safety of all patients receiving care in the department. It is understood that this care is provided chiefly in the emergency room, the operating room, the ICU, the surgical wards, and the surgical clinics.

2. Maximize the safety of patients receiving surgical care.

3. Minimize morbidity and mortality of surgical patients and to avoid unnecessary days of inpatient care.

4. Improve efficiency in the delivery of service.

B. RESPONSIBILITY

1. The Chief of Surgery has overall responsibility for the conduct of the Surgical Performance, Improvement and Patient Safety (PIPS) program. The Chief of Surgery may delegate portions of this responsibility to the Trauma Medical Director, or the Director of the OASIS Outpatient Clinic.

C. REPORTING

Performance improvement/patient safety and utilization management activity records will be maintained by the clinical service. Minutes will be sent to the Medical Staff Services Department.

D. CLINICAL INDICATORS

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

F. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

G. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

H. MEDICAL RECORDS

The members of the Surgery Service are committed to the maintenance of complete, accurate, and timely medical records. These requirements are set forth in the ZSFG Bylaws and Rules and Regulations, which define the minimum standards for Medical Record completion.

1. Operative Records

   Dictated operative reports are required for all major and minor operative procedures performed in the operating suite, whether inpatient or outpatient. Operations or procedures performed in the surgical or OASIS clinics will generally be capable of being performed under local anesthesia and of minor extent. A dictated operative note will not be required for these procedures, but they must be documented in the medical chart by an operative procedure note.

   Dictated operative reports should, contain the following elements (minimum):

   a. Pre-operative diagnosis
   b. Post-operative diagnosis
   c. Operative procedure(s) performed
   d. Surgeon(s)
   e. Narrative description of the operation
   f. Major findings
   g. Complications
   h. Estimated blood loss
   i. Specimens

2. Discharge Summaries

   Dictated discharge summaries will be completed on all patients hospitalized for more than 48 hours, and for those trauma patients surviving less than 48 hours. Patients hospitalized less than 48 hours may have a handwritten or dictated discharge summary at the discretion of the treating resident or attending physician. Dictated discharge summaries will contain a succinct description of the reasons for hospitalization, the course of treatment, complications of treatment, condition on discharge, and plans for post-hospitalization care.

   As noted above, consistently delinquent operative or medical records may result in temporary or permanent loss of privileges as outlined in the Medical Staff Bylaws.

I. INFORMED CONSENT

1. All decisions for operative treatment should involve the active participation of the patient or their surrogate and should be made after appropriate discussions of the details of the procedure and expectations

for the procedure, and attendant alternatives, risks, benefits, and complications.

2. Documentation of "Informed Consent" on medical staff-approved forms is required for the following:
    a. All surgical procedures performed in the operating room, procedure rooms, ICU, or wards.
    b. All procedures performed in the clinic unless specifically included on the list of procedures that do not require consent.
    c. All procedures involving laser therapy.

3. Documentation of patient consent will be provided by a properly signed and completed ZSFG Operative Consent Form.
4. The operating surgeon will also provide a Preoperative Note in the progress notes section of the patient's chart (typically on a pre- and post-operative note form). This note should include elements outlined in I.1. above.

X. MEETING REQUIREMENTS

A. MEETING CRITERIA

In accordance with ZSFG Medical Staff Bylaws, all Active members of the ZSFG medical staff are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, and the annual Medical Staff Meeting. This information will be located in the provider files.

Clinical Services (faculty) meetings are conducted at monthly for the purpose of discussing clinical service needs, financial monitoring, educational and research agendas, and other business as appropriate.

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.

B. COMMITTEES

Members of the Department of Surgery either Chair or participate in the following ZSFG committees

1. Multidisciplinary Trauma Peer Review Committee (TMD serves as Chair)
2. Hospital PIPS
3. Risk management
4. MEC (Chief and Trauma Director are ex officio members)
5. Disaster (Trauma Medical Director)
6. Operating Room (Chief is ex officio member & co-chair)
7. Transfusion
8. Critical Care
9. PEMT
10. CPG
11. Credentials

12. Cancer
13. Others as needed

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. OPERATIONAL

All house staff will receive and are required to review the online orientation module, “Surgical Resident Orientation to the Operating Room" (see Attachment C.5). All new faculty members will be oriented by the Chief of Surgery and have meetings scheduled to meet other key physician and nursing colleagues to assist in orientation to the hospital. The Chief of Surgery will be responsible for ensuring that 24-hour a day, 365 day-a-year attending and resident surgeon coverage is available for the hospital.

B. SCHEDULES

Full-time faculty must submit their requests for time off to the Chief of Surgery at least two months ahead of time. Full-time faculty must note on their schedule the reasons for days off (i.e., personal, work-related business).

All approved schedule requests will be kept on file with the scheduling administrative assistant. She/he will coordinate with the 3M and ISIS clinics and the OR regarding out-of-office faculty schedule blocking. Absence from clinic and release of OR time will not be accommodated (except in case of an emergency or illness) if the notification is shorter than 6 weeks in advance.

Once the trauma/service calendars are completed, it is up to the individual attending surgeon to find coverage should they wish to trade dates. In the event of an illness, the back-up surgeon will be called to provide in-house coverage until the schedule can be rearranged.

C. CLINICAL

The evaluation and documentation of patients admitted to the hospital are discussed in section IX D and IX E.

D. RISK MANAGEMENT

The Chief of Service will ensure that hospital policies regarding leaving against medical advice, restraints, informed consent, DNR, universal precautions, and the use of interpreters are followed by members of the Surgery Service.

XII. ADOPTION AND AMENDMENT

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

Surgery Privileges

SURGERY 2022
(07/2022 MEC & JCC)

38.00 General Surgery- CORE (pt. 1) ___

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

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

Breast

- Incision and drainage of abscess/cysts
- Excisional biopsy

Skin, Soft Tissue, Musculoskeletal

- Excisional/incisional resection of skin and subcutaneous tissues
- Biopsy of skin and soft tissue lesions, including excisional biopsy
- Debridement of skin and soft tissue
- Hidradenectomy
- Debridement of burn wounds
- Split thickness skin graft
- Full thickness skin graft
- Lymph node biopsy
- Fasciotomy
- Placement of negative pressure dressing devices
- Other emergency procedures not otherwise specified

Head and Neck

- Open Or Percutaneous Tracheostomy
- Cricothyroidotomy
- Biopsy of neck mass
- Biopsy of thyroid nodule/mass
- Other emergency procedures not otherwise specified
- Temporal artery biopsy

Abdomen – Peritoneum

- Exploratory Laparotomy
- Diagnostic Laparoscopy
- Drainage Abdominal Abscess
- Open Repair Inguinal/Femoral Hernia
- Open Repair Ventral Hernia
- Laparoscopic Repair Ventral Hernia
- Insertion Peritoneal Dialysis Catheter
- Other emergency procedures not otherwise specified
- Open repair of diaphragmatic hernia

38.00 General Surgery- CORE (pt. 2) ___

Abdomen - Liver, Biliary, Pancreas, Spleen

- Open cholecystectomy
- Laparoscopy cholecystectomy
- Cholangiogram
- Open Common Bile Duct Exploration
- Choledoscopy
- Repair Common Bile Duct Injury
- Choledochoenteric Anastomosis
- Operation For Gallbladder Cancer (When Found Incidentally)
- Hepatic Biopsy
- Partial Hepatectomy
- Drainage Liver Abscess
- Distal Pancreatectomy
- Pancreatic Debridement
- Drainage of pancreatic Pseudocyst
- Splenectomy
- Other emergency procedures not otherwise specified

Abdomen - GI tract

- Repair/Resection Of Perforated Esophagus
- Partial/Total Gastrectomy
- Open or Laparoscopic Gastrostomy/Jejunostomy
- Repair Duodenal Perforation
- Truncal Vagotomy
- Open or Laparoscopic Enterostomy/Enterectomy
- Open or Laparoscopic Colostomy/Colectomy
- Hemorrhoidectomy
- Banding for Internal Hemorrhoids
- Lateral Internal Sphincterotomy
- Drainage Anorectal Abscess
- Pilonidal Cystectomy
- Anal Fistulotomy/Seton Placement
- Other emergency procedures not otherwise specified

Endoscopy

- Diagnostic Esophagogastroduodenoscopy
- Diagnostic Sigmoidoscopy
- Diagnostic Colonoscopy

38.05 General Surgery - Special Privileges ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or experience or Subspecialty Board Certification.

PROCTORING: INITIAL - 2 observed operative procedures and 10 retrospective reviews per Category of operative procedures.

REAPPOINTMENT - 2 operative procedures per Category in the previous 2 years. For those procedures that are rarely performed and, as such, there is no frequency or volume of cases required, each case will be reviewed and for each privilege a running evaluation of all cases will be performed after each case

A. Skin, Soft Tissue, Musculoskeletal ___

1 Wide Local Excision Melanoma ___

2 Sentinel lymph node biopsy ___

3 Axillary, femoral, or cervical lymph node dissection ___

B. Head and Neck ___

1 Cricopharyngeal Myotomy ___

2 Excision Zenker'S Diverticulum ___

3 Excision thyroglossal duct cyst ___

4 Glossectomy ___

C. Abdomen – Peritoneum ___

1 Laparoscopic Repair Inguinal Hernia ___

2 Laparoscopic Repair Femoral Hernia ___

3 Laparoscopic repair of hiatal or other diaphragmatic hernia ___

D. Abdomen - Liver, Biliary, Pancreas, Spleen ___

1 Laparoscopic Common Bile Duct Exploration ___

2 Intraoperative Ultrasound ___

3 Operation for Gallbladder or Bile Duct Cancer ___

4 Elective Liver Segmentectomy/Lobectomy ___

5 Elective Pancreaticoduodenectomy ___

6 Elective Ampullary Resection ___

7 Elective Pancreatectomy ___

8 Longitudinal Pancreaticojejunostomy, Frey Procedure, Beger Procedure ___

E. Abdomen - GI tract ___

1 Total Esophagectomy ___

2 Esophagogastrectomy ___

3 Laparoscopic Anti-Reflux Procedure ___

4 Open Anti-Reflux Procedure ___

5 Laparoscopic Bariatric Procedure ___

6 Laparoscopic Heller Myotomy ___

F. Endoscopy ___

1 Percutaneous Endoscopic Gastrostomy ___

2 Therapeutic Esophagogastroduodenoscopy ___

3 Esophagogastroduodenoscopy with biopsy ___

4 Therapeutic Colonoscopy ___

5 Colonoscopic Biopsy/Polypectomy ___

6 ERCP ___

G. Endocrine ___

1 Thyroidectomy ___

2 Parathyroidectomy ___

3 Open Or Laparoscopic Adrenalectomy ___

4 Pancreatic Enucleation ___

38.10 Breast - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or experience or Subspecialty Board Certification.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Biopsy breast lesion
- Duct Excision
- Lumpectomy with or without wire liocalization and/or Magseed
- Partial or Simple Mastectomy
- Modified Radical or Radical Mastectomy
- Sentinel lymph node biopsy
- Axillary Lymph Node Dissection
- Stereotactic Breast Biopsy

38.15 Colorectal - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Colon and Rectal Surgery.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.. .

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Stapled Hemorrhoidectomy
- Repair Complex Anorectal Fistulae
- Complex Anal Sphincter Reconstruction
- Excision Of Anal Cancer
- Transanal Resection For Tumor
- Total Proctocolectomy, Ileoanal Pull-Through, Ileal-Pouch Procedures
- Abdominoperineal Resection
- Pelvic Exenteration For Rectal Cancer
- Complex Recto-Vaginal Fistula/Rectocele Repairs
- Open Or Laparoscopic Operation For Rectal Prolapse
- Perineal Repair Rectal Prolapse

38.20 Trauma - Core (pt. 1) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.. .

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

Skin, Soft Tissue, Musculoskeletal

- Exploration and Repair of Wounds and Complex Lacerations/Traumatic Injuries
- Repair Tendons
- Major Extremity Amputations
- Hip Disarticulation
- Forequarter Amputation
- Girdlestone Procedure
- Other emergency procedures not otherwise specified

Head and Neck

1. Emergency Neck Exploration
2. Thyroidectomy/Parathyroidectomy for Trauma
3. Repair/Resection of Cervical Tracheal Injury
4. Repair/Resection of Cervical Esophageal Injury
5. Esophagostomy
6. Pharyngostomy
7. Other emergency procedures not otherwise specified

GU tract

1. Nephrectomy
2. Renorrhaphy
3. Adrenalectomy
4. Ureteral resection/repair
5. Ureteral reimplantation
6. Repair of bladder
7. Cystotomy/Cystectomy
8. Placement of supra-pubic tube
9. Urethral resection/repair
10. Orchiectomy
11. Scrotal exploration
12. Hysterectomy
13. Oopherectomy
14. Salpyngectomy
15. Cesearan section for trauma
16. Other emergency procedures not otherwise specified

38.20 Trauma - Core (pt. 2) ___

Thoracic

- Emergency sternotomy
- Emergency thoracotomy
- Tube thoracostomy
- Thoracentesis
- Bronchoscopy, flexible
- Pericardial window, diagnostic or therapeutic
- Repair of cardiac injury
- Emergency repair of tracheal/bronchial injury
- Emergency pulmonary resection
- Evacuation of hemothorax, open
- Evacuation of hemothorax, thoracoscopic
- Repair of diaphragm via thoracic approach, open
- Emergency repair of chest wall defects
- Emergency esophageal repair/resection
- Other emergency procedures not otherwise specified

Vascular

- Emergency vascular control of hemorrhage
- Emergency arterial ligation, repair and/or bypass, all sites
- Emergency venous ligation, repair and/or bypass, all sites
- Angiography
- Venography
- Percutaneous central venous line placement
- Venous cutdown for vascular access
- Placement of tunneled or implanted venous access devices
- Porto-systemic shunt
- Placement and Management of Resusciative Balloon Occlusion of the Aorta (REBOA)
- Other emergency procedures not otherwise specified

38.25 Plastic Surgery - Core ___

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

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Incision and Drainage of Abscess
- Flexor/Extensor Tendon Repair, Tenolysis, Drainage of Tendon Sheath
- Local Skin/ Muscle Rotational Flap, Skin Tissue Rearrangement
- Repair Nailbed Injury
- Release A-1 Pulley, Pulley Reconstruction
- Fasciotomy
- Separation of Digit Syndactyly, Excision of Supranumery Digit
- Carpal/Cubital Tunnel Release
- Completion Amputation Of Digit
- ORIF/CRPP Radius, Ulnar, Carpal, Metacarpal, Phalangeal Fractures
- Removal of Foreign Body
- Placement of Tissue Expander
- Breast Reconstruction With TRAM, Free Perforator Flap
- Breast Capsulotomy/Capsulectomy
- Breast Reconstruction with Saline/Silicone Implant, Removal Saline/Silicone Implants
- Nipple Reconstruction
- ORIF Mandibulomaxillary/ZMC/Nasal/Nasoethmoid/Orbital Floor Fracture
- Full Thickness (FTSP) Or Split Thickness Skin Graft (STSG)
- Abdominal Wall Reconstruction, Components Separation, Mesh Placement
- Lower Extremity Reconstruction with local or free flap
- Head and Neck Reconstruction with local or free flap
- Trunk reconstruction with local or free flap
- Debridement, Skin and Subcutaneous Tissue, Muscle and Bone
- Placement of Negative Pressure Dressing Devices

38.30 Plastic Surgery - Special Privileges ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic Surgery with documented additional training and/or experience or Subspecialty Board Certification.

PROCTORING: INITIAL - 2 observed operative procedures and 10 retrospective reviews per Category of operative procedures.

REAPPOINTMENT - 2 operative procedures per Category in the previous 2 years. For those procedures that are rarely performed and, as such, there is no frequency or volume of cases required, each case will be reviewed and for each privilege a running evaluation of all cases will be performed after each case

A. Microvascular ___

1 Use Of Operating Microscope, Repair Blood Vessel/ Nerve, Digit ___

2 Replantation ___

3 Free Myo/Skin Flap Microvascular Anastamosis ___

B. Hand ___

1 Incision/Drainage Abscess, Finger or Hand ___

2 Palmar Fasciotomy Dupuytren's Contracture ___

3 Palmar Fasciectomy Dupuytren's Contracture ___

4 Closed Capsulotomy ___

5 Open Capsulotomy ___

6 Excision Bone Cysts ___

7 Excision Bone Tumors ___

8 Bone Grafts, Wrist, Hands or Fingers ___

9 Arthrodesis, Wrist, Hand or Finger Joints ___

10 Tenolysis ___

11 Tenorrhaphy ___

12 Tendon Transfer ___

13 Free Tendon Graft, From Arm or Leg ___

14 Arthroplasty with Implant ___

15 Ligament Repair Or Reconstruction ___

16 Reconstruction Hand Deformities ___

17 Amputation, Finger, Hand or Forearm ___

18 Fractures/Dislocations ___

19 Carpal/Cubital Tunnel Release ___

20 Brachial Plexus exploration ___

21 Neurolysis ___

22 Nerve Transfer ___

23 Nerve Tranpositions ___

24 Nerve Repair, Primary ___

25 Nerve Repair, Secondary with Nerve Graft ___

26 Removal of Foreign Bodies ___

27 Replantation of Fingers and/or Hand ___

28 Wrist Arthroscopy ___

29 Carpal Bone Fractures ___

30 Wrist Fractures ___

C. Craniofacial ___

1 Closed Reduction and Mandibulomaxillary (MMF) Fixation of Mandible Fracture ___

2 Open Reduction and Internal Fixation of Mandible Fracture ___

3 Open Reduction and Internal Fixation of Zygoma Fracture ___

4 Open Reduction and Internal Fixation of Orbital Floor Fracture ___

5 Open Reduction and Internal Fixation of Orbital Wall Fracture ___

6 Open Reduction and Internal Fixation of Zygomaticomaxillary (ZMC) ___

7 Complex Fracture ___

8 Open Reduction and Internal Fixation of Noso-Orbital Ethmoid Fracture ___

9 Open Reduction and Internal Fixation of Le Fort I Fracture ___

10 Open Reduction and Internal Fixation of Le Fort II Fracture ___

11 Open Reduction and Internal Fixation of Le Fort III Fracture ___

12 Cleft Lip Repair ___

13 Cleft Palate Repair ___

14 Resection of Arteriovenous Malformation ___

15 Complex Tissue Rearrangement, Scalp ___

D. Gender Affirming Surgery ___

1 Feminizing Mammoplasty, primary ___

2 Feminizing Mammoplasty, revision ___

3 Masculinizing Chest Surgery, primary ___

4 Masculinizing Chest Surgery, revision ___

5 Vaginoplasty, penile inversion ___

6 Vaginoplasty, colon or peritoneum ___

7 Phalloplasty, microvascular ___

8 Phalloplasty, non-microvascular ___

38.31 Plastic Surgery - Laser Surgery ___

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

PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at ZSFG

REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at ZSFG

- Removal of Congenital and Acquired Lesions (Tattoos, Hemangiomas, Pigmented Lesions)

38.32 Acute Trauma Care ___

SCOPE: On-call trauma coverage for the initial resuscitation and comprehensive management of the acutely injured patient. Includes acute operative management of thoracic and vascular injuries, and initial surgical critical care of the trauma patient.

CRITERIA:
1. Completion of ACGME-approved residency with ABS Board certification/eligibility in General Surgery.
2. Current ATLS certification (provider)
3. Clinical performance and commitment consistent with standards for general surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons.

_____ _____

Trauma Medical Director **Date**

38.35 Thoracic Surgery - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Thoracic Surgery.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Bronchoscopy
- Open Decortication and/or Pleurectomy
- Thoracoscopic Decortication and/or Pleurectomy
- Thoracotomy for empyema
- Thoracoscopy for empyema
- Repair/resection trachea/bronchus, elective
- Elective thoracotomy for pulmonary resection
- Elective thoracoscopy for pulmonary resection
- Repair of diaphragm via thoracic approach
- Elective repair of chest wall defects/deformities
- Elective thymectomy
- Open Reduction and Internal Fixation Rib Fractures
- Insertion of venous cannula for veno-venous ECMO, open or percutaneous
- Insertion of arterial cannula for veno-arterial ECMO, open or percutaneous.
- Insertion of permanent pacemaker

38.40 Thoracic Surgery - Special Privileges ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Thoracic Surgery.

PROCTORING: INITIAL - 2 observed operative procedures and 10 retrospective reviews of operative procedures.

REAPPOINTMENT - 2 operative procedures in the previous 2 years. For those procedures that are rarely performed and, as such, there is no frequency or volume of cases required, each case will be reviewed and for each privilege a running evaluation of all cases will be performed after each case

1. Cardiopulmonary bypass

38.45 Vascular Surgery - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery in Vascular Surgery.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of operative procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core operative procedures in the previous two years of a sampling of the procedures listed below.

- Angiography
- Venography
- Endarterectomy or thrombectomy of the lower extremity, upper extremity, abdominal, thoracic or cervical vessels (arterial or venous)
- Surgical bypass of the lower extremity, upper extremity, abdominal, thoracic or cervical vessels (arterial or venous)
- Open repair of aneurysms (excluding vessels in the pericardium and intracranial)
- Endovascular repair of the aorta, including the arch, thoracic and abdominal aorta
- Thoracic outlet decompression with rib resection and neurolysis
- Injection and ablation procedures of pseudoaneurysms and venous structures
- Creation or revision of arteriovenous fistula and grafts, open or percutaneous
- Percutaneous vascular access and placement of indwelling vascular catheters (arterial or venous)
- Endovascular treatment of the lower extremity, upper extremity, abdominal, thoracic or cervical vessels (arterial or venous, excluding vessels in pericardium and intracranial), including angioplasty, stent deployment, atherectomy, intravascular ultrasound, thrombectomy and thrombolysis.
- Excision, resection or biopsy of artery, vein or graft
- Amputation of the lower extremity
- Debridement of skin, subcutaneous, fascia, muscle, bone
- Tube thoracostomy
- Fasciotomy, upper and lower extremity
- Placement and Management of Resusciative Balloon Occlusion of the Aorta (REBOA)

38.50 Critical Care - Core ___

PREREQUISITES: PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery in Surgical Critical Care.

PROCTORING: INITIAL - 5 observed operative procedures and 15 retrospective reviews of procedures of a sampling of the procedures listed below.

REAPPOINTMENT - 10 core procedures in the previous two years of a sampling of the procedures listed below.

- Placement of percutaneous central lines
- Placement of arterial lines
- Intubation
- Bronchoscopy
- Placement tube thoracostomy
- Thoracentesis
- Pericardiocentesis
- Paracentesis
- Lumbar puncture
- Insertion of transvenous pacemaker
- Pulmonary artery catheter insertion
- Emergency cricothyroidotomy
- Cardioversion
- Defibrillation
- Placement of esophageal balloon for hemostasis
- Bedside ultrasonography
- Patient Controlled Analgesia

38.55 Cardiothoracic Pre-Operative Evaluation - Core ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with documented additional training and/or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Thoracic Surgery.

PROCTORING: INITIAL – 2 retrospective reviews of cases of a sampling of the procedures listed below.

REAPPOINTMENT - 2 retrospective reviews of cases of a sampling of the procedures listed below.

- Evaluate and make recommendations for potential Cardiac Surgery of inpatient and outpatient.

38.65 Waived Testing ___

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

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

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

- Fecal Occult Blood Testing (Hemoccult®)
- Vagnal Ph Testing (Ph Paper)
- Urine Chemstrip® Testing
- Urine Pregnancy Test (Sp® Brand Rapid Test)

38.70 Diagnostic Radiology - Fluoroscopy ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery and current X-Ray/Fluoroscopy Certificate, or a member.

PROCTORING and REAPPOINTMENT: Presentation of valid California Fluoroscopy certificate

38.80 Procedural Sedation ___

PREREQUISITES:
The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.08 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 Emergency Medicine 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

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

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____
CTSI Medical Director Date

APPROVED BY

____ ____________________

Division Chief Date

____ ____________________

Service Chief Date

Appendix A. OR Block Time

MONDAY:

4.0 OR's available –, Plastic Surgery (Terry), General Surgery, Vascular (1st and 3rd Mondays), Emergency General Surgery

TUESDAY:

2.5 OR's available Breast Surgery (Wong), Surgical Oncology (Alseidi), Plastic Surgery (Terry)

WEDNESDAY:

2.5 OR available Surgery (), Plastic Surgery (Soo), Emergency General Surgery

THURSDAY:

3.5 OR's available – Surgery (), Plastic Surgery (Young, Hansen, Terry)

FRIDAY:

1.5 OR's available – Vascular (Vartanian, Oskowitz), Emergency General Surgery

APPENDIX B: SURGERY HOUSE STAFF COMPETENCIES

Refer to CHN Intranet site, House Staff Competencies link.

APPENDIX C – ADDITIONAL CLINICAL SERVICE SPECIFIC ATTACHMENTS

1. **ATTACHMENT C1: AFFILIATED PROFESSIONALS**
2. **ATTACHMENT C2: SURGERY CLINICAL SERVICE PROCTORING PLAN**
3. **ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN**
4. **ATTACHMENT C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL**
5. **ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY**
6. **ATTACHMENT D: JOB DESCRIPTIONS**

APPENDIX C ATTACHMENT C1: AFFILIATED PROFESSIONALS

(TRAUMA NURSE PRACTITIONER BINDER KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX C: ATTACHMENT C2 - SURGERY CLINICAL SERVICE PROCTORING PLAN

SURGERY CLINCIAL SERVICE
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL PROCTORING PLAN

I. REQUIREMENTS

A Proctoring will be required who request surgical privileges within the Surgery Clinical Service at Zuckerberg San Francisco General Hospital. The proctoring, which is carried out, will be specific to the area in which privileges are requested.

C Applicants for surgical privileges at ZSFG who are accredited on the active staff at UCSF campus hospitals and UCSF affiliated hospitals (SFVAMC, CPC, Kaiser SF), have faculty appointments in the UCSF Department of Surgery, and perform the majority of their surgery at a UCSF campus hospital or UCSF affiliated hospital will be assumed to have been adequately proctored and will not be required to have direct observation on their cases in the operating room. Unless the Chief of Surgery determines that there is a reason for intraoperative proctoring.

D Proctoring will consist of these activities:

1. <u>Intraoperative Observation</u>
   Direct intraoperative observation of applicants will be carried out by one of the assigned proctors for enough cases in each category of privileges to assure competence in the technical and operative aspects of surgery.

2. <u>Complication Review</u>
   All deaths and complications occurring in patients treated by the applicant during the provisional year of staff appointment will be tabulated, and the conclusions of the surgery D&C conference regarding the specific complication will be reviewed.

E. The proctor appointed for the applicant and the Chief of Surgery will meet periodically to review the above areas, and determine when to discontinue monitoring in areas D.1. and D.2., based on the number of cases and competence demonstrated. At any point in the proctoring process, if the proctor and the Chief of Surgery feel that the applicant is not qualified in a specific area, they may revoke provisional privileges in that area and shall notify the applicant and the Credentials Committee in writing of this action.

F Anyone performing general surgery can be placed under observation at any time when it is deemed indicated by (1) the Chief of Service, (2) the Credentials Committee, (3) the Medical Executive Committee, or (4) the Operating Room Committee. The duration of observation shall be at the discretion of the Chief of Service, and a report shall be made at the end of this time to the requesting committee.

II. APPOINTMENT AND RESPONSIBILITITES OF PROCTORS

A. Any member of the Department of Surgery, who is a member of the Active Staff, or member of the Courtesy Staff with a UCSF faculty appointment, may be appointed as a proctor. The proctor must be experienced in the areas being evaluated, but need not have the same Board Certification or subspecialty certification as the applicant.

B. One or more proctors will be appointed by the Chief of Surgery for each applicant. The Chief of Surgery may participate as a proctor or may independently evaluate any aspect of patient care performed by the applicant.

C. The applicant will notify one of the proctors of all cases scheduled during the proctoring period, so that they may arrange to be present during surgery, until the requirements of Section I, D.1. above, have been satisfied. The applicant may schedule surgery at his or her discretion and it will be the responsibility of the proctor to attend if he wishes.

