ZSFG JOINT CONFERENCE COMMITTEE MEETING

September 22, 2025

MEDICAL STAFF Report

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   e. Management of Benign and Malignant Breast Condition Standardized Procedure

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on September 22, 2025
September 2025 MEC Meetings

COMMUNITY PRIMARY CARE (CPC) CLINICAL SERVICE REPORTS: Joseph L. Pace, MD
The highlights of the CPC report are as follows:

I. Mission and Vision- The mission and vision of Community Primary Care (CPC) are grounded in our True North Values—delivering affirming, team-based, whole-person healthcare with pride, respect, inclusion, and a deep sense of belonging. Their work is guided by a strong focus on anti-racism, equity, and access to care, while fostering a culture of integration across all services.

II. Scope of Clinical Service-The primary care clinics serve patients across San Francisco by providing various scopes of care.

A. Community Primary Care- There are 10 clinics/programs across San Francisco which provide full spectrum primary care for children, adolescents, pregnant women, and adults. Specialized services for: Adolescents/Transitional Age Youth (CHPY), Elders 55 and over (Curry), Gender Health (CMHC, TWUHC), People Experiencing Homelessness/unstable housing (TWUHC), People Living With HIV (CMHC, MHHC, SEFHC, TWUHC), and Addiction Medicine (PHHC, TWUHC; coming soon: SEFHC)

B. Behavioral Health and Substance Use Services include Primary Care Behavioral Health teams, Primary Care Psychiatry, Office Based Opiod Treatment (PHHC and TWUHC). Community Primary Care has partnered with four Behavioral Health Homes: Mission Mental Health, Chinatown North Beach, South Market Mental Health and Sunset Mental Health

C. Primary Care ancillary specialty services-These include Clinical Pharmacy, Complex Care Management, Dental (clinic and school-based), Integrative Health (acupuncture, mind-body modalities and integrative pain management), Neurology Memory Clinics (CPHC, SEFHC), OB/Gyn (CHPY-New Generations and SEFHC), Nutrition/Food as Medicine and Podiatry.

D. The Centralized Call Center includes New Patient Access Units, a Nurse Advice Line, support for scheduling CPC appointments and dedicated Telephone Appointment Providers Line.

E. Whole Person Integrated Care (WPIC)- The service has number of programs such as Maria X Martinez Health Resource Center, Medical Respite and Sobering Center, nursing services in Permanent Supportive Housing (PSH), Permanent Supportive Housing Advanced Clinical Services (PHACS), Shelter Health, and Street Medicine.

III. Leadership and Providers

A. Leadership-Dr. Joseph Pace oversees all Primary Care-both community-based and ZSFG campus sites. The leadership structure includes a multidisciplinary team representing various clinics and programs, ensuring coordinated oversight and integration across services.

B. There are 175 credentialed CPC providers, consisting of physicians, podiatrist, and advanced practice clinicians.

IV. Financial Report

Revenue and Expense Overview: The primary revenue sources for the reporting period include Medi-Cal (28%), the Quality Incentive Pool (28%), the General Fund (25%), the Global Payment Program (15%), Medicare (3%), and Work Orders (1%). On the expense side, 76% of expenditures were allocated to salary and fringe benefits, while the remaining 24% covered operating costs.

Patient Volume (July 2024 – February 2025): During this period, Community Primary Care (CPC) recorded approximately 145,000 completed encounters and around 98,000 billable encounters. The current staffing total is 546 employees.

V. Performance Improvement Patient Safety (PIPS)

Antiracism and Equity- CPC continues to advance antiracism and equity through multiple initiatives. A notable outcome is the 82% reduction in access-related grievances—from 17 between September and November 2023 to just 3 between January and March 2025—following the implementation of a new access model. Efforts also focus on closing equity gaps and improving patient experience, with 70% to 84% of patients reporting they feel treated with respect and without bias.

Improving Access to Care- CPC is focused on improving access for patient, reduce waste, and optimizing Epic utilization. Since the go-live in September 2024, the Silver Avenue site has consistently met DHCS access targets, as reflected in its median Third Next Available Return Appointment (TNAA) performance. Additionally, Primary Care has achieved a 97% reduction in the number of patients on the new patient waitlist for establishing care since July 2024.

Building a culture of integration- CPC continues to strengthen integrated care through several key initiatives. The Maxine Hall Behavioral Health (BH) has increased volume of unduplicated clients served by behavioral health provider with Behavioral Health Integration. The STAR partnership supports overdose prevention through contingency management, team-based addiction treatment with nursing involvement, on-site addiction specialists, and the rollout of long-acting injectable (LAI) buprenorphine protocols and internal PCP e-consults. Additionally, CPC is strengthening integration through initiatives like PCSIT, which standardizes clinical communication, PCLOB, which builds leadership skills and quality improvement, and the Workplace Safety program, to develop a standardized, equitable approach for managing disruptive patient behaviors that supports both staff and patients.

VI. Summary

A. Strengths-CPC benefits from a comprehensive, integrated care model, supported by strong leadership and effective multidisciplinary collaboration. The program has made notable progress in improving access and advancing equity, with high levels of engagement from both patients and staff.

B. Challenges and Opportunities-Key challenges include maintaining recent improvements in equity and access, optimizing new patient intake processes, and improving billing practices to enhance financial stewardship. These areas also present opportunities for continued growth and innovation.

C. Goals- CPC aims to expand behavioral health integration and strengthen billing practices. The team remains committed to advancing equity and anti-racism efforts, investing in workforce development, and revenue growth strategies include increasing billable encounters, optimizing billing workflows, and maximizing participation in pay-for-performance programs.

VII. Community Primary Care (CPC) Rules and Regulation- The Committee expressed its appreciation to Dr. Joseph Pace and the Community Primary Care team for their dedication to delivering high-quality care. Dr. Pace was especially recognized for his exceptional leadership, steadfast commitment, and ongoing strategic efforts in advancing the department's mission. A motion for the committee to approve the updated Community Primary Care Rules and Regulations was made and approved. Approval from the Health Commission is requested for the Community Primary Care (CPC) Service Rules and Regulations.

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG September 22, 2025
September 2025 MEC Meetings

Clinical Service Report and Rules and Regulations:

a) Community Primary Care (CPC) Service Report
b) Community Primary Care (CPC) Rules and Regulations

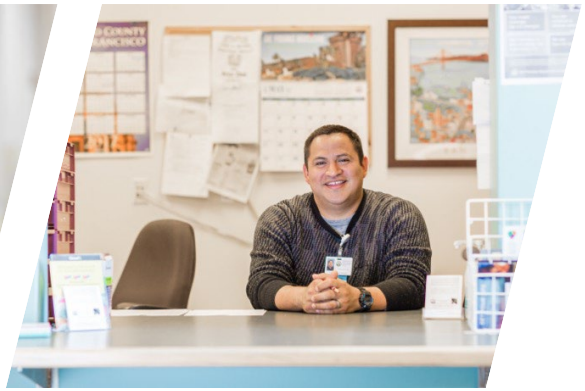
Credentials Committee:

a) Summary of Changes: Ambulatory Care Standing Order Protocol Update September 2025
b) SFHN Ambulatory Care Clinics Combined Standing Order Protocols for Health Care Maintenance (SOP)
c) OB/Gyn Standardized Procedure-NP/PA/Certified Nurse Midwife
d) Management of Benign and Malignant Breast Condition Standardized Procedure

COMMUNITY PRIMARY CARE
BIANNUAL CLINICAL SERVICE REPORT TO THE ZSFG MEDICAL EXECUTIVE COMMITTEE

JOSEPH L. PACE, MD
PRIMARY CARE CHIEF MEDICAL OFFICER
CHIEF OF SERVICE, COMMUNITY PRIMARY CARE

September 8, 2025



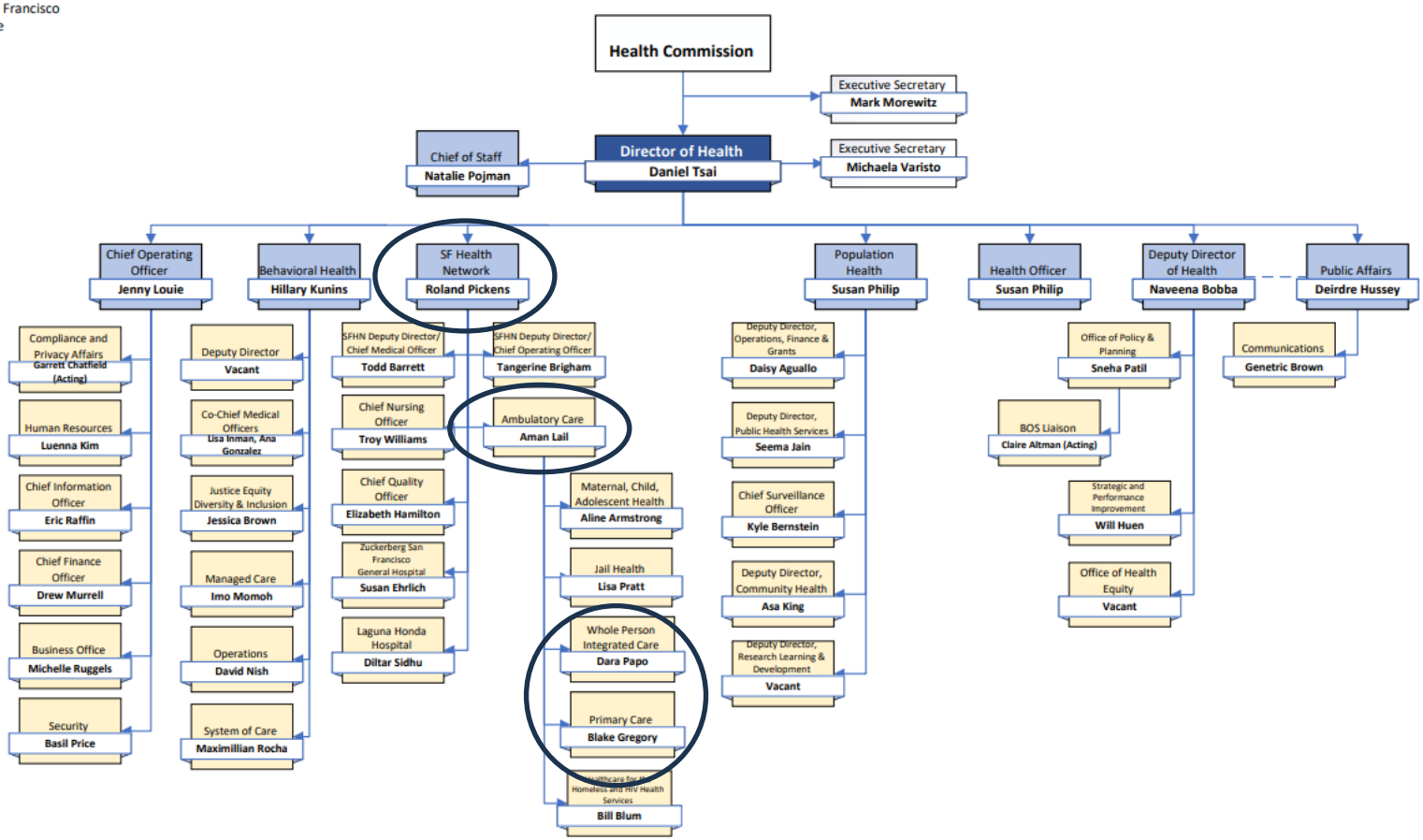
San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

DPH Organizational Chart

City and County of San Francisco
Daniel L. Lurie
Mayor

San Francisco Department of Public Health
Daniel Tsai
Director of Health



Last updated: 07/01/25

Our Vision

1st Choice for Health Care and Well Being

Improve the Health of the Patients We Serve

Optimize Access, Operations, and Cost-Effectiveness

Ensure Excellent Patient Experience

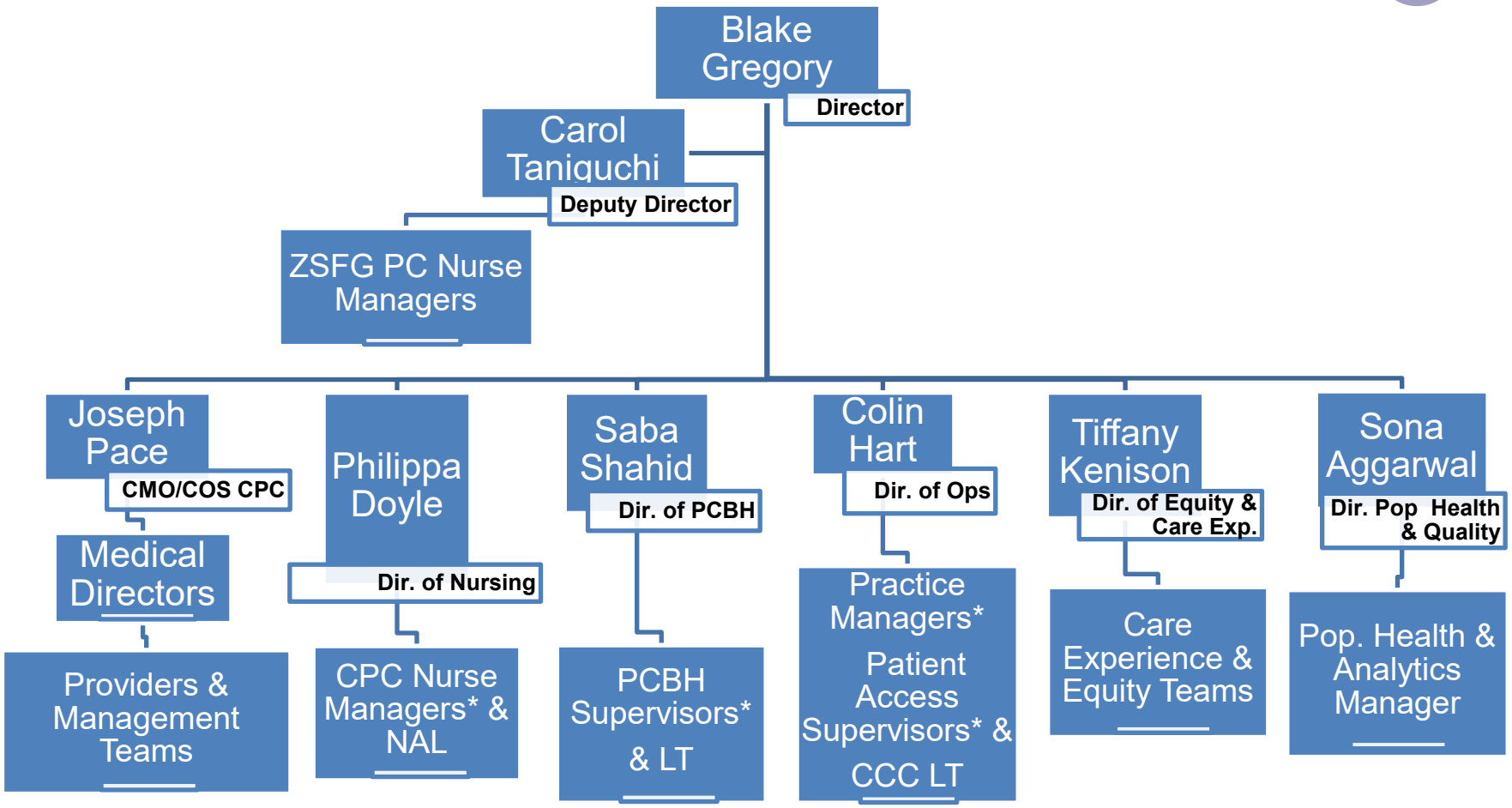
TRUE NORTH VALUES

Safety | Quality | Care Experience | People Development | Financial Stewardship | Equity