D. A proctoring form for each operative observation will be completed by the proctor and submitted to and maintained by the Chief of Surgery. These will be kept in the applicant's clinical service credentials file and will be confidential as legally defined within hospital surgical Performance, Improvement and Patient Safety process.

APPENDIX C: ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

APPENDIX C: ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY

1. **The Faculty clinic absentee** window is set at 6 weeks. In the event that the physician will not be available after the 6 week window has passed for a non-emergent reason:

    a. When a faculty absentee form is filled out, the clinic staff is responsible for informing the faculty member and the Department Assigned Administrative Assistant of receipt of the absentee date/time via email.
    b. The Attending has to directly inform the clinic nursing director, and the chief of surgery in writing including the reason for missing clinic. A specific reason (academic, out of town, site visit commitment) must be given.
        i. Action plan as understood by clinic staff will be communicated back to faculty member and Department Assigned Administrative Assistant via email to include
            1. Date of expected absence
            2. Plan for alternative coverage/rescheduling
        ii. Faculty must make every attempt at obtaining coverage – either from another attending assigned to that clinic or by having another attending cover the patient load, OR
        iii. As an alternative, patients can be rescheduled to one of the two back flow clinics on Monday or Thursday PM for the following week. This will be first come first serve.
2. **Faculty timeliness**:
    a. Service expectations are that the patients are roomed and ready to be seen by 9 AM/1 PM so that clinic can start immediately. The service expects the attending to be on time for clinic and if not the clinic will call the attending by 9:15 or 1:15. If no response from the attending they are to call the Chief of Service or designee.
3. **Attending surgeons will be automatically excused from clinic when they are covering the service or are assigned to the ICU.** This includes the ICU service at UCSF Moffit ,VAMC and UCSF Mission Bay
    a. Faculty who need to see patients should use Monday afternoon overflow clinic time during the following week.
4. **Clinic Room Assignment:**
    a. NP's will use the room in the back of the clinic to complete H&P's.
    b. MEA's have been proposed to help staff the rooms and will be assigned to specific rooms to help with patient throughput.
    c.
5. **H&P's:** If the day of surgery is within 30 days of the last clinic visit, an interim H&P update is completed by the surgical attending or resident in the pre-operative area. In the event that surgery is > 30 days from the last clinic visit, a full H&P is to be completed by a member of the surgical team.
6. **Block time in the OR:**
    a. OR blocks may only be released by the attending assigned to that block. This should be done as soon as the attending knows she/he will be unavailable (on service; out of town etc). In general, these blocks should be released two months ahead of time. Once the OR time has been released, the clinic OR calendar will clearly state that the time has been released. Once released it cannot be reclaimed.
        i. Other attendings may not schedule surgeries on a block day that is not theirs unless it has been released.
        ii. See appendix A for OR block schedule.

7. **Scheduling templates:**
    a. Each Faculty will be assigned a template designed by attending with an expectation that they will see between 5-10 new patients per week in general surgery and a similar number of follow-ups. However, some attendings are only part-time and may see fewer patients.

SURGERY CLINICAL SERVICE

PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

I. ORGANIZATION

The Surgery Clinical Service at Zuckerberg San Francisco General Hospital, under the umbrella of the hospital-wide Surgical Performance, Improvement, and Patient Safety Committee, operates a quality management program within the Surgery Clinical Service with multiple facets. These activities, to be described below, are carried out under the direction of the Chief of Surgery. They, in turn, report to the ZSFG Surgical Performance, Improvement, and Patient Safety Management Committee.

II. PURPOSE

The overall purpose of the Surgical Performance, Improvement, and Patient Safety Committee is to (1) continuously monitor feedback and (2) ultimately improve the quality of patient care delivered by the Surgery Clinical Service. Monitoring exists for both surgical and resident staff, in addition to system monitoring for the Trauma Service. The intent of this monitoring is to identify and correct specific individual and system problems.

III. SCOPE

The services, which are included within this program, are the Acute Care Surgery Service (which include General Surgery, Emergency General Surgery, Trauma, and Surgical Critical Care), Vascular Surgery and Plastic Surgery Services. Oversight of the Vascular and Plastic Surgery Surgical Performance, Improvement and Patient Safety program is delegated to the Chief of the Division of Vascular Surgery and Plastic Surgery, repectively. Orthopedics, Neurosurgery, Urology, Otolaryngology (ENT), and Ophthalmology are not included within the Surgery Clinical Service and are responsible for the independent operation of their programs.

IV. IDENTIFICATION OF PROBLEMS

Three general methods are used to identify and correct problems that occur within a busy teaching hospital environment. These are as follows:

A. Routine Surveillance

The activities grouped under this heading are carried out as continuous activities for monitoring and ensuring the quality of care, and providing optimal teaching to students and residents.

1. Daily Attending Ward Rounds

   Ward rounds are made by surgical attendings with senior or chief residents on every service and every patient is seen and evaluated daily. Diagnostic and treatment plans, and clinical course are reviewed. A daily progress note is generated by each attending on every patient and filed in the electronic medical record.

2. Daily Trauma Nurse Clinical Rounds

   An experienced Emergency/Trauma Nurse (most often the Trauma Program Coordinator or Trauma Case Manager) rounds daily with the Trauma Service Residents and collects data concurrently regarding diagnosis and treatment of trauma patients. Specific patient complications, as well as system

problems (E.g., missed triage, delay in trauma team activation, etc.) are tabulated and reported back to the Trauma Director. Patient complications are also reported by the resident staff at a weekly Service meeting. Data collected by the Trauma Program Coordinator is entered into the computerized Trauma Registry and analyzed for discrepancies in predicted vs. observed outcome as described below.

3. Surgical Mortality and Morbidity Conference
   This conference is held weekly and all available Surgery Clinical Service attendings and residents attend. Weekly statistics are reviewed, and all deaths and complications are reported and discussed. All deaths and complications are then entered in the computerized departmental registry and are categorized as preventable, possibly preventable, non-preventable, or systems problem according to the responsible attending and resident for later compilation and analysis. In addition, complications or deaths are assigned a Severity Index (SI) rating on a 5-point scale as follows:

   SI-1: minor inconvenience. (Examples: superficial surgical site infection, pneumonia, UTI, uncomplicated missed injury)
   SI-2: moderate severity, slight prolongation hospital stay. (Examples: DVT requiring Coumadin, deep SSI requiring percutaneous drainage, iatrogenic pneumothorax)
   SI-3: complication associated with prolonged stay, need for readmission or additional procedures or interventions. (Examples: wound dehiscence, respiratory arrest, pulmonary embolus, post-operative bleeding requiring reoperation.)
   SI-4: Complication requiring major intervention, associated with prolonged morbidity or inconvenience. (Examples: Enteroatmospheric fistula, reoperation requiring ostomy, multiple additional procedures or admissions)
   SI-5: Long-term or permanent morbidity, disability, or death.(Examples: Death, major amputation, permanent brain injury).

4. Monitoring of Incomplete Charts and Undictated Operative Notes
   All surgical charts of discharged patients from the preceding week are prepared by Medical Records weekly and are reviewed by the Surgery Clinical Service residents and attendings. All incomplete entries, unsigned medical student notes or orders, or absent discharge summaries are completed.

   An independent system is used for the completion of operative notes. The Medical Records Department notified the Chief of Surgery weekly with a written list of all incomplete operative notes. The Chief of Surgery directly contacts the responsible individual to ensure the timely completion of the dictation.

B. Exception Reporting
The second method of identification of problems is via the reporting or unusual or unexpected occurrences. These problems are then individually investigated and evaluated and are referred to the Chief of Service or Trauma Director/Trauma QA Committee for resolution.

1. Unusual Occurrence Report
   Incident reports are completed by the nursing staff according to a set of defined indicators (e.g., drug reaction, patient complaint, unexpected return to the operating room, post-operative bleeding, etc) and these are channeled to the Chief of Surgery when any surgical patient or surgical staff is involved with the incident. These are individually investigated and either resolved or referred to the most appropriate body for resolution.

2. Interdepartmental Incidents
   System problems arising on surgical units between Services, etc. not requiring specific Unusual Occurrence Reports, are reported back to the Trauma Program Coordinator by faculty, residents, or nursing/ancillary personnel. This reporting system is in addition to routine surveillance made by the Trauma Program Coordinator as described previously. Specific problems are then forwarded to either the Chief of Surgery or the Trauma Director/Trauma PIPS Committee for discussion/resolution.

C. Use of Clinical Indicators
With the advent of the clinical registry of all surgical patients, it has become possible to greatly expand the scope of this activity and identify attending-specific information related to patient outcomes. This activity is steadily evolving as more information is accumulated in the registry. The following are indicators currently in place.

1. Surgical Site Infections (General and Plastic Surgery)
   Overall wound infection rates are monitored by the Infection Control Committee and reported to the Chief of Surgery. These are attending specifics and may be discussed at the weekly Morbidity and Mortality Conference.

2. Attending Specific Compilation of Deaths and Complications (General Surgery)
   Aggregate compilation of deaths and complications on a quarterly basis for each attending surgeon is compiled and reviewed by the departmental staff quarterly, in order to allow inter-attending comparison of rates.

3. Trauma Attending Presence at 900 Trauma Activations
   The expectation of the ACS Trauma Center Verification is that a surgical attending will respond to the highest level trauma activations within 15 minutes of the patient's arrival in the ED, monitored by the Trauma Medical Director as part of the trauma PIPS process.

4. Unexplained Return to the Operating Room
   Information reported at M&M conference will be compiled to determine surgeon specific rates.

V. PROBLEM RESOLUTION

Resolution of problems identified by the above mechanisms occurs on multiple levels, as seems most appropriate to the individual circumstances. The principal methods are the following:

A. Individual Discussion

Minor problems related to individual behavior, administrative problems, and interpersonal or communication problems are best dealt with on an individual level. This is done by the Attending Surgeon on a given service in the process of daily contact and patient surveillance described above. Unusual problems are brought to the attention of the Chief of Surgery, who discusses the problem(s) with the individual(s) involved when they are in the Surgery Clinical Service. Similar problems involving nursing personnel are dealt with by the Trauma Nurse Coordinator either through the Head Nurse of the Unit involved or the individual nurse.

B. Group Discussion/Education –Surgery M&M Conference

The most common mechanism for evaluating and correcting problems in a teaching environment is through the constant education of the trainees involved in the process. This is accomplished as a significant part of the weekly Mortality and Morbidity Conference, in which the problems are identified and then discussed in detail as to methods of avoidance or prevention. Expected standards of care, standards of monitoring, priority setting, methods of assessment, etc., are communicated to all levels of resident staffs.

C. Trauma Surgical Performance, Improvement, and Patient Safety Committee

This conference is attended by representatives from all clinical services involved in the care of the trauma patient, as well as from nursing, and interdepartmental issues, policy changes, pre-hospital care issues, and more global institutional issues are addressed at this committee. The primary function of the Trauma PIPS Committee is to formulate and implement policy in response to system problems that arise and are identified by the methods described above. The clinical indicators specific to trauma patients are also reported back to this Committee. The Trauma PIPS meeting is conducted by the Trauma Director, who also sits on the Hospital Trauma PIPS Committee as a surgical representative.

APPENDIX C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL

(KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX D: JOB DESCRIPTIONS

CHIEF OF SURGERY CLINICAL SERVICE JOB DESCRIPTION

Chief of Surgery Clinical Service

Position Summary:

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

Reporting Relationships:

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

Position Qualifications:

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

Major Responsibilities:

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

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

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

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

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of

service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs.

Performing all other duties and functions spelled out in the ZSFG Medical Staff Bylaws.

TRAUMA PROGRAM MEDICAL DIRECTOR

General Description:

The trauma medical director is a general surgeon, appointed by the Hospital through the Executive Administrator, to lead the multidisciplinary activities of the Trauma Program. The role of the TMD will be to work with service Chiefs and hospital administration in order to organize, manage, and develop the Trauma Program, and to seek to improve the Trauma Center in terms of quality, volume, scope of services, and cost-effectiveness of trauma care.

Qualifications:

- Current ABMS board certification in General Surgery.
- Fellow in good standing of the American College of Surgeons (ACS).
- Member in good standing of active medical staff, ZSFG.
- Advanced competency and special interest in trauma care and surgical critical care.
- Active involvement in clinical trauma care and surgical critical care.
- Active involvement in regional or national trauma education.
- Active involvement/participation in regional & national trauma organizations.
- Active involvement and demonstrated proficiency in trauma-related research.
- Demonstrated leadership skills & established history of positive collegial relationships with professional and ancillary staff in an acute care environment.
- Minimum of three years of prior experience in an established designated trauma center or system.
- Demonstrated leadership in peer-review committee functions for ‘sentinel’ or ‘critical’ case review.
- Demonstrated commitment to the underlying principles of Trauma Performance Improvement, Trauma Program requirements by the ACS Committee on Trauma, and Title 22, and the process of trauma program verification and designation.

Appointment, reappointment, review, termination

- Appointed by the ZSFG Executive Administrator, in collaboration with the Chief of Surgery.
- Requires approval of Department Chair.
- Requires approval of the majority of the MEC Chiefs of Services.
- The term of appointment is three years.
- TMD performance review conducted every three years by the MEC. More often at the direction of the ZSFG Executive Administrator.
- The TMD may be removed by the Chief of Surgery, the Department Chair, or the ZSFG Executive Administrator in conjunction with a majority of MEC Chiefs of Service.

Responsibilities:

1) General Administrative Responsibilities and reporting relationships

- Directs the multidisciplinary functions of the trauma program.
- Provides the medical liaison between trauma team members and hospital administration.
- Responsible for ensuring that the quality of trauma patient care provided at ZSFG is commensurate with the institution’s designation as a Level 1 center and as the sole provider of trauma services to the City & County of San Francisco.

- Takes action to correct deficiencies in coverage, response, or competence in the provision of trauma care by members of the trauma panel and trauma team.
- Regularly provides reports on Trauma Program performance to the MEC, including topics and issues related to policy, operations, staffing, quality improvement, and compliance with the Trauma Performance Agreement.
- Helps develop institutional policies, procedures and protocols, as needed, to improve the quality and cost-effectiveness of trauma care.
- Acts to further develop and promote the ZSFG trauma program as a regional resource.
- Acts as the principal clinical supervisor for the Trauma Program Nurse Practitioners.
- Reports directly to the ZSFG Executive Administrator.
- Collaborates with other Hospital Administrators, Chief of Staff, and Chiefs of Service.
- Monitors compliance with trauma performance agreement.
- Participates in CHN strategic planning.

2) Performance Improvement (PI) program

- Ensures that appropriate peer review is conducted for all types of adverse or potentially adverse events.
- Chairs Multidisciplinary Peer Review Committee.
- Helps develop clinical practice guidelines.
- Monitors as needed and makes recommendations regarding trauma-related hospital privileges and credentials for members of the trauma team.
- Monitors, as needed, facility standards to ensure that they are commensurate with Level 1 Center function.
- Reports matters of critical importance related to trauma patient care, as needed, directly to other administrative agencies or officers within the Department of Public Health or related CCSF agencies (e.g. SFPD, SFFD).

3) Trauma Center designation & verification

- Interacts with SF EMSA in reviewing Trauma Center performance consistent with the requirements in Title 22.
- Works with SF EMSA in revising, as needed, the CCSF Trauma Plan.
- Directs planning and preparation for ACS-COT Trauma Center site surveys and any additional site surveys that the local EMSA may require.

4) Trauma Registry

- Maintains control/oversight of Trauma Registry in conjunction w/ hospital administration.
- Responsible for overseeing timely updates of same.
- Establishes guidelines for use of ZSFG Trauma Registry data outside the Trauma Program.
- Reviews and approves written requests for registry data use by individuals or departments.

5) Credentialing / privileges

- Reviews, as needed, the performance and qualifications of Trauma Surgeons & members of the trauma team providing trauma care at ZSFG.
- Adds/removes trauma surgeons from trauma panel, subject to the approval by TEC.
- Acts to restrict or suspend trauma-related privileges, as necessary and for just cause, in conjunction with the TEC, for any member of the trauma team.

- Recommends and/or approves recommendation, as indicated, for trauma privileges for members of the trauma team.

6) Pre-hospital care

- Involved in review/development of pre-hospital policies, practices, and procedures.
- Meets regularly with EMSA director, paramedic medical director & paramedics, as needed for purposes of: 1) City disaster planning, 2) Trauma triage, 3) Title 22 compliance, 4) Trauma system performance improvement, 5) Pre-hospital performance improvement.

7) Prevention

- Identifies a member of the trauma team or trauma panel who acts to coordinate injury prevention at ZSFG.
- Monitors and acts to promote/enhance injury prevention activities at ZSFG.
- Acts as a liaison and/or consultant for the Dept. of Public Health for purposes of organizing and promoting injury prevention programs and activities.

8) Patient & Community relations (outreach)

- Helps support & develop trauma patient/family satisfaction projects.
- Develops strategic relationships with referring hospitals & physicians for purposes of improving trauma care and facilitating any requested transfers.
- Supports and helps to provide provider educational offerings within the region.
- Participates in regional trauma audit committees as needed.
- Helps to develop and provide trauma consulting services, as needed, to surrounding communities.

9) Trauma Education / training / research

- Actively supports and participates trauma-related research and educational programs including those for medical students, residency programs, and post-graduate education.
- Participates in regional trauma audit committees as needed.
- Is actively involved in ATLS, Stop the Bleed and ASSET courses.

10) Participation at regional & national level (per ACS)

- Participates in local, regional, and national trauma-related activities and organizations.
- Participates in the trauma activities of the American College of Surgeons Committee on Trauma.

11) Managerial / Financial

- Works with trauma business mgr. & senior administrator to effect improvement in LOS, cost effectiveness as needed
- Implements policy/practice changes to help improve cost effectiveness.
- Ensures establishment of appropriate call schedules for all specialties.
- Assists TP manager in developing/meeting budgetary goals.

INTENSIVE CARE UNIT MEDICAL DIRECTORS
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
JOB DESCRIPTION

The Medical Directors are physician leaders in critical care responsible for coordinating clinical care, clinical operations, and education and training in alignment with Zuckerberg San Francisco General Hospital's mission, vision, values and goals. The unit Medical Directors report to the ZSFG Critical Care Medical Director (CCMD) and work closely with the mangers of nursing and other allied healthcare professions to implement strategies for optimizing patient care and operational efficiency.

MISSION STATEMENT

The Medical Directors are committed leaders in continuous clinical innovation, quality improvement, and excellence in medical education.

QUALIFICATIONS

Board-certified in a relevant specialty as well as Critical Care Medicine
Credentialed ZSFG physician or eligible for such credentialing
Excited and inspired by the opportunity to make changes and improve systems
Strong commitment to the mission statement and responsibilities of the position
Outstanding professional credibility and personal integrity
Exceptional clinical skills
Demonstrated ability for teamwork and collaborative problem-solving using an analytical and systematic approach
Excellent verbal and written communication skills
Ability to provide leadership to physicians and other health care professionals

DUTIES AND RESPONSIBILITIES

XIII. Reporting Relationships

- Although the Medical Directors are full-time UCSF faculty members with an appointment within an academic department, in this position, they report directly to the ZSFG Critical Care Medical Director
- The Medical Directors work in close partnership with the other ICU Medical Directors and the ZSFG Critical Care Medical Director
- The Medical Directors work collaboratively with the ICU faculty and inter-disciplinary ICU care team

Performance Improvement and Patient Safety

- Develop and implement clinical protocols and quality improvement projects
- Review potential ICU-wide projects in the Critical Care Directors meetings
- Monitor the performance of the various protocols and analyze the results for further improvement
- Review relevant clinical quality data and performance measures and share findings to the ZSFG Critical Care Medical Director monthly
- Review and address major adverse events, near-misses, and patient safety vulnerabilities and coordinate Morbidity & Mortality Conferences

Clinical Operations

- Ensure adequate critical care physician staffing of intensive care units
- Coordinate call schedules for ICU faculty, fellows, and residents
- Assist the ZSFG Critical Care Medicine Director in optimizing patient flow in all ICU beds, coordinating with the Emergency Department, inpatient units, Operating Room, and Post-Anesthesia Care Unit
- Assist ZSFG Critical Care Medical Director in standardization and analysis of compliance in documentation, billing practices, and financial analysis of ICU operations
- Work with ICU nursing and hospital leadership to assure compliance with all regulatory requirements

Leadership and Communication

- Meet monthly with the ICU nurse manager and other healthcare professional leaders in the ICU to ensure close collaboration, coordination, and clear communication
- Meet monthly with the ZSFG Critical Care Medical Director and other ICU Medical Directors to standardize and coordinate care among all critical care units
- Participate in scheduled unit-specific ICU faculty meetings
- Participate in quarterly combined ICU faculty meetings
- Attend Quarterly ICU multi-disciplinary Grand Rounds
- Host and coordinate one ICU multi-disciplinary Grand Rounds per academic year
- Co-lead annual ICU faculty retreat
- Initiate and lead recurring multi-disciplinary Quality Improvement reviews in partnership with other services (ED, Trauma Surgery, Anesthesia, Family Medicine, Medicine, Otolaryngology, etc.)

Supervision of ICU Faculty

- Review clinical and teaching performance of individual Attendings and provide regular feedback, including compliance with protocols, promptness on rounds, and completion of teaching evaluations
- Ensure participation in quality improvement initiatives and adherence to standardized practices
- Set expectations and ensure Attending adherence to professional behavior standards at all times
- Ensure satisfactory Attending participation at various ICU faculty meetings and Grand Rounds

Medical Education (as applicable to the individual units)

- Resident and Fellow scheduling
- Serve as Medical Student Clerkship Director
- Coordinate Resident and Student evaluations
- Coordinate Journal Club, didactic teaching sessions, and other educational activities

Some duties above may be delegated with the understanding that the Medical Director is responsible for ensuring all tasks are completed.

Committees

All Medical Directors serve on a minimum of two Medical Staff committees, assigned upon mutual agreement with the ZSFG Critical Care Medical Director, including, but not limited to:

- Critical Care Committee
- Procedural Sedation Subcommittee of Pharmacy & Therapeutics Committee
- Trauma Peer Review Committee
- Performance Improvement and Patient Safety Committee
- Donor Committee
- Code Blue Committee
- Ethics Committee

Time Commitment

The Medical Director positions are 0.2 FTE commitment for each for the Medical and Surgical ICUs. When there are Co-Directors, duties are divided evenly and the expected effort is 0.1 FTE each. Division of responsibility is negotiated between the Co-Directors with the ZSFG Critical Care Medical Director and specific duties are clearly delineated.

Term of Appointment

The term of appointment as ICU Medical Director is one year subject to annual renewal based on satisfactory performance of the physician in this role and the needs of ZSFG. There is an initial evaluation after the first 6 months of appointment and annually thereafter. Review is performed jointly by the ZSFG Critical Care Medical Director and Chief Medical Officer. Consideration of non-renewal of appointment will be discussed in advance with the faculty member's Service Chief.

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:	SP for Emergency Department NP/PA
Department:	ZSFG Emergency Department
Dept Chief:	Dr. Chris Colwell
SP Author(s):	Tina King, NP (original author), Jeanne Hoffman, NP (update 2026)
Update #1:	Removal of Clinical Decision Unit (CDU) mentions
Reason/Explanation for Revision:	There is no CDU associated with the ED anymore, with no plan for one in the future
Update #2:	Updated minimum educational and work experience requirements for hire
Reason/Explanation for Revision:	Previous requirements listed were not clear nor specific enough
Update #3:	Added specification to Procedural SPs, such as "suturing, I&D, splints," as well as changed number of proctoring cases required to be uniform among SPs of similar procedures
Reason/Explanation for Revision:	SPs did not specify what the procedure was associated with the SP (i.e., "wound care," "splinting"). There was unnecessary variation in number of proctoring cases required among similar procedures, which was confusing.

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below.

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

Community Health Network of San Francisco
Zuckerberg San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE - NURSE PRACTITIONER / PHYSICIAN ASSISTANT IN THE EMERGENCY DEPARTMENT ~~AND CLINICAL DECISION UNIT~~

PREAMBLE

Title: Nurse Practitioner /Physician Assistant in the Emergency Department ~~and Clinical Decision Unit~~

I. Policy Statement

A. It is the policy of the Community Health Network and Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, 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 to be kept ~~in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Emergency Department~~in the department and ~~of San Francisco General Hospital and Trauma Center and~~ on file in the Medical Staff Office.

II. ~~Functions To Be Performed~~Explanation of NP/PA Function/Role in the Emergency Department ~~-~~ ~~–~~ Functions to be performed

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

~~P~~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 ~~PA's~~PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PA's must log 100 hours of continuing medical education every two years and sit for a recertification examination every ten years (~~6 year~~6-year recertification cycle prior to 2014, 10-year recertification cycle starting in 2014 and thereafter~~)..~~). Graduation from an

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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, PA's perform health care-related functions under physician oversight and with the utilization of standardized procedures and the Physician Assistant Practice Agreement.

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

III. Circumstances Under Which NP/PA May Perform Function
Specific Functions and Requirements for the NP/PA working in the ED Circumstances Under Which NP/PA May Perform Function:

A. Setting
1. Emergency Department

A. Setting:
2.

The functions of the NP/PAPA in the ED & CDU include management of acute injury or illness, self-limiting injury/illness, acute stages of chronic disease, medical screening exams, and phone calls related to patient pharmacy issues, attending radiology over-reads, culture results on specimens obtained in the ED, calls from patients seen in the ED with questions, and assistance with coordination of care, are to provide management for acute self-limiting injury/illness or acute stages of chronic diseases and pprescription refills. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). Outpatient settings to include the Radiology Department and Emergency Department.

B. Supervision
1. The NP/PA is responsible and accountable to:

Chief of Emergency Services (or Designee), and the ED Director of Nursing.
2. A consulting physician to be available to the NP/PA, by phone, in person, or by other electronic means;, this may include but is not limited to the aattendings, chief residents and fellows.
3. Attending 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. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions.
i. At time of discharge for a CDU patient.

IV. Scope of Practice – Protocols:

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~~Protocols~~

~~1.~~ Health Care Management - Primary Care/Specialty Care
~~2.~~ Health Care Management - Urgent/Acute Care
~~3~~
~~.~~ Health Care Management - Emergent Care
~~4.~~
Furnishing Medications/Drug Orders

~~5~~
~~.~~ Protocol #1: Soft Tissue injury and Wound Care
~~6~~
~~.~~ Protocol #2: Musculo-skeletal Strains or ~~or~~ Sprains
~~7~~
~~.~~ Protocol #3: Slit Lamp Exam
~~8~~
~~.~~ Protocol #4: Arthrocentesis
~~9~~
~~.~~ Protocol #5: Lumbar Puncture
~~10.~~ Protocol #6: Paracentesis
~~11.~~ Protocol #7: Ordering Transfusions
~~12. Protocol #8: Waived testing~~

V. Requirements for Hiring and NP/PA for ~~the~~ ED~~Nurse Practitioner / Physician Assistant~~

A. Basic Training, Education and Licensure ~~Education~~

~~Successful completion of an education program, which conforms to the Board of Registered Nurses (BRN) requirements for licensure (NPs) or to the Accreditation Review Commission on Education for the Physician Assistant (ARC) – PA standards~~
~~Active California RN license (NPs)~~
~~Master's Degree in Nursing from an accredited institution (NPs)~~
~~Active California NP license in either Family NP (FNP), Adult NP (ANP), or Acute Care NP (ACNP), or Adult-Gerontology Acute Care NP (AG-ACNP) / Physician Assistant License.~~
~~Maintenance of National NP Board Certification (NP) / National Commission on the Certification of Physical Assistants (SCPPA) certification.~~

~~1. Active California Registered Nurse/ Physician Assistant License.~~
~~2. Successful completion of an education program, which conforms to Board of Registered Nurses (BRN) requirements for licensure or to the 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 (NCPPA) certification.~~
~~4. Possession of a furnishing and dispensing license and DEA Number at time of of hire.~~
~~75. Maintenance of certification of Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS).~~
~~86. Possession of a National Billable Provider Identifier or must have submitted an application.~~
~~97. Copies of licensure and certificates must be on file at the Medical Staff Office.~~
~~108. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center Physician Assistant Practice Agreement.~~

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1. Successful completion of an education program, which conforms to the Board of Registered Nurses (BRN) requirements for licensure (NPs) or to the Accreditation Review Commission on Education for the Physician Assistant (ARC) – PA standards
2. Active California RN license (NPs)
3. Master's Degree (or higher) in Nursing from an accredited institution (NPs)
4. Active California NP license in either Family NP (FNP), Adult NP (ANP), or Acute Care NP (ACNP), or Adult-Gerontology Acute Care NP (AG-ACNP) / Physician Assistant License.
5. Maintenance of National NP Board Certification (NP) / National Commission on the Certification of Physical Assistants (SCPPA) certification.
6. Possession of a furnishing and dispensing license and DEA Number at time of hire.
7. Maintenance of certification of Basic Life Support (BLS) and Advanced Cardiac Life Support (ACLS).
8. Possession of a National Billable Provider Identifier or must have submitted an application.
9. Copies of licensure and certificates must be on file at the Medical Staff Office.
10. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center Physician Assistant Practice Agreement.

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B. Specialty Training and/or Experience

~~New hire NPs must come with Emergency Department (ED) experience in one of the following ways:~~

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~~One or more years of working at least half-time as an ED NP within the last year~~
~~One or more years of working full-time at an Urgent Care Clinic~~
~~If the new hire NP has worked less than one year half-time as an ED NP, or less than one year full-time as an Urgent Care Clinic NP, then they must also have at least one year of working as an ED RN within the last four years~~
~~If the new hire NP is a new graduate ACNP or AG-ACNP, then must have at least two years working at least half-time as an ED RN at a Level II or higher trauma center in the last three years~~
~~If the new hire NP is a new graduate FNP or ANP and did not do final school clinical rotations in an ED, then must have either worked one year full-time as an ED RN at a Level I trauma center in the last year, *or*, have worked at least half-time as an ED RN at a Level II trauma center in the last two years~~
~~Note that if an NP applies with less experience than specified above, they can still be considered for employment if their interview and experience are deemed adequate by the Medical Director (or MD designee), ED Nursing Director, and Lead NP~~

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~~Training~~

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~~1. Master's Degree in n Nursingfrom an accredited institution and NP specialization in Acute Care/Trauma, Adult Medicine or Family Medicine~~

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~~2. Six months to one year experience as an ED NP within the last~~
2. ~~New hire PAs must have t~~Two ~~(2)~~ years ~~of~~ ~~experience as a registered nurse/physician assistant~~PA ~~in an adult medical clinic~~Urgent Care Clinic ~~or an inpatient acute Med/Surg, Critical Care, or~~ an ED~~Emergency Department setting within the last three (3) years.~~

New hire NP/PAs in the Emergency Department (ED) experience in one of the following ways:

1. NP: Greater than, or equal to, one year in emergency medicine or urgent care within the past year.
2. Minimum of one year ED RN experience within the past threefour years, if the above NP minimums are not met.
3. New Graduate FNP, ACNP or AG-ACNP: must have a minimum two years of ED RN experience at a Level I, II or II higher trauma center in the past threefour years.
4. Exceptions to the above will be considered for employment if their interview and experience are deemed adequate by the Medical Director (or MD designee), ED Nursing Director, and Lead NP.
5. PA: Minimum of 2 years of experience in emergency medicine or urgent care within the past three years

C. Evaluation of NP/PA cCompetence in performance of Sstandardized Pprocedures.

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

   A Clinical Practice:
   - The new hire NP/PA will have between one to three months of being oriented and proctored to determine competence. During this time, a minimum of twenty cases of patients with an ESI acuity of at least 3 must be seen in collaboration with an attending MD, -and satisfactorily presented and managed. Throughout the orientation and proctoring period, the Lead NP and Medical Director (or MD designee) will evaluate the NP/PA to identify if additional orientation and proctoring is needed and provide specific guidance for improvement. Additionally, if the new hire NP/PA is exceeding expectations, their orientation and proctoring period might be concluded.

   The Lead NP will review random cases during the orientation and proctoring period, through chart review and discussion with the attending physician overseeing the case, to ensure at least twenty cases met performance expectations.

   The new hire will also be proctored for the Special Standardized Procedures during the orientation and proctoring period. The specific requirements are listed in the individual protocols. At the conclusion of the standardized procedure training, the Medical Director physician designee will assess the NP/PA's ability to practice.
   Clinical Practice
   - Length of proctoring period will be 3 months, during which time 20 cases will be proctored by or presented to an ED Attending physician. An initial written evaluation of NP/PA performance will be conducted at the conclusion of this period.
   - The evaluations will be conducted by nursing and physician clinical supervisors and approved by the Chief of Emergency Services
   - Additional, procedurally specific requirements are listed in individual protocols.
   - The NP/PA will complete a signed skills checklist upon completion of the proctoring period.
   - The proctoring period may be extended or shortened depending on the skill level of the NP/PA and the quality/number of experience(s) obtained during the proctoring period. *Length of proctoring period will be up to three (3)*

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months. The term may be shortened or lengthened at the discretion of the supervising clinical provider; however, the proctoring period shall not exceed the six (6) months CCSF probationary period.

~~2. Annual: Medical Director or physician designee will evaluate the NP/PA's competence through an annual performance appraisal and appropriate competency validation for the setting which will include feedback from colleagues, physicians, and/or direct observation~~

~~2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director or physician designee at appropriate intervals until acceptable skill level is achieved~~

23. Ongoing Professional Performance Evaluation (OPPE)

Every ~~six months~~year, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office. Medical Director or physician designee and Lead NP will evaluate the NP/PA's competence through an annual performance appraisal and appropriate competency validation for the setting which will include feedback from colleagues, physicians, and/or direct observation, as well as chart reviews

3. Follow up

Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director (or MD designee) and Lead NP at appropriate intervals until acceptable skill level is achieved

44. ~~Biennial~~Biennial Reappointment

: Medical Director (or ~~, designated physician~~MD designee~~or designated clinical provider~~), or ~~designated same discipline peer~~Lead NP must evaluate the NP/PA's clinical competence with chart audit or direct observation.

~~n.~~

~~a.~~ ~~a.~~ Health care Management: Five ~~5~~ chart reviews and/or direct observations every two~~2~~ years

a.

~~b.~~ ~~b.~~ Furnishing Medications and Drug Orders: Five~~5~~ chart reviews and/or direct observations every two~~2~~ years

b.

~~c.~~ Additional, procedurally specific requirements as listed in individual protocols

c.

VI. Development and Approval of Standardized Procedure

A. Method of Development

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

Commented [KA8]: Does Annual OPPE align with other SPs?

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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 affiliated staff and the Medical Director and as practice changes.

D. Revisions

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

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PROTOCOL ~~#1~~: Health Care Management – Primary Care/Specialty Care

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A. DEFINITION

This protocol covers the procedure for age-appropriate health care management in primary care in the Emergency Department and Clinical Decision Unit. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses.

B. DATA BASE

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

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Perform ~~age appropriate~~age-appropriate screening tests, and /or diagnostic tests for purposes of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   c. Immunization update.
   d. Referral to specialty clinics and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical, or laboratory findings.
   d. Upon request of patient, 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. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions.
   i. At time of discharge~~. for a CDU patient.~~

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.

4. Follow-up
   As indicated and appropriate to patient health status and diagnosis.

E. RECORD KEEPING
All information from patient visits will be recorded in the ED medical record

PROTOCOL ~~#2~~: Health Care Management – Urgent/Acute Care

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A. DEFINITION
This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions in the ED~~/CDU~~.

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 (e.g. stable, unstable, uncontrolled).

D. PLAN
1. 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. Upon request of patient, NP, PA, 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. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
   i. At time of discharge ~~for a CDU patient~~.

3. Education
   Patient education including treatment modalities.
   Discharge information and instructions.

4. Follow-up
   As indicated and appropriate to patient health status, and diagnosis.

E. RECORD KEEPING
All information from patient visits will be recorded in the Emergency Department medical record.

PROTOCOL ~~#3~~: Health Care Management – Emergent Care

A. DEFINITION
This protocol covers the procedure for health care management of emergency situations in the ED~~/CDU~~, which are acute and life threatening.

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Signs of illness or injury from family, friends or observers.
   c. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory, Point of Care Testing (POCT) and imaging 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 (e.g. stable, unstable, critical, life-threatening).

D. PLAN
1. Therapeutic Treatment Plan
   a. Initial treatment and stabilization of patient that may include all modalities of BLS and ACLS for which the NP/PA holds current certification.
   b. Concomitant notification of physician and immediate management by a physician.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician or specialty areas (e.g. operating room, intensive care, labor and delivery) and supportive services, as appropriate.

2. Patient conditions requiring Attending Consultation:
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, PA, or physician
   e. 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 ~~r~~response.
   h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
   i. At time of discharge ~~for a CDU patient~~.

3. Education
   Patient and/or family education as appropriate.

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4. Follow-up
   As indicated and appropriate to patient health status and diagnosis.

E. RECORD KEEPING
   All information from patient encounter will be recorded in the ED medical record.

PROTOCOL:#4 Furnishing Medications/Drug Orders

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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 a DEA number.

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

Alternatively:

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

The practice site (clinic or inpatient), 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 following formularies may be used by the NP/PA's in the Emergency Department: Zuckerberg San Francisco General Hospital and Trauma center,/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows ZSFG Administrative policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (policy no. 13.5).

B. DATA BASE

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

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Describe physical findings that support use of 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. NPs/CNMs may order Schedule II - III controlled substances for patients with the following patient specific protocols: These protocols may be listed on the patient chart, in the medications section of the electronic health record (EMR), 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. parameters for acute conditions including maximum daily morphine equivalents and duration of treatment
      iv. parameters for treatment with chronic opioids including checking CURES, toxicology screening, treatment plan and clinic specific policies
      v. Name of medications, dosage, frequency, route and quantity, amount of refills authorized and time period for follow-up.

   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. (NP), DEA no., if applicable

2. Patient conditions requiring consultation:
   a. Problem which does not resolve after reasonable trial of therapies.
   b. Initiation or change of medication other than those in the formulary.
   c. Unexplained historical, physical or laboratory findings.
   d. Upon request of patient, NP, PA, or physician.
   e. Failure to improve pain and symptom management.
   f. Acute, severe respiratory distress
   g. An adverse response to respiratory treatment or a lack of therapeutic response.

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

4. Follow-up
   a. As indicated by patient health status, diagnosis, and periodic review

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of treatment course.

E. RECORD KEEPING
All medications furnished by NPs/CNMs and all drug orders written by PAs will be recorded in the medical record.

PROTOCOL #~~15~~: Soft Tissue Injury and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the ED~~/CDU~~ by the NP/PA.

This protocol includes two specialized procedures: Wound closure (including suturing, gluing) and Incision and Drainage.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:
   a. Indications
      - This protocol covers patients presenting to the Emergency Department for assessment and treatment of lacerations, abrasions, avulsions, bites and stings, burns and abscesses
      -
   b. Indication for consultation with attending physician or specialist~~Precautions~~
      - Vascular compromise or cases where direct pressure does not stop bleeding
      - Wounds requiring large area of debridement or excision prior to closure
      - Wounds with bone fragments involved
      - Wounds with tendon, ligament, vessel or nerve involvement
      - Head laceration where galea disruption is greater than 2 cm.
      - Facial lacerations with cosmetic consideration (ie. eyelids and vermillion borders)
      - Lacerations penetrating into joints
      - Patients requiring conscious sedation
      - Children under the age of 10
      - Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
      - Wounds requiring repair of cartilage
   c. Contraindications
      - None

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Appropriate motor, sensory and vascular exam of the involved area according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

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Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed.
   b. Time out performed per hospital policy.
   c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   d. Diagnostic tests for purposes of disease identification.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, PA, 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. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
   i. At time of discharge ~~for a CDU patient~~.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment

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Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
1. ~~New practitioner will attend wound care/suturing course or lab (at outside facility or through ZSFG ED).~~ If the NP/PA has not performed suturing or I&D either in their employment or during clinical rotations in NP school, they must obtain training prior to initiation of proctoring of the procedure. Training can ~~be~~ come from online ~~course~~ modules, in person, conferences, and so on. A clinical lab is not required. 2. Documentation of training can include course enrollment, a completion certificate, or other evidence of completion. ~~Documentation of Completion of Training: orientation checklist, wound care lab letter, or certificate~~ ~~3. Documentation of completion of training must be sent to the Medical Staff Office~~

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Proctoring

1. ~~A minimum of 2 successful demonstrations for a new provider, observed by an experienced provider (MD, NP, or PA) and 1~~ observed ~~demonstrationcase for an experienced provider.~~A minimum of two~~hree~~ cases of suturing of a laceration must be performed with and observed by an MD or NP.
2. A minimum of two cases of incision and drainage of an abscess must be performed with and observed by a clinical provider~~n MD or NP~~.

Reappointment

Ongoing competency evaluation.

a. ~~Perform wound care/suturing a minimum of 1 time every 2 years~~Perform suturing a minimum of one time every two years.
b. ~~One chart review every 2 years~~Perform I&D a minimum of one time every two years.

~~Any additional comments:~~

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PROTOCOL #~~26~~: Assessment and Management of Musculoskeletal ~~Sprains or Strains~~Injuries

A. DEFINITION
This protocol covers the initial assessment of patients with musculoskeletal injuries.

This protocol includes the specialized procedure of Splinting.

1. Location to be performed: Emergency Department~~/CDU~~

2. Performance of procedure/minor surgery:

i. ~~-~~Indications
~~_~~This protocol covers patients presenting to the Emergency department for assessment and treatment of fractures, strains and sprains.

ii. Precautions
None

iii. Exclusion (or referral to Attending Physician, Emergency Medicine Resident or Surgical Resident, PGY II or above) under the following circumstances:
a. ~~a.~~ Vascular compromise~~d~~b~~.~~
b. Unstable joint

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting chief complaint~~.~~ including mechanism of injury.
   b. Pertinent past medical history, surgical history, current medications and allergies.

2. Objective Data
   a. Physical exam of the involved and adjacent area including documentation of any swelling, ecchymosis, pain, range of motion, instability, crepitance or effusion and appropriate neuro-vascular exam.
   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.
   b. Time out performed per hospital policy
   ~~a. Ice pack for first 24-48 hours followed by ice or heat~~
   ~~b. Diagnostic tests for purposes of disease identification.~~
   c. Rest and elevation of affected part
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

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e. Provide necessary written and verbal instructions including sprain care, crutch walking as appropriate
f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, PA, 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. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
   i. At time of discharge ~~for a CDU patient~~.

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 ED medical record and EMR as appropriate

F. Summary of Prerequisites, Proctoring and Reappointment

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: ~~1. The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times, no fewer than 2 times for experienced practitioners.~~ here are no prerequisites to be completed prior to proctoring.
Proctoring ~~a. New practitioner to procedure, a minimum of 2 successful observed demonstrations~~ ~~b. Experienced practitioner to procedure, a minimum of 1 successful observed demonstration~~ A minimum of two~~hree~~ orthoglass or plaster splints placed for a fracture of an extremity must be performed with and observed by ~~an attending MD or NP~~a clinical provider.
Reappointment ~~a. Documentation of Completion of Training (e.g. orientation checklist, letter, certificate, guides list or chart reviews)~~ ~~b. Documentation of completion of training must be sent to the Medical Staff Office~~ ~~c. Who will be the evaluator: ED Attending physicians~~ ~~d. Ongoing competency evaluation.~~

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~~1. Perform a minimum of 1 exam every 2 years to maintain proficiency~~ ~~2. One chart review needed for annual review~~ Perform a minimum of one splint placement every two years.
~~Any additional comments:~~

PROTOCOL #~~37~~: Slit Lamp Exam

A. DEFINITION

This protocol describes the use of the slit lamp for patients presenting with ~~external~~ eye complaints.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:
   a. Indications
      - The slit lamp examination is indicated in any eye complaint requiring illumination or magnification of the ~~external~~ eye area (i.e. lid/lashes, cornea, iris, anterior chamber) for complaints such as eye redness, ~~or~~ foreign body sensation, or other.

   b. Precautions and Contraindications
      - None

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting eye complaint.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

2. Objective Data
   a. Physical exam including visual acuity appropriate to the eye complaint.
   b. The slit lamp exam is performed following standard medical technique according to the departmental resources (per manufacturer's instructions) with or without fluorescein as indicated.
   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.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Screening tests performed as part of age-appropriate health maintenance.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to Ophthalmologist or Primary Care as needed.

2. Patient conditions requiring ~~Attending Consultation~~attending physician or specialist consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, PA, or physician
   e. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress.

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g. An adverse response to respiratory treatment, or a lack of therapeutic response.
h. Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
i. At time of discharge ~~for a CDU patient~~.
h. Eye complaints including acute loss of vision or visual field, globe rupture, new increased intraocular pressure, or other emergent eye complaints

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3. Education
Discharge information and instructions.

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

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the ED medical record and EMR as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: ~~The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times.~~There are no requirements prior to initiation of proctoring. ~~1.~~
Proctoring ~~a. New practitioner to procedure, a minimum of 3 successful observed demonstrations~~ ~~b. Experienced practitioner to procedure, a minimum of 3 successful observed demonstrations~~ ~~c. Explanation needed for any exceptions to minimum requirements~~ Two~~hree~~ slit lamp exams need to be performed with and observed by a clinical provider.~~n attending MD or NP.~~
Reappointment ~~a~~ Perform one slit lamp exam a minimum of one time in two years. ~~Documentation of Completion of Training (e.g. letter, certificate, orientation check off, guides list or chart reviews)~~ ~~b. Documentation of completion of training must be sent to the Medical Staff Office~~ ~~c. Who will be the evaluator: ED Attending physicians~~ ~~d. Ongoing competency evaluation.~~ ~~1. Perform a minimum of 3 exams every 2 years~~ ~~2. One chart review needed for annual review~~
~~Any additional comments:~~

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PROTOCOL #~~48~~: Arthrocentesis

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A. DEFINITION
This protocol covers arthrocentesis of ~~the knee and elbow~~a joint.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:
   a. Indications
      - Acute and chronic inflammatory musculoskeletal diseases/disorders such as osteoarthritis, tenosynovitis, bursitis, gout, ~~and~~ entrapment neuropathies.
      - ~~Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of the joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of this will distinguish among hemarthrosis, effusion, fracture and septic arthritis.~~
   b. Precautions and indication for consultation with ED attending MD or specialist
      - Patients with a coagulopathy
      - Potential for neurovascular injury
   c. Contraindications
      - Severe ~~dermatitis or~~ soft tissue infection overlying the joint.

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, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to 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.
   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~~ED attending notification prior to procedure

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a. All patients requiring this procedure.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: There is no prerequisite to initiation of proctoring.~~a. The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times, no fewer than 2 times for an experienced practitioner.~~
Proctoring ~~Period~~ ~~a. New and experienced NP/PAs will perform a minimum of 2 successful observed demonstrations~~ ~~c. Explanation needed for any exceptions to minimum requirements~~ Complete three ~~arthocentesis~~arthrocentesis procedures performed with and observed by an attending MD.
~~Training~~ ~~a. Direct observation of procedure no fewer than 2 times, direct supervision of procedure no fewer than 2 times.~~
Reappointment ~~a.~~ Perform a minimum of one procedure per year for two years. ~~Documentation of Completion of Training: orientation checklist, skills lab, letter, certificate, guides list or chart reviews~~ ~~b. Documentation of completion of training must be sent to the Medical Staff Office~~ ~~c. Who will be the evaluator: ED Attending Physicians~~ ~~d. Ongoing competency evaluation.~~ ~~1. Perform a minimum of 1 procedures every 2 years~~ ~~2. One chart review needed for annual review~~
~~Any additional comments:~~

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PROTOCOL #59: Lumbar Puncture

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A. DEFINITION

This protocol covers lumbar puncture. Training, guidelines and evaluation for satisfactory performance is described in the preamble Section V. subsections C and D.

1. Location to be performed: Emergency Department.

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2. Performance of procedure/minor surgery:

a. Indications

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Lumbar puncture should be performed primarily on patients with severe headache with or without fever of unknown origin, especially if an alteration of consciousness is present. Aspiration of the spinal fluid with subsequent analysis of this may be necessary in the diagnosis of CSF infection, bleeding or embolus (e.g. meningitis, syphilis, subarachnoid hemorrhage, MS).

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b. Precautionstions

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Indication for brain CT scan prior to LP include the following:

- Age >60 yrs.
- Immunocompromised patients
- Known CNS lesions
- Recent seizure activity
- Abnormal level of consciousness
- Focal findings on neurological exam

c. Contraindications

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- Infection in the tissues near the puncture site.
- Increased intracranial pressure, if suspected rule out with head CT.
- Coagulopathy.

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging evaluation (head CT), as indicated, relevant to history and exam.
   c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   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.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.

d. Screening tests performed as part of age-appropriate health maintenance.
~~e. Biopsy tissue is sent to pathology.~~
ef. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
fg. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring ~~Attending Consultation~~ED attending MD notification
   a. All patients requiring this procedure must have attending MD involved.

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 EMR as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment

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Requirements to be completed prior to initiation of proctoring and provision of direct patient care: ~~The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 times, no fewer than 2 times for an experienced practitioner.~~ There are no prerequisites needed prior to proctoring initiation.
Proctoring Three lumbar punctures to be performed with and observed by an ED attending MD.~~a. New practitioner to procedure, a minimum of 3 successful observed demonstrations and 3 chart reviews~~ ~~b. Experienced practitioner to procedure, a minimum of 2 successful observed demonstrations and 2 chart reviews~~ ~~c. Explanation needed for any exceptions to minimum requirements~~
Reappointment ~~a. Documentation of Completion of Training: orientation checklist, completion of skills lab, letter, certificate, guides list or chart reviews~~ ~~b. Documentation of completion of training must be sent to the Medical Staff Office~~ ~~c. Who will be the evaluator: ED Attending Physician.~~ ~~d. Ongoing competency evaluation.~~ ~~1. Perform a minimum of 3 procedures every 2 years needed to maintain proficiency~~ ~~2. Three chart reviews needed for annual review~~ Perform a minimum of three~~wo~~ LPs per every~~ear for~~ two years.
~~Any additional comments:~~

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PROTOCOL #~~610~~: Paracentesis

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A. DEFINITION

Paracentesis is the insertion of a needle into the peritoneal cavity to aspirate peritoneal fluid for analysis and/or relieve pressure caused by ascites. Ultrasound guidance by an experienced ultrasound physician ~~(ED Attending, resident)~~ is used to guide needle placement.

1. Location to be performed: Emergency Department

2. Performance of procedure/minor surgery:
   a. Indications
      For the purposes of this protocol, paracentesis may be used to evaluate the etiology of ascites (infectious, malignant, or cirrhosis)
      - To relieve the symptoms of ascites
   b. Precautions
      - Use caution in coagulopathy
   c. Contraindications
      - Infection in the overlying soft tissues near the puncture site.
      - Intestinal obstruction

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.
   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. All patients requiring this procedure.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment

a. There is no prerequisite prior to the initiation of proctoring. Requirements to be completed prior to initiation of proctoring and provision of direct patient care: The NP/PA is directly observed performing the procedure by an experienced provider (MD, NP, or PA) 3 cases with 3 chart reviews. b. All paracentesis procedures will be ultrasound guided by an experienced ultrasound provider (ED Attending or Resident).
Proctoring a. The NP/PA will be proctored for a minimum of 2 successful cases b. Explanation needed for any exceptions to minimum requirements Three paracentesis procedures to be performed with and observed by an ED attending MD.
Reappointment a. Documentation of Completion of Training: orientation checklist, completion of skills lab, letter, certificate, guides list or chart reviews b. Documentation of completion of training must be sent to the Medical Staff Office c. Who will be the evaluator.: ED Attending Physicians d. Ongoing competency evaluation. 1. Perform a minimum of 1 procedure every 2 years 2. One chart review every 2 years needed for annual review Perform a minimum of threewo paracentesis procedures every year for two years.
Any additional comments:

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PROTOCOL #~~711~~: ~~-~~Ordering Blood Product Transfusions

A. DEFINITION
Ordering the administration of whole blood or blood components, i.e., red blood cells, fresh frozen plasma, platelets and cryoprecipitate.

1. Location to be performed: Emergency Department ~~or Clinical Decision Unit~~

2. Performance of procedure/minor surgery:
   a. Indications
      - Anemia
      - Thrombocytopenia or platelet dysfunction
      - Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means
   b. Precautions
      - Blood and blood components must be given according to ZSFG guidelines.
      - Emergency exchange transfusion orders are not covered by this standardized protocol - these must be countersigned by the responsible physician.
      - 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 thrombocytopenic 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 ROS 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) POCT will be performed according to ZSFG POCT P&P 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

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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) Acute, severe respiratory distress.
g) An adverse response to respiratory treatment, or a lack of therapeutic response.
h) Patients requiring arthrocentesis, lumbar puncture, paracentesis or transfusions
i) At time of discharge ~~for a CDU patient~~.

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

4. Follow-up
   As appropriate for the patients condition and reason transfusion were ordered

E. Record Keeping
Patient visit, consent forms, and other transfusion-specific documents (completed transfusion report and "blood sticker") will be included in the medical record, EMR and other patient data bases, as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Successful completion of ZSFG Transfusion Training course (note – the specific course may change according to ZSFG modules) Training program for this protocol includes: 1. Read and sign assignments: 2. ZSFG Admin P&P 2.3: Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options. 3. ZSFG Transfusion Training Course Education module. 4. ZSFG Transfusion Guidelines b. Successful completion of Transfusion Training course test on blood ordering & informed consent with at least 80% test score on both exams.
Proctoring: a. Read and Sign the ZSFG Administrative Policy and Procedure 2.03 "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. ~~Until documentation of 5 countersigned transfusion orders~~
Reappointment Competency Documentation: a. Completion of the two education modules and completion of the two examinations with a passing score of 80%. b. Performance of 1 transfusion order per year and 1 medical record review per year. c. Review of any report from the Transfusion Committee. d. Evaluator will be the medical director or other designated provider ~~Renewal required every two years with documentation of successful completion of the required educational modules or PPMP quizzes.~~

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Commented [EK20]: Are we still doing these quizzes?

Commented [PV21R20]: yes with reappointments

	Provider must have passed each required module with a score of 80%.
Any additional comments: N/A	

PROTOCOL #12: Procedure: Waived Testing

A. DEFINITION

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

1) Location where waived testing is to be performed: Emergency Department and Clinical Decision Unit.

2) The following non-instrument based waived tests are currently performed at ZSFG in the ED and CDU:

a. Fecal Occult Blood Testing (Hemocult ®)
Indication: Assist with detection or verification of occult blood in stool.

b. Vaginal pH Testing (pH Paper)
Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.