Build a Strong Foundation of a Healthy, Engaged, and Sustained Primary Care Workforce

We Provide High Quality Health Care that Enables San Franciscans to Live Vibrant, Healthy Lives

Primary Care Organizational Chart



*matrix supervision

Primary Care Clinics Serving Our City

Adult primary care

Serving adults, children, families

CHPY, or Community Health Programs for Youth

Scope of Services

- Community Primary Care
  - Ten clinics/programs across San Francisco
  - Full spectrum primary care (children, adolescents, pregnant people, adults)

- Special Population Focus
  - Adolescents/Transitional Age Youth (CHPY)
  - Elders 55 and over (Curry)
  - Gender Health (CMHC, TWUHC)
  - People Experiencing Homelessness/unstable housing (TWUHC)
  - People Living With HIV (CMHC, MHHC, SEFHC, TWUHC)
  - Addiction Medicine (PHHC, TWUHC; coming soon: SEFHC)

Scope of Services (cont'd)

- Behavioral Health and Substance Use Services
  - Primary Care Behavioral Health teams
  - Primary Care Psychiatry
  - Behavioral Health Homes
    - CMHC/MMH, CPHC/CTNB, OPHC/SMH, SOMMH/TWUHC
  - Office Based Opioid Treatment
    - Buprenorphine
    - Methadone (PHHC, TWUHC)

- PC Specialty Services
  - Clinical Pharmacy
  - Complex Care Management
  - Dental- clinic and school based
  - Integrative Health- acupuncture and mind-body modalities; Integrative Pain Mngmnt.
  - Neurology- Memory Clinics (CPHC, SEFHC)
  - OB/Gyn- (CHPY-New Generations, SEFHC)
  - Nutrition/Food As Medicine
  - Clinical Pharmacy
  - Podiatry (community-based PC, WPIC, Jail Health)

Scope of Services (cont'd)

- Centralized Call Center
  - New Patient Access Unit
  - Nurse Advice Line
  - Telephone Appointment Providers

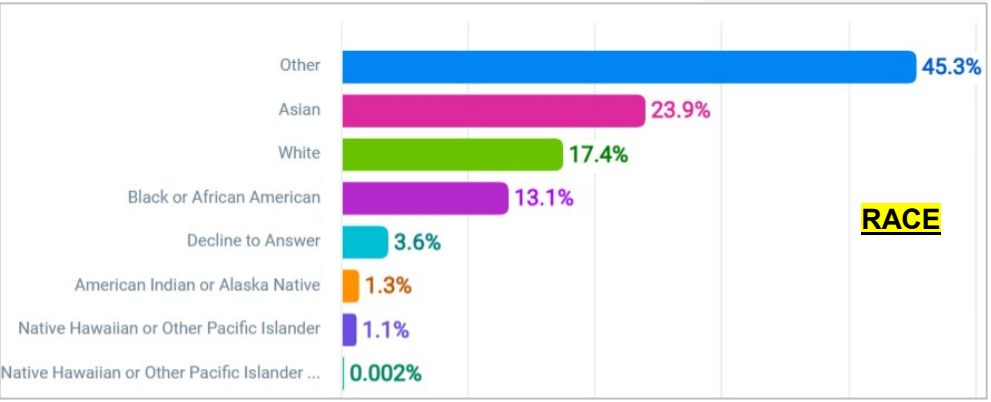
- Whole Person Integrated Care (WPIC)
  - Maria X Martinez Health Resource Center
  - Medical Respite and Sobering Center
  - Nursing Services in Permanent Supportive Housing (PSH)
  - Permanent Supportive Housing Advanced Clinical Services (PHACS)
  - Shelter Health
  - Street Medicine

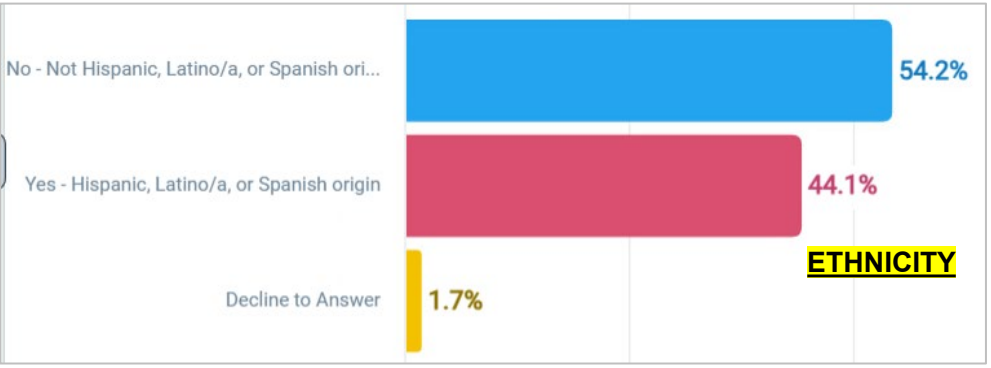
CPC Credentialed Providers

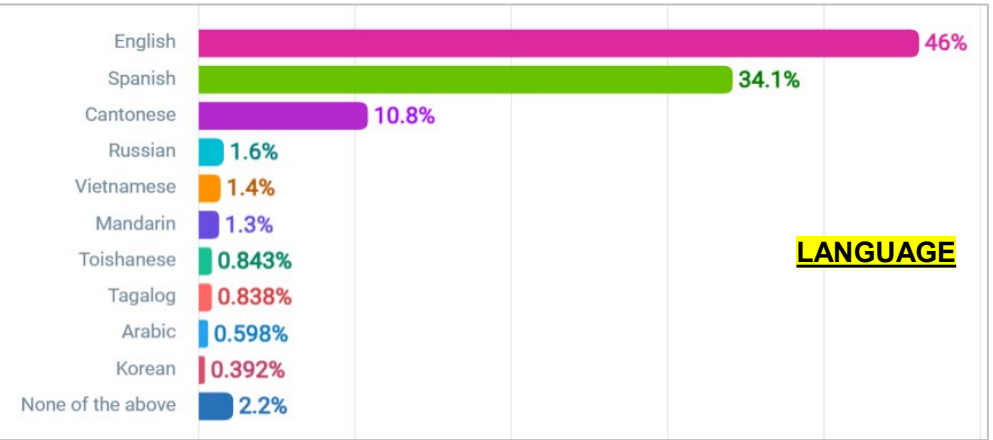
- Family Medicine/Internal Medicine Physicians: 76
- Nurse Practitioners/Physician Assistants: 46
- Dentists: 10
- Psychiatric Providers (MD and NP): 10
- Clinical Pharmacists: 9
- Acupuncturists: 9
- Obstetrician/Gynecologists (New Gen and SEFHC): 9
- Podiatrists: 4
- Neurologists: 2

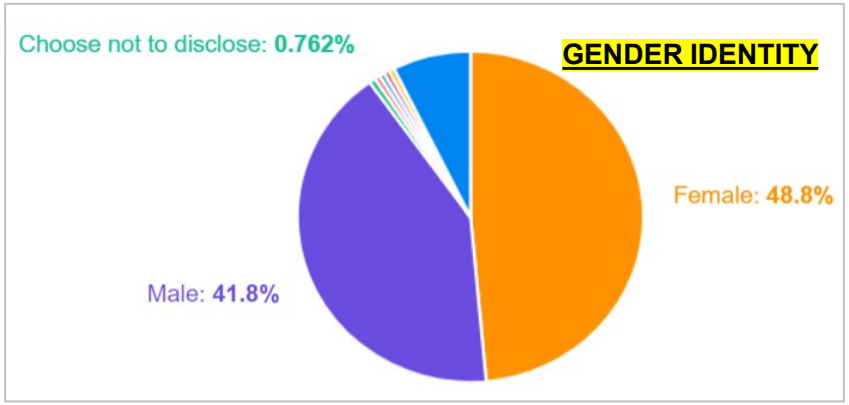
Our Patients

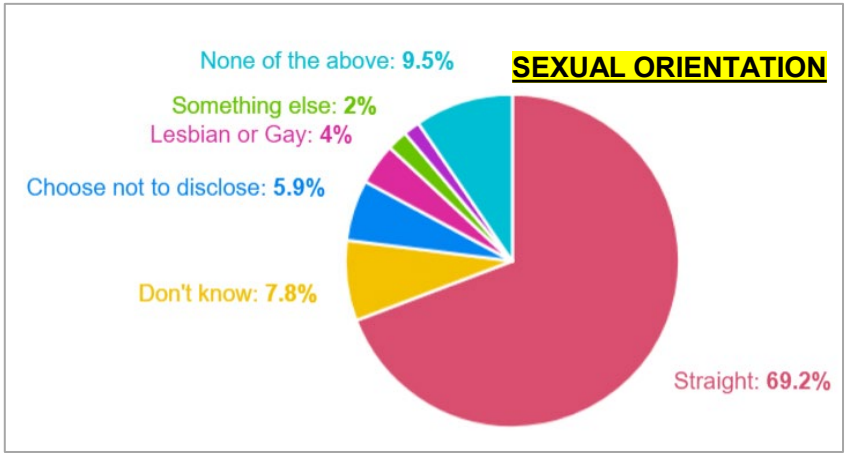
Empanelment:
- **56,702** active patients (seen in past 18 months)
- **49,617** enrolled and not seen in past 18 months



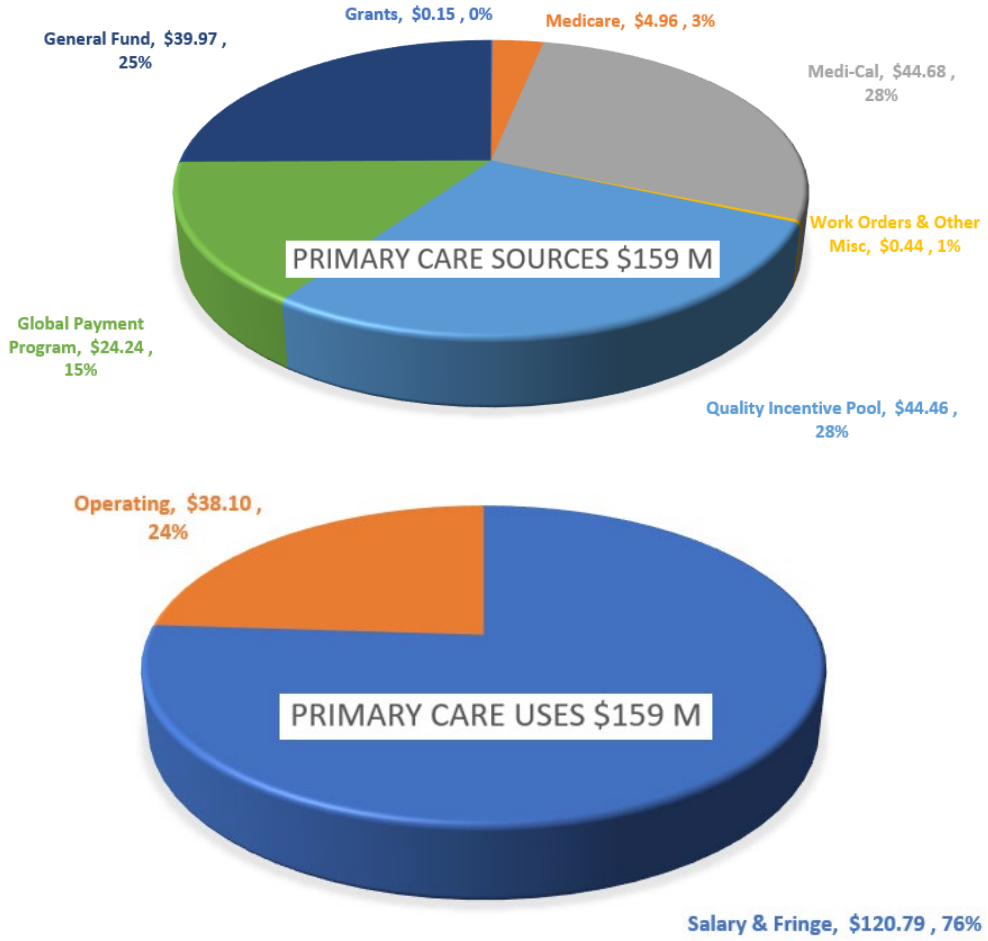








Primary Care Budget



FY 26 budget and current staffing level

	STAFFING		
	Filled	Vacant	Total
Primary Care	496	92	589
NAL & CCM	25	3	28
Call Center	25	12	37
Total	**546**	**107**	**653**