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 or EMR

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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 not outdated? 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

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

~~Certification as NP or PA 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 or PPMP 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~~required learning modules~~.~~
~~Reappointment Competency Documentation:~~ ~~Renewal required every two years with documentation of successful completion of the required Halogen or PPMP quizzes. Provider must have passed each required module with a score of 80%.~~learning modules~~.~~
~~Any additional comments: N/A~~

2025~~1~~ EMERGENCY DEPARTMENT ~~AND CLINICAL DECISION UNIT~~ STANDARDIZED PROCEDURES AND PROTOCOLS

Medical Director or Division Chief: Christopher Col~~s~~well, MD
Initial Author: Tina King, Lead NP
2025 Revision: Jeanne Hoffman, Emergency Department Lead NP

CIDP Approval Date: 2/4/26~~1/06/2021~~
Credentials Approval Date:~~: 2/01/2021~~
MEC Approval Date:~~: 2/18/2021~~
Gov. Body Approval Date: ~~2/23/2021~~

San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA

PROVIDER NAME: _____ Major site: _____

CLINICAL SERVICE: EMERGENCY DEPARTMENT Other sites: _____

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
CORE				
HCM: Acute, Urgent, Emergent Care	3 months that may be extended or shortened depending on the skill level and quality/number of experience(s) obtained during the proctoring period. 20 cases either proctored by or presented to ED attending Physician. which should represent all core procedures. Chart review of all presented cases.	Designated physician or proctoring peer by 5 chart reviews or direct observations every 2 years which may represent multiple core procedures.		
Furnishing Medications/Drug Orders	As noted in the Acute, Urgent, Emergent Care proctoring	As noted in the Acute, Urgent, Emergent Care Reappointment Criteria.		
SPECIAL				
Soft Tissue Injury and Wound Care #1	Direct observation of 2 cases of suturing and 2 of I & D.	Performance of 1 suturing procedure and 1 I & D every 2 years		
Musculo-skeletal Strains and Sprains #2	Direct observation of 2 orthoglass or plaster splints placed.	Performance of 1 splint replacement procedure every 2 years.		
Slit Lamp #3	Direct observation of 2 cases.	Performance of 1 procedure every 2 years.		
Arthrocentesis ~~and Inaarticular Injections~~#4	Direct observation of ~~3~~2 procedures~~eases~~. ~~Chart review of all observed cases.~~	Performance of 1 procedure per year. ~~every 2 years and 1 chart review annually~~		
Lumbar Puncture #5	Direct observation of 3 cases. ~~and 3 chart reviews for a new provider, 2 observations and 2 chart reviews for an experienced provider.~~	Performance of 3 procedures ~~and 3 chart reviews~~ every 2 years.		
~~Musculo-skeletal Strains and Sprains~~	~~Direct observation of 2 cases and 2 chart reviews for new provider, 1 for~~	~~Performance of 1 exam/procedure and 1 chart review every~~		

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STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
	~~experienced.~~	~~2 years.~~		
Abdominal Paracentesis #6	Direct observation of 34 cases ~~and 4 chart reviews~~.	Performance of 34 procedures ~~and 4 chart reviews~~ every 2 years.		
~~Slit Lamp~~	~~Direct observation of 5 cases and 5 chart reviews.~~	~~Performance of 5 procedures and 5 chart reviews every 2 years.~~		
~~Soft Tissue Injury and Wound Care~~	~~Direct observation of 2 cases and 2 chart reviews.~~	~~Performance of 1 procedure and 1 chart review every 2 years~~		
Ordering Blood Transfusions #7	Read and Sign ZSFG Policy and Procedure 2.3. Read ~~Blood~~ Transfusion Guidelines section of the Laboratory Manual. Review of 1 transfusion order countersigned and documented in the patient medical record. ~~Proctoring: Until 5 countersigned transfusion orders~~	Completion of two education modules ~~of two training courses~~ with a passing score of 80%. Review of 1 transfusion performed and 1 medical record reviewed per year. Review any Transfusion Committee reports. ~~Performance of 2 transfusion orders every 2 years.~~		
~~Waived Testing a. Fecal Occult Blood b. Vaginal pH testing c. Urine Pregnancy d. Urine Dipstick~~	~~Completion of education module quizzes for each test with a passing score of 80%.~~	~~Completion of education module quizzes for each test with a passing score of 80%.~~		

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_____ _____

Chief of Service or designee 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.

Anatomic Pathology Privilege List

Summary of Changes:

Revised Anatomic Pathology Privilege list - 4.05 AUTOPSY AND SURGICAL PATHOLOGY: Reduce the number of cases required at reappointment from 100 to 10 for every two year period.

4.05 AUTOPSY AND SURGICAL PATHOLOGY

PROCTORING: Satisfactory evaluation of at least 50 autopsy or diagnostic surgical pathology specimens during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory evaluation of at least ~~100~~ 10 autopsy or diagnostic surgical pathology specimens during the past two (2) years.

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Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Anatomic Pathology 2017

Provider Name:

Privilege	Status	Approved

Pathology ANATOMIC PATHOLOGY 2017
(04/08 MEC /11/09 Admin. Rev.)

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

4.00 BASIC PRIVILEGES-GENERAL PATHOLOGY ___

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pathology.

4.05 AUTOPSY AND SURGICAL PATHOLOGY ___

PROCTORING: Satisfactory evaluation of at least 50 autopsy or diagnostic surgical pathology specimens during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory evaluation of at least ~~100~~ 10 autopsy or diagnostic surgical pathology specimens during the past two (2) years.

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4.10 CYTOLOGY ___

PROCTORING: Satisfactory evaluation of at least 50 specimens during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory evaluation of at least 100 specimens during the past two (2) years.

4.15 FINE NEEDLE ASPIRATIONS ___

PROCTORING: Satisfactory performance of at least 5 procedures during the past the three (3) month probationary period.

REAPPOINTMENT: Satisfactory performance of at least 10 procedures during the past two (2) years.

4.20 SPECIAL PATHOLOGY ___

MINIMUM CRITERIA: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pathology, or the American Subspecialty Board of:

4.25 HEMATOPATHOLOGY ___

PROCTORING: Satisfactory performance of at least 5 diagnostic examinations during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory performance of at least 10 diagnostic examinations during the past two (2) years

4.30 NEUROPATHOLOGY ___

PROCTORING: Satisfactory performance of at least 5 diagnostic examinations during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory performance of at least 10 diagnostic examinations during the past two (2) years.

4.35 DERMATOPATHOLOGY ___

PROCTORING: Satisfactory performance of at least 25 diagnostic examinations during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory performance of at least 100 diagnostic examinations during the past two (2) years.

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Anatomic Pathology 2017

Provider Name:

Privilege	Status	Approved

4.40 CYTOPATHOLOGY (INCLUDING FINE NEEDLE ASPIRATIONS) ___

PROCTORING: Satisfactory performance of at least 50 diagnostic examinations during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory performance of at least 100 diagnostic examinations during the past two (2) years.

4.45 MOLECULAR GENETIC PATHOLOGY ___

PROCTORING: Satisfactory performance of at least 5 diagnostic examinations during the three (3) month probationary period.

REAPPOINTMENT: Satisfactory performance of at least 10 diagnostic examinations during the past two (2) years.

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

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____
CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_____ _____
Applicant Date

APPROVED BY

_____ _____
Division Chief Date

_____ _____
Service Chief Date

MS.08.01.03: Summary of Changes

Clinical Service	Community Primary Care Family & Community Medicine Medicine – General Internal Medicine OB/GYN Pediatrics
Privilege/Standardized Procedure	**Insertion of Contraceptive Implant** • *Community Primary Care* - *Privilege 8.46 a; Standardized Procedure D-1* • *Family & Community Medicine* - *Privilege 14.39 a (new); Standardized Procedure F-1* • *Medicine – General Internal Medicine* - *Privilege 50.15 a; Standardized Procedure #26* • *OB/GYN* - *Privilege 24.04, I-1; 24.51; Standardized Procedure #11* • *Pediatrics* - *Privilege 32.26; Standardized Procedure*
Prerequisites	Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course. *Established Experience:* Documentation of greater than five (5) cases in the past two (2) years. *Limited Experience:* Documentation of less than five (5) cases in the past two (2) years
Proctoring	*Established Experience:* Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience. *Limited Experience:* Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.
Reappointment	Review of one (1) case in the past two (2) years.

Clinical Service	Community Primary Care Family & Community Medicine Medicine – General Internal Medicine OB/GYN Pediatrics
Privilege/Standardized Procedure	**Removal of Contraceptive Implant** • *Community Primary Care* - *Privilege 8.46 b; Standardized Procedure D-2* • *Family & Community Medicine* - *Privilege 14.39 b (new); Standardized Procedure F-2* • *Medicine – General Internal Medicine* - *Privilege 50.15 b; Standardized Procedure #27* • *OB/GYN* - *Privilege 24.04, I-2; Standardized Procedure #12* • *Pediatrics* - *Privilege 32.27; Standardized Procedure*
Prerequisites	Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience. *Established Experience*: Documentation of greater than five (5) cases in the past two (2) years. *Limited Experience*: Documentation of less than five (5) cases in the past two (2) years
Proctoring	*Established Experience*: Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience. *Limited Experience*: Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.
Reappointment	Review of two (2) cases in the past two (2) years.

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Community Primary Care 2022

Provider Name:

Privilege	Status	Approved

CPC COMMUNITY PRIMARY CARE 2022
(02/2022 MEC)

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

8.10 BASIC PRIVILEGES: ADULT ___

Provides medical care to adults (18 years of age or older) with primary medical problems, provides preventive health care, and performs minor treatment procedures in the OUTPATIENT SETTING. Includes routine exam and treatment procedures including anoscopy, incision and draining of superficial abscess, minor surgical procedures, e.g. excisional biopsies or laceration repair, and arthrocentesis. All procedures requiring anesthesia to be performed under local anesthesia.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the ABMS Board of Family Medicine or Internal Medicine. Clinical competence will be demonstrated by proctoring outcomes, peer review, experience, letters of recommendation and similar criteria. Training and/or experience must include care of adults (e.g., internal medicine or family medicine).

PROCTORING: A minimum of 5 representative cases will be reviewed for initial proctoring.

REAPPOINTMENT: For reappointment, a review of a minimum of 3 outpatient cases.

8.20 BASIC PRIVILEGES: PEDIATRICS ___

Provides medical care to children and transitional youth (0 to 24 years of age) with primary medical problems, provides preventive health care, and performs minor treatment procedures in the OUTPATIENT SETTING. Includes routine exam and treatment procedures including anoscopy, incision and draining of superficial abscess, minor surgical procedures, e.g. excisional biopsies or laceration repair, and arthrocentesis. All procedures requiring anesthesia to be performed under local anesthesia.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the ABMS Board in Pediatrics or Family Medicine. Clinical competence will be demonstrated by proctoring outcomes, peer review, experience, letters of recommendation and similar criteria. Training and/or experience must include care of children and transitional youth (e.g., family medicine or pediatrics).

PROCTORING: A minimum of 5 representative cases will be reviewed for initial proctoring.

REAPPOINTMENT: For reappointment, a review of a minimum of 3 outpatient cases.

8.21 RESTRICTED CPC - 8.20 BASIC PRIVILEGES: PEDIATRICS ___

This physician shall perform history and exams of patients for purpose of assisting the DAC team. Physician will not be the attending on record and will not document in the EHR. Physician will not have any billing activities.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the ABMS Board in Pediatrics.

PROCTORING: Observation of 2 patient interview sessions within 12 months (one must be within first 6 months of appointment).

REAPPOINTMENT: Observation of 2 patient interview sessions.

8.30 BASIC PRIVILEGES: PERINATAL CARE ___

Provides prenatal care to pregnant women and pre- and postpartum care in the ambulatory setting, in accordance with protocols of the CPC Service. All procedures requiring anesthesia to be performed under local anesthesia.

Delineation Of Privileges

Community Primary Care 2022

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the ABMS Board of Family Medicine. Clinical competence will be demonstrated by proctoring outcomes, peer review, experience, letters of recommendation and similar criteria. Training and/or experience must include perinatal care (e.g., family medicine).

PROCTORING: A minimum of 5 representative cases will be reviewed for initial proctoring.

REAPPOINTMENT: For reappointment, a review of a minimum of 3 outpatient cases.

8.31 ULTRASOUND IN PREGNANCY ___

Limited to determination of fetal gestational age, confirmation of presentation, placenta location, amniotic fluid adequacy, and confirmation of fetal heart rate.

a. Basic First and Second Trimester Ultrasound (for dating, viability and location of pregnancy) ___
PREREQUISITES: 8.30 Basic Privileges: Perinatal Care

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 dating ultrasounds.For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 8 hour obstetric ultrasound course followed by direct observation of 10 dating ultrasounds and a further retrospective review of an additional 10 dating ultrasound cases/images.

REAPPOINTMENT: Retrospective review of 4 cases/images in the past 2 years

b. Limited Third Trimester Ultrasound (assessment of viability, fetal position, placental location, single deepest pocket of amniotic fluid) ___
PREREQUISITES: 8.30 Basic Privileges: Perinatal Care

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 limited third trimester ultrasounds.For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 4 hour obstetric ultrasound course followed by case review and direct observation of 5 limited third trimester ultrasounds.

REAPPOINTMENT: Retrospective review of 2 cases/images in the past 2 years

8.40 CPC PROCEDURE PRIVILEGES ___

Physicians may apply for each of the following procedural privileges separately, based on qualifications and scope of practice. Must be currently Board Admissible, Board Certified, or Re-Certified by the ABMS Board of Family Medicine or Internal Medicine.

8.41 LUMBAR PUNCTURE ___

PREREQUISITES: Physicians must have CPC Basic Privileges (8.10 or 8.20).

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases

8.42 PARACENTESIS ___

PREREQUISITES: Physicians must have CPC Basic Privileges (8.10).

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases

8.43 ENDOMETRIAL BIOPSY ___

Delineation Of Privileges
Community Primary Care 2022

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Physicians must have CPC Basic Privileges (8.10) or (8.20).

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases

8.44. INSERTION Of INTRAUTERINE DEVICE (IUD) ___

PREREQUISITES: Physicians must have CPC Basic Privileges (8.10) or (8.20).

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases

8.45 COLPOSCOPY AND CRYOSURGERY FOR GYNECOLOGIC PROCEDURES ___

PREREQUISITES: Physicians must have CPC Basic Privileges (8.10).

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases Requested

8.46 CONTRACEPTIVE IMPLANT INSERTION/REMOVAL ___

a. INSERTION OF CONTRACEPTIVE IMPLANT

~~PREREQUISITES: Physicians must have CPC Basic Privileges (8.10 or 8.20)~~

~~PROCTORING: Proof of completion specialized course in insertion/removal of device.~~

~~REAPPOINTMENT: Review of 2 cases.~~

PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: Review of one (1) case in the past two (2) years.

b. REMOVAL OF CONTRACEPTIVE IMPLANT

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Delineation Of Privileges
Community Primary Care 2022

Provider Name:

Privilege	Status	Approved

PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: Review of two (2) cases in the past two (2) years.

8.47 LASER SURGERY ___

Removal of congenital and acquired lesions (tattoos, hemangiomas. pigmented lesions)

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

PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at SFGH

REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at SFGH.

8.50 LIMITED CPC PRIVILEGES ___
Includes Patient Management limited to the areas below:

8.51 CPC PODIATRY ___
Evaluation and non-invasive treatment of common podiatric medical pathology including corns, callous, nails, General referrals and consultation with regard to basic podiatric medical pathology. Surgical procedures includes nail avulsion, chemical matrisectomies, biopsy and debridement of cutaneous lesions or simple infection process relative to nail and skin. All procedures requiring anesthesia to be performed under local anesthesia in the outpatient setting.

PREREQUISITES: Satisfactory completion of an approved residency program in Podiatric Medicine required.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases Requested

SERVICE APPROVAL: Initial approval and reappointment review and approval

_____ _____
Chief, Orthopedic Surgery or Designee Date

8.52 CPC LICENSED CLINICAL PSYCHOLOGY ___
Provide individual and family counseling and therapy.

Delineation Of Privileges

Community Primary Care 2022

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Clinical Psychologists must hold a doctoral degree in Psychology from an approved APA accredited program, and must be licensed on the basis of the doctorate degree in psychology by the State of California, Board of Psychology.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

SERVICE REVIEW: Initial approval and reappointment review and approval

_____ _____
Chief, Psychiatry Service or Designee Date

8.53 CPC PSYCHIATRY ___
Outpatient management of psychiatric problems and conditions.

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

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

SERVICE REVIEW: Initial approval and reappointment review and approval

_____ _____
Chief, Psychiatry Service or Designee Date

8.54 CPC NEUROLOGY ___
Perform memory evaluation and/or other special neurological assessments.

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

PROCTORING: A minimum of 5 representative cases will be reviewed for initial Proctoring.

REAPPOINTMENT: Review of 3 cases.

SERVICE REVIEW: Initial approval and reappointment review and approval

_____ _____
Chief, Neurology or Designee Date

8.55 CPC DENTISTRY ___
Provides professional dental services to general hospital and dental clinic patients; instructs patients in correct oral hygiene and dental care; performs dental operations and treats mouth diseases; refers cases requiring difficult oral surgery and medical attention to proper department.

PREREQUISITES: Requires completion of the curriculum of an approved school of dentistry and possession of the D.M.D. degree or D.D.S. degree. Requires possession of valid license to practice dentistry issued by the State Board of Dental Examiners.

PROCTORING: A minimum of 5 representative cases will be reviewed for initial proctoring.

REAPPOINTMENT: Review of 3 cases.

Delineation Of Privileges

Community Primary Care 2022

Provider Name:

Privilege	Status	Approved

SERVICE REVIEW: Initial approval and reappointment review and approval

_____ _____
Chief, Oral Surgery or Designee Date

8.56 CPC ACUPUNCTURE ___
Performs acupuncture, acupressure, and moxibustion in the CHN facilities or in the patient's home.

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

PROCTORING: 5 direct observations and 5 cases to be reviewed by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. Direct observations and chart reviews may be on the same patient or on different patients. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for privileging recommendation.

REAPPOINTMENT: Review of five 5 cases by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for reappointment recommendation.

8.57 CPC OBSTETRICS AND GYNECOLOGY ___
Outpatient management of Obstetrics and Gynecology problems and conditions.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Obstetrics $ Gynecology.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

SERVICE REVIEW: Initial approval and reappointment review and approval

_____ _____
Chief, OB & Gynecology or Designee Date

8.58 CPC REPRODUCTIVE HEALTH ___

(NB: No need to apply for this if privileged in CPC Basic Pediatrics or CPC Ob/Gyn as this privilege falls within their scope.)
Perform family planning, preconception counseling, STD prevention, IPV prevention, and other outpatient management related to sexual health, excluding pregnancy, for patients aged 6-24.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Obstetrics & Gynecology, Family Medicine or Pediatrics.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

8.58A IUD Insertion ___

PROCTORING: Review of 2 cases.
REAPPOINTMENT: Review of 2 cases.

8.58B Contraceptive Implant Insertion/Removal ___

Delineation Of Privileges

Community Primary Care 2022

Provider Name:

Privilege	Status	Approved

PROCTORING: Proof of completion specialized course in insertion/removal of device.
REAPPOINTMENT: Review of 2 cases.

SERVICE REVIEW: Initial approval and reappointment review and approval

_____ _____
Chief, OB & Gynecology or Designee Date

8.60 WAIVED TESTING ___

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

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

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

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

a. Fecal Occult Blood Testing (Hemoccult®) ___

b. Vagnal Ph Testing (Ph Paper) ___

c. Urine Chemstrip® Testing ___

d. Urine Pregnancy Test (Sp® Brand Rapid Test) ___

I hereby request clinical privileges as indicated above.

_____ _____
Applicant Date

APPROVED BY

_____ _____
Division Chief Date

_____ _____
Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Community Primary Care

Provider Name:

Privilege	Status	Approved

AFF 2014 Community Primary Care
(Updated 08/26/2014)

INDICATE PRIMARY CLINIC SITE: _____ ___

CORE STANDARDIZED PROCEDURES ___

PREREQUISITES: Active California license, Board Certification, Basic Life Support (BLS) from an approved provider, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP, PNP or CNM.

PROCTORING: Three months in length, including 1 case of direct observation and 5 chart reviews. The reviewer will be the Medical Director or a physician designee.

REAPPOINTMENT: 5 chart reviews every 2 years

a. Health Care Management, Primary Care ___

b. Health Care Management, Acute And Urgent Care ___

c. Health Care Management, Prenatal Care ___

d. Furnishing Medications And Drug Orders ___

e. Management Of Benign And Malignant Breast Conditions (Restricted To Breast Clinic NPs) ___

PROCTORING: Direct observation of 3 cases and 5 chart reviews.

REAPPOINTMENT: Performance of 5 chart reviews every two years.

SPECIAL STANDARDIZED PROCEDURES ___

a. ARTHROCENTESIS AND INTRAARTICULAR INJECTION ___

PREREQUISITE: Direct observation of 2 procedures being performed by an experience provider.

PROCTORING: Direct observation of 2 procedures for a new provider and direct observation for an experienced provider. Chart review for a observed procedures.

REAPPOINTMENT: Performance of 1 procedure and 1 chart review every 2 years.

b. ENDOMETRIAL BIOPSY ___

PREREQUISITES: At least 6 months experience in Women's Health Care. Direct observation of 2 procedures being performed by an experienced provider.

PROCTORING: Direct observation of 2 procedures for a new provider and 1 direct observation for an experienced provider. Chart review for all observed procedures.

REAPPOINTMENT: Performance of 1 procedure and 1 chart review every 2 years.

c. INCISION AND DRAINAGE AND ABSCESSES ___

PREREQUISITES: Training in procedure by a qualified provider.

PROCTORING: 2 successful observed procedures by a new provider and 1 successful observation by an experienced provider.

REAPPOINTMENT: Completion of 1 procedure and 1 chart review every 2 years.

d. INSERTION AND REMOVAL OF CONTRACEPTIVE IMPLANT ___

Delineation Of Privileges

AFF Community Primary Care

Provider Name:

Privilege	Status	Approved

~~PREREQUISITE: Completion of a Transdermal Contraceptive Implant sponsored training program. At least 6 months experience in Women's Health Care.~~

~~PROCTORING: 2 successful insertions and 2 successful removals for a new provider and 1 successful insertion and 1 successful removal for experienced provider. Only providers trained in implanon insertion and removal can act as proctors.~~

~~REAPPOINTMENT: Chart review of 1 insertion and 1 removal every 2 years.~~

1. INSERTION OF CONTRACEPTIVE IMPLANT

PREREQUISITE: Completion of a company sponsored training class
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years
PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.
REAPPOINTMENT: Review of one (1) case in the past two (2) years.

2. REMOVAL OF CONTRACEPTIVE IMPLANT

PREREQUISITE: Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years
PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: Review of two (2) cases in the past two (2) years.

e. INSERTION OF INTRAUTERINE DEVICE ___

PREREQUISITE: At least 6 months of experience in Women's Health Care.

PROCTORING: Direct observation of 2 procedures for a new provider and 1 direct observation for an experienced provider.

REAPPOINTMENT: Performance of 1 procedure and 1 chart review every 2 years.

Delineation Of Privileges

AFF Community Primary Care

Provider Name:

Privilege	Status	Approved

f. SURFACE TRAUMA AND WOUND CARE ___

PREREQUISITES: Completion of a wound care course either from outside or at SFGH.

PROCTORING: Direct observation of 2 procedures for an experienced provider. 2 chart reviews of the procedure.

REAPPOINTMENT: Performance of 1 procedure and 1 chart review every 2 years.

g. SPLINTING ___

PREREQUISITE: Training in procedure by a qualified provider.

PROCTORING: Direct observation of 2 procedures for a new provider and direct observation of 1 procedure for an experienced provider. 1 chart review.

REAPPOINTMENT: Perform 1 procedure and 1 chart review every 2 years.

h. TATTOO REMOVAL ___

PREREQUISITE: Observation of 25 cases. Completion of laser safety module prepared by SFGH Laser Safety Committee and baseline eye examination within the previous 1 year.

PROCTORING: 10 cases by a privileged provider.

REAPPOINTMENT: Performance of 5 procedures and 5 chart reviews every two years.

i. WAIVED TESTING ___

PREREQUISITE: Clinical Assignment within the Community Primary Care Service.

PROCTORING: Completion of Healthstream quizzes for each test with a passing score of 80%.

REAPPOINTMENT: Completion of Healthstream quizzes for each test with a passing score of 80%.

1. Fecal Occult Blood ___
2. Vaginal Ph Testing ___
3. Urine Pregnancy ___
4. Urine Dipstick ___

j. eREFERRAL SPECIALTY TRIAGE ___

PREREQUISITES: 6 months experience in the specific specialty area, are providing care to patients in the area they are reviewing, understanding of algorithms or referral guidelines used for screening, triaging and prioritizing of patients.

PROCTORING: Review of 5% of the eReferral consultation decisions concurrently during the first 3 months. Review will be done by the Medical Director or designee.

REAPPOINTMENT: Review of 1 eReferral every two years.

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

Delineation Of Privileges

AFF Community Primary Care

Provider Name:

Privilege	Status	Approved

APPROVED BY

_____ _____

Division Chief Date

_____ _____

Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Family And Community Medicine

Provider Name:

Privilege	Status	Approved

JCC: 01/2026

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

14.00 OUTPATIENT CLINIC PRIVILEGES ___

14.01 AMBULATORY CARE PRIVILEGES FOR FAMILY MEDICINE PREPARED PHYSICIANS ___
Perform basic procedures within the usual and customary scope of Family Medicine; diagnosis, management, treatment, preventive care, and minor procedures for patients of all ages in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service, and may write informational notes in the SFGH inpatient medical record.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.02 AMBULATORY CARE PRIVILEGES FOR INTERNAL MEDICINE OR EMERGENCY MEDICINE PREPARED PHYSICIANS ___
Perform basic procedures within the usual and customary scope of Internal Medicine or Emergency Medicine; diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service and may write informational notes in the SFGH inpatient medical record.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Internal Medicine, the American Board of Emergency Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.03 BEHAVIORAL HEALTH CENTER PRIVILEGES ___
Performs basic procedures within the usual and customary scope of Family Medicine or Internal Medicine; diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Behavioral Health Center.

Concurrence of Behavioral Health Center Medical Director required:

_____ _____
Signature, Behavioral Health Ctr Medical Director Date

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-certified by the American Board of Family Medicine, or the American Board of Internal Medicine.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

14.10 INPATIENT CARE PRIVILEGES ___
Admit and be responsible for hospitalized adults. Admissions may include medical, surgical, gynecological, and neurological problems, and medical complications in pregnant patients with obstetric consultation. May also follow patients admitted to critical care units in a consultative capacity.

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Family And Community Medicine

Provider Name:

Privilege	Status	Approved

14.11 FAMILY MEDICINE INPATIENT SERVICE PRIVILEGES ___
Perform basic procedures within the usual and customary scope of Family Medicine; diagnosis, management, treatment, preventive care, and minor procedures for hospitalized adults.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.12 SKILLED NURSING FACILITY CARE PRIVILEGES ___
Perform basic procedures within the usual and customary scope of Family Medicine or Internal Medicine; diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the SFGH Skilled Nursing Facility (SNF).

Concurrence of Skilled Nursing Facility Medical required:

_____ _____
Signature, Skilled Nursing Facility Medical Director Date

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified byt the American Board of Family Medicine, the American Board of Internal Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.13 NURSERY PRIVILEGES ___
Render care to well newborns, including admitting and performing routine evaluations and management.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Case review for 3 newborn admissions

REAPPOINTMENT: Case review of 2 newborn admissions

14.20 PERINATAL PRIVILEGES ___
Render care to women during the perinatal period, including specific privileges 14.21 through 14.27, if requested and approved below:

14.21 NORMAL VAGINAL DELIVERY ___
Including administration of local anesthesia, performance of episiotomy, and repair of lacerations other than those involving the rectal sphincter.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Case review and direct observation of a minimum of 3 deliveries.

REAPPOINTMENT: Review of 3 cases.

14.22 VACUUM ASSISTED DELIVERIES (OB CONSULTATION REQUIRED) ___

Concurrence of the Chief of OB/Gyn required:

_____ _____
Signature, chief of OB/GYN Date

Delineation Of Privileges

Family And Community Medicine

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: For applicants with documentation of prior successful performance of a minimum of 25 vacuum assisted deliveries: case review and direct observation of a minimum of 2 deliveries using vacuum assistance. For applicants with documentation of fewer than 25 vacuum assisted deliveries: case review and direct observation of 5 deliveries using vacuum assistance.

REAPPOINTMENT: Case review of 1 delivery using vacuum assistance.

14.23 FIRST ASSIST IN CESAREAN DELIVERY (OBSTETRICS CONSULTATION REQUIRED) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of prior successful performance of a minimum of 25 Cesarean deliveries.

PROCTORING: Case review and direct observation of 5 Cesarean deliveries.

REAPPOINTMENT: Case review of 1 Cesarean delivery.

Concurrence of the Chief of OB/Gyn required:

_____ _____

Signature, Chief of OB/GYN Date

14.24 ULTRASOUND IN PREGNANCY ___

Limited to determination of fetal gestational age, confirmation of presentation, placenta location, amniotic fluid adequacy, and confirmation of fetal heart rate.

a. Basic First and Second Trimester Ultrasound (for dating, viability and location of pregnancy) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 dating ultrasounds.For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 8 hour obstetric ultrasound course followed by direct observation of 10 dating ultrasounds and a further retrospective review of an additional 10 dating ultrasound cases/images.

REAPPOINTMENT: Retrospective review of four (4) cases/images in the past 2 years.

b. Limited Third Trimester Ultrasound (assessment of viability, fetal position, placental location, single deepest pocket of amniotic fluid) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 limited third trimester ultrasounds.
For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 4 hour obstetric ultrasound course followed by case review and direct observation of 5 limited third trimester ultrasounds.

REAPPOINTMENT: Retrospective review of two (2) cases/images in the past 2 years.

Delineation Of Privileges
Family And Community Medicine

Provider Name:

Privilege	Status	Approved
14.25 External Cephalic Version PREREQUISITES: Currently admissible, certified, or recertified by the American Board of Family Medicine; active FCM Cesarean delivery privileges; and documentation of a minimum of 2 procedures. PROCTORING: Concurrent review of 2 cases. REAPPOINTMENT: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.		___
14.26 CESAREAN DELIVERY PREREQUISITES: Currently admissible, certified, or recertified by the American Board of Family Medicine; completion of 12-month fellowship including training in operative obstetrics; and documentation of a minimum of 50 Cesarean deliveries or active Cesarean delivery privileges within the last 5 years. PROCTORING: Concurrent review of 5 Cesarean deliveries. REAPPOINTMENT: Satisfactory performance of a minimum of 10 Cesarean deliveries in 2 years. Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process. Concurrence of the Obstetrics and Gynecology Service Chief required. _____ Signature, Obstetrics and Gynecology Service Chief		___
14.27 POSTPARTUM STERILIZATION Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine; and documentation of a minimum of 10 procedures within the last 2 years. Proctoring: Concurrent review of 2 cases. Reappointment: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.		___
14.30 SPECIAL PRIVILEGES Physicians may apply for each of the following procedural privileges separately based on qualifications and scope of practice.		___
14.31 LUMBAR PUNCTURE PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases, one of which may be performed on a simulated model. REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.		___
14.32 PARACENTESIS PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases, one of which may be performed on a simulated model. REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.		___

Delineation Of Privileges

Family And Community Medicine

Provider Name:

Privilege	Status	Approved
14.33 THORACENTESIS PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases, one of which may be performed on a simulated model. REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.		___
14.34 PLACEMENT OF CENTRAL VENOUS CATHETER, INCLUDING FEMORAL VENOUS CATHETER PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases, one of which may be performed on a simulated model. REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.		___
14.35a ENDOMETRIAL BIOPSY PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases. REAPPOINTMENT: Review of 2 cases.		___
14.35b. INSERTION Of INTRAUTERINE DEVICE (IUD) PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40). PROCTORING: Review of 2 cases. REAPPOINTMENT: Review of 2 cases.		___
14.36 SURGICAL TERMINATION OF FIRST TRIMESTER INTRAUTERINE PREGNANCY Perform surgical abortions in the first trimester of pregnancy at appropriate facilities at SFGH. PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Family Medicine. Completion of at least 20 hours of formal training in surgical abortion, including first trimester ultrasound for confirmation of intrauterine pregnancy and determination of gestational age, during residency or a CME program, and documentation of 50 procedures. PROCTORING: Case review of 3 surgical terminations. REAPPOINTMENT: Case review of 2 terminations.		___
14.37 VASECTOMY PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine. Completion, as a licensed physician, of a minimum of 20 vasectomy procedures under supervision of a privileged and Board Certified Urologist or Family Physician. PROCTORING: Review of 5 cases. REAPPOINTMENT: Review of 3 cases.		___
14.38 CIRCUMCISION		___

Delineation Of Privileges
Family And Community Medicine

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Family Medicine. Documentation of proficiency from a Residency program with at least 5 cases, OR, documentation of previous privileges at another hospital with at least 5 cases, OR, minimum of 5 cases performed with assistance from a supervising attending with circumcision privileges, until provider and supervisor determine the provider can perform under proctoring.

PROCTORING: Direct observation of 3 independently performed cases (consecutive/concurrent).

REAPPOINTMENT: Review of 3 cases.

14.39 CONTRACEPTIVE IMPLANT INSERTION/REMOVAL

a. INSERTION OF CONTRACEPTIVE IMPLANT

PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: Review of one (1) case in the past two (2) years.

b. REMOVAL OF CONTRACEPTIVE IMPLANT

PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: Review of two (2) cases in the past two (2) years.

14.40 LIMITED AMBULATORY CARE PRIVILEGES ___

14.41 ACUPUNCTURE ___
Perform acupuncture, acupressure, and moxibustion in the Family Medicine Inpatient Service, Family Health Center (FHC), Skilled Nursing Facility, FHC Satellites and in the patient's home.

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Delineation Of Privileges

Family And Community Medicine

Provider Name:

Privilege	Status	Approved

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

PROCTORING: 5 direct observations and 5 cases to be reviewed by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. Direct observations and chart reviews may be on the same patient or on different patients. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for privileging recommendation.

REAPPOINTMENT: Review of 5 cases by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for reappointment recommendation.

14.42 DENTISTRY ___

Provide professional dental services to hospital and clinic patients; instruct patients in correct oral hygiene and dental care; treat mouth diseases; refer cases requiring oral surgery and medical attention to proper department.

PREREQUISITES: Requiring completion of the curriculum of an approved school of dentistry and possession of the DDS degree. Requires possession of a valid license to practice dentistry issued by the State Board of Dental Examiners.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.43 CLINICAL PSYCHOLOGY ___

Provide individual and family counseling and therapy.

PREREQUISITES: Clinical Psychologists must hold a doctoral degree in Psychology from an approved APA accredited program, and must be licensed on the basis of the doctorate degree in Psychology by the State of California, Board of Psychology.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.44 ALLERGY AND IMMUNOLOGY ___

Work-up, diagnose, consult, treat, and interpret clinical findings of adult and pediatric patients in the ambulatory setting with allergy or immunologic diseases. Core privileges include allergy skin testing and interpretation.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Internal Medicine and the American Board of Allergy and Immunology or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.50 WAIVED TESTING ___

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

Delineation Of Privileges

Family And Community Medicine

Provider Name:

Privilege	Status	Approved

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

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

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

a. Fecal Occult Blood Testing (Hemoccult®) ___

b. Vaginal Ph Testing (Ph Paper) ___

c. Urine Chemistrip® Testing ___

d. Urine Pregnancy Test (Sp® Brand Rapid Test) ___

14.60 STRAIN-COUNTERSTRAIN MANIPULATIVE MEDICINE PRIVILEGE ___

Perform manipulation principally for the purpose of relief of primarily muscular pain on the Family Medicine Inpatient Service, Family Health Center, Skilled Nursing Facility, FHC satellites, and in the patient's home.

PREREQUISITES: Successful completion, by a licensed physician, of at least 30-hours instruction and didactic training course designed for health care professionals and authorized to provide CME or CE credits. In addition, five hours of supervised clinical practice, either during or after residency or completion of training in a Doctor of Osteopathy training program.

PROCTORING: 5 direct observations and 5 cases to be reviewed by a SFGH medical staff member who either maintains Strain-Counterstrain privileges or is a Doctor of Osteopathy who has received training in the Strain-Counterstrain technique.

REAPPOINTMENT: Review of five 5 cases.

14.80 ADDICTION MEDICINE ___

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

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

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

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

_____ _____

Addiction Medicine Director/Designee Date

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

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

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Family And Community Medicine

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

_____ _____

Division Chief Date

_____ _____

Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Family And Community Medicine 2020

Provider Name:

Privilege	Status	Approved

AFF_2020 Family and Community Medicine

CORE STANDARDIZED PROCEDURES ___

PREREQUISITES: Active California RN, NP or PA license, Board certification (NP) or NCCPA (PA), Maintenance of American Heart Association Basic Life Support for Health Care providers (BLS-HCP), possession of a National Provider identifier or has submitted an application, Furnishing Number and DEA number, If no Furnishing or DEA number explanation is required. Specialty training Adult or Family Medicine with at least 2 years of clinical experience in specialty area desired. PA sign and adhere to the ZSFG PA Practice Agreement.

PROCTORING: 5 chart reviews and direct observation. At least one case representing each core protocol. The reviewer will be the Medical Director or other physician designee.

REAPPOINTMENT: 5 chart reviews every 2 years. Chart review shall include at least one case representing each core protocol.

a. CORE MANAGEMENT, PRIMARY CARE/INPATIENT UNITS ___

b. CORE MANAGEMENT, ACUTE AND URGENT CARE ___

c. CORE MANAGEMENT, PRENATAL CARE ___

d. CORE, FURNISHING MEDICATIONS/DRUG ORDERS ___

e. CORE, DISCHARGE OF INPATIENTS ___
(For Inpatient Units, 4A Skilled Nursing Facility And Behavioral Health Unit Only)

SPECIAL STANDARDIZED PROCEDURES ___

a. INCISION AND DRAINAGE OF ABSCESS ___

REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: 1 year experience in wound care. Training per FCM guidelines listed in this SP.

PROCTORING: 2 direct observation for a new provider and 1 direct observation for an experienced provider. Explanation needed for exceptions to minimum requirements. Chart review of all proctored cases.

REAPPOINTMENT: Performance of 1 procedure and 1 chart review every two years.

b. ARTHROCENTESIS AND INTRAARTICULAR INJECTIONS ___

REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: The NP/PA will observe a privileged provider (MD, NP or PA) 2 times. Training per FCM guidelines listed in this SP.

PROCTORING: 2 direct observations for a new provider and 1 direct observation for an experienced provider for each injection site. Chart review of all proctored cases.

REAPPOINTMENT: Performance of 2 procedures and 2 chart reviews every two years.

c. NAIL DEBRIDEMENT ___

Delineation Of Privileges

AFF Family And Community Medicine 2020

Provider Name:

Privilege	Status	Approved

REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: Training by a qualified provider. Review of unit policies.

PROCTORING: Direct observation of 2 successful procedures for a new provider and direct observation of 1 successful procedure for an experienced provider. Chart review of all observed procedures.

REAPPOINTMENT: Performance of 1 procedure per year and 1 chart review per two years.

d. SPLINTING ___

REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: Procedure performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

PROCTORING: Direct observation of 2 procedures for a new provider and I direct observation for an experienced provider. Chart review of all observed procedures.

REAPPOINTMENT: Performance of 1 procedure and 1 chart review every two years.

e. SURFACE TRAUMA AND WOUND CARE ___

REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: New practitioner will attend a would care/suturing course a lab (at outside facility or through ZSFG.

PROCTORING: Direct observation of 2 successful procedures for a new provider and 1 direct observation for an experienced provider. Chart review of all observed procedures.

REAPPOINTMENT: Performance of 1 procedures and 1 chart reviews every two years.

f. INSERTION AND REMOVAL OF ~~A~~ CONTRACEPTIVE IMPLANT ___

1. ~~1.~~ INSERTION OF ~~A~~ CONTRACEPTIVE IMPLANT ___

~~REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: Completion of a company sponsored training program.~~
PREREQUISITE: Completion of a company sponsored training class
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING: ~~2 successful insertions for a new provider and 1 insertion for an experienced provider. Chart review of all observed cases.~~
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: ~~4 insertions and 1 chart review every 2 years.~~Review of one (1) case in the past two (2) years.

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Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Family And Community Medicine 2020

Provider Name:

Privilege	Status	Approved
2. REMOVAL OF ~~A~~ CONTRACEPTIVE IMPLANT		___
~~REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OFPROCTORING AND PROVISION OF DIRECT PATIENT CARE: Completion of a company sponsored training program.~~ PREREQUISITE: Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience. Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years. Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years		
PROCTORING: ~~3 successful removals for a new provider and 2 removals for an experienced provider. Chart review of all observed cases.~~ Adequate Experience: Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience. Inadequate Experience: Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.		
REAPPOINTMENT: ~~6 removal procedures and 1 chart review every 2 years.~~ Review of two (2) cases in the past two (2) years.		
g. INTRAUTERINE DEVICE INSERTION		___
REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: At least 6 months experience in women's health care. Review of department policies and procedures. PROCTORING: Direct observation of 2 insertions and 2 chart reviews both new provider and provider who has prior experience with independent IUD insertion. REAPPOINTMENT: Performance of 1 insertion every 2 years and 1 chart review every two years.		
h. ENDOMETRIAL BIOPSY		___
REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: At least 6 months experience in women's health care. Provider will observe a qualified provider do procedure 2 times. PROCTORING: Direct observation of 3 successful procedures for a new provider and direct observation of 2 successful procedures for an experienced provider. Chart review of all direct observations. REAPPOINTMENT: Performance of 1 procedure and 1 chart review every 2 years.		
i. SKIN BIOPSY: SHAVE, PUNCH AND EXCISION		___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Family And Community Medicine 2020

Provider Name:

Privilege	Status	Approved
REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: 2 direct observations of a qualified provider doing each procedure, review of aseptic technique and review of departmental policy and procedure. PROCTORING: Direct observation of 2 successful performances of each type of biopsy for a new provider and 1 direct observation of a successful performance of each type of biopsy for an experienced provider. Chart review of all observed cases. REAPPOINTMENT: Direct observation of 1 of each procedure and 1 chart review of each procedure every two years.		
j. TRIGGER POINT INJECTIONS REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: Training by 3 direct observations of a qualified provider performing trigger point injections will occur. PROCTORING: Direct observation of 2 successful procedures for each injection site for a new provider and 1 direct observation of a successful procedure for each injection site for an experienced provider. Chart review of all observed cases. REAPPOINTMENT: Performance of 2 injections and 2 chart reviews every two years.		___
k. NAIL REMOVAL/MATRISECTOMY REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND DIRECT PATIENT CARE: PROCTORING: Direct observation of 2 procedures for new provider and 1 procedure for an experienced provider. Chart review of all observed cases. REAPPOINTMENT: Performance of 1 procedure and 1 chart review every 2 years.		___
l. ABDOMINAL PARACENTESIS REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: Training by a privileged provider or documentation of previous training. PROCTORING: Providers new to procedure must complete a minimum of 4 observed successful procedures and 4 chart reviews prior to completions of proctoring period. One of the procedures may be performed on a simulated model. Experienced providers must complete a minimum of 2 successful procedures prior to completion of proctoring period. REAPPOINTMENT: To maintain ongoing competency, a minimum of 4 procedures every 2 years must be met. One of the procedures may be performed on a simulated model. If requirements are not met, provider will be proctored through 1 successful procedure. Four chart reviews every two years. Evaluation must be done by Medical Director or designated physician.		___
m. LUMBAR PUNCTURE REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: Completion of standardized procedure training on site. PROCTORING: Minimum of 3 successful observed demonstrations and 3 chart reviews. REAPPOINTMENT: Completion of three procedures and 3 chart reviews every 2 years.		___
n. ORDERING TRANSFUSIONS		___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Family And Community Medicine 2020

Provider Name:

Privilege	Status	Approved

REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: Successful completion of the ZSFG Transfusion Training course and successful completion of Transfusion Training course test on blood ordering and informed consent. Must have an 80% test score on both examinations.

PROCTORING: Read and Sign the ZSFG Administrative Policy and Procedure 2.03 "Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options". Read ZSFG Transfusion Guidelines in Laboratory manual. Review of 1 (some say "countersigned") transfusion order and review of documentation in the patient medical record.

REAPPOINTMENT: Completion of the two education modules and completion of the two examinations with a passing score of 80%. Performance of 1 transfusion order and review of 1 medical record every 2 years. Review of any report from the Transfusion Committee. Evaluator will be the medical director or other designated physician.

o. WAIVED TESTING ___

REQUIREMENTS TO BE COMPLETED PRIOR TO INITIATION OF PROCTORING AND PROVISION OF DIRECT PATIENT CARE: 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 the online learning modules for each Waived Test the practition is performed at ZSFG with a passing score of at least 80%.

REAPPOINTMENT: Successful completion of the online learning modules with a passing score of at least 80% every two years.

1. Fecal Occult Blood ___
2. Vaginal pH Testing ___
3. Urine Pregnancy ___
4. Urine Dipstick ___

I hereby request clinical privileges as indicated above.

_____ _____
Applicant Date

APPROVED BY

_____ _____
Division Chief Date

_____ _____
Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Medicine General Internal Medicine 2021

Provider Name:

Privilege	Status	Approved

MedGIM GENERAL INTERNAL MEDICINE 2017
(11/2024 MEC)

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

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

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

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

50.11 LUMBAR PUNCTURE ___

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine.

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

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

50.12 THORACENTESIS ___

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine.

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

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

50.13 PARACENTESIS ___

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine.

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

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

50.14 CENTRAL VENOUS LINE PLACEMENT ___

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine.

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

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

50.15 CONTRACEPTIVE IMPLANT INSERTION/REMOVAL ___

a. INSERTION OF CONTRACEPTIVE IMPLANT

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Delineation Of Privileges

Medicine General Internal Medicine 2021

Provider Name:

Privilege	Status	Approved

PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: Review of one (1) case in the past two (2) years.

~~PREREQUISITES: Physicians must have GIM Basic Privileges (50.00)~~

~~PROCTORING: Proof of completion specialized course in insertion/removal of device.~~

~~REAPPOINTMENT: Review of 2 cases.~~

b. REMOVAL OF CONTRACEPTIVE IMPLANT

PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: Review of two (2) cases in the past two (2) years.

50.16 INSERTION OF INTRAUTERINE DEVICE ___

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine and currently or previously (in the past 5 years) credentialed at another institution for this privilege OR completion of a training program (in the past 5 years) that included IUD insertion training OR completion of 5 supervised IUD insertions with a credentialed provider.

PROCTORING: Direct observation of 2 insertions by a qualified provider.

REAPPOINTMENT: Review of 2 cases.

50.30 ADDICTION MEDICINE ___
Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

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Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Medicine General Internal Medicine 2021

Provider Name:

Privilege	Status	Approved

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

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

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

_____ _____

Addiction Medicine Medical Director/Designee Date

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

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_____ _____

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

APPROVED BY

_____ _____

Division Chief Date

_____ _____

Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Medicine

Provider Name:

Privilege	Status	Approved

AFF Medicine
(JCC 01/2025)

Setting: ___
Location of practice is: Inpatient Units, GCRC, Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Infusion Center, 3 D Gastroenterology Clinic, Occupational Health Service, Positive Health Clinic, Hematology/Oncology Clinic, 1M and 5F Cardiology Clinics, Ward 17 Renal Dialysis, Pulmonary Outpatient Diagnostic Service (PODS), the Bronchoscopy Suite in Endoscopy Center, and the Emergency Department.

Acute Medicine/Division Of Hospital Medicine ___

Adult General Medical Clinic ___

Cardiology Clinic ___

Gastroenterology Clinic ___

Hematology/Oncology Clinic ___

HIV/ID & Global Medicine ___

Occupational Clinic ___

Pulmonary Medicine ___

Renal Clinic ___

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

CORE STANDARDIZED PROCEDURES ___

PREREQUISITES: Active California license, Board certification,(staff hired prior to Board requirement will be "grandfathered " in at reappointment), Basic Life Support (BLS) from an approved provider, Advanced Cardiac Life Support (ACLS) for noted procedures, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an ANP, FNP, PNP or PA.

PROCTORING: Three months in length or time needed to review of 10 cases and 5 medical record reviews. The reviewer will be the Medical Director or a physician designee.

REAPPOINTMENT: Chart reviews as noted in each protocol every 2 years.

#1: HEALTH CARE MANAGEMENT, ACUTE AND URGENT CARE ___

#2: HEALTH CARE MANAGEMENT, PRIMARY CARE ___

#3. DISCHARGE OF INPATIENT ___

#4. FURNISHING MEDICATIONS AND DRUG ORDERS ___

#5. OCCUPATIONAL HEALTH SCREENING (OCCUPATIONAL HEALTH SERVICES ONLY) ___

Delineation Of Privileges

AFF Medicine

Provider Name:

Privilege	Status	Approved

SPECIAL STANDARDIZED PROCEDURES ___

#6. EVALUATION AND TREATMENT OF OCCUPATIONAL ILLNESS/INJURY (OCCUPATIONAL HEALTH SERVICES ONLY) ___

PREREQUISITE: On site training by OHS physician in California and CCSF Worker's Compensation procedures and management of body fluid exposure.

PROCTORING: Direct observation of 3 evaluations and treatments.

REAPPOINTMENT: Review of 4 chart reviews every 2 years.

#7. eREFERRAL ___

PREREQUISITES: 6 months experience in the specific specialty area, are providing care to patients in the area they are reviewing, understanding of algorithms or referral guidelines used for screening, triaging and prioritizing of patients.

PROCTORING: Concurrent review of the first 20 eReferral consultations.

REAPPOINTMENT: Review of 1 eReferral every two years

#8. ABDOMINAL PARACENTESIS ___

PREREQUISITE: On site training by a privileged provider or documentation of previous training.

PROCTORING: Direct observation of 4 procedures for a new provider and 2 procedures for an experienced provider. Chart review of all observed cases.

REAPPOINTMENT: Perform 4 procedures and 2 chart reviews every 2 years.

#9: ARTHROCENTESIS AND INTRAARTICULAR INJECTION ___

PREREQUISITE: On site training by a privileged provider or documentation of previous training.

PROCTORING: Direct observation of 3 procedures for a new provider and 2 direct observations for an experienced provider. Chart review for all observed procedures.

REAPPOINTMENT: Performance of 4 procedures and 2 chart reviews every 2 years

#10. BONE MARROW ASPIRATION AND BIOPSY ___

PREREQUISITE: On site training by a privileged provider or documentation of previous training.

PROCTORING: Direct observation of 3 procedures for a new provider and 2 procedures for an experienced provider. Chart review of all observed cases.

REAPPOINTMENT: Performance of 2 procedures and 2 chart reviews every 2 years.

#11. COLONOSCOPY (ACLS REQUIRED) (GI SERVICE ONLY) ___

PREREQUISITE: View videotapes from ASGE video library. Demonstrate proper set up of equipment.

PROCTORING: Direct observation of 140 procedures, including 10 routine colonoscopy mucosal biopsies and 40 colonoscopy polypectomies for a new provider. An experienced provider must complete 6 demonstrations with 3 mucosal biopsies and 3 poylpectomies. Review of 50 procedure notes by trained provider.

REAPPOINTMENT: Performance of 3 colonoscopies with mucosal biopsy and 3 polypectomies. Observation of 1 patient encounter and 3 chart reviews

Delineation Of Privileges

AFF Medicine

Provider Name:

Privilege	Status	Approved
#12. EGD (ACLS REQUIRED) (GI SERVICE ONLY) PREREQUISITES: View video tapes from the ASGE video library. Observation of procedure equipment setup. PROCTORING: Direct observation of 130 diagnostic EGD with administration of moderate sedation for a new provider. 5 direct observations for an experienced provider. Review of 50 procedure notes. REAPPOINTMENT: Completion of 3 procedures and observation of 3 patient encounters every 2 years.		___
#13. ESOPHAGEAL MANOMETRY AND PROLONGED AMBULATORY pH MONITORING (ACLS REQUIRED) (GI SERVICE ONLY) PREREQUISITES: Review of departmental policies and procedures. Demonstrate ability to set up procedure equipment. Observe 5 procedures by a qualified provider. PROCTORING: Perform a minimum of 3 procedures. Review of 20 procedure notes by a qualified provider. REAPPOINTMENT: Perform 2 procedures every 2 years. Direct observation of 2 patient encounters every 2 years.		___
#14. EXERCISE TREADMILL TEST (ACLS REQUIRED) PREREQUISITE: Completion of a 12 lead EKG course or onsite training. PROCTORING: Performance of 3 procedures for a new provider and 2 procedures for an experienced provider. Chart review of all observed cases. REAPPOINTMENT: Perform 2 procedures and 2 chart reviews every 2 years.		___
#15. HIGH RESOLUTION ANOSCOPY PREREQUISITE: Completion of a one week course in theory and practice of anal colposcopy at UCSF or other recognized university. PROCTORING: Direct observation o 50 procedures and 3 chart reviews by a credentialed colposcopist. REAPPOINTMENT: Perform 20 procedures and 3 chart reviews.		___
#16. INCISION AND DRAINAGE SKIN ABSCESSES WITH ADMINISTRATION OF LOCAL ANESTHESIA PREREQUISITES: Training by a privileged provider or documentation of previous training. PROCTORING: 2 successful observed procedures by a new provider and 1 successful observation by an experienced provider. REAPPOINTMENT: Completion of 1 procedure and 1 chart review every 2 years.		___
#17. INTRAVENTICULAR CHEMOTHERAPY ADMINISTRATION VIA OMAYA RESERVOIR		___

Delineation Of Privileges

AFF Medicine

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Training will consist of instruction by clinical directors or physician/NP designee.

PROCTORING: Proctoring period for practitioners will be a minimum of 3 successful observed demonstrations within the proctoring period, if there are insufficient opportunities within the proctoring period, and then procedure will be supervised until the minimum requirement is met.

REAPPOINTMENT:
A. A minimum of 2 procedures within a 2 year period. If no opportunities occur within a 2 year period, provider will be supervised for 1 additional procedure when the opportunity occurs.
B. 2 chart reviews every 2 years.

#18. LUMBAR PUNCTURE ___

PREREQUISITES: On site training by a privileged provider or documentation of previous training.

PROCTORING: Perform 3 procedures for a new provider and 2 procedures for an experienced provider.

REAPPOINTMENT: 3 procedures and 1 chart review every 2 years.

#19. LUMBAR PUNCTURE WITH ADMINISTRATION OF INTRATHECAL CHEMOTHERAPY ___

PREREQUISITE: On site training by a privileged provider or documentation of previous training.

PROCTORING: Perform 3 procedures for a new provider and 2 procedures for an experienced provider. Minimum of 2 chart reviews.

REAPPOINTMENT: 2 procedures and 1 chart review every 2 years.

#20. MODERATE SEDATION (GI AND PULMONARY SERVICES ONLY) ___

PREREQUISITE: Read Hospital Policy 19.8 Procedural Sedation: Moderate and Deep" and completion of the procedural sedation test. Completion of the ZSFG Moderate Sedation educational module for Nursing Staff.

PROCTORING: Direct observation by a qualified provider of 50 procedures with moderate sedation for a new provider and 10 observations for an experienced provider. Review of 50 procedure notes.

REAPPOINTMENT: Completion of 3 procedures and 1 direct observation of a patient encounter. Maintain ACLS certification.

#21. ORDERING BLOOD TRANSFUSIONS ___

PREREQUISITES: Completion of SFGH Transfusion Training Course. Completion of Training Course on Informed Consent. Requires a passing score of 80%.

PROCTORING: Read and Sign of SFGH Policy and Procedure 2.3. Read Blood Transfusion section of the Laboratory Manual. Review of 1 transfusion order.

REAPPOINTMENT: Completion of 2 education modules with a passing sore of 80%. Order 2 transfusions every 2 years. Review any reports from the hospital Transfusion Committee.

#22. ORDERING CHEMOTHERAPY ___

Delineation Of Privileges

AFF Medicine

Provider Name:

Privilege	Status	Approved

PREREQUISITE: On site training by a privileged provider or documentation of previous training.

PROCTORING: All new providers will have all chemotherapy orders cosigned for 3 months. Experienced providers will have 2 orders reviewed by the Clinical Director.

REAPPOINTMENT: 3 orders and 2 chart reviews reviewed every 2 years.

#23. SKIN BIOPSIES (SHAVE, PUNCH, EXCISION) ___

PREREQUISITE: On site training by a privileged provider or documentation of previous training. Direct observation of aseptic technique.

PROCTORING: Performance of 3 of each type of biopsy for a new provider and 2 of each type of biopsy for an experienced provider.

REAPPOINTMENT: Perform 1 of each type of biopsy and 1 chart review every 2 years

#24. THORACENTESIS ___

PREREQUISITES: On site training by a privileged provider or documentation of previous training.

PROCTORING: Direct observation of 3 procedures for a new provider and direct observation of 2 procedures for an experienced provider.