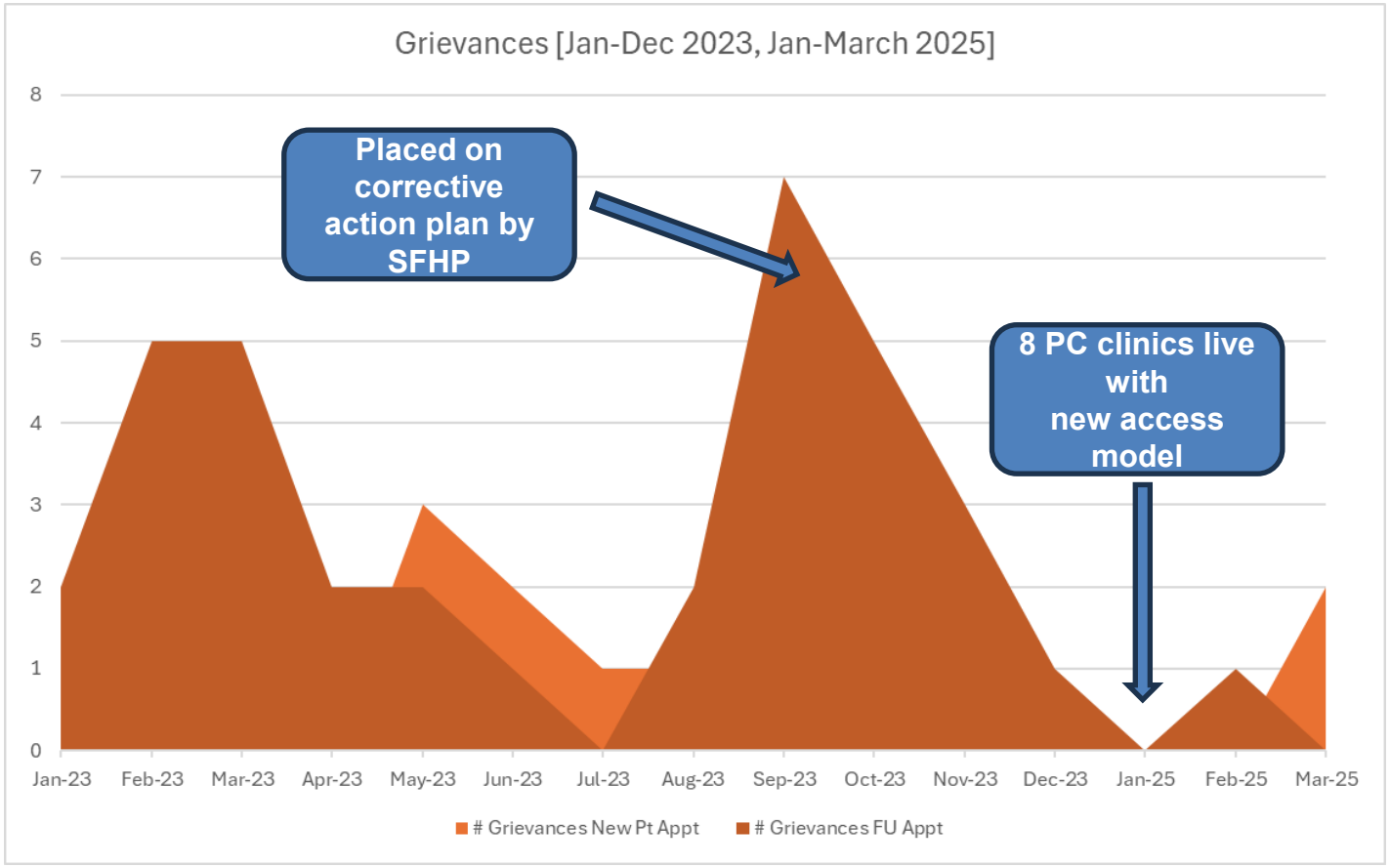
July 2024-February 2025:
PC CPC Completed Encounters: ~145K
PC CPC Billable Encounters: ~98K

Mission & Vision FY 2024

Proudly providing team-delivered, affirming, whole healthcare; sustaining each other and our communities with respect and belonging.

Antiracism and Equity

Improving Access to Care: Outcomes



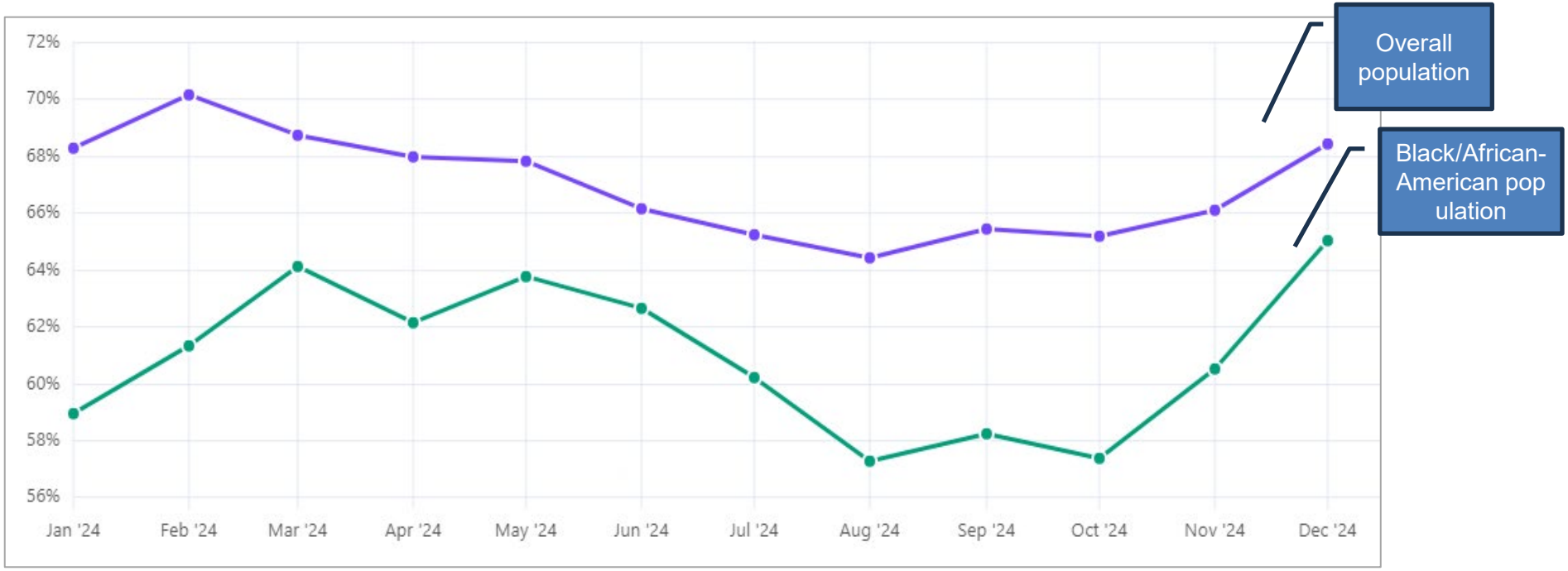
Patient grievances related to access: Dramatic drop in access-related grievances with new access model. From Sept-Nov 2023, 17 grievances were filed. From Jan-March 2025, 3 grievances were filed, ***an 82% decline in grievances.***

There is No Quality without Equity

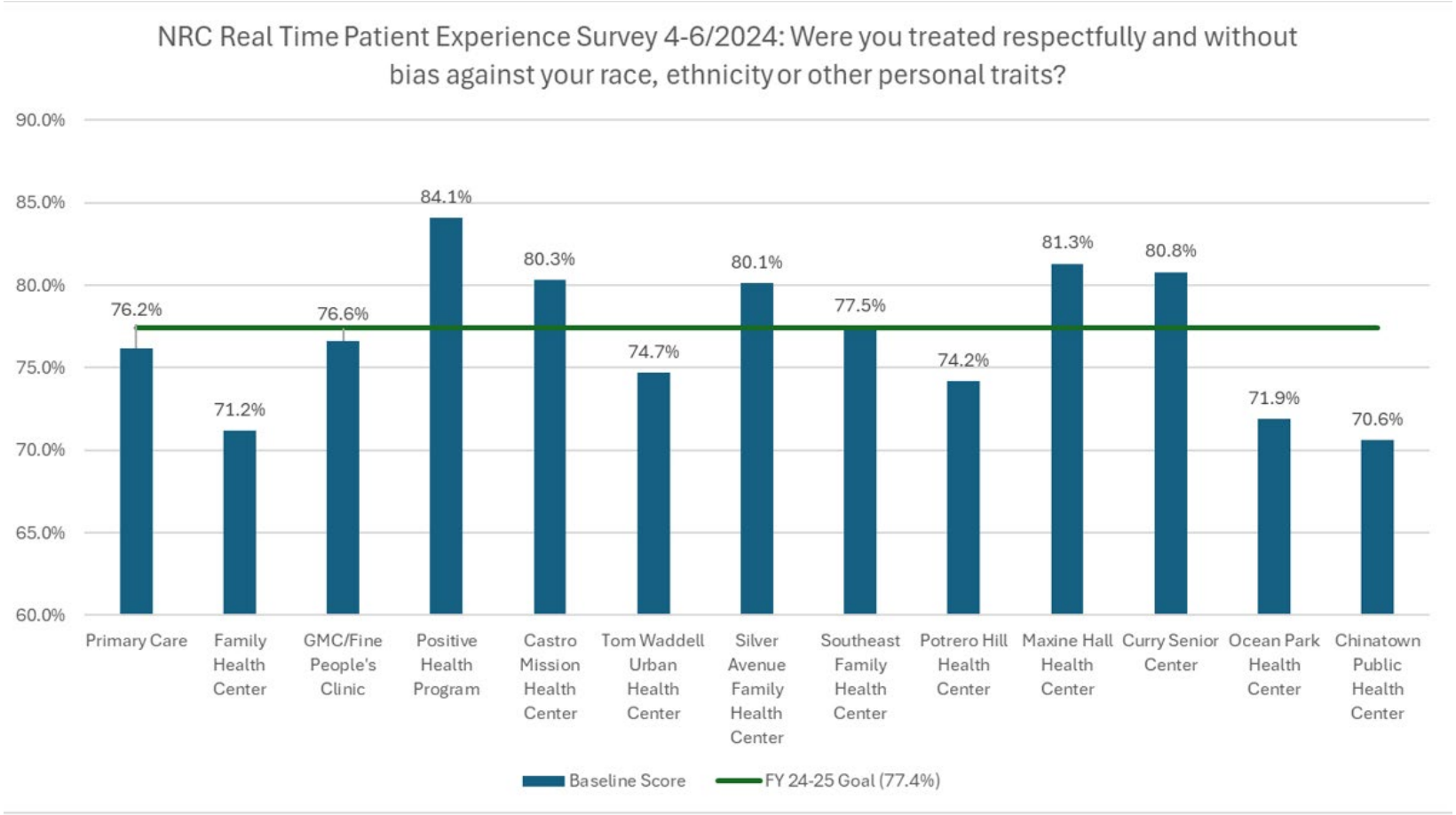
Many initiatives focus on reducing equity gaps.

Well Child Checks age 6-11

- **+6%** rate increase
- **+6%** gap closure

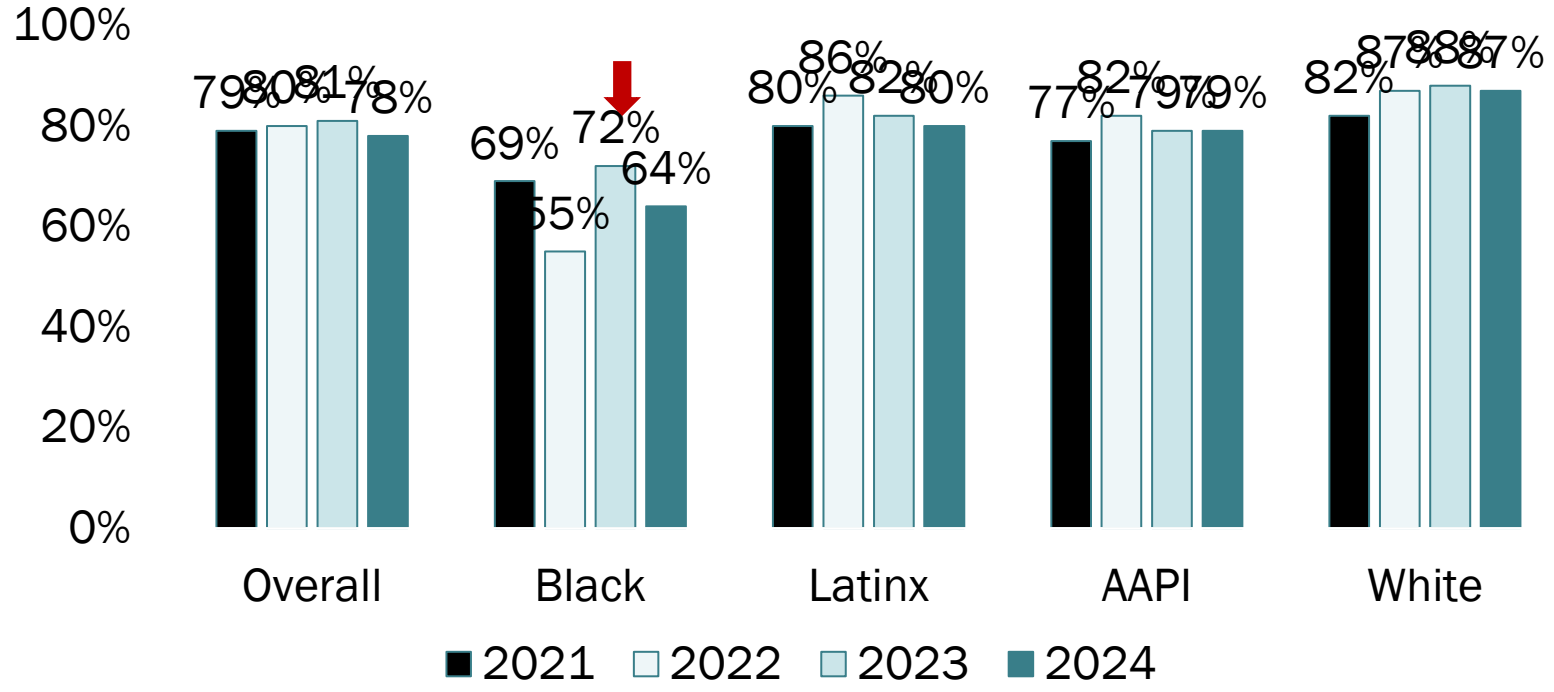


Root Causes of Disparities: Bias in Care

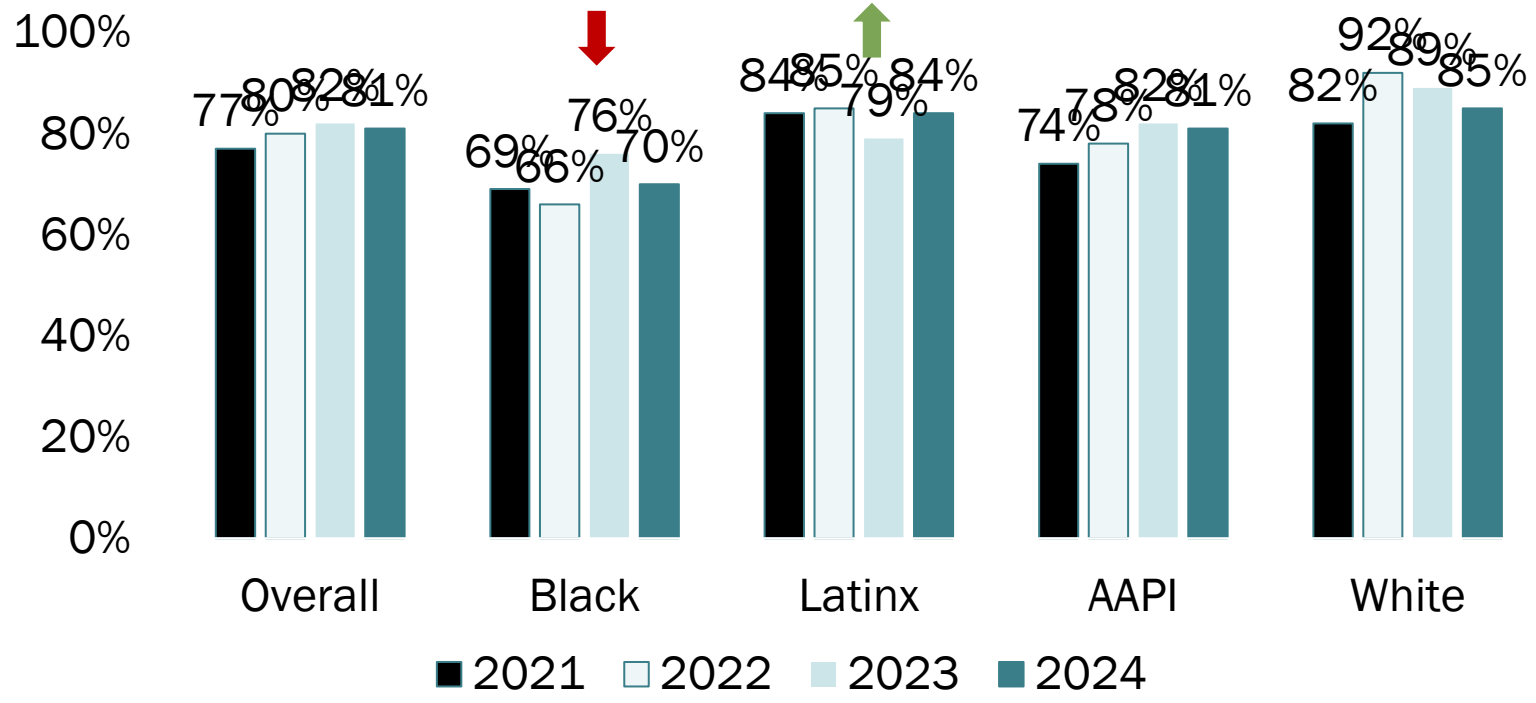


Patient Experience Survey: Survey administered after clinic visits. The data here is broken down by PC clinic.