REAPPOINTMENT: Perform 2 procedures and 2 chart reviews every 2 years.

#25. WAIVED TESTING ___

PREREQUISITE: Clinical assignment within the Department of Medicine.

PROCTORING: Completion of Health stream quizzes for each test with a passing score of 80%.

REAPPOINTMENT: Completion of Health stream quizzes for each test with passing score of 80%.

Fecal Occult Blood ___

Vaginal Ph Testing ___

Urine Pregnancy ___

Urine Dipstick ___

#26. ~~CONTRACEPTIVE IMPLANT INSERTION~~ INSERTION OF CONTRACEPTIVE IMPLANT ___

Delineation Of Privileges

AFF Medicine

Provider Name:

Privilege	Status	Approved

PREREQUISITES: ~~Completion of a company sponsored training program~~
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING: ~~Direct observation of 2 insertions by a qualified provider for providers new to this procedure. Direct observation by a qualified provider of 1 insertion for an experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years). Chart review of all observed cases.~~
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: ~~A minimum of 6 insertions every 2 years. One chart review needed every 2 years.~~ Review of one (1) case in the past two (2) years.

#27. ~~CONTRACEPTIVE IMPLANT REMOVAL~~ REMOVAL OF CONTRACEPTIVE IMPLANT ___

PREREQUISITES: ~~Completion of a company sponsored training class~~ Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years

PROCTORING: ~~Performance of a minimum of 6 removals for a new provider and 2 removals for a provider who has prior experience with independent removal. Proctor must be a qualified provider. Chart review of all observed cases.~~
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: ~~Performance of 8 removals every 2 years. Two chart review needed every 2 years.~~ Review of two (2) cases in the past two (2) years.

APPROVED BY

_____ _____
Division Chief Date

_____ _____
Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

OBSTETRICS & GYNECOLOGY (OB/GYN)

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

24.00 CORE PRIVILEGES ___

24.01 OUTPATIENT CLINIC: OBSTETRICS ___

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 50 clinic visits in the previous 2 years

a. Prenatal Care Visits, Both Low And High Risk Patients. If indicated for patient and/or provider safety, site may also include the patient's home, a community location, or another safe, private location. ___

b. Interpretation Of Fetal Monitoring ___

c. Treatment Of Medical Complications Of Pregnancy Including, But Not Limited To: Pregnancy Induced Hypertension, Chronic Hypertension, Diabetes Mellitus, Renal Disease, Coagulopathies, Cardiac Disease, Anemias And Hemoglobinopathies, Thyroid Disease, Sexually Transmitted Disease, Pulmonary Disease, Thromboembolic Disorders, Infectious Disease, Ectopic Pregnancy And Other Accidents O Pregnancy, Such As Incomplete, Complete, Or Missed Abortion ___

24.02 BASIC OB/GYN ULTRASOUND ___

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: Interpretation of 5 ultrasound exams. Interpretation of 3 ultrasound exams for UCSF-trained Fellows/Residents.

REAPPOINTMENT: Interpretation of 10 ultrasound exams in the previous two years

a. Localization Of Intrauterine Pregnancy (Ie. Diagnose Iup) ___

b. Evaluation Of Fetal Viability And Heart Rate ___

c. Estimation Of Gestational Age, Fetal Weight ___

d. Fetal Presentation ___

e. Evaluation Of Vaginal Bleeding, Placental Location ___

f. Measurement Of Cervical Length ___

g. Amniotic Fluid Estimation (AFI) ___

24.03 INPATIENT OBSTETRICAL CARE ___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Note: Procedures marked with an asterisk may only be performed by obstetrician gynecologists, unless the physician has received additional obstetrical training and experience and has been approved by the Chief of OB/GYN & RS to perform these procedures.

PROCTORING: Observed care of 3 patients, each of whom has received at least one of the procedures below. For UCSF-trained residents and fellows: observed care of 2 patients, each of whom has received at least one procedure below.

REAPPOINTMENT: 15 procedures in the previous two years

a. Routine Inpatient Antepartum, Intrapartum, And Postpartum Care ___

b. Management Of Spontaneous And Induced Labor ___

c. Pudendal Block* And Local Anesthesia ___

d. Fetal Assessment, Antepartum And Intrapartum ___

e. Internal Fetal Monitoring ___

f. Normal Cephalic Vaginal Delivery ___

g. Episiotomy And Repair, Including 1St And 2Nd Degree Lacerations ___

h. Exploration And Repair Of The Vagina And Cervix ___

i. Deliver Placenta ___

j. Evaluate, Diagnose, Treat, And Provide Consultation For Medical Conditions Complicating Pregnancy (Beyond That Contained In Routine Inpatient Antepartum, Intrapartum, And Postpartum Care)* ___

l. Tubal Sterilization, Post-Partum* ___

m. Non-Genetic Amniocentesis* ___

n. Forceps Delivery* ___

o. Delivery By Vacuum Extraction* ___

p. Manual Or Instrumental Extraction Of The Placenta And Fragments* ___

q. Cesarean Section (Primary Surgeon)* ___

r. Treatment of Cervical Insufficiency (Cervical Cerclage))* ___

s. External Version Of Breech Presentation* ___

t. Vaginal Breech Delivery* ___

u. Vaginal Multiple Fetus Delivery* ___

v. Repair Of Rectal Injury (3rd And 4th Degree Laceration)* ___

w. Cesarean Hysterectomy* ___

x. Vaginal Birth After Caesarean Section* ___

y. Pregnancy Termination Via Labor Induction* ___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

24.04 OUTPATIENT CLINIC: GYNECOLOGY ___

Evaluate, diagnose, treat, and provide consultation, pre-and post-operative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgical disorders and injuries of the mammary glands. When inpatient gynecologic care privileges have been approved, procedures in this privilege group also can be performed in the hospital operating room.

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: Review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 50 clinic visits in the previous 2 years

a. Preventive Health Visits: Well Women, Family Planning Visits ___

b. Problem-Oriented Gynecologic Visits ___

c. Microscopic Diagnosis Of Urine And Vaginal Smears ___

d. Colposcopy ___

e. Vulvar, Vaginal And Cervical Biopsy ___

f. Endometrial Biopsy ___

g. Cervical Or Endometrial Polypectomy ___

h. Insertion And Removal Of Intrauterine Contraceptive (IUC) ___

i. Insertion And Removal Of Contraceptive Implant ___

1. INSERTION OF CONTRACEPTIVE IMPLANT

PREREQUISITE: Completion of a company sponsored training class
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years
PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.
REAPPOINTMENT: Review of one (1) case in the past two (2) years.

Delineation Of Privileges
Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

2. REMOVAL OF CONTRACEPTIVE IMPLANT

PREREQUISITE: Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years
PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: Review of two (2) cases in the past two (2) years.

j. Pessary Fitting ___

k. Trigger Point Injection ___

l. Cryosurgery (Cervix, Vulva, Vagina) ___

m. Loop Electrosurgical Excision Procedure (LEEP), Cervix ___

n. Bartholin Duct Procedures (Incision And Drainage, Marsupialization) ___

o. Dilation And Curettage, Suction Curettage And Manual Uterine Aspiration, Including Abortions Up To 18 Weeks' Gestation ___

p. Simple Cystometry ___

q. Paracervical And Intracervical Block ___

r. Insertion Of Cervical Dilator ___

s. Anoscopy ___

24.05 INPATIENT GYNECOLOGY AND GYNECOLOGIC SURGERY ___

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.

PROCTORING: 5 observed operative procedures, including at least one laparotomy and one laparoscopy.

REAPPOINTMENT: 15 operative procedures in the previous two years

a. Admission Of Patients With Gynecologic Issues ___

b. Care Of Admitted Post-Op And Non-Operative Gyn Patients ___

c. Repair Of Vaginal, Vulvar Or Cervical Lacerations ___

d. Drainage Or Removal Of Pelvic Abscess (Vaginal, Laparoscopic Or Open) ___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved
e. Placement Of Intra-Uterine Balloon Catheter To Manage Bleeding		___
f. Excision, I&D Or Surgical Management Of Vulvar Or Vaginal Lesions And Abscesses		___
g. Dilatation And Curettage, Suction Curettage, Manual Uterine Aspiration; Diagnostic Or Therapeutic, Including Abortions Up To 18 Weeks' Gestation		___
h. Cervical Cone Biopsy, LEEP Procedure		___
i. Hysterectomy, Abdominal		___
j. Hysterectomy, Vaginal		___
k. Hysterectomy, Laparoscopic-Assisted Or Total Laparoscopic		___
l. Exploratory Laparotomy		___
m. Adnexal Procedures (Open Or Laparoscopic) Such As: Salpingectomy, Salpingostomy, Oophorectomy, Ovarian Detorsion, Ovarian Cystectomy, Ovarian Biopsy, Salpingo-Oophorectomy		___
n. Myomectomy, Abdominal Or Vaginal		___
o. Incidental Appendectomy		___
p. Fistula Repairs (Vesicovaginal Or Rectovaginal)		___
q. Repair Simple Rent/ Tear Of Bowel Or Bladder		___
r. Perineoplasty, Labiaplasty		___
s. Repair Of Cystocoele, Rectocele, Enterocele		___
t. Tuboplasty		___
u. Hernia Repair (Incisional Or Umbilical)		___
v. Paracentesis		___
w. Wound Management: I&D, Skin Debridement Wound Dehiscence, Wound Closure		___
x. Cytoscopy		___
y. Hysteroscopy: Diagnostic Or Operative Including Polypectomy, Myomectomy,Adhesiolysis, Septum Removal, Endometrial Ablation		___
z. Laparoscopy, Diagnostic Or Operative Including Adnexal Procedures, Management Of Ectopic, Chromopertubation, Adhesiolysis, Biopsy, Fulgaration Or Excision Of Endometriosis, Myomectomy		___
aa. Tubal Sterilization		___
bb. Non-Hysteroscopic Endometrial Ablation Techniques		___
cc. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgical privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be for their expertise in gynecologic surgery.		___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved
24.06 EMERGENCY GYNECOLOGY AND GYNECOLOGIC SURGERY Evaluate, diagnose, treat, and provide consultation, inpatient care and pre-and post-operative care necessary to correct or treat female patients of all ages presenting urgently or already hospitalized with injuries and disorders of the female reproductive system and the genitourinary system such as ectopic pregnancy, adnexal torsion, ruptured ovarian cyst, miscarriage, reproductive infections, uterine bleeding and trauma.		___
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.		
PROCTORING: 3 observed operative procedures including at least one laparoscopy.		
REAPPOINTMENT: 15 procedures in the previous two years including at least 4 laparoscopies or laparotomies		
a. Admission Of Patients With Gynecologic Issues		___
b. Care Of Admitted Post-Op And Non-Operative Gyn Patients		___
c. Surgical And Non-Surgical Treatment Of Ectopic Pregnancy And Suspected Ectopic Pregnancy		___
d. Surgical And Non-Surgical Treatment Of Miscarriage		___
e. Placement Of Intra-Uterine Balloon Catheter To Manage Bleeding		___
f. Exam Under Anesthesia		___
g. Excision, I&D Or Surgical Management Of Vulvar And Vaginal Lesions And Abscesses		___
h. Dilatation And Curettage, Suction Curettage, Manual Uterine Aspiration; Diagnostic Or Therapeutic, Including Abortions Up To 18 Weeks' Gestation.		___
i. Exploratory Laparotomy		___
j. Diagnostic Laparoscopy, Lysis Of Adhesions		___
k. Adnexal Procedures (Open Or Laprascopic) Including: Salpingectomy, Salpingostomy, Oophorectomy, Ovarian Cystectomy, Ovarian Drilling, Ovarian Biopsy, Ovarian Detorsion, Oophoropexy		___
l. Drainage Or Removal Of Pelvic Abscess (Vaginal, Laparoscopic Or Open)		___
m. Repair Of Vaginal, Vulvar Or Cervical Lacerations And Trauma		___
n. Myomectomy, Abdominal Or Vaginal		___
o. Repair Simple Rent/Tear Of Bowel Or Bladder		___
p. Paracentesis		___
q. Wound Management: Skin Debridement, Wound Dehiscence, Wound Closure		___
r. Cystoscopy		___
s. Emergent Hysteroscopy		___
t. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgical privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be for their expertise in gynecologic surgery.		___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved
24.10 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: Currently Board Admissible, Board Certified, or Re- Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology or General Surgery.		
PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.		
REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.		
a. Fecal Occult Blood Testing (Hemoccult®)		___
b. Vaginal Ph Testing (Ph Paper)		___
c. Urine Chemstrip® Testing		___
d. Urine Pregnancy Test (Sp® Brand Rapid Test)		___
24.20 SPECIAL PRIVILEGES		___
24.21 ABORTIONS GREATER THAN 18 WEEKS' GESTATION (Also Request 24.25 To Practice In Women'S Options Center)		___
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.		
PROCTORING: 3 observed operative procedures. 2 observed operative procedures for UCSF-trained Fellows/Residents.		
REAPPOINTMENT: 10 procedures in the previous two years		
a. Abortions by dilation and evacuation at greater than 18 weeks' gestation		___
b. Intra-Fetal Or Intra-Amniotic Injection		___
24.22 LASER THERAPY		___
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Appropriate training, complete the laser safety module prepared by the SFGH Laser Safety Committee at http://insidechnsf.chnsf.org/det/HealthStream.htm and baseline eye examination within the previous 1 year.		
PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at SFGH. 2 observed procedures for UCSF-trained Fellows/Residents.		
REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at SFGH.		
a. Laser Therapy Of The Cervix		___
b. Laser Therapy Of The Vagina, Vulva, And Perineum		___

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved
24.24 UROGYNECOLOGY		___
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology.		
PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents.		
REAPPOINTMENT: 15 operative procedures in the previous two years		
a. Urodynamics		___
b. Intravesical and Intraurethral Injections		___
c. Abdominal Bladder Neck Suspension Procedures		___
d. Vaginal Bladder Neck Suspension Procedures		___
e. Vaginal Vault Suspension Procedures		___
f. Urethral Procedures: Dilation Of Urethral Stricture		___
g. Colpocleisis		___
24.25 PROCEDURAL SEDATION Procedural sedation privilege is required for those who will work in Women's Options Center.		___
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 Obstetrics and Gynecology or the American Board of Family Medicine and has completed at least one of the following: 1) Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or, 2) Management of 10 airways via BVM or ETT per year in the preceding 2 years or, 3) Current Basic Life Support (BLS) certification by the American Heart Association		
PROCTORING: Review of 5 cases. Review of 5 cases for UCSF- Fellows/Residents.		
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: 1) Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or, 2) Management of 10 airways via BVM or ETT per year for the preceding 2 years or, 3) Current Basic Life Support (BLS) certification by the American Heart Association		
24.41 GYNECOLOGIC ONCOLOGY		___

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Current certification or active participation in the examination process leading to subspecialty certification in gynecologic oncology by the American Board of Obstetrics and Gynecology PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents. REAPPOINTMENT: 15 operative procedures in the previous two years, at least 5 of which are performed at SFGH		
a. Evaluate, Diagnose, Treat, And Provide Consultation And Treatment To Female Patients With Gynecologic Cancer And Complications Resulting There From, Including Carcinomas Of The Cervix, Ovary, Fallopian Tubes, Uterus, Vulva, And Vagina And The Performance Of Procedures On The Bowel, Urethra, And Bladder As Indicated.		___
b. Radical Hysterectomy For Treatment Of Invasive Carcinoma Of The Cervix		___
c. Radical Surgery For Treatment Of Gynecologic Malignancy To Include Procedures On Bowel, Ureter, Or Bladder, As Indicated		___
d. Treatment Of Invasive Carcinoma Of Vulva By Radical Vulvectomy		___
e. Treatment Of Invasive Carcinoma Of The Vagina By Radical Vaginectomy		___
24.42 MATERNAL-FETAL MEDICINE		___
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology. Successful completion of postgraduate training program in Maternal and Fetal Medicine and current certification or active participation in the examination process leading to subspecialty certification in maternal and fetal medicine by the American Board of Obstetrics and Gynecology. PROCTORING: Observed care of 3 patients REAPPOINTMENT: Care of 20 patients in the previous 2 years		
a. Evaluate, Diagnose, Treat, And Provide Consultation Regarding Patients With Medical And Surgical Complications Of Pregnancy Such As Maternal Cardiac, Pulmonary, Metabolic, Connective Tissue Disorders, And Fetal Malformations, Conditions, Or Disease		___
b. Genetic Amniocentesis And Chronic Villus Sampling.		___
c. Level 2 Obstetrical Ultrasound, Including Doppler		___
d. Invasive Fetal Procedures, Including Cordocentesis, Intrauterine Fetal Transfusion, Cardiocentesis, And Fetal Injections.		___
e. Management Of Labor, Operative Deliveries And Postpartum Care For High-Risk Obstetric Patients, Including Use Of Pudendal Block And Local Anesthesia, If Indicated.		___
f. Treatment Of Cervical Insufficiency (Cervical Cerclage)		___
24.43 ADDICTION MEDICINE Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.		___

Delineation Of Privileges
Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and board admissible, certified or re-certified by the American Board of Obstetrics and Gynecology. Approval of the Director of the Addiction Medicine Service required for all applicants.

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

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

24.50 DUAL DEPARTMENT APPOINTMENT ___
ONLY FOR THOSE WHO DO NOT HAVE A PRIMARY APPOINTMENT IN OB/GYN
Physicians trained in specialties other than obstetrics and gynecology may apply for dual appointment in the Department of Obstetrics and Gynecology for specified privileges, assuming that training and experience in a residency, fellowship, or clinical practice can be documented.

24.51 Women's Option Center Procedures (Dual Department Appointment Only) ___

PREREQUISITES:
1. Successful completion of an ACGME accredited postgraduate training program in family medicine, internal medicine, or pediatrics
2. Current medical staff appointment to a SFGH clinical department (other than the Department of Obstetrics and Gynecology)
3. Completion of a fellowship program in family planning or documentation of training and experience in performing the requested procedures in residency, fellowship, or clinical practice. If a family planning fellowship has not been completed, clinical experience in the past 5 years of practice must include, at a minimum,

- Insertion of contraceptive implants (5 procedures)
  - Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.
  - Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.
  - Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years
- Insertion of intrauterine contraceptives (5 procedures)
- Abortions up to 18 weeks' gestation (50 procedures)
- Abortions greater than 18 weeks' gestation (50 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (15 procedures)

PROCTORING:
- Insertion of contraceptive implants (2 procedures)
  - Adequate Experience: Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.
  - Inadequate Experience: Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.
- Insertion of intrauterine contraceptives (2 procedures)
- Abortions up to 18 weeks' gestation (5 procedures)
- Abortions greater than 18 weeks' gestation (5 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (5 procedures)

REAPPOINTMENT (procedures in the past 2 years):
- Insertion of contraceptive implants (~~2 procedures~~ Review of one (1) case)
- Insertion of intrauterine contraceptives (2 procedures)
- Abortions up to 18 weeks' gestation (10 procedures)
- Abortions greater than 18 weeks' gestation (10 procedures)
- Basic obstetrical ultrasound as an adjunct to abortion (10 procedures)

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Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved
24.511 Insertion Of Contraceptive Implants (5 procedures)		___
24.512 Insertion Of Intrauterine Contraceptives (5 procedures)		___
24.513 Abortions Up To 18 Weeks' Gestation (50 procedures)		___
24.514 Abortions Greater Than 18 Weeks' Gestation (50 procedures)		___
24.515 Basic Obstetrical Ultrasound As An Adjunct To Abortion		___
24.61 LICENSED CLINICAL PSYCHOLOGIST Provide individual counseling and psychotherapy at the New Generations Health Center PREREQUISITES: Must hold a doctoral degree in Psychology from an approved APA accredited program and must be licensed by the State of California, Board of Psychology. PROCTORING: Review of 5 cases by a clinical psychologist on the SFGH Medical Staff. REAPPOINTMENT: Review of 3 cases by a clinical psychologist on the SFGH Medical Staff.		___
90.00 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings. PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants. PROCTORING: All OPPE metrics acceptable REAPPOINTMENT: All OPPE metrics acceptable		___

_____ _____

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

APPROVED BY

_____ _____

Division Chief Date

_____ _____

Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

AFF Obstetrics and Gynecology
(06/2025 MEC)

Basic Training and Education
1. Active California Registered Nurse, Nurse Practitioner, Certified Nurse-Midwife/or Physician Assistant license.
2. Successful completion of an education program, which conforms to the Board of Registered Nurses (BRN) requirements for licensure or to the Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP/CNM) or 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.
8. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center Practice Agreement Copies of Practice Agreement must be kept at each practice site for each PA.

Indicate Clinic Site(s) ___

5M Obstetrics, Midwifery, & Gynecologic Clinic ___

H22/25 Labor And Delivery/Postpartum ___

6G Women'S Options Center ___

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

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

CORE STANDARDIZED PROCEDURES ___

PREREQUISITE: Active California license, Board certification, Basic Life Support (BLS) from an approved provider, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an FNP, ANP, WHNP, OB/GYN NP, CNM or PA.

PROCTORING: Three months in length, including 3 direct observations and associated chart reviews representing each core procedure (HCM acute/urgent care, HCM well person care, HCM prenatal care, furnishing, and discharge of inpatients), with no less than 10 observations/chart reviews in total.

#1. HEALTH CARE MANAGEMENT, ACUTE/URGENT CARE ___

#2. HEALTH CARE MANAGEMENT, WELL PERSON CARE ___

#3. HEALTH CARE MANAGEMENT, PRENATAL CARE ___

#4. FURNISHING MEDICATIONS AND DRUG ORDERS ___

#5. DISCHARGE OF INPATIENTS ___

Delineation Of Privileges

AFF Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

f. MANAGEMENT OF BENIGN AND MALIGNANT BREAST CONDITIONS (RESTRICTED TO BREAST CLINIC) ___

PROCTORING: Direct observation of 3 cases and 5 chart reviews

REAPPOINTMENT: Performance of 5 chart reviews every 2 years.

SPECIAL STANDARDIZED PROCEDURES ___

#6. eCONSULT ___

PREREQUISITE: 6 months of experience in the specific specialty and are providing care to patients in the area they are reviewing, understanding of algorithms or referral guidelines used for screening, triaging and prioritizing of patients.

PROCTORING: Review of first 20 consultations. Review will be done by the consulting physician.

REAPPOINTMENT: Review of 5 eConsult consultations every 2 years.

#7. COLPOSCOPY AND CRYOTHERAPY ___

PREREQUISITE: One week course (14 hours) in theory and practice of cervical colposcopy. Certificate of course completion required.

PROCTORING: Direct observation of 25 procedures for a new provider, including 10 examinations which include biopsy and also 3 cryotherapy procedures. An experienced provider must show proof of doing 25 procedures elsewhere and be observed doing 5 colposcopies and 1 cryotherapy procedure at ZSFGH.

REAPPOINTMENT: Perform 4 procedures and 2 chart reviews every 2 years.

#8. ENDOCERVICAL POLYP REMOVAL ___

PREREQUISITE: N/A

PROCTORING: Training on site by a qualified provider or at another site with documentation of competency then direct observation of 1 procedure for both a new and experienced provider. Chart review of all observed procedures.

REAPPOINTMENT: Perform 2 procedures and 2 chart reviews every 2 years.

#9. ENDOMETRIAL BIOPSY ___

PREREQUISITE: N/A

PROCTORING: Training on site by a qualified provider or at another site with documentation of competency then direct observation of 3 procedures for a new provider and 1 procedure for an experienced provider with independent endometrial biopsy. Chart review of all observed cases.

REAPPOINTMENT: Performance of 6 procedures and 4 chart reviews every 2 years.

#10. EPISIOTOMY AND PERINEAL LACERATION REPAIR ___

PREREQUISITE: Completion of a CNM program.

PROCTORING: Concurrent observation of 3 vaginal deliveries including episiotomy and/or laceration repair with chart review of all observed cases.

REAPPOINTMENT: 5 procedures and 1 chart review every two years.

#11. ~~CONTRACEPTIVE IMPLANT INSERTION~~ INSERTION OF CONTRACEPTIVE IMPLANT ___

Delineation Of Privileges

AFF Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

PREREQUISITE: ~~Completion of training program.~~ Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING: ~~3 successful insertions for a new provider and 2 insertions for an experienced provider. Chart review of all observed cases. Proctor must be a qualified provider.~~
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: ~~Performance of at least 6 insertions with 1 chart review every 2 years.~~
Review of one (1) case in the past two (2) years.

#12. ~~CONTRACEPTIVE IMPLANT REMOVAL~~ REMOVAL OF CONTRACEPTIVE IMPLANT ___

PREREQUISITE: ~~Completion of training program.~~ Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years

PROCTORING: ~~3 successful removals for a new provider and 2 removals for an experienced provider. Chart review of all removals. Proctor must be a qualified provider.~~
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: ~~Performance of at least 6 removals with 1 chart review every 2 years.~~
Review of two (2) cases in the past two (2) years.

#13. INTRAUTERINE DEVICE INSERTION ___

PREREQUISITE: N/A

PROCTORING: Training on site by a qualified provider or at another site with documentation of competency then direct observation of 3 insertions for a new provider and 2 insertions for an experienced provider with independent IUD insertion. Observation of 3 cervical and 3 intrauterine blocks for a new provider and 2 cervical and 2 intrauterine blocks for a provider who has prior experience with independent cervical blocks. Chart review of all observed cases.

REAPPOINTMENT: Performance of 6 procedures and 2 chart reviews every 2 years.

#14. INTRAUTERINE DEVISE REMOVAL: NON-VISUALIZED STRINGS ___

Delineation Of Privileges

AFF Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

PREREQUISITE: I year experience with IUD insertions.

PROCTORING: Direct observation of 6 IUD removals of non-visualized strings. Chart review of all observed cases.

REAPPOINTMENT: Perform 6 procedures and 1 chart review every 2 years.

#15. PRE-OP EVALUATION FOR SECOND TRIMESTER ABORTION ___

PREREQUISITE: Training in paracervical blocks, mechanical dilation and osmotic dilator placement. One on one directly supervised training in mechanical dilation and dilator insertion.

PROCTORING: Direct observation of 5 procedures and 3 chart reviews. If proficiency is not demonstrated after 5 procedures, the NP/CNM/PA will continue to be proctored until competence achieved. Proctoring should be completed with in the first 6 months of initial granting of new privileges and must be completed within the first year of initial granting of new privileges.

REAPPOINTMENT: Perform 5 procedures and 2 chart reviews every 2 years.

#16. TRIGGER POINT INJECTIONS FOR PELVIC PAIN ___

PREREQUISITE: Training will be provided on site by an experienced provider.

PROCTORING: Observation of 2 injections for each site for a new provider and 1 injection for each site for an experienced provider. Chart review of all observed cases.

REAPPOINTMENT: 2 procedures and 1 chart review every 2 years.

#17. LIMITED OBSTETRIC ULTRASOUND ___

PREREQUISITE:
Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR Recent (within 5 years) experience in limited obstetric ultrasound at gestational age 30 ultrasound exams). Experience must be verified by a letter from prior institution.

PROCTORING:
Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently performing limited obstetric ultrasonography. These exams must be of gestational sacs, embryos, or fetuses at

REAPPOINTMENT:
Clinicians will be evaluated for continued competency through consultant (as per Preamble section III2b) chart review. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.

Additional consideration:
If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed.All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.

#18. LIMITED OBSTETRIC ULTRASOUND >14 WEEKS GESTATIONAL AGE ___

Delineation Of Privileges

AFF Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

PREREQUISITE:
a.Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR b.Recent (within 5 years) experience in limited obstetric ultrasound for >14 weeks' gestational age assessment (including > 30 ultrasound exams). Experience must be verified by a letter from prior institution.

PROCTORING:
Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently using limited obstetric ultrasonography to date a >14week pregnancy. For clinicians whose prerequisite was training, not documented experience, the proctoring will be consecutive and concurrent. Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review the images prior to the patient's discharge. If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Director of Obstetrics or his/her physician designee(s) within 24 hours.

REAPPOINTMENT:
Clinicians will be evaluated for continued competency through consultant chart review. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.

Additional Consideration:
If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed.All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.