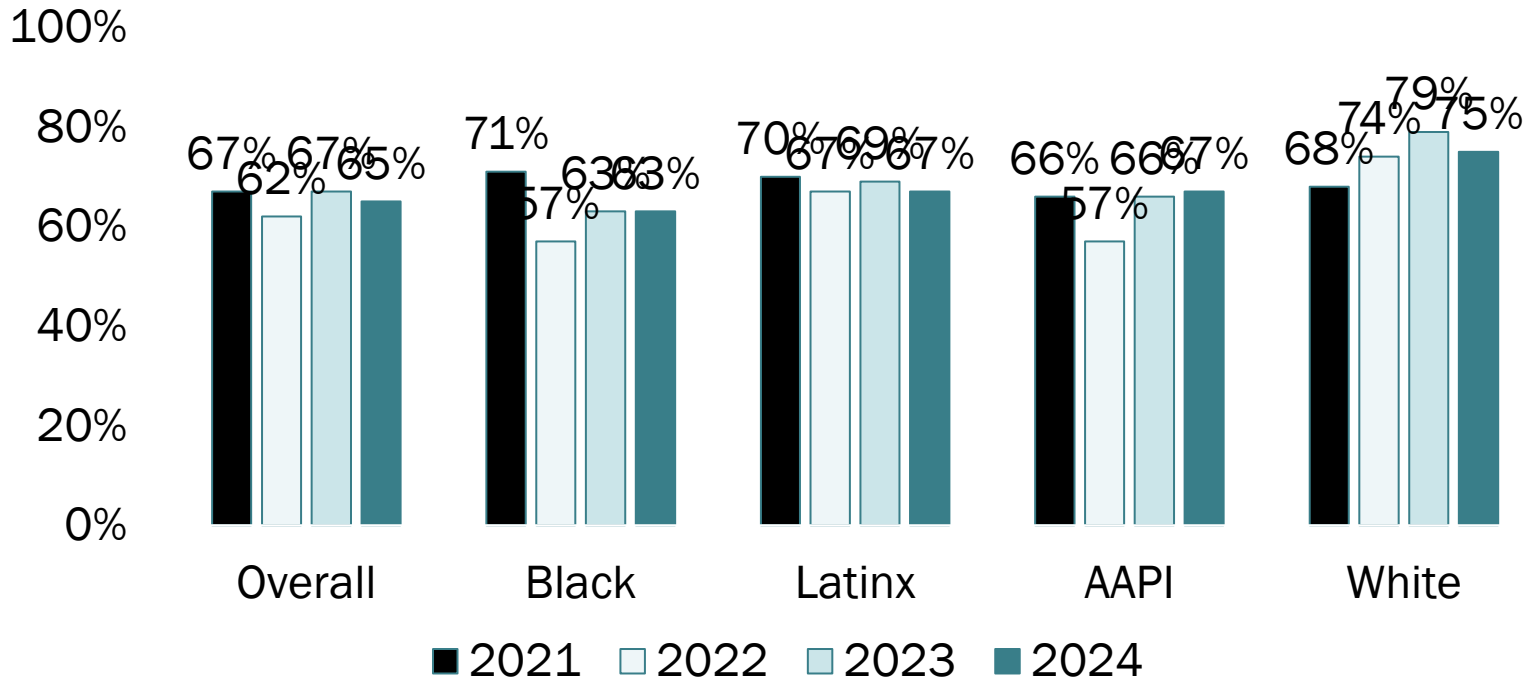
% who agree “Staff from my department treat community members from all racial/ethnic groups with respect”



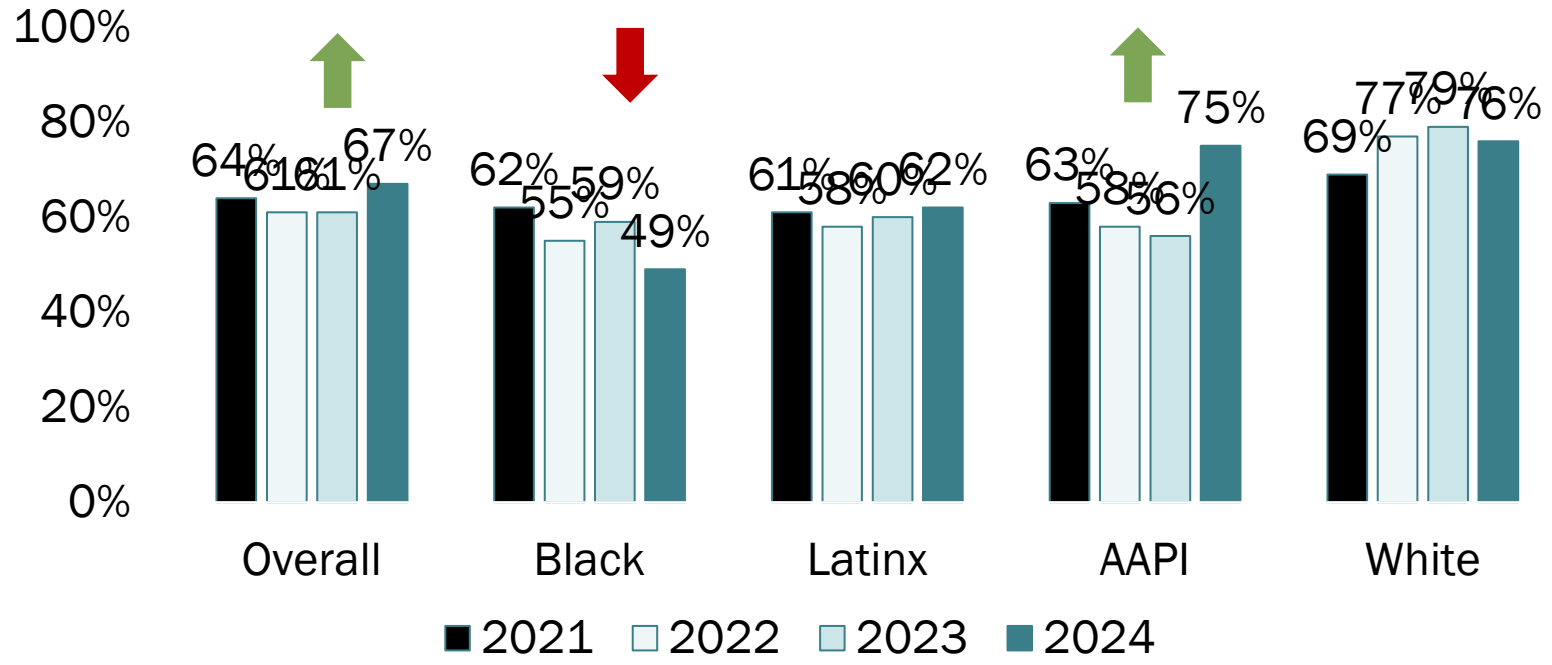
% who agree “Managers in my department treat staff from all racial/ethnic groups with respect”



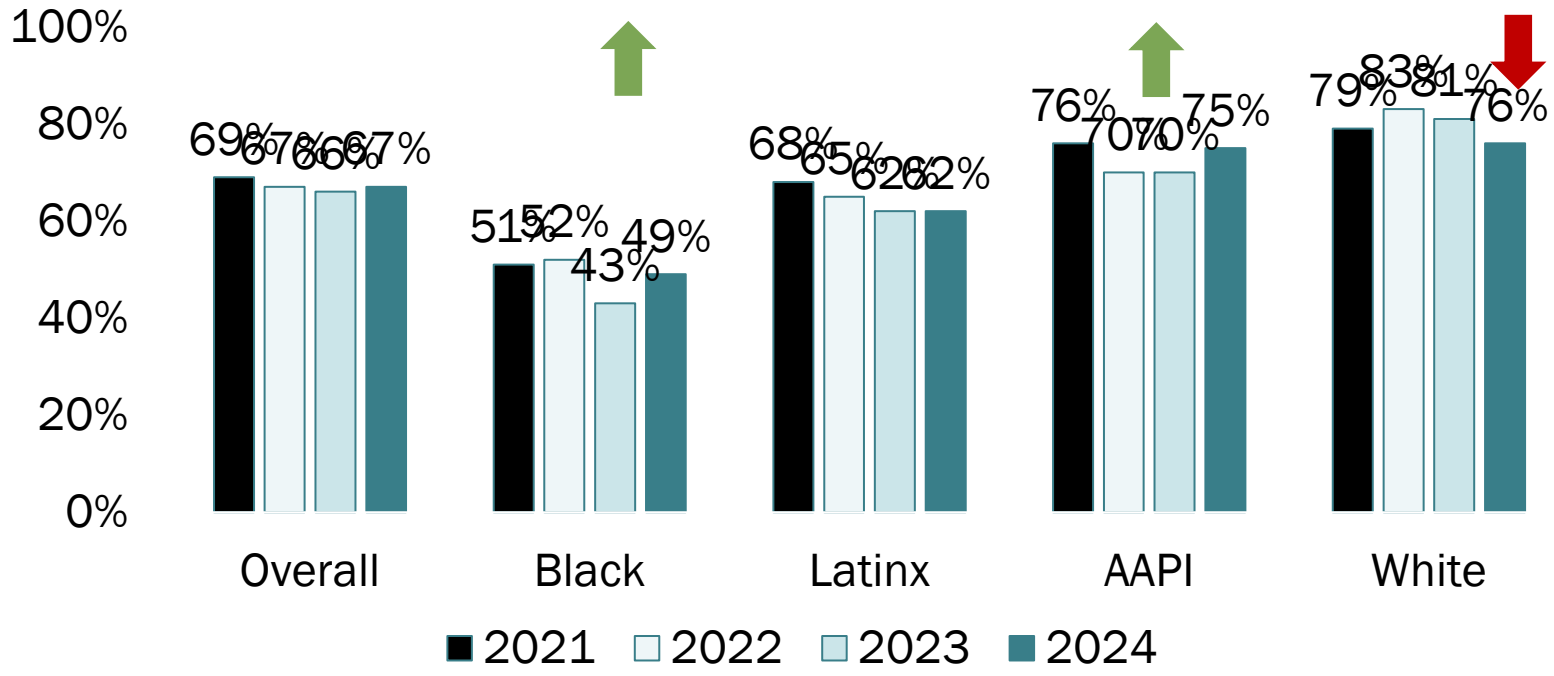
% who agree “I feel comfortable talking about race and racism in the workplace”



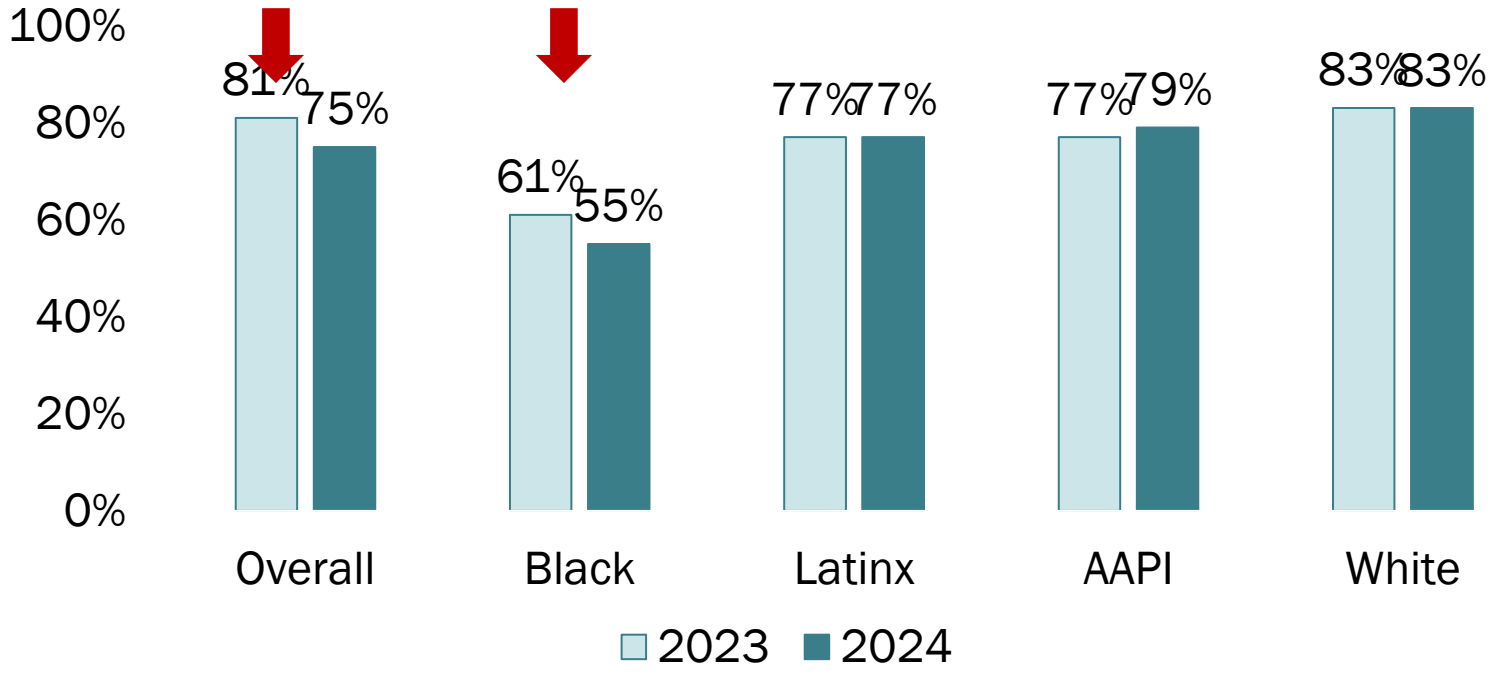
% who agree “I am actively involved in advancing racial equity in my work”