#19. LIMITED OBSTETRIC ULTRASOUND: THIRD TRIMESTER ASSESSMENT OF CARDIAC ACTIVITY, PRESENTATION, AND AMNIOTIC FLUID ___

PREREQUISITE:
a.Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR b.Recent (within 5 years) experience in limited obstetric ultrasound in the third trimester (including > 30 ultrasound exams). Experience must be verified by a letter from prior institution.

PROCTORING:
Clinicians must perform a minimum of 5 ultrasounds (including fetal presentation and DVP) to demonstrate competency prior to independently performing limited third trimester obstetric ultrasonography. For clinicians whose prerequisite was training, not documented experience, the proctoring will be consecutive and concurrent. Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review the images prior to the patient's discharge.

REAPPOINTMENT:
Clinicians will be evaluated for continued competency through 1 peer chart review every 2 years.

Additional Consideration:
If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed.

#20. WAIVED TESTING ___

Delineation Of Privileges

AFF Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

PREREQUISITE: Clinical Assignment within the Community Primary Care Service

PROCTORING: Completion of quizzes for each test practitioner is performing with a score of at least 80%.

REAPPOINTMENT: Completion of required quizzes for each test and received a score of at least 80% every two years.

1. Fecal Occult Blood ___
2. Vaginal pH Testing ___
3. Urine Pregnancy ___
4. Urine Dipstick ___

#21. FIRST TRIMESTER ASPIRATION ABORTION ___

PREREQUISITE: N/A

PROCTORING: Completion of the Early Abortion Training curriculum and 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. Finally, completion of 30 procedures under direct observation.

REAPPOINTMENT: 10 procedures every 2 years. 3 chart reviews every year. Also, successful renewal of procedural sedation protocol at time of reappointment or ongoing supervision of all procedures by attending physician.

#22. PROCEDURAL SEDATION ___

PREREQUISITE: Completion of ZSFG Procedural Sedation test with passing score of 80%. Completion of registered nurse Procedural Sedation Education Module. BLS certification. Furnishing license and DEA number.

PROCTORING: Direct observation of 30 procedures for new provider and 10 for an experienced provider. Review of 30 procedure notes.

REAPPOINTMENT: 3 procedures observed by Medical Director or designee every 2 years. Completion of Procedural Sedation education module with a passing score of 80%. Maintenance of BLS certification.

#23. VULVAR SKIN BIOPSY (EXCISION, PUNCH) ___

PREREQUISITE: Onsite training

PROCTORING: Direct observation of 5 procedures, at least 2 of each type. Review of 3 charts.

REAPPOINTMENT: Chart review of 2 procedures.

#24. CNM FIRST-ASSIST FOR CESAREAN SECTION ___

Delineation Of Privileges

AFF Obstetrics And Gynecology

Provider Name:

Privilege	Status	Approved

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

One of the following:

1. Completion of the UCSF Nurse-Midwifery Education Program First-Assist for Cesarean-Section training module.
2. Surgical first-assist certification [certified registered nurse first assistant (CRNFA), certified surgical assistant (CSA), or certified surgical first assistant (CSFA)]
3. Documentation of surgical first-assist privileges (or approved standardized procedures) held at another institution within the past two years.

PROCTORING: New practitioner to procedure: 3 cases in which there are 2 surgeons present, including the OB attending who is available to directly assist the CNM. More than 3 cases may be needed per OB attending discretion. These will be followed by 3 cases in which the CNM acts independently as the first assist. Experienced practitioner must show documentation of 1st assist privilege held at another facility within the past 2 years: 3 cases in which the CNM acts independently as the first-sasist. Proctor must be an OB attending physician.

REAPPOINTMENT: 4 procedures every 2 years. Ongoing feedback will be provided by the OB attending physician as well as through the departmental quality review process.

I hereby request clinical privileges as indicated above.

_____ _____

Applicant Date

APPROVED BY

_____ _____

Division Chief Date

_____ _____

Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

Pediatrics

Provider Name:

Privilege	Status	Approved

PEDIATRICS
(06/2025 MEC & 06/2025 JCC)

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.

32.10 CORE PRIVILEGES ___
Admit, work-up and provide treatment and consultative services to pediatric patients and transitional age youth, in the ambulatory and inpatient (non-ICU) setting; including lumbar punctures.
Specifically to: Inpatients 0 to ≤ 21 years; Outpatient 0 to ≤ 24 years

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

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.11 PEDIATRIC HOSPITALIST PRIVILEGE ___
Admit, work-up and provide treatment and consultative services to pediatric patients in the ED and all inpatient settings. Privileges include diagnostic and therapeutic treatment interventions, and procedures, including lumbar puncture.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics. Current PALS certification by the American Heart Association.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.20 SPECIAL PEDIATRIC PRIVILEGES ___

32.21.1 CENTRAL LINE PLACEMENT ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or Pediatric Critical Care Medicine.

PROCTORING: Review of 3 cases.

REAPPOINTMENT: Review of 2 cases.

32.22 LASER SURGERY ___
Removal of congenital and acquired lesions (tattoos, hemangiomas, pigmented lesions)

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

PROCTORING: 2 observed procedures

REAPPOINTMENT: 2 cases in the previous two years

32.23 CIRCUMCISION ___

Delineation Of Privileges

Pediatrics

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Family Medicine. Documentation of proficiency from a Residency program with at least 5 cases, OR, documentation of previous privileges at another hospital with at least 5 cases, OR, minimum of 5 cases performed with assistance from a supervising attending with circumcision privileges, until provider and supervisor determine the provider can perform under proctoring.

PROCTORING: Direct observation of 3 independently performed cases (consecutive/concurrent).

REAPPOINTMENT: Review of 3 cases.

32.24 PROCEDURAL SEDATION ___

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics 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 pediatric airways via BVM or ETT per year in the preceding 2 years or,
- Current BLS, NRP, or PALS 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 pediatric airways via BVM or ETT per year for the preceding 2 years or,
- Current BLS, NPR, or PALS certification (age appropriate) by the American Heart Association

32.25 INSERTION OF INTRAUTERINE DEVICE (IUD) ___

PREREQUISITES: Currently board admissible, board certified or re-certified by the American Board of Pediatrics, American Board of Pediatrics in Adolescent Medicine, or special dispensation from the chief of service for equivalent training. Documentation of appropriate additional training.

PROCTORING: 2 observed procedures.

REAPPOINTMENT: 2 cases in the previous 2 years.

~~32.26 CONTRACEPTIVE IMPLANT INSERTION/REMOVAL~~32.26 INSERTION OF CONTRACEPTIVE IMPLANT ___

Delineation Of Privileges

Pediatrics

Provider Name:

Privilege	Status	Approved

~~PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Family Medicine, American Board of Internal Medicine, American Board of Obstetrics and Gynecology, or American Board of Pediatrics. Proof of completion specialized course in insertion/removal of device.~~

~~PROCTORING: Direct observation of 1 insertion and 1 removal by a qualified provider.~~

~~REAPPOINTMENT: Review of 2 insertion and 2 removal cases.~~

PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: Review of one (1) case in the past two (2) years.

32.27 REMOVAL OF CONTRACEPTIVE IMPLANT
PREREQUISITE:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years

PROCTORING:
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: Review of two (2) cases in the past two (2) years.

32.30 CARE OF NEWBORNS ___
Management of well and sick neonatal patients in conjunction with the Attending Neonatologist. Includes attendance at high-risk deliveries, neonatal resuscitation and stabilization, diagnostic and therapeutic treatment, interventions, and procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics. Current NRP certification by the American Heart Association.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

Delineation Of Privileges

Pediatrics

Provider Name:

Privilege	Status	Approved

32.40 PEDIATRIC SUBSPECIALTY PRIVILEGES ___

Patient management, including diagnostic and therapeutic treatment, procedures and interventions.

32.41 ADOLESCENT MEDICINE ___

Provide comprehensive primary preventive care, including family planning, evaluations, assessment, and management of chronic diseases common to adolescents and young adults.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Adolescent Medicine or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.42 ALLERGY AND IMMUNOLOGY ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with allergy or immunologic diseases in the ambulatory and inpatient settings. Core privileges include allergy skin testing and interpretation.

PREREQUISITES: Currently Board Admissible, Board Certified, Re-Certified by the American Board of Pediatrics or a subspecialty board of Pediatrics and the American Board of Allergy and Immunology or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.43 CHILD ABUSE ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with suspected child abuse in the ambulatory and inpatient settings. Core privileges include forensic physical and/or sexual abuse exams using colonoscopy, or other photo documentation of injuries.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Child Abuse, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.44 GENETICS ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with genetics diseases in the ambulatory and inpatient settings.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics and the American Board of Medical Genetics, or special dispensation from the chief of service for equivalent training or a member of the Service prior to 10/17/00.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.45 NEONATOLOGY/PERINATAL ___

Management of critically ill newborns including diagnostic and therapeutic treatment, procedures and interventions, umbilical arterial and umbilical venous line placement, neonatal intensive care, neonatal resuscitation, ventilator management including conventional and high-frequency ventilators, inhaled Nitric Oxide (NO), endotracheal intubation, lumbar puncture, tube thoracostomy for pneumothorax, thoracentesis, paracentesis, pericardial tube placement for pneumopericardium, surfactant administration, parenteral nutrition, bladder tap, exchange transfusion

Delineation Of Privileges

Pediatrics

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Neonatology.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.45.1 Peripherally Inserted Central Catheter (PICC) Line Placement ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or a member of Service prior to 10/17/00. Documentation of additional training/experience

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.50 PEDIATRIC CARDIOLOGY ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with cardiovascular disease; and electrocardiography interpretation including signal averaged ECG in the ambulatory and inpatient settings.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Pediatric Cardiology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.51 PEDIATRIC DERMATOLOGY ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with dermatologic diseases in the ambulatory and inpatient settings. Core privileges include skin biopsy and interpretation of results.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Dermatology in Pediatric Dermatology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.52 PEDIATRIC GASTROENTEROLOGY ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with gastroenterology diseases in the ambulatory and inpatient settings.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Pediatric Gastroenterology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.53 PEDIATRIC INFECTIOUS DISEASE ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients with infectious diseases in the ambulatory and inpatient settings.

Delineation Of Privileges

Pediatrics

Provider Name:

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics in Pediatric Infectious Disease, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.54 PEDIATRIC NEUROLOGY ___

Work-up, diagnose, consult, treat and interpret clinical findings of pediatric patients in the ambulatory and inpatient settings with neurology diseases.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology with special qualifications in Child Neurology, or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

32.70 LIMITED PRIVILEGES ___

32.71 EXAM ONLY ___

The physician shall perform exams on patients for teaching purposes for residents or medical students. The physician will have no involvement in the clinical care of patients.

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

PROCTORING: Observation of 2 teaching sessions.

REAPPOINTMENT: Observation of 2 teaching sessions.

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

Admit and follow pediatric 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

_____ _____

Service Chief Date

Zuckerberg San Francisco General Hospital

Delineation Of Privileges

AFF Pediatrics 2019

Provider Name:

Privilege	Status	Approved

AFF Pediatrics 2019
Updated 10/2024

CORE STANDARDIZED PROCEDURES ___

PREREQUISITES: Active California license, Board certification, Basic Life Support (BLS) from an approved provider, possession of a Medicare/Medical Billable Provider identifier or have submitted an application, Furnishing Number and DEA number if applicable. Must be an FNP, PNP or PA. Nurse Practitioners hired prior to 2003 will be grandfathered for requirement of Board Certification.

PROCTORING: 3 months in length or the time needed to complete 5 chart reviews with at least 1 case representing each core protocol and 1 case of direct observation that represents each core protocol. Reviewer will be the Medical Director or a physician designee.

REAPPOINTMENT: 5 chart reviews with at least 1 case representing each core protocol every 2 years. Completion of a list of Continuing Education Classes, clinical meetings attended and direct observation of care.

HEALTH CARE MANAGEMENT, ACUTE/URGENT CARE ___

HEALTH CARE MANAGEMENT. PRIMARY CARE ___

FURNISHING MEDICATIONS AND DRUG ORDERS ___

SPECIAL PROCEDURES ___

TATTOO REMOVAL ___

PREREQUISITE: Observation of 25 tattoo removal clinic sessions. Completion of laser safety module prepared by the SFGH Laser Committee and baseline eye examination within the previous 1 year.

PROCTORING: 10 cases by a provider with active privilege for tattoo removal or who has met proctoring and reappointment competency requirements as outlined in the SP.

REAPPOINTMENT: 5 procedures and 5 chart reviews every 2 years.

INSERTION OF CONTRACEPTIVE IMPLANT ~~INSERTION~~ ___

PREREQUISITE: ~~Completion of a company sponsored training class~~
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course.

Adequate Experience: Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience: Documentation of less than five (5) cases in the past two (2) years

PROCTORING: ~~3 insertion procedures for a new provider and 2 insertions for an experienced provider with 2 chart reviews.~~
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive insertion (at the right location and depth) for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive insertions (at the right location and depth) for providers with inadequate experience.

REAPPOINTMENT: ~~6 procedures and 1 chart review every 2 years.~~ Review of one (1) case in the past two (2) years.

REMOVAL OF CONTRACEPTIVE IMPLANT ~~REMOVAL~~\ ___

Delineation Of Privileges

AFF Pediatrics 2019

Provider Name:

Privilege	Status	Approved

PREREQUISITE: ~~Completion of a company sponsored training course.~~
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience.

Adequate Experience:
Documentation of greater than five (5) cases in the past two (2) years.

Inadequate Experience:
Documentation of less than five (5) cases in the past two (2) years

PROCTORING: ~~3 Removal procedures for a new provider and 2 removals for an experienced provider with 2 chart reviews.~~
Adequate Experience:
Direct observation by a qualified provider of one (1) contraceptive removal for providers with adequate prior experience.

Inadequate Experience:
Direct observation by a qualified provider of two (2) contraceptive removals for providers with inadequate experience.

REAPPOINTMENT: ~~6 procedures and 1 chart reviews every 2 years.~~ Review of two (2) cases in the past two (2) years.

INSERTION OF INTRAUTERINE DEVICE ___

PREREQUISITE: Training on site by a qualified provider.

PROCTORING: 3 insertion procedures for new provider and 2 insertion procedures for experienced provider with chart review of all observed cases.

REAPPOINTMENT: 6 insertions and 1 chart review every 2 years.

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

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

Daniel Lurie
Mayor

Medical Executive Committee (MEC)
Summary of Changes

Name of Document: SFHN Ambulatory Standing Order Protocol (SOP)

Current	Revision	Explanation for Revision
Ambulatory SOP references CDC for immunization guidance	Replace CDC with CDPH for immunization guidance to align w/ SFDPH Population Health commitment to evidence-based immunization schedule (p.6, 13, 16)	Excerpt from 1/7/26 Health Advisory: "SFDPH strongly supports the evidence-based childhood and adolescent immunization schedule recommended by the American Academy of Pediatrics (AAP) and endorsed by the California Department of Public Health (CDPH) and West Coast Health Alliance. Despite federal changes on January 5, 2026 overhauling the U.S. childhood immunization schedule, California's recommended schedule remains unchanged, including immunization requirements for school and childcare entry. In September 2025, California state law was updated to ensure that our state's immunization policies continue to align with evidence-based standards and the recommendations of professional medical groups like the AAP."

		EZIZ.org (VFC/VFA vaccine website) also references CDPH.

San Francisco Health Network (SFHN) Clinics
Date Adopted: July 2019
Last Review/Approval Date: June 2025

SFHN Ambulatory Care Clinics Combined Standing Order Protocols for Health Care Maintenance and Chronic Disease Management

STATEMENT OF POLICY:
The ZSFG Medical Staff policy regarding Standing Order Protocols (SOPs) for Health Care Maintenance and Chronic Disease Management is that it must be renewed annually by the designated primary care provider or ambulatory care provider of record. Specifically, SOPs enable authorized staff members with appropriate training to apply SOPs applicable to the patient's visit type and care delivery site/ setting, in order to complete panel management in-reach and outreach activities.

1. SFHN Ambulatory Care Clinics allow appropriately trained clinical staff to follow Standing Orders when the order meets the following criteria:
    a. Describes a specific patient-care task;
    b. Describes patient-related criteria required to qualify for task; and
    c. Defines a time period during which task may be performed.

2. The Standing Order is initiated and/or checked as received and reviewed in the medical record by the supervising provider or Clinical Leadership annually. All requisitions to the laboratory, x-ray, or other services are made under the name of the supervising/treating or primary clinician.

3. All staff will be oriented/trained to the Standing Order protocols prior to generating or executing standing orders for any patient, using available standard work documents. The Clinical Leadership of each clinic site/department must document staff who have been appropriately trained and achieved competency on completing aspects of the Standing Order Protocol. The Clinical Leadership is also responsible for assuring compliance and adherence of staff to the standing order protocols.

4. The Standing Orders described in this document reflect the boundaries of the scope of practice of Medical Assistants as described in the regulations of the Medical Board of California that state, “Medical Assistants are not allowed to read, interpret or diagnose symptoms or test results.” The Standing Orders described in this document for Ophthalmology/Optometry management reflect the boundaries of the scope of practice of Allied Ophthalmic Personnel (AOP) as described in the regulations of the International Joint Commission on Allied Health Personnel in Ophthalmology (IJCAHPO), “AOP may not diagnose or treat eye disorders and may not prescribe medications; they are not independent practitioners.” In the SFHN Ophthalmology

clinic, AOP refers to Certified Ophthalmic Assistant, Certified Ophthalmic Technicians, Certified Ophthalmic Medical Technologists, Registered Ophthalmic Ultrasound Biometrists, and Certified Diagnostic Ophthalmic Sonographers.

5. All immunizations or other medications given by non-licensed staff require documented verification by a licensed clinician (MD, DO, NP, CNM, PA, RN).

6. Newly created Standing Orders will be reviewed and approved to assess safety, and congruence with approved clinical guidelines. Standing Orders will be reviewed annually, and more frequently whenever corresponding clinical guidelines and best practices are revised. Departments sponsoring Standing Orders are responsible for the annual review of those Standing Orders.

7. Authorized staff members with appropriate training includes DPH/UCSF clinical staff (Registered Nurses, Licensed Vocational Nurses, delegated Medical Evaluation Assistants, Allied Ophthalmic Personnel, and delegated Health Workers) and Clinical support volunteer staff, as defined in the ZSFG Volunteer Policy Appendix F. While appropriately trained clinical staff members can complete all of the elements in the standing order protocol, appropriately trained Clinical support volunteer may only order diagnostic imaging and blood tests that are prompted by the Care Gaps section of EPIC.

8. Definitions
   - *Licensure:* refers to a restricted practice requiring a vetting process by which individuals are deemed qualified to perform that practice and are thus *licensed*. Certain clinical staff members are licensed by the State of California to perform defined patient-care activities.
   - *Standing Order:* an order for a specific set of patient-care activities that may be applied to any patient meeting certain criteria during a defined time period.
   - *Abbreviations Used:* Registered Nurse (RN), Licensed Vocational Nurses (LVN), Medical Evaluation Assistant (MEA), Health Workers I-IV (HW)

PROCEDURE FOR SFHN ADULT PRIMARY CARE:

ABDOMINAL AORTIC ANEURYSM SCREENING	For men aged 65-75, who have ever smoked, order a "vascular ultrasound abdominal aortic aneurysm screening evaluation" if no abdominal imaging done (ultrasound; CT with or without contrast; or MRI with or without contrast) between ages 65-74.
BREAST CANCER SCREENING	For a woman aged 40-74, authorized staff members with appropriate training will do the following: 1. If last mammogram > 18 months, order mammogram
CERVICAL CANCER SCREENING	For a patients with a cervix > 21, authorized staff members with appropriate training will do the following: 1. For patients aged 21-29, if last cytology test (PAP) > 33 months, verify with provider whether a PAP is indicated and if indicated, determine whether PAP will be done at the same visit or at a future visit. If PAP will be done at same visit, set up PAP tray and order "PAP cytology exam." If PAP will be done at a future visit, schedule patient for PAP as appropriate. 2. For patients > age 30, if last PAP > 57 months with HPV co-test or >33 months without HPV co-test, verify with provider whether a PAP is indicated and if indicated, determine whether PAP will be done at the same visit or at a future visit. If PAP will be done at same visit, set up PAP tray and order "PAP cytology exam" and " Human Papillomavirus (HPV), High Risk Genotype by PCR." If PAP will be done at a future visit, schedule patient for PAP as appropriate.
CHOLESTEROL SCREENING	Authorized staff members with appropriate training will do the following: Order lipid panel[6] 1. If male and aged 35 and older OR women aged 45 and older 2. If male aged 20-35 or female 20-45, AND with one of the following cardiovascular risk factors: a. Diabetes. b. Previous personal history of CHD or non-coronary atherosclerosis (e.g., abdominal aortic aneurysm, peripheral artery disease, carotid artery stenosis). c. A family history of cardiovascular disease before age 50 in male relatives or age 60 in female relatives. d. Tobacco use. e. Hypertension. f. Obesity (BMI ≥30)
CHRONIC CONTROLLED	If a patient presents requesting refills of controlled medications, Authorized staff members with appropriate training will do the following:

MEDICATION USE	1. If no Utox in last 10 months, order Utox
CHRONIC KIDNEY DISEASE SCREENING	Authorized staff members with appropriate training will order the following for patients aged 18 and older: 1. With a diagnosis of diabetes: a basic metabolic panel and a urine microalbuminuria if not completed within the prior 10 months 2. With a diagnosis of hypertension: a basic metabolic panel and urine microalbuminuria if not completed within the prior 10 months 3. With an estimated glomerular filtration rate (eGFR) < 60: a urine microalbuminuria if not completed within the prior 10 months
COLORECTAL CANCER SCREENING	For a patient aged 45-75, authorized staff members with appropriate training will review the care gap for guidance and do the following: 1. If colonoscopy within 10 yrs → Review last colonoscopy for recommendations on interval screening to confirm screening is up to date. If there is no recommendation about when to complete the next colonoscopy, refer to provider. 2. If colonoscopy > 10 yrs OR if FOBT/FIT >10 months OR if No FOBT/FIT → Order and offer FIT 3. If No colonoscopy AND if (FOBT/FIT >10 months or No FOBT/FIT) → Order and offer FIT
CONGESTIVE HEART FAILURE CARE	Authorized staff members with appropriate training will obtain an O2Sat
COPD/ASTHMA CARE	Authorized staff members with appropriate training will obtain an O2Sat
DEPRESSION SCREENING	Authorized staff members with appropriate training will do the following: If last PHQ2 is >10 months old, complete PHQ-2 screening questions and enter results into EHR
DIABETES SCREENING	Authorized staff members with appropriate training will order an A1c for the following patients 1. For patients who have a history of prediabetes, order A1c if no A1c has been done in the past 10 months 2. For patients who do not have a history of prediabetes a. Age ≥ 45, order A1C if not done in the past 30 months b. Age 18-44, order A1C if not done in the past 30 months and if patient has a BMI of ≥ 23
DIABETES MANAGEMENT	Authorized staff members with appropriate training will do the following: 1. If last A1c > 10 months (or at an interval per local clinic program protocol), order A1c 2. If last metabolic panel > 10 months, order serum metabolic panel 3. If last urine microalb/Cr (UACR) > 10 months, order urine microalb/Cr (UACR) 4. Review CareGap active for Teleretinal Screening 5. If clinic has a TRS camera, and no future appointment already scheduled with 4M, place order and complete teleretinal imaging. 6. If clinic does not have a TRS camera, refer to 4M for teleretinal screening.

	7. If last foot exam > 10 months: a. Perform Monofilament Test. b. Record MFT test results in EHR. c. If result is abnormal, refer to Podiatry
DYSURIA	If patient presents with complaint of dysuria, order a point of care urinalysis
HIV+ CARE	Authorized staff members with appropriate training will do the following: 1. If newly diagnosed HIV+, order the following labs if never documented: a. Blood tests: hepatitis A antibody, hepatitis B core IgG, surface antibody and antigen, hepatitis C antibody HLA-B*5071, Syphilis test, HIV Genotype WITH Integrase resistance, HIV Viral Load, Toxo IgG, G6PD, CD4 b. For women: Vaginal (clinician or self-collected) swab for GC/CT and trichomoniasis NAAT c. For heterosexual men: Urine GC/CT d. For MSM: Urine, pharyngeal and rectal GC/CT 2. Order CBC w/ Platelets (if ≥ 3 mos after last), CD4 T Cells (if ≥ 3 mos after last), HIV Viral Load (if ≥ 3 mos after last), fasting Lipid Panel (if ≥ 10 mos after last), Syphilis test (if ≥ 3 mos after last), HIV-1 Genotype (if ≥ 10 mos after last), Quantiferon (if ≥ 10 mos after last), CMP (if ≥ 3 mos after last), GC/CT (if ≥ 6 mos after last), Hgb A1c (if ≥ 10 mos after last), Urinalysis (if ≥ 10 mos after last), Urine Microalbumin (if ≥10 mos after last) 3. If patient was never given MCV (Meningococcal Vaccine/Menactra), give 2 doses of MCV 8-12 weeks apart (previously vaccinated persons who received only one dose should receive a 2nd dose at the earliest opportunity, even if longer than 12 weeks). A booster dose should be given every 5 years. 4. Page the PHAST team to discuss immediate initiation of ART: 415-443-3892 5. Contact the SFDPH LINCS team to refer patient for partner services: 415-487-5506
HIV SCREENING	Authorized staff members with appropriate training will do the following: 1. If EHR does not contain any prior HIV test result, order "HIV 1/2 ANTIBODY" 2. If patient is at increased risk for HIV[4], order "HIV 1/2 ANTIBODY" if last done > 10 mo ago
HEPATITIS B SCREENING	Authorized staff members with appropriate training will do the following: If a patient is age > 18 years old order "Hepatitis B HBV Surface Antigen" AND "Hepatitis B HBV Surface Antibody" AND "Hepatitis B Total HBV Core Antibody" if not previously done.
HEPATITIS C SCREENING	Authorized staff members with appropriate training will do the following: 1. If a patient is age ≥18 years old AND EHR does not contain any prior

	result of "HEPATITIS C HCV ANTIBODY," order "HEPATITIS C HCV ANTIBODY." 2. If a patient is pregnant AND EHR does not contain any prior result of "HEPATITIS C HCV ANTIBODY," during current pregnancy, order "HEPATITIS C HCV ANTIBODY."
IMMUNIZATIONS	The RN/LVN or delegated MEA/HW under the supervision of a provider administers immunization per CDPH's Immunization Recommendations~~CDC's Adult Immunization Schedule as found on www.cdc.gov~~. All nursing staff are expected to know the contraindications of all immunizations offered at Zuckerberg San Francisco General and the Community Primary Care Clinics. The RN/LVN or delegated MEA/HW will complete the following steps before administering immunizations: i. Reviews vaccination due in the Electronic Health Record (EHR) at time of visit. ii. Verifies vaccinations to be administered. iii. Gives patient Vaccination Information Sheet (VIS). iv. Checks chart, immunization card, EHR to verify the patient's immunization history. v. Completes the Screening Questionnaire for Adults vi. Reviews the completed Screening Questionnaire for contraindications before administering immunizations. vii. Obtains patient's oral agreement prior to administering immunizations after VIS given. viii. If any questions or concerns about administering immunizations, contacts Charge Nurse or provider. ix. Delegated MEA/HW has licensed clinician verify immunizations prior to administering, per clinic workflows.
MEDICAL DETOXIFICATION	If a patient presents for medical detoxification initial assessment, authorized staff members with appropriate training will do the following: 1. Order CBC w/ plt and diff, CMP, PT/INR 2. If no PPD or QFT w/i last 12 mos, order QFT or place PPD 3. If previous PPD+ or QFT+, AND no CXR w/i last 12 mos, order CXR PA+LAT 4. If female aged 18-50, order UPreg
PHARMACY PANEL MANAGEMENT	The clinical pharmacist can initiate or adjust medications for this patient according to the San Francisco Health Network Standardized Procedure for Ambulatory Care Clinical Pharmacist.
PrEP (Pre-Exposure Prophylaxis) LABS	Authorized staff members with appropriate training will do the following: Order PrEP Initial Labs during patient intake appointment: HIV Ab/Ag, HIV viral load, HBsAg, HBsAb, HBcAb, Hepatitis C ab, Hepatitis A total ab, CMP, Syphilis test, UPreg,

	i. For women: Vaginal (clinician or self-collected) swab for GC/CT and trichomoniasis NAAT ii. For heterosexual men: Urine GC/CT iii. For MSM: Urine, pharyngeal and rectal GC/CT Order PrEP Follow-Up Labs while on PrEP (≥ 3 months after last): HIV Ab/Ag, BMP, UPreg, Syphilis test, i. For women: Vaginal (clinician or self-collected) swab for GC/CT and trichomoniasis NAAT ii. For heterosexual men: Urine GC/CT iii. For MSM: Urine, pharyngeal and rectal GC/CT; HCV ab (if >10 mo since last)
PREGNANCY INTENTION SCREENING	For a woman aged 12-50 (or post menarche and pre menopause) authorized staff members with appropriate training will confidentially ask: 1 Last menstrual period 2 Would you like to be tested for pregnancy today? 3 If yes, perform a urine pregnancy test if patient agrees or requests; report result to the provider.
STI SCREENING	Authorized staff members with appropriate training will do the following: Obtain and document a confidential phone number for any patient age <25 *All sexually active people ≥ 12 - ≤ 50 years of age who could become pregnant:* • Syphilis if no record of prior test (if at increased risk*, test if last done >10 mo) *Sexually active women < 25 years of age:* • Urine or vaginal gonorrhea (GC) and chlamydia (CT) if last done >10 mo • HIV if no record of prior test (if at increased risk*, test if last done >10 mo) *Sexually active women ≥ 25 years of age and at increased risk for STIs** • Urine or vaginal gonorrhea (GC) and chlamydia (CT) if last done >10 mo • HIV if last done >10 mo • Syphilis if last done >10 mo *Sexually active men who have sex with women < 25 years of age and at increased for STIs** • Urine gonorrhea (GC) and chlamydia (CT) if last done >10 mo • HIV if last done > 10 mo