% who agree “My department is taking active steps to improve racial equity”



% who agree “People working at my clinic treat peers from all racial/ethnic groups with respect”



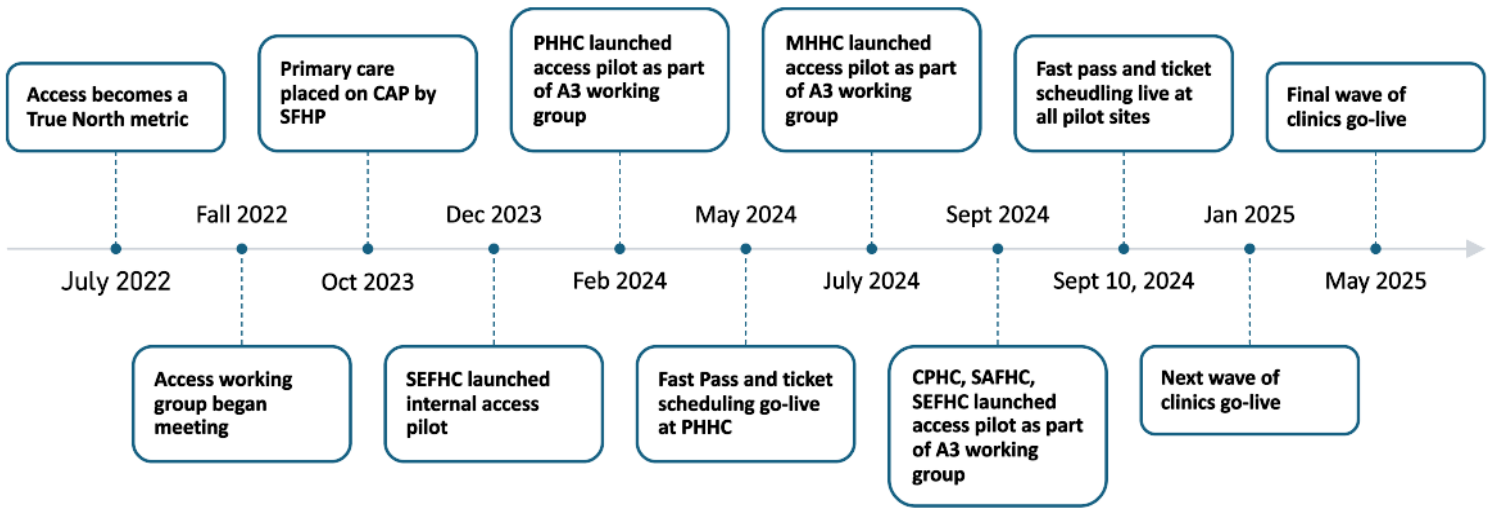
Improving Access to Care

San Francisco
Department of Public Health

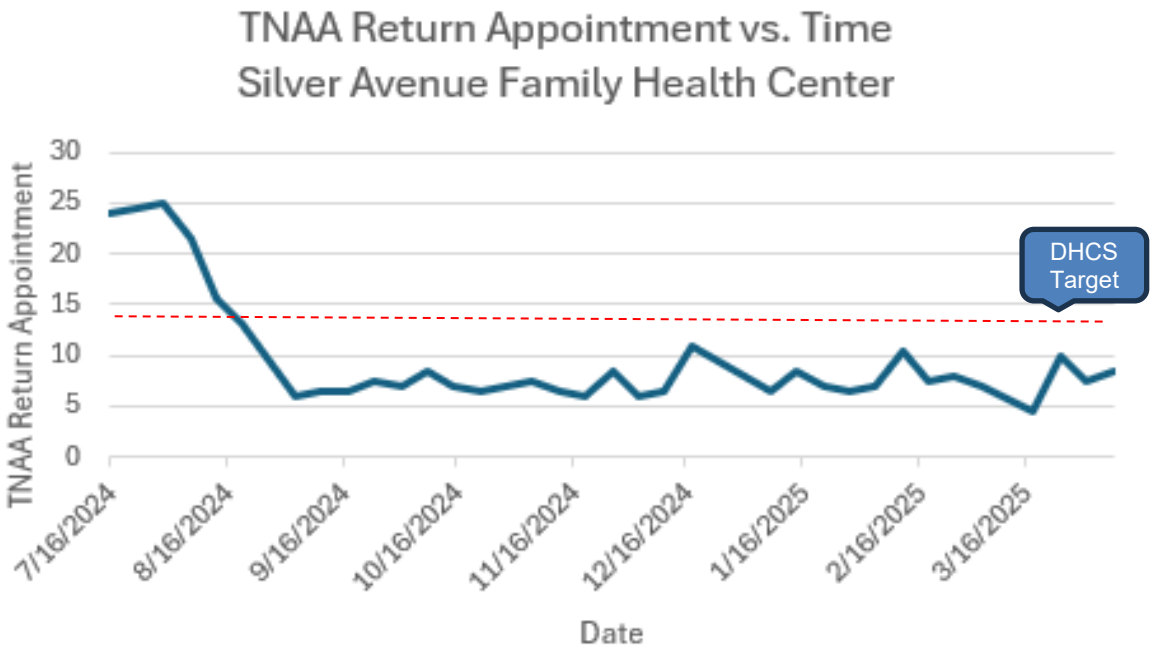
Improving Access to Care

- Goals:
  - Improve access for patients
  - Reduce waste
  - Use Epic effectively

Access Project Timeline



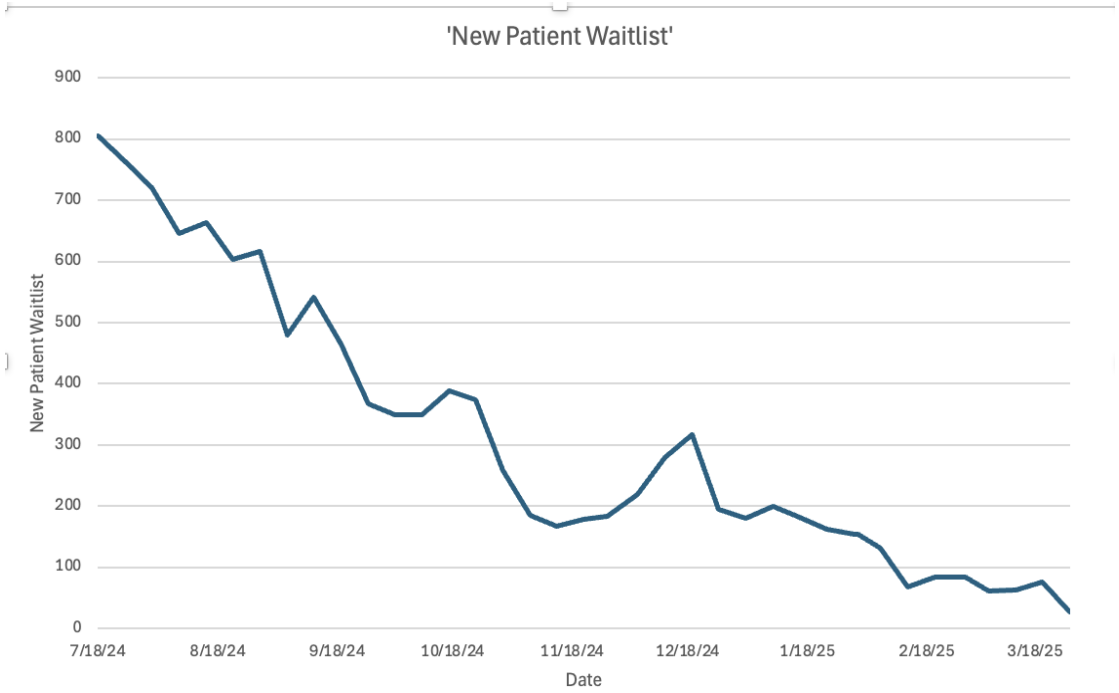
Improving Access to Care: Outcomes



Median Third Next Available Return Appointment (TNAA) vs. Time

Since go-live in Sept 2024, Silver Avenue has consistently achieved DHCS access targets.

Improving Access to Care: Outcomes

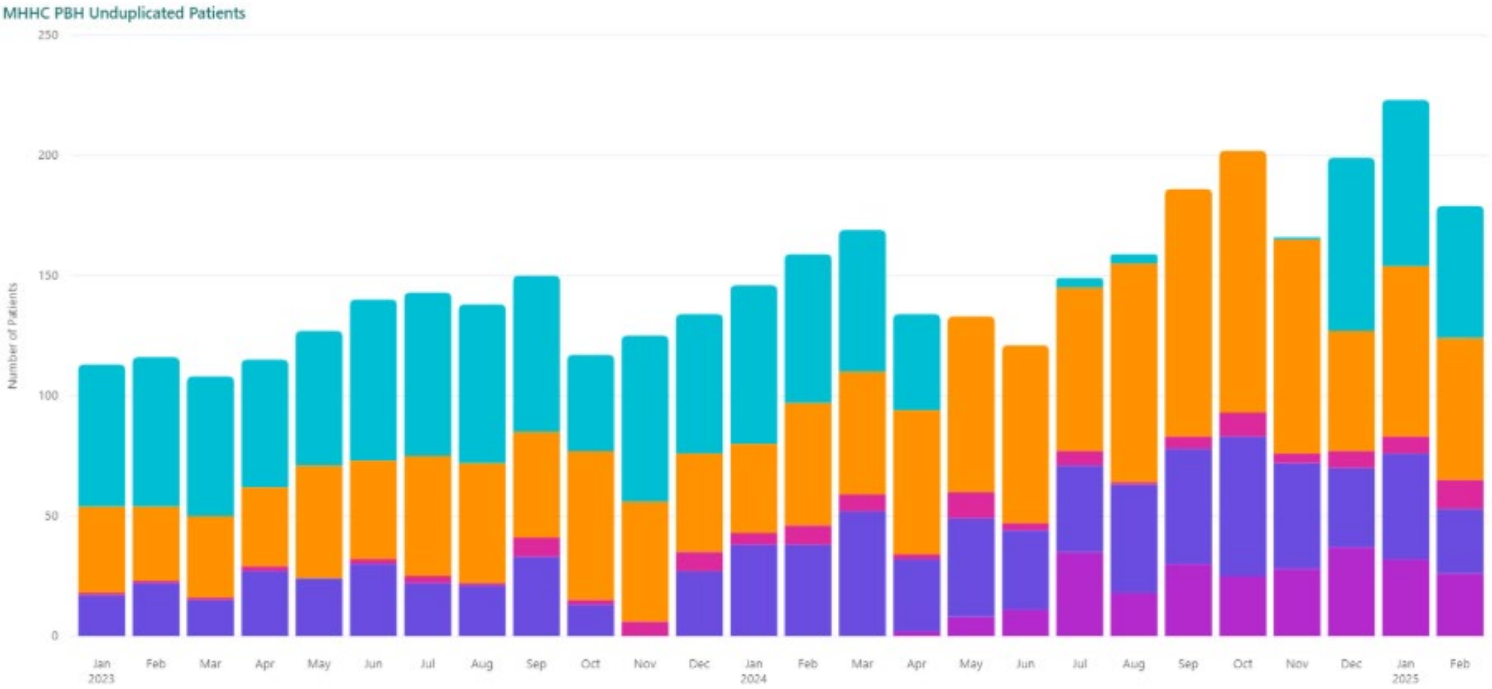


New patient waitlist trend over time.
Primary care has achieved a **97% reduction** in patients on the new patient waitlist awaiting an establish care appointment since July 2024.

Building a Culture of Integration

Integration with City Priorities

Number of unduplicated clients served per Behavioral Health provider



Time

<u>Integrated Behavioral Health:</u>

- Same-day access to services
- Increased number of clients served

Maxine Hall Behavioral Health (BH) unduplicated clients
Increased volume of unduplicated clients served by behavioral health provider with Behavioral Health Integration.

Integration with City Priorities

STAR partnership to reduce overdose deaths:

- Contingency management
- Team-based addiction treatment
- On-site addiction specialists
- On-site long-acting injectable (LAI) buprenorphine

Integration

Primary Care Standardization Improvement Team (PCSIT)

- Owners: PC CMO, DON, DOP
- Who: Multidisciplinary: staff, managers, leaders
- Why: Improve quality of care, patient and staff experience
- How: Standardize clinical communications across PC and ambulatory care
- What: Medication refills, communications between CCC and NAL, patient forms completion, abnormal cancer screening tracking

Integration

Primary Care Leadership Onboarding (PCLOB)

- Owners: PC CMO, DON, DPCBH, Dir. Equity & Care Exp.
- Who: Multidisciplinary cohort or new supervisors, managers, directors
- Why: Provide a forum for learning, networking and skill building across disciplines
- How: In person cohort, 36 hours over 6 months
- What: getting things done; working as an effective management team; leading quality improvement and change management; building personal capacity to identify and address dominant culture characteristics in how we work, problem solve and address conflict

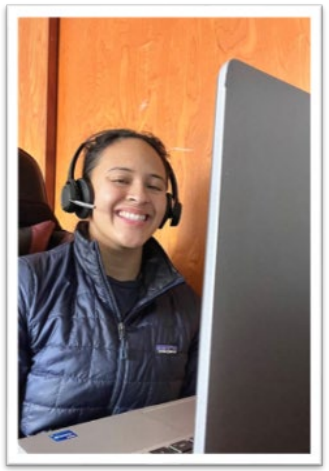
Integration

Primary Care Workplace Safety

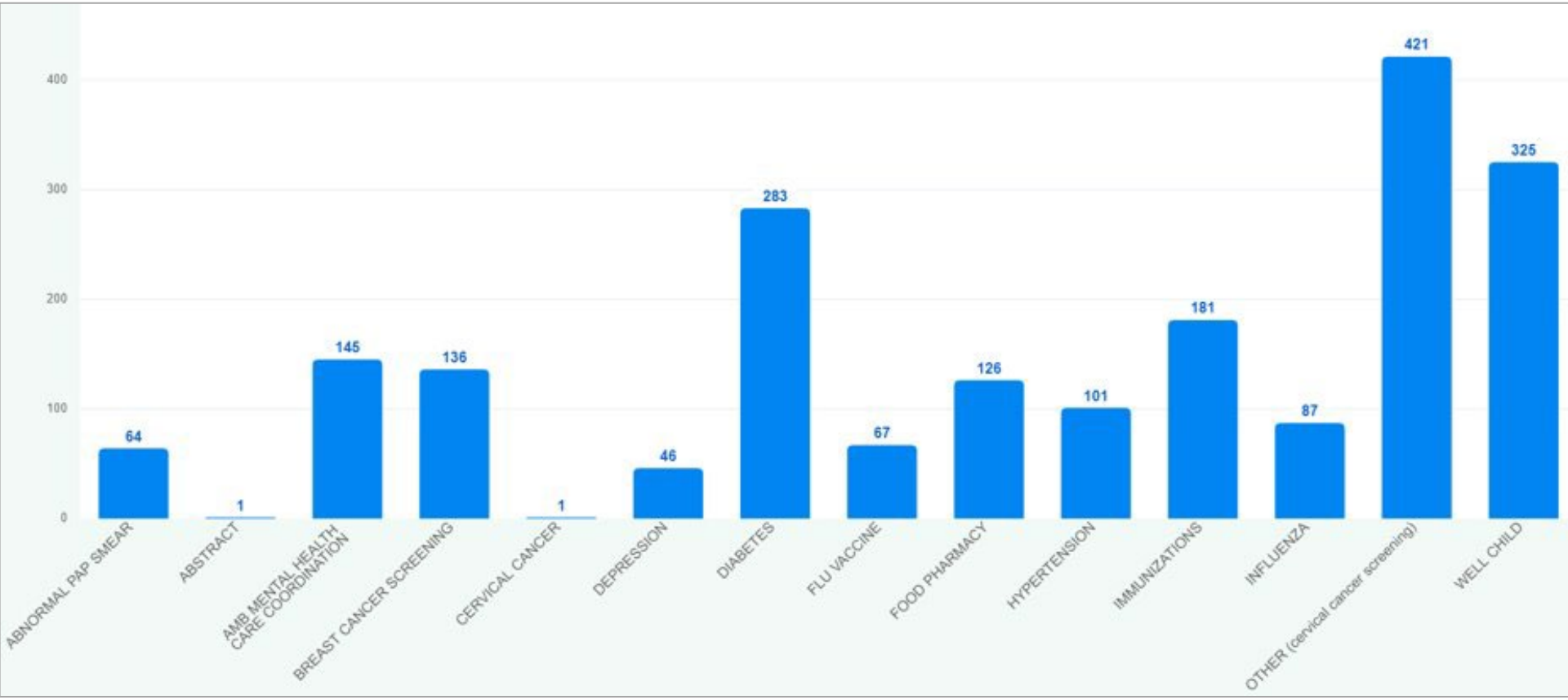
- Owners: PC CMO, Director of Equity and Care Experience
- Who: Policy Workgroup with representation from PC, WPIC, BHS, and Risk Management
- Why: Create a standardized approach to addressing disruptive patient behaviors that supports staff and patients in a trauma informed and equitable way
- How: Implementation workshops with PC managements teams, launch meetings with staff, basic de-escalation training with BERT, monthly incident review committee meetings, liaison with SC and SFHP

Population Health & Quality Improvement

Population Health Outreach



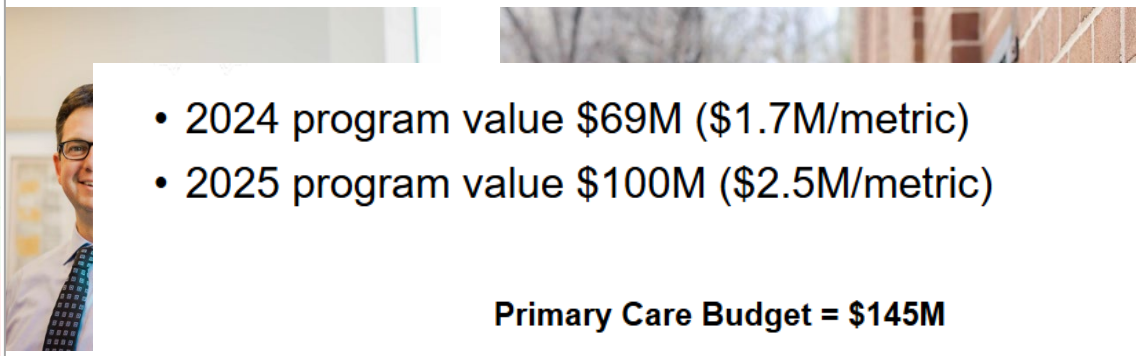
Health Workers created **21,000 outreach encounters** this year to improve access to care, close care gaps, and support pay-for performance goals



Medi-Cal Quality Incentive Pool (QIP) Program 2024

SFHN achieved <u>100% funding</u>!

		Effective Month	202501
Metric	**Type**	**Target**	**01/01/2024 - 12/31/2024**
Controlling High Blood Pressure (Q-CBP)	Priority	65.79%	68.02%
Glycemic Status Assessment for Patients with Diabetes ** (Q-GSD)	Priority	29.44%	28.37%
Breast Cancer Screening Improving Health Equity Black/African American (Q-BCS-IHE-BAA)	Priority	57.50%	58.94%
Glycemic Status Assessment for Patients with Diabetes - Improving Health Equity Black/African American ** (Q-GSD-IHE-BAA)	Priority	30.11%	32.03%
Glycemic Status Assessment for Patients with Diabetes - Improving Health Equity Hispanic ** (Q-GSD-IHE-H)	Priority	32.76%	32.92%
Breast Cancer Screening (Q-BCS)	Priority	60.28%	64.73%
Cervical Cancer Screening (Q-CCS)	Priority	50.85%	52.51%
Child and Adolescent Well Care Visits (Q-WCV)	Priority	51.64%	50.82%
Childhood Immunization Status (Q-CIS10)	Priority	45.26%	49.79%
Chlamydia Screening in Women (Q-CHL)	Priority	67.39%	76.31%
Colorectal Cancer Screening (Q-CMS130)	Priority	58.44%	61.19%
Developmental Screening-1to3years-All (Q-DEV-YR13)	Priority	47.13%	75.95%
Immunizations for Adolescents (Q-IMA)	Priority	48.80%	60.04%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 1 (informational only) (Q-CMS138-1)	Priority		96.03%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 2 (Q-CMS138-2)	Priority	82.41%	80.86%
Preventative Care and Screening: Tobacco Use - Screening and Cessation Intervention - Rate 3 (Q-CMS138-3)	Priority	92.51%	91.96%
Well-Child Visits in the First 15 Months of Life Rate 1 (Q-W30-15)	Priority	73.17%	75.44%
Well-Child Visits in the First 30 Months of Life Rate 2 (Q-W30-30)	Priority	68.09%	72.43%



- 2024 program value $69M ($1.7M/metric)
- 2025 program value $100M ($2.5M/metric)

Primary Care Budget = $145M

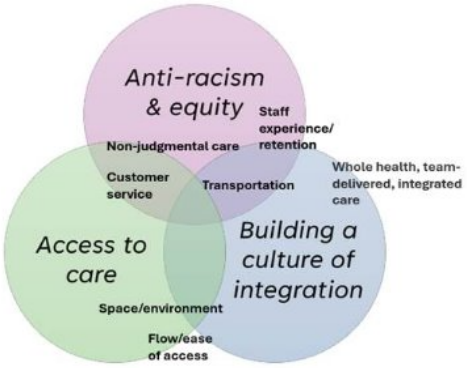
2024 QIP = 34%

PRIMARY CARE UPDATES

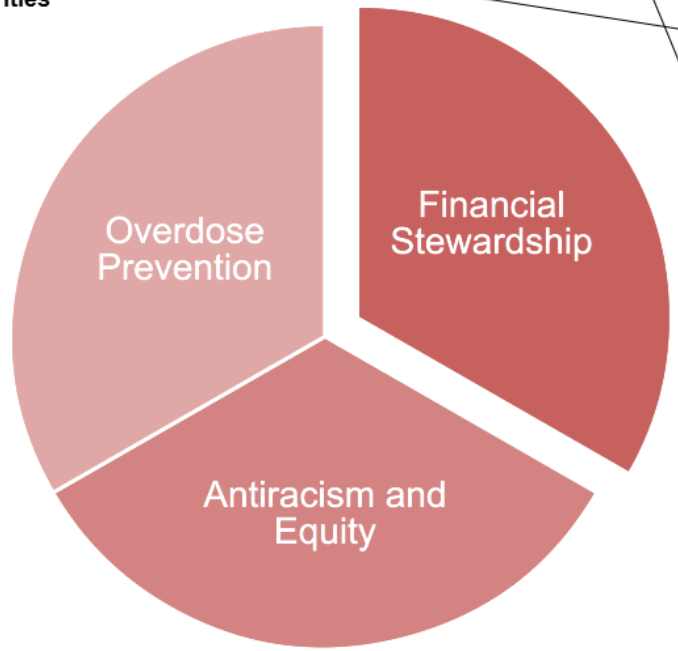
Priorities for FY 2025-2026

HOW IS PC ALIGNING WITH DPH PRIORITIES?

PC Priorities FY24-25



PC Priorities FY25-26



Coming summer 2025: SFHN and PC-wide Hoshin strategic planning process

PRIMARY CARE UPDATES

Financial Stewardship

DPH budget highlights:

- DPH is committed to 1) preserving services as much as possible, 2) supporting our workforce
- DPH has had **zero layoffs** and cut 182 FTE of vacant positions
- To balance the budget, DPH commits to **$240M increased revenue in FY25-26 and $291M increase in FY 26-27.**
    - *For context, **Primary Care generated about $55M of revenue** across all sites last year.*
- Goal: increase revenue by:
    1. Generating more billable encounters
    2. Optimizing billing
    3. Maximizing pay-for-performance programs

PRIMARY CARE UPDATES

Financial Stewardship

What are we doing around budget?

- Revenue Generation Working Group is up and running.
- Medical directors are working with their teams on low-hanging fruit to generate revenue
- Working with other disciplines (dental, nutrition, PCBH, and others) to identify additional revenue opportunities
- We are moving forward on workflows that are low effort/high impact (i.e. "just do it" solutions) that will easily lead to more revenue.
  - Example: billing for after-hours calls for physicians (~$600K of revenue)--this is work we are already doing.

PRIMARY CARE UPDATES

Financial Stewardship: Access Updates

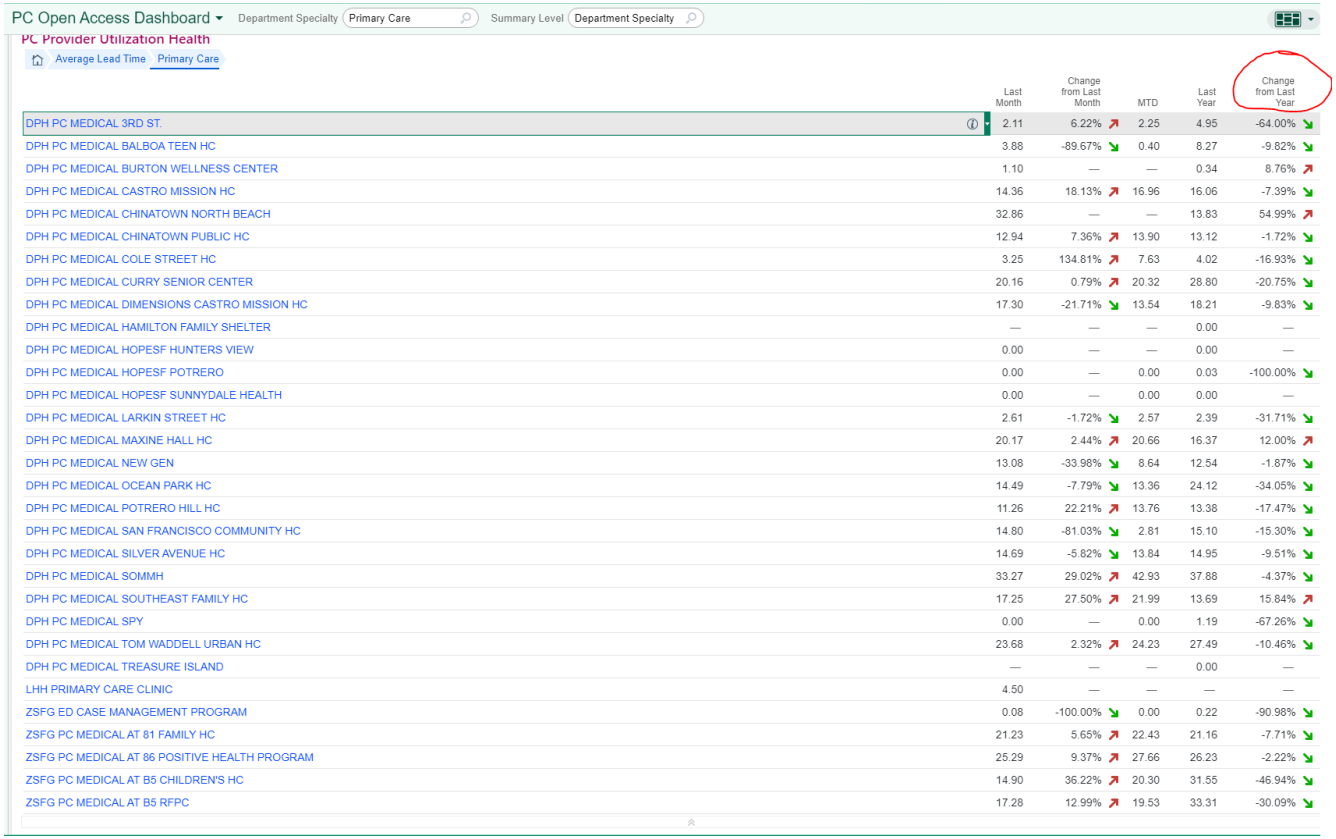
- All PC clinics now live with new access workflows and tools
- Now in "optimization" phase of access work
- Huge kudos to all PC managers, providers, staff for of the thought and work that went into this project! We celebrate you!!