	• Syphilis if last done >10 mo
	
	*Sexually active men who have sex with women ≥ 25 years of age and at increased for STIs**
	• HIV if last done > 10 mo
	• Syphilis if last done >10 mo
	
	Sexually active men who have sex with men
	• HIV if last done > 10 mo
	• Syphilis if last done > 10 mo
	• GC and CT from all sites of exposure if last tested > 10 mo ago
	  ○ Urine if insertive anal sex or received oral sex in the last 12 months
	  ○ Pharyngeal swab if performed oral sex on a penis in the last 12 months
	  ○ Rectal swab if receptive anal sex in the last 12 months
	
	Sexually active transgender people
	• HIV if last done > 10 mo
	• Syphilis if last done > 10 mo
	• Offer GC and CT screening based on current anatomy and sites of exposure
	  ○ Urine if has a penis and insertive anal sex or received oral sex in the last 12 months
	  ○ Pharyngeal swab if performed oral sex on a penis in the last 12 months
	  ○ Rectal swab if receptive anal sex in the last 12 months
	  ○ Vaginal swab or urine if has a cervix and had receptive vaginal (front hole) sex in last 12 months
	
	Sexually active people living with HIV
	• Syphilis if last done > 10 mo
	• Offer GC and CT screening based on current anatomy and sites of exposure
	  ○ Urine if has a penis and insertive anal sex or received oral sex in the last 12 months
	  ○ Pharyngeal swab if performed oral sex on a penis in the last 12 months
	  ○ Rectal swab if receptive anal sex in the last 12 months
	  ○ Vaginal swab or urine if has a cervix and had receptive vaginal (front hole) sex in last 12 months
	
	Note: Vaginal, rectal, and throat swabs can be self-collected by the patient. If patient chooses to do self-collection, provide them with the appropriate multi-site swab and instructions on self-collection (Throat swab - Engl, Span or Rectal swab - Engl, Span)
	https://www.sfcdcp.org/wp-content/uploads/2018/01/Chlamydia-

	Gonorrhea-TMA-SFDPH-FINAL-01.19.2021.pdf Swab instruction (English visuals): • http://www.sfcityclinic.org/providers/VaginalSwab_ENG.pdf • http://www.sfcityclinic.org/providers/PharyngealSwab_ENG.pdf • http://www.sfcityclinic.org/providers/RectalSwab_ENG.pdf Patient instructions in Spanish are available on the SFCC website: http://www.sfcityclinic.org/providers/#SelfCollection **Sex with a man who has sex with men, history of STI in the past year, contact with sex partner with HIV/STI, methamphetamine use, non-prescribed opiate use, unstable housing or homelessness, sex work, intimate partner violence, or incarceration.*
TB SCREENING	If a patient meets one of the following criteria[2]: a. Foreign born (except Canada and Australia) b. Marginally housed or homeless c. Has diabetes d. Current or former tobacco smoker e. HIV positive f. Immunosuppressed g. Requirement by program/school/employment Authorized staff members with appropriate training will do the following: a. If EHR does not contain any prior result of "Quantiferon TB" OR "PPD", order "Quantiferon TB Gold In-Tube" or place PPD b. If TB screening is for annual requirement by program/school/employment AND no previous +PPD or +QFT, order "Quantiferon TB Gold In-Tube" or place PPD if none in last 12 months; if previous PPD+ or QFT+, AND no CXR w/in last 12 mos, order CXR PA+LAT
THYROID DISEASE CARE	Authorized staff members with appropriate training will do the following: 1. If new patient at initial encounter with known thyroid disease, order TSH with reflex to FT4
TRANSGENDER/MSM CARE	For transgender patients interested in hormonal reassignment of gender, authorized staff members with appropriate training will do the following: 1. Order baseline labs[7]: CBC with differential, CMP, glucose, hepatitis A antibody, hepatitis B surface antibody and antigen, hepatitis C antibody, Syphilis test, lipid profile, prolactin level (for MTF), HIV antibody, Quantiferon (TB blood test), urine GC/CT 2. MSM and Transgender persons who have sex with men: If patient was never given MCV (Meningococcal Vaccine/Menactra), give 2 doses of MCV 8-12 weeks apart (previously vaccinated persons who received only one dose should receive a 2nd dose at the earliest opportunity,

	even if longer than 12 weeks). A booster dose should be given every 5 years. 3. MSM and Transgender persons who have sex with men: If patient was never given MPOX vaccine, give 2 doses of MPOX 4 weeks apart.

APPENDIX:

1. American College of Obstetricians and Gynecologists (ACOG)
2. "New Guidelines for TB Infection Screening, Treatment, and Referrals to the SF TB Clinic," Julie Higashi, MD PhD, TB Controller, Disease Prevention and Control Branch, Population Health Division, San Francisco Department of Public Health, Summer 2013
3. Increased risk for HIV: anal intercourse without a condom, having vaginal intercourse without a condom and with more than 1 partner whose HIV status is unknown, exchanging sex for drugs or money (transactional sex), having other sexually transmitted infections (STIs) or a sex partner with an STI, and having a sex partner who is living with HIV or is in a high-risk category.
   Increased risk for gonorrhea or chlamydia: Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.
   Increased risk for syphilis: women who have sex with men who have sex with men, STD in the past year, sex work, methamphetamine use, homelessness, or incarceration. Syphilis Infection in Non-pregnant Adults and Adolescents: Screening U.S. Preventive Services Task Force/ June 7th, 2016
4. American Diabetes Association 2020
5. *Final Update Summary: Lipid Disorders in Adults (Cholesterol, Dyslipidemia): Screening*. U.S. Preventive Services Task Force. July 2015.
6. Protocols for Hormonal Reassignment of Gender, Tom Waddell Health Center, 05/07/13

PROCEDURE FOR SFHN AMBULATORY SPECIALTY CARE:

In addition to Standing Order Protocols for Primary Care, the following may apply to specific specialty care clinics.

CARDIOLOGY MANAGMENT	Authorized staff members with appropriate training will do the following: 1. Obtain O2 Sat on all patients each provider visit 2. Perform ECG on the following patients: a. New Cardiology Clinic patients at initial visit b. All visits in Electrophysiology Clinic c. Patients with new complaint of acute chest pain 3. Annually for all patients with heart failure to screen for left bundle branch blockOrder Chest x-ray (PA and lateral) for new pacemaker patients, one-week post implant. 4. Metabolic panel, CBCs, PT/INR on all patients prior to the following procedures: a. Cardiac catheterization b. Transesophageal echocardiogram c. Cardioversion d. Pacemaker implants
CHRONIC KIDNEY DISEASE SCREENING	Authorized staff members with appropriate training will order the following: 1. With a diagnosis of diabetes: a basic metabolic panel and a urine microalbuminuria if not completed within the prior 10 months 2. With a diagnosis of hypertension: a basic metabolic panel and urine microalbuminuria if not completed within the prior 10 months 3. With an estimated glomerular filtration rate (eGFR) < 60: a urine microalbuminuria if not completed within the prior 10 months
CONTRACEPTION COUNSELING	For a woman aged 12-50 (or post menarche and pre menopause), authorized staff members with appropriate training will confidentially ask: "Would you like to become pregnant in the next year?" 1. If no, refer patient to a trained staff member to discuss options for pregnancy prevention 2. If yes, refer patient to a trained staff member to provide preconception counseling
DIABETES SCREENING	Authorized staff members with appropriate training will order an A1C for the following patients: 1. For patients who have a history of prediabetes, order A1c if no A1c has been done in the past 10 months 2. For patients who do not have a history of prediabetes a. Age ≥ 45, order A1C if not done in the past 30 months b. Age 18-44, order A1C if not done in the past 30 months and if patient has a BMI of ≥ 23
DIABETES MANAGEMENT	Authorized staff members with appropriate training will do the following: 1. If last A1c > 3-4 months, order A1c

	2. Obtain POCT blood glucose test for new and established patients at every diabetes clinic visit. 3. If last urine microalbumin/Cr > 10 months, order urine microalbumin/Cr 4. If last serum metabolic panel > 10 months, order serum metabolic panel 5. If last foot exam > 10 months Perform Monofilament Test. 6. If last diabetes retinal eye exam > 10 months, place order for referral for diabetic retinal screen
OPHTHALMOLOGY/ OPTOMETRY MANAGEMENT	Authorized staff members with appropriate training will do the following: 1. Review patient's Electronic Health Record prior to clinic. 2. Verify ophthalmic diagnostic orders (appendix A and appendix B) that need to be performed for the visit according to standard work. 3. Place ophthalmic diagnostic order on behalf of the appropriate clinician. Note that ALL ophthalmic diagnostic orders that are ordered by AOP require documented verification by a licensed clinician (MD/OD/DO). 4. Complete diagnostic tests accordingly. 5. Document finding(s) in the electronic health record.
PREGNANCY TESTING	Authorized staff members with appropriate training will order a urine pregnancy test for patients under the following circumstances: 1. Requested by the patient (women of all ages). 2. If the patient is missing monthly menses. 3. If the patient is scheduled for dental surgery with anesthesia 4. If the patient is starting or continuing a teratogenic drug. 5. If the patient is having a uterine or cervical procedure 6. before initiating contraception, unless healthcare provider reasonably certain patient is not pregnant. 7. If the patient is being seen in Reproductive Endocrinology and Infertility (REI) Clinic.
PULMONOLOGY MANAGEMENT	Authorized staff members with appropriate training will do the following: 1. Obtain O2 Sat on all patients each provider visit 2. Ambulatory/exertional oximetry testing a. All patients annually b. All Patients needing O2 prescription or prescription renewals c. All patients with O2 Sat of <94% on RA or < 94% on O2 as currently ordered d. O2 can be applied temporarily and titrated for testing on patients who do not have a current O2 order. Initiate O2 at 2 liters via nasal cannula or simple mask and titrate as necessary to maintain O2 Sat > = 94%
RADIOLOGY patients	Authorized staff members with appropriate training will do the following: 1. CT with Contrast Studies: Serum Creatinine and GFR if none in chart within 45 days of contrast study date.

REFERENCES

1. CDPH's Immunization Recommendations~~CDC Adult Immunization Schedule (www.cdc.gov)~~

2. One Key Question (Frayne DJ, Verbiest S, Chelmow D, et al. Health Care System Measures to Advance Preconception Wellness: Consensus Recommendations of the Clinical Workgroup of the National Preconception Health and Health Care Initiative. Obstetrics & Gynecology. 2016;127(5):863-872. doi: 10.1097/AOG.0000000000001379)

3. American College of Obstetricians and Gynecologists (ACOG)

4. Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.

5. American Diabetes Association (ADA) 2017 Guidelines

6. Final Update Summary: Lipid Disorders in Adults (Cholesterol, Dyslipidemia): Screening. U.S. Preventive Services Task Force. July 2015.

7. Adapted from Centers for Medicare and Medicaid Guidelines. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Oxygen-Therapy-Text-Only.pdf

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Appendix A Ophthalmic Diagnostic Orders

1. OPTICAL COHERENCE TOMOGRAPHY (OCT) – LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)
   A. OCT MACULA
   B. OCT RNFL
   C. ANTERIOR SEGMENT OCT
   D. OCT OPTIC NERVE
   E. OCT-ANGRIOGRAPHY
2. VISUAL FIELD – LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)
   A. HUMPHREY VISUAL FIELD (30-2, 24-2, 10-2, SUPERIOR 36)
   B. AUTOMATED VISUAL FIELD (DYNAMIC VISUAL FIELD, GOLDMANN VISUAL FIELD)
3. OPTICAL BIOMETRY- LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)
4. ULTRASOUND – LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)
   A. A-SCAN (A-SCAN BIOMETRY, IMMERSION A-SCAN, DIAGNOSTIC A-SCAN, CONTACT A-SCAN)
   B. B-SCAN (ULTRASOUND BIOMICROSCOPE(UBM), POSTERIOR B-SCAN, ANTERIOR B-SCAN)
5. POSTERIOR PHOTO – LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)
   A. COLOR FUNDUS PHOTO
   B. OPTIC DISC PHOTO –STEREO, NON-STEREO
   C. FUNDUS AUTOFLUORESCENCE
   D. TELERETINAL SCREENING PHOTOGRAPHY
6. EXTERNAL PHOTO – LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)
   A. SLIT LAMP PHOTO
   B. EXTERNAL PHOTO
7. TOPOGRAPHY – – LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)
8. FLUORESCEIN ANGIOGRAPHY -– LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)*
9. ICG ANGIOGRAPHY – LEFT EYE (OS), RIGHT EYE (OD), BOTH EYES (OU)*

*only the component of image orders is included in this protocol.

Appendix B Ophthalmic Diagnostic Order Sets for Sub-Specialty Clinics in Ophthalmology

All patients who are scheduled in the following sub-specialty clinic or for the following visit reason in ophthalmology will need the following diagnostic tests according to clinic protocol, unless indicated otherwise.

1. Retina Sub-Specialty
   A. Surgical Retina Clinic
      1) Diabetic Patients
         - Color Fundus Photo
         - OCT Macula
      2) Non-Diabetic Patients
         - OCT Macula
   B. Medical Retina Clinic
         - OCT Macula
2. Laser 3 and all other visits for intravitreal injection or possible intravitreal injection
         - OCT Macula
3. Diagnostic Testing for Biometry
         - Optical Biometry
         - Topography
         - A-Scan Biometry if unable to obtain axial length in optical biometry, or axial length difference equal or greater than 0.3mm in optical biometry.
4. Neuro-Ophthalmology Clinic
         - VISUAL FIELD
         - OCT Macula
         - OCT RNFL
         - COLOR FUNDUS PHOTO
5. Pre-Op and Post-Op for Pterygium excision
         - Topography
         - Slit Lamp Photo
6. Pre-op for Ptosis
         - Humphrey Visual Field – Superior 36 (Ptosis Field)
         - External Photo
7. Diabetic Retinal Screening Clinic
         - Teleretinal Screening Photography

PROCEDURE FOR SFHN PEDIATRIC PRIMARY CARE:

In addition to Standing Order Protocols for Primary Care, the following may apply to specific primary care clinics.

PROCEDURE:

ANEMIA SCREENING	The authorized staff with the appropriate training will screen for **anemia** once between ages 9-18 mo and once between ages 2yo-3 yo, hemoglobin (hemocue) can be performed annually for participants of the WIC program (ie 3-5yo).
FLUORIDE VARNISH	The authorized staff with appropriate training will apply up to 0.1 ml fluoride varnish to any child with erupted teeth at every visit, up to four times a year, through the 6th birthday after obtaining verbal consent from the guardian.
IMMUNIZATION	The authorized staff with the appropriate training under the supervision of a provider administers **immunization** per Zuckerberg San Francisco General recommendations (see attached; based on annual CDPH Immunization Recommendations~~CDC guidelines as found on eziz.org~~). All nursing staff are expected to know the contraindications of all immunizations offered at Zuckerberg San Francisco General and the Community Primary Care Clinics
LEAD	Screen for **lead** once after the first birthday (typically at 12mo WCC visit) and once again between the 2nd and 5th birthdays.

TB SCREENING	The authorized staff with appropriate training conducts TB risk factor screening annually and documents the result in the medial record and on required paper forms.
	• **TB SCREENING** is considered positive if a patient meets one of the following criteria:
	  ○ Birth, travel or residence in a TB endemic area (outside of US, Canada, Australia, New Zealand, Western or Northern Europe) for >1 month since last screening
	  ○ Has had a household member with confirmed active TB since the last screening
	  ○ Confirmed HIV positive
	  ○ Starting or currently on immunosuppression therapy
	• If the TB SCREENING is positive, authorized staff will:
	  ○ If EHR does not contain any prior result of "Quantiferon TB" OR "PPD", order "Quantiferon TB Gold In-Tube" for patients born outside of the United States or place PPD for patients born in the United States.
	  ○ If there is documentation of previous PPD+ or QFT+, AND no CXR within the last 12 months, order CXR PA+LAT
	• If authorized staff with appropriate training suspects the patient is at risk but is unsure about risk level or which test to order/perform, they should check with provider for that visit.
	• All nursing staff are expected to know the contraindication of placing a PPD (there are no true contraindications of placing a PPD, but it should not be done in someone with a prior positive PPD, history of tuberculosis, active rash on arms, born outside of the United States, or

	receipt of MMR vaccine <4 weeks before).
TEEN SCREENING/STI SCREENING	**Teen Screening (ages 12-17):** The following SOPs are protected to the teen patient and should not be performed in front of a guardian/caregiver. • The authorized staff with the appropriate training shall collect Urine dip (clean catch) for females > 12 years old with symptoms of dysuria, urgency or frequency, • The authorized staff with the appropriate training shall perform a urine pregnancy test at patient request or if >age 12 and responds yes to the question, "Could you be pregnant today?" and will report any positive result to the provider. • **STI SCREENING**: o Obtain and document a confidential phone number. o If patient aged >= 15yo regardless of sexual activity ▪ Order urine or vaginal* GC/CT if last done >10 mo, obtain sample, and send ▪ If EHR does not contain any prior HIV test result, order "HIV 1/2 ANTIBODY/ANTIGEN", obtain sample, and send. o If aged >12 and sexually active: ▪ Order urine or vaginal* GC/CT if last done >10 mo, obtain sample, and send ▪ If EHR does not contain any prior HIV test result, order "HIV 1/2 ANTIBODY/ANTIGEN", obtain sample, and send. o Additional STI screening per provider discretion
Transcutaneous bilirubin	Obtain a Transcutaneous Bilirubin (TcB) using a Trancutaneous Bilimeter at Newborn visits for neonates through the first 14 days of life for all visits and up to 28 days of life when requested.

PROCEDURE FOR SFHN PERINATAL CARE:

In addition to Standing Order Protocols for Primary Care, the following applies to clinics providing perinatal care.

Prenatal Decision Support Tool and Standing Orders – Designed to facilitate initiation of Prenatal duties by authorized staff with the appropriate training when patients come for a Prenatal intake and/or appointment with an ObGyn/Prenatal provider without requiring a direct MD order.

Gestational age	Name of test or Vaccination	Testing Frequency/Situation	Referrals/Education
At any gestational age at OB intake visit or earliest possible prenatal visit	Initial Labs: ○ ABO/Rh Blood Type and Screen ○ CBC ○ Ferritin ○ Syphilis test ○ Rubella antibody IgG ○ Varicella antibody IgG ○ Hepatitis B surface antibody, Hepatitis B surface antigen, and Hepatitis B core antibody if not previously documented.Hepatitis C Antibody ○ HIV ½ Antibody and Antigen ○ Hemoglobin A1c ○ Urine Culture ○ Chem 7 urine dip ○ Quantiferon if positive TB risk assessment by CDPH Risk Assessment Tool (link) Gonorrhea (GC) and Chlamydia (CT)	Once Perform only if not already documented in chart	○ Refer to Genetic Counseling for Advanced Maternal Age (AMA) ○ Refer to Genetic Counseling for 1+ "YES" answer from genetic questionnaire on California Prenatal Screening Program (CPSP care plan) ○ Complete CPSP Orientation within 30 days of prenatal care initiation. ○ Complete initial CPSP Assessments for Nutritionist (30 Min), Psychosocial (30 min), Health Education (30 min), minimum required time per California Perinatal Services Program (CPSP) ○ Refer to US – dating, NT (11-14 2/7 weeks), Fetal survey (18-20 weeks.) ○ WIC Referral ○ Dental Referral ○ Assess dependent care needs and appointment navigation. ○ PHN/BIH/SisterWeb Doula Referral ○ Refer to RD if initial A1c 5.7-6.4
	Early GLT	Within one week of results if initial hemoglobin A1c 5.7-6.4. If entering care >35 weeks consult provider to individualize care.	
	NIPT (cell free fetal DNA genetic screening), carrier screening if indicated	Once at >10 weeks gestational age.	
	Prenatal Vitamins	Dispense as needed throughout the pregnancy. 1 tablet daily throughout pregnancy and post-partum	

	Vaccinations:		
	COVID-19	At any gestational age if not up to date	
	Hepatitis A series	Complete series if ~~Hep A non-immune and~~ not up to date and	
	Hepatitis B series	At any gestational age if Hep B non-immune	
	Influenza	Prenatal specific vaccine, during flu season yearly	
	Tdap	Once between 27-36 weeks of gestation if not previously given	
	RSV	Once at 32-36 weeks gestation from September to January	
15 – 21 WEEKS	msAFP (second trimester genetic screening)	Once at specific to gestational age (15-21 weeks)	○ Refer to Genetic Counseling , if Abnormal Expanded Screen results
	Urine dip Chem-2 (glucose and protein only)	Every High Risk OB visit (HROB clinic) or in routine prenatal care if the patient has hypertensive disease, h/o pre-eclampsia or HELLP in prior pregnancy, kidney disease, autoimmune disorder (lupus, APLS), thyroid disease, sickle cell anemia	○ Complete 2nd trimester CPSP Assessments (Psychosocial/ Nutrition/Health Education ○ ○ Refer to US - Fetal survey (18-22 wks.) ○
	Urine dip Chem 7	UTI symptoms, diabetes, or h/o recurrent UTI	
	Prenatal Vitamins	Dispense if not taking already: 1 tablet daily throughout pregnancy and post-partum	
	Vaccinations:		
	COVID-19	At any gestational age if not up to date	
	Hepatitis A series	Complete series if ~~Hep A non-immune and~~ not up to date and	at high risk for Hepatitis A or severe infe
	Hepatitis B series	At any gestational age if Hep B non-immune	
	Influenza	Prenatal specific vaccine, during flu season yearly	

24 – 28 WEEKS	3rd Trimester Labs: GLT, 1 hour Syphilis antibody/RPR serology CBC Ferritin HIV ½ antibodies and antigen GTT as needed	GTT once as needed based on GLT result	○ Complete 3rd Trimester CPSP Assessments (Nutrition/Psychosocial/Health Education)
	Prenatal Vitamins	Dispense if not taking already: 1 tablet daily throughout pregnancy and post-partum	
	Rhogam	ABO/Rh and antibody screen prior to administration of Rhogam Give Rhogam at 28 weeks if Rh negative	
	Urine dip Chem 7	UTI symptoms	
	Vaccinations:		
	COVID-19	At any gestational age if not up to date	
	Hepatitis A series	Complete series if ~~Hep A non-immune and~~ not up to date and	at high risk for Hepatitis A or severe infe
	Hepatitis B series	At any gestational age if Hep B non-immune	
	Influenza	Prenatal specific vaccine, during flu season yearly	
	Tdap	Once between 27-36 weeks of gestation if not previously given	
28 – 36 WEEKS	Prenatal Vitamins	Dispense if not taking already: 1 tablet daily throughout pregnancy and post-partum	○ Refer to Post-Partum Tubal Ligation Class (if applicable) ○ Breast feeding education material ○ Birth preferences and assess childcare resources as needed for planned admission ○ Order breast pump ○ Offer L&D tour ○ PPTL consent papers to be signed by 35 6/7 weeks
	Urine dip (glucose and protein only) Urine dip Chem 7	Every High Risk OB visit (HROB clinic) or in routine prenatal care if the patient has hypertensive disease, h/o pre-eclampsia or HELLP in prior pregnancy, kidney disease, autoimmune disorder (lupus, APLS), thyroid disease, sickle cell anemia UTI symptoms, diabetes, or h/o recurrent UTI	

	Vaccinations:		
	COVID-19	At any gestational age if not up to date	
	Hepatitis A series	Complete series if ~~Hep A non-immune and~~ not up to date and at high risk for Hepatitis A or severe infe	
	Hepatitis B series	At any gestational age if Hep B non-immune	
	Influenza	Prenatal specific vaccine, during flu season yearly	
	Tdap	Once between 27-36 weeks of gestation if not previously given. Recommend Td to newborn close contacts (partner, caregivers)	
	RSV	Once at 32-36 weeks gestation from September to January	
36 – 41 WEEKS	Prenatal Vitamins	Dispense if not taking already: 1 tablet daily throughout pregnancy and post-partum	○ Breast feeding education
	Urine dip (glucose and protein only) Urine dip Chem 7	Every High Risk OB visit (HROB clinic) or in routine prenatal care if the patient has hypertensive disease, h/o pre-eclampsia or HELLP in prior pregnancy, kidney disease, autoimmune disorder (lupus, APLS), thyroid disease, sickle cell anemia UTI symptoms, diabetes, or h/o recurrent UTI	
	Repeat GC and CT and Trichomonas screening	At 36 weeks if <25 years old or high risk	
	Vaccinations:		
	COVID-19	At any gestational age if not up to date	
	Hepatitis A series	At any gestational age if Hep A non-immune	
	Hepatitis B series	At any gestational age if Hep B non-immune	
	Influenza	Prenatal specific vaccine, during flu season yearly	
	Tdap	Once if not previously given	
	RSV	Once at 32-36 weeks gestation from September to January	
	US position check Group B Strep	Once at 36 weeks Once at 36 weeks	Antenatal testing Clinic collect/self-collect

POST PARTUM	Prenatal Vitamins	Dispense if not taking already: 1 tablet daily throughout pregnancy and post-partum	○ Complete Postpartum CPSP Assessments (Nutrition/Psychosocial/Health Education) ○ Screen for Depression (PHQ-2 or Edinburgh
	GLT, 2 hour	At 6 weeks post-partum only if patient is diagnosed with GDM during pregnancy	
	Vaccinations:		
	COVID-19	If not up to date	
	Hepatitis A series	At any gestational age if Hep A non-immune	
	Hepatitis B series	At any gestational age if Hep B non-immune	
	Influenza	During flu season yearly if not Up to date	
	Tdap	If not up to date	
	MMR	Postpartum if not up to date	
	Varicella	Postpartum if not up to date	
	HPV	Postpartum if not up to date	
	Urine dip (chem 7)	UTI symptoms, diabetes, or h/o recurrent UTI	

REFERENCES: These standards are a distillation of recommendations from both medical literature and provider input, including but not limited to: United States Preventive Service Taskforce, American College of Obstetricians and Gynecologist, The American College of Nurse-Midwives, Advisory Committee on Immunization Practices, and Center for Disease Control.

APPROVAL

Ambulatory Care Committee	June 2025
Medical Executive Committee	August 2025