PRIMARY CARE UPDATES

Financial Stewardship: Access Updates

Appointment lead team time has decreased at 85% of clinics

Average lead time decreased from 20.4 to 16.6 days over past 12 months



PC Open Access Dashboard — Department Specialty: Primary Care — Summary Level: Department Specialty

PC Provider Utilization Health

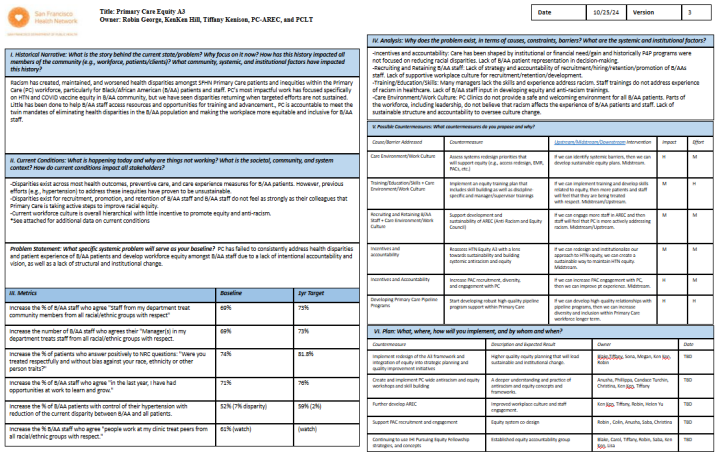
Average Lead Time | Primary Care

	Last Month	Change from Last Month	MTD	Last Year	Change from Last Year
DPH PC MEDICAL 3RD ST.	2.11	6.22%	2.25	4.95	-64.00%
DPH PC MEDICAL BALBOA TEEN HC	3.88	-89.67%	0.40	8.27	-9.82%
DPH PC MEDICAL BURTON WELLNESS CENTER	1.10	—	—	0.34	8.76%
DPH PC MEDICAL CASTRO MISSION HC	14.36	18.13%	16.96	16.06	-7.39%
DPH PC MEDICAL CHINATOWN NORTH BEACH	32.86	—	—	13.83	54.99%
DPH PC MEDICAL CHINATOWN PUBLIC HC	12.94	7.36%	13.90	13.12	-1.72%
DPH PC MEDICAL COLE STREET HC	3.25	134.81%	7.63	4.02	-16.93%
DPH PC MEDICAL CURRY SENIOR CENTER	20.16	0.79%	20.32	28.80	-20.75%
DPH PC MEDICAL DIMENSIONS CASTRO MISSION HC	17.30	-21.71%	13.54	18.21	-9.83%
DPH PC MEDICAL HAMILTON FAMILY SHELTER	—	—	—	0.00	—
DPH PC MEDICAL HOPESF HUNTERS VIEW	0.00	—	—	0.00	—
DPH PC MEDICAL HOPESF POTRERO	0.00	—	0.00	0.03	-100.00%
DPH PC MEDICAL HOPESF SUNNYDALE HEALTH	0.00	—	0.00	0.00	—
DPH PC MEDICAL LARKIN STREET HC	2.61	-1.72%	2.57	2.39	-31.71%
DPH PC MEDICAL MAXINE HALL HC	20.17	2.44%	20.66	16.37	12.00%
DPH PC MEDICAL NEW GEN	13.08	-33.98%	8.64	12.54	-1.87%
DPH PC MEDICAL OCEAN PARK HC	14.49	-7.79%	13.36	24.12	-34.05%
DPH PC MEDICAL POTRERO HILL HC	11.26	22.21%	13.76	13.38	-17.47%
DPH PC MEDICAL SAN FRANCISCO COMMUNITY HC	14.80	-81.03%	2.81	15.10	-15.30%
DPH PC MEDICAL SILVER AVENUE HC	14.69	-5.82%	13.84	14.95	-9.51%
DPH PC MEDICAL SOMMH	33.27	29.02%	42.93	37.88	-4.37%
DPH PC MEDICAL SOUTHEAST FAMILY HC	17.25	27.50%	21.99	13.69	15.84%
DPH PC MEDICAL SPY	0.00	—	0.00	1.19	-67.26%
DPH PC MEDICAL TOM WADDELL URBAN HC	23.68	2.32%	24.23	27.49	-10.46%
DPH PC MEDICAL TREASURE ISLAND	—	—	—	0.00	—
LHH PRIMARY CARE CLINIC	4.50	—	—	—	—
ZSFG ED CASE MANAGEMENT PROGRAM	0.08	-100.00%	0.00	0.22	-90.98%
ZSFG PC MEDICAL AT 81 FAMILY HC	21.23	5.65%	22.43	21.16	-7.71%
ZSFG PC MEDICAL AT 86 POSITIVE HEALTH PROGRAM	25.29	9.37%	27.66	26.23	-2.22%
ZSFG PC MEDICAL AT B5 CHILDREN'S HC	14.90	36.22%	20.30	31.55	-46.94%
ZSFG PC MEDICAL AT B5 RFPC	17.28	12.99%	19.53	33.31	-30.09%

PRIMARY CARE UPDATES

Anti-racism and Equity

- Antiracism and equity workshops across PC
- Growing and investing in PC Patient Advisory Councils
- Building and expanding Anti-racism and Equity Council (AREC)
- Transformed approach to Quality Improvement
- Equity A3 and Bias-Free Care A3
- Ongoing trainings and workshops for leaders, managers, staff



San Francisco Health Network

Title: Primary Care Equity A3
Owner: Robin George, KenKen Hill, Tiffany Kenison, PC-AREC, and PCLT

Date	10/25/24	Version	3

I. Historical Narrative: What is the story behind the current state/problem? Why focus on it now? How has this history impacted all members of the community (e.g., workforce, patients/clients)? what community, systemic, and institutional factors have impacted this history?

Racism has created, maintained, and worsened health disparities amongst SFHN Primary Care patients and inequities within the Primary Care (PC) workforce, particularly for Black/African American (B/AA) patients and staff. PC's most impactful work has focused specifically on HTN and COVID vaccine equity in B/AA community, but we have been disparities returning when targeted efforts are not sustained. Little has been done to help B/AA staff access resources and opportunities for training and advancement.. PC is accountable to meet the twin mandates of eliminating health disparities in the B/AA population and making the workplace more equitable and inclusive for B/AA staff.

II. Current Conditions: What is happening today and why are things not working? What is the societal, community, and system context? How do current conditions impact all stakeholders?

-Disparities exist across most health outcomes, preventive care, and care experience measures for B/AA patients. However, previous efforts (e.g., hypertension) to address these inequities have proven to be unsustainable.
-Disparities exist for recruitment, promotion, and retention of B/AA staff and B/AA staff do not feel as strongly as their colleagues that Primary Care is taking active steps to improve racial equity.
-Current workforce culture is overall hierarchical with little incentive to promote equity and anti-racism.
*See attached for additional data on current conditions

Problem Statement: What specific systemic problem will serve as your baseline? PC has failed to consistently address health disparities and patient experience of B/AA patients and develop workforce equity amongst B/AA staff due to a lack of intentional accountability and vision, as well as a lack of structural and institutional change.

III. Metrics	*Baseline*	*1yr Target*
Increase the % of B/AA staff who agree "staff from my department treat community members from all racial/ethnic groups with respect"	69%	75%
Increase the number of B/AA staff who agrees their "(Manager(s) in my department treats staff from all racial/ethnic groups with respect.	69%	75%
Increase the % of patients who answer positively to NRC questions: "Have you treated respectfully and without bias against your race, ethnicity or other person traits?"	74%	81.8%
Increase the % of B/AA staff who agree "in the last year, I have had opportunities at work to learn and grow."	72%	76%
Increase the % of B/AA patients with control of their hypertension with reduction of the current disparity between B/AA and all patients.	52% (7% disparity)	59% (2%)
Increase the % B/AA staff who agree "people work at my clinic treat peers from all racial/ethnic groups with respect."	61% (watch)	(watch)

IV. Analysis: Why does the problem exist, in terms of causes, constraints, barriers? What are the systemic and institutional factors?

-Incentives and accountability: Care has been shaped by institutional or financial need/gain and historically P4P programs were not focused on reducing racial disparities. Lack of B/AA patient representation in decision-making
-Recruiting and Retaining B/AA staff: Lack of strategy and accountability of recruitment/hiring/retention/promotion of B/AAs staff. Lack of supportive workplace culture for recruitment/retention/development.
-Training/Education/Skills: Many managers lack the skills and experience address racism. Staff trainings do not address experiences of racism in healthcare. Lack of B/AA staff input in developing equity and anti-racism trainings.
-Care Environment/Work Culture: PC Clinics do not provide a safe and welcoming environment for all B/AA patients. Parts of the workforce, including leadership, do not believe that racism affects the experience of B/AA patients and staff. Lack of sustainable structure and accountability to oversee culture change.

V. Possible Countermeasures: What countermeasures do you propose and why?

Cause/Barrier Addressed	Countermeasure	Alignment/Alignment/Opportunities Intervention	Impact	Effort
Care Environment/Work Culture	Assess systems redesign priorities that will support equity (e.g., access redesign, EMR, PACs, etc.)	If we can identify systems barriers, then we can develop sustainable equity plans. Midstream.	H	M
Training/Education/Skills + Care Environment/Work Culture	Implement an equity training plan that includes skill building as well as discipline specific and manager/supervisor trainings	If we can implement training and develop skills related to equity, then more patients and staff will feel that they are being treated with respect. Midstream/Upstream.	M	H
Recruiting and Retaining B/AA Staff + Care Environment/Work Culture	Support development and sustainability of AREC (Anti-Racism and Equity Council)	If we can engage more staff in AREC and then staff will find that PC is more actively addressing racism. Midstream/Upstream.	M	M
Incentives and accountability	Reassess HTN Equity A3 with a lens towards sustainability and building systemic antiracism and equity	If we can redesign and institutionalize our approach to HTN equity, we can create a sustainable way to maintain HTN equity. Midstream.	M	M
Incentives and Accountability	Increase PAC recruitment, diversity, and engagement with PC	If we can increase PAC engagement with PC, then we can improve pt experience. Midstream.	H	M
Developing Primary Care Pipeline Programs	Start developing robust high-quality pipeline program support within Primary Care	If we can develop high quality relationships with pipeline programs, then we can increase diversity and inclusion within Primary Care workforce longer term.	H	H

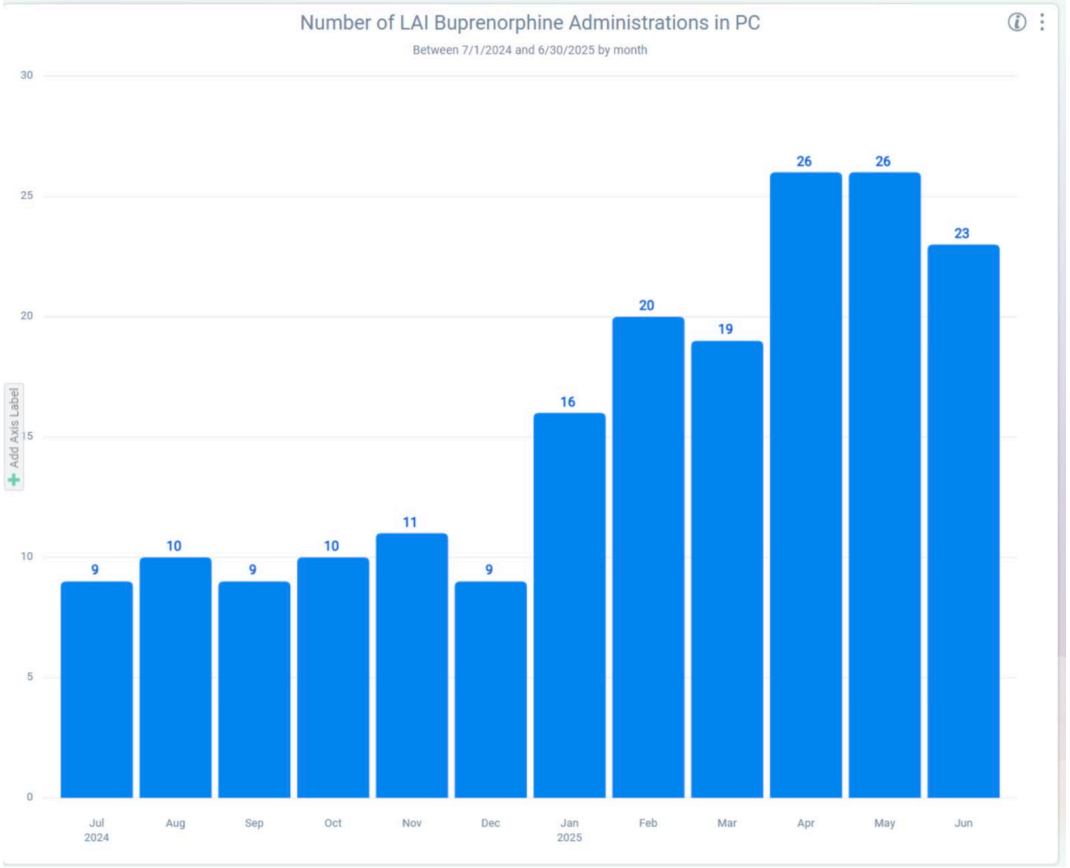
VI. Plan: What, where, how will you implement, and by whom and when?

Countermeasure	Description and Expected Result	Owner	Date
Implement redesign of the A3 framework and integration of equity into strategic planning and quality improvement initiatives	Higher quality equity planning that will lead sustainable and institutional change.	Kim/Tiffany, Sonia, Megan, Ken too, Robin	TBD
Create and implement PC wide antiracism and equity workshops and skill building	A deeper understanding and practice of antiracism and equity concepts and frameworks.	Anusha, Philippa, Candace Turchin, Christina, Ken too, Tiffany	TBD
Further develop AREC	Improved workplace culture and staff engagement	Ken too, Tiffany, Robin, Helen Yu	TBD
Support PAC recruitment and engagement	Equity system co-design	Robin, Colin, Anusha, Saba, Christina	TBD
Continuing to use Int Pursuing Equity Fellowship Strategies, and concepts	Established equity accountability group	Blake, Eoni, Tiffany, Robin, Saba, Ken too, Iris	TBD

PRIMARY CARE UPDATES

Overdose Prevention

- DPH and mayoral priority
- **What is PC doing?**
  - Expanding access to treatment for OUD
  - Growing contingency management programs
  - Partnerships with WPIC and BHS
  - Training on RN-driven model for OUD care



DPH, SFHN, ZSFG Committees

ZSFG Committee on Interdisciplinary Practice

-Ann Kim

Epic Ambulatory Domain

-Carol Taniguchi

DPH Data Governance- Data Stewardship, Privacy, Compliance and Security Sub-Committee

-Joseph Pace

ZSFG Ambulatory Care Committee

-Joseph Pace (co-chair)

-Philippa Doyle, Stephanie Le

ZSFG Credentials Committee

-Joseph Pace

MSO AB 890 Work Group

-Vanessa Aspericueta

-Joseph Pace

ZSFG Medical Executive Committee

-Joseph Pace

ZSFG Security Leadership

-Carol Taniguchi

DPH Equity Leads

-Robin George

-Kenneth (Ken Ken) Hill

-Tiffany Kenison

ZSFG Nurse Executive Committee

-Carol Taniguchi

Epic Leadership Team

-Blake Gregory

-Carol Taniguchi

ZSFG PIPS

-Blake Gregory

SFHN Expanded Executive Leadership

-Blake Gregory

SFHN CPG Joint Operation Committee

-Blake Gregory

Managed Care Operations

-Blake Gregory

ZSFG P&T Committee

-Anusha McNamara

Advanced Practice Provider Committee

--Vanessa Aspericueta (co-chair)

Teaching Activities

Pre-Graduate/Certificate Students

Medical
Nurse Practitioner
Nursing (RN, LVN)
Medical Assistant
Social Work
Marriage and Family Therapy
Clinical Pharmacy
Paramedic

Post-Graduate

Physicians (FM, IM)
Nurse Practitioner
Physician Assistant
Clinical Pharmacist

Thank you

PCLT
Blake Gregory (sharing slides on PC vision, budget, QI and PI initiatives)
Carol Taniguchi
Philippa Doyle
Colin Hart
Tiffany Kenison (sharing STEP slides)
Saba Shahid
Sona Aggarwal
Pop Health
Megan Stevenson
Performance Improvement
Jean Grady
Farah Del Arroz
Paul Glantz
MSO
Michelle Garcia
Fidez Bituin (CPC liaison to MSO)
Spencer Chow
Michelle Mai
Jennifer Siapno
James Frieberg

Our mission-driven managers, clinicians and staff

And our patients, who continue to entrust us with their care

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 :	*Community Primary Care*
Date of last approval:	*May 2023*
Summary of R&R updates:	
Update #1:	*Change May 2023 to September 2025* *Change CHN TO SFHN*
Update #2:	
Update #3:	
Update #4:	
Update #5:	

Medical Staff Services Department
Zuckerberg San Francisco General Hospital and Trauma Center
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COMMUNITY PRIMARY CARE CLINICAL SERVICE RULES AND REGULATIONS

MEC Approval Date: ~~May 2023~~September 2025

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

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I. COMMUNITY PRIMARY CARE CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Community Primary Care (CPC) service has direct responsibility for the conduct of medical care within all its ambulatory clinical sites. The purpose of the CPC service is to:

1. Ensure that all patients receive the highest quality health care and associated services. It is the mission of the CPC service to provide accessible, sustainable, high quality health care to San Franciscans who seek primary care medical services through SFDPH. The guiding philosophy is one of community-oriented primary care, which includes the following principles: a) integration of health and psychosocial services provided to individuals with public health services that focus on the health of the community as a whole; b) a commitment to working with the community as a partner, combining the professional expertise of the Department of Public Health and the CPC service with the experience and insight of the community, to develop comprehensive health needs assessments and plans to address those needs; and c) a multi-disciplinary model of care that can respond to the range of health and psychosocial problems experienced by the community.

2. Ensure that access to care is not adversely affected by race, sex, religion, national origin, immigration status, age, handicap, sexual orientation, diagnosis, ability to pay, or source of payment, subject to state and federal laws and regulations.

3. Ensure that all providers and staff in our clinics maintain high quality performance of their professional duties.

B. MEDICAL STAFF MEMBERSHIP REQUIREMENTS

Requirements for membership in the CPC service include:

1. A position as a clinician in one or more of the CPC health centers,

   Membership on the medical or affiliated professional staff of Zuckerberg San Francisco General Hospital (ZSFG) membership on the Medical Staff of Zuckerberg San Francisco General Hospital 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, Article II, Rules and Regulations and accompanying manuals.

C. ORGANIZATION and STAFFING OF THE COMMUNITY PRIMARY CARE CLINICAL SERVICE

1. Organization of the CPC service

The Community Primary Care (CPC) service is the clinical service of ZSFG comprised of the community-based primary care health centers and associated programs of the San Francisco Health Network, the health care delivery arm of the San Francisco Department of Public Health (SFDPH). The Community Primary Care (CPC) service is organized under the laws of the City and County of San Francisco through its governing body, the San Francisco Health Commission, and the Bylaws of the Medical Staff of Zuckerberg San Francisco General Hospital (ZSFG). The Rules and Regulations of the CPC Service have been created to further delineate the proper conduct of Medical Staff and affiliated professional staff professional activities within the Community Primary Care service's clinical sites.

Community Primary Care includes ten health centers and associated satellite locations operating under the jurisdiction and authority of the "parent" health center. In addition, the CPC service has jurisdiction and authority over the professional activities of its members at any other approved site where medical care may occur, such as home visits, visits to patients at ZSFG (except where the Bylaws of the ZSFG Medical Staff grant authority over professional activities at ZSFG to another clinical service), visits to patients in hospice or skilled nursing facilities, community-based nursing sites, and other such sites. The CPC service does not extend to any clinic or facility not operated by or affiliated with DPH.

2. CPC health centers

The member health centers/programs of Community Primary Care include:

1. Castro-Mission Health Center
2. Maxine Hall Health Center
3. Silver Avenue Family Health Center
4. Chinatown Public Health Center
5. Ocean Park Health Center
6. Potrero Hill Health Center
7. Southeast Health Center
8. Tom Waddell Urban Health Center

9. Curry Senior Center
10. Community Health Programs for Youth (Assisted Care/After Care (ACAC), Balboa Teen Health Center, Burton High School Wellness Center, CARECEN 2nd Chance Tattoo Removal Clinic, Cole Street Youth Clinic, Dimensions Clinic, Michael Baxter Larkin Street Clinic, 3rd Street Youth Center and Clinic, SPY Medical Clinic, , Willie Brown Middle School Health and Wellness Center, New Generation Health Center)
11. Whole Person Integrated Care (WPIC)
    - Tom Waddell Urgent Care
    - Street Medicine/Shelter Health
    - Medical Respite and Sobering Center
    - Permanent Supportive Housing Nursing

12. Community-based nursing sites which are considered satellites of health centers

3. CPC Chief of Service

The responsibilities of the CPC Chief of Service are as follows:

The Chief of Service of the Community Primary Care service shall be a licensed physician and member of the Medical Staff of ZSFG. The Chief of Service may also serve as Director of Primary Care and/or Primary Care Chief Medical Officer, San Francisco Health Network, Department of Public Health, City and County of San Francisco. In accordance with ZSFG Bylaws, the Chief of the CPC service shall be board certified in a primary care specialty.

The Chief of Service is responsible for all professional credentialing and privileging activities within the CPC Service, including the quality of medical care provided by the Medical Staff. The Chief of Service is responsible for enforcement of the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals, and these Rules and Regulations of the CPC Service. The Chief of Service organizes and oversees the conduct of graduate and undergraduate health science education within the CPC service in consultation with the Associate Dean and other appropriate officials of the University of California, San Francisco (UCSF) and the Primary Care Chief Medical Officer. The Chief or his/her designee represents the CPC Medical Staff on appropriate ZSFG, SFHN, DPH, San Francisco Health Plan, and other committees.

The Chief of Service is responsible for planning, organizing, and directing the clinical activities of Medical Staff within Community Primary Care. He or she participates in the planning, development, and implementation of primary care goals and strategies for care along with other DPH, SFHN and ZSFG staff. In addition, the CPC Chief of Service develops, implements, and monitors policies, procedures, systems, and standards for primary care medical services to ensure the effective delivery of medical services in compliance with local, state, and federal laws, rules, and regulations pertaining to the practice of medicine.

4. CPC health center Medical Directors

CPC health center Medical Directors are appointed by the SFHN Director of Primary Care and Primary Care Chief Medical Officer, with the approval of the Director of Ambulatory Care, Director of the San Francisco Health Network, and the Director of Health.

CPC Medical Directors are responsible for:

a. The overall clinical services of the health center.

b. The supervision and evaluation of clinical work performed by the Medical Staff and affiliated professional members of the CPC service who practice at the health center.

c. Assuring that the Medical Staff at their health center and affiliated ambulatory care sites practice medicine within the limits of the clinical privileges assigned to them.

d. Establish and maintain an effective Quality Improvement program at the health center, including gathering and evaluating data related to quality of care and professional standards regarding CPC Service members who practice at their health center, and taking action as may be appropriate. In the performance of these duties, the CPC health center Medical Directors report directly to the CPC Chief Medical Officer who reports to the Director of Primary Care.

5. Committees of the CPC Service

The members of the CPC Service shall have representatives on standing committees, subcommittees, and ad hoc committees of the ZSFG Medical Staff as appropriate and in accordance with Article VII of the ZSFG Medical Staff Bylaws.

In addition, SFHN Primary Care shall have the following standing committees and meetings:

- Primary Care Quality Improvement, Metric Orientation, Validation and Standardization Committee
- Primary Care Management Team Meetings

In addition, the Medical Staff of the CPC service may, from time to time, create its own ad hoc or standing committees, which shall assist in the maintenance of medical staff professional activities within the CPC service.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Community Primary Care service is in accordance with ZSFG Bylaws Article II, *Medical Staff Membership*, the Medical Staff Rules and Regulations, as well as these Clinical Service Rules and Regulations.

Appointment procedures for the CPC service, ZSFG Medical Staff and Affiliated Professionals are as follows:

1. An applicant for appointment to the CPC service shall complete the relevant DPH application form and submit to the Medical Director of the CPC health center to which the applicant is applying, who will review the DPH application with the CPC Chief Medical Officer. An applicant who wishes to work in multiple CPC health centers may submit his/her application directly to the CPC Chief Medical Officer. The application will be accompanied by documentation including, but not limited to: proof of training, proof of licensure, DEA certification (if applicable), resume, and letters of recommendation attesting to clinical competence and ethical character of the applicant.

2. Minimum training requirements are delineated in Section III - Delineation of Clinical Privileges.

3. An application for appointment to the Zuckerberg San Francisco General Hospital Medical Staff or Affiliated Professional will be submitted to the ZSFG Medical Staff Office for processing in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, and the CPC Rules and Regulations. Applications are reviewed and forwarded by the Chief of Service to the ZSFG Medical Staff Credentials Committee with a written recommendation for delineated privileges to be granted. Upon review and recommendation by the ZSFG Credentials Committee, the application is forwarded to the Medical Executive Committee. Final approval is received from the Health Commission.

4. Granting of clinical privileges within CPC is contingent upon successful completion of the application process for ZSFG Medical Staff or Affiliated Professional Staff. Initial staff

appointments are proctored for one year, during which time proctoring activity will occur as defined in Section IV. A.2.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Community Primary Care service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

1) Medical staff status change
The process for medical staff status change for members of the Community Primary Care clinical service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service rules and regulations.

2) Modification/changes to privileges
The process for modification/change to privileges for members of the Community Primary Care clinical service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

C. PRACTITIONER PERFORMANCE PROFILES

CPC service practitioner performance profiles are maintained by each CPC health center Medical Director and reviewed by the CPC Chief of Service. In order to have clinical privileges renewed, practitioners must demonstrate ongoing clinical competence, as demonstrated by chart reviews, peer review, Ongoing Provider Performance Evaluations (OPPE), and SFDPH performance appraisals.

D. AFFILIATED PROFESSIONALS

The process for appointment and reappointment for Affiliated Professionals through the Community Primary Care Clinical Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations. Affiliated professionals include nurse practitioners, nurse midwives, physician assistants, licensed acupuncturists, and clinical pharmacists. All affiliated professionals shall maintain a current job description at their clinical site, and shall operate under Standardized Procedures approved by the Committee on Interdisciplinary Practice and the Credentials Committee.

E. STAFF CATEGORIES

The Community Primary Care Clinical Service shall fall into the same staff categories, which are described in Article III of the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Community Primary Care 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.

B. ANNUAL REVIEW OF CLINCIAL SERVICE PRIVILEGE REQUEST FORM

The Community Primary Care Privilege Request Form shall be reviewed annually and modified as indicated.

C. CLINICAL PRIVILEGES and MODIFICATION/CHANGE TO PRIVILEGES

1. CPC clinical service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, and accompanying manuals. All requests for clinical privileges in the Community Primary Care service will be evaluated and approved by the CPC Chief of Service, the ZSFG Medical Staff Credentials Committee and the Governing Body. The granting of these privileges is subject to verification of proficiency based on the applicant's education, training, experience, and demonstrated competency. The applicant shall have the burden of establishing his or her qualifications and competency for the clinical privileges requested.

2. All requests for clinical privileges are proctored during a mandatory one-year period. During the proctoring period, the CPC member will be reviewed and evaluated, according to the guidelines laid out in the Rules and Regulations of the CPC service.

3. Community Primary Care service privileges permit practice within the community-based clinics of the San Francisco Department of Public Health and other approved locations where medical care is provided by CPC Medical Staff members.

4. Applicants and CPC members may request additional privileges or privileges in other ZSFG Clinical Services at any time. The CPC Chief of Service must be notified by the applicant of privileges requested of and granted by other ZSFG clinical services.

5. All CPC service members must be members of the ZSFG Medical Staff or Affiliated Professionals. Medical Staff membership will be Active for clinicians who work 50% or more time in CPC sites, and Courtesy for those who work less than 50% time in CPC sites.

6. All Active and Courtesy members of the CPC Service will have equal voting and membership rights within the CPC Service. Voting and membership rights within the ZSFG Medical Staff are as defined by the ZSFG Medical Staff Bylaws. The CPC Service membership is represented on the Medical Executive Committee of ZSFG by the CPC Chief of Service.

7. Applicants requesting clinical privileges in the CPC service shall fill out the CPC Privilege Request Form, newly revised July 2009, to include expanded special privileges for procedures no longer encompassed within core privileges. These special privileges require additional documentation of procedures performed within prior two years and if any complications occurred.

8. Successful applicants for limited privileges (i.e. Podiatry, Licensed Clinical Psychologist, Psychiatry) in the CPC service are subject to those policies adopted by the ZSFG Medical Staff clinical services which define conditions of practice for these specialties (e.g., the definition of an outpatient procedure), and are further subject to appropriate peer review within their specialty.

9. The process for modification/change to the privileges of members of the CPC service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

D. TEMPORARY PRIVILEGES

Temporary 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.

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

Monitoring and proctoring requirements for the Community Primary Care clinical service shall be the responsibility of the Chief of Service.

1. **INITIAL APPOINTMENT** will be made on the basis of demonstrated competence in the candidate's previous training and/or clinical practice.

    a. **PHYSICIANS** must demonstrate completion of residency training in a primary care specialty or prior experience in clinical primary care practice in the CPC health centers (prior to July 1, 2000) with demonstrated clinical competency equivalent to having completed a residency training program in a primary care specialty. Equivalent clinical competence will be demonstrated by proctoring outcomes, peer review, experience, letters of recommendation, and similar criteria.

    b. **NURSE PRACTITIONERS** must demonstrate completion of training in an appropriate primary care specialty and certification by the California Board of Registered Nurses as a Nurse Practitioner.

    c. **PHYSICIAN ASSISTANTS** must demonstrate completion of training in an appropriate primary care specialty and certification by the appropriate state-licensing agency.

    d. **DENTISTS, CLINICAL PHARMACISTS, PODIATRISTS, PSYCHOLOGISTS, LICENSED ACUPUNCTURISTS** must demonstrate completion of training in their respective field and certification/licensure by the appropriate state-licensing agency.

2. **PROCTORING**

    a. During the **PROCTORING** period (one [1] year), the number of representative cases specified in the CPC privileging requirements will be reviewed as part of the proctoring process.

    b. The Medical Directors of the CPC health centers/clinical sites are responsible for proctoring all providers based at their site or appointing a proctor for privileges which they do not hold. The site Medical Director or his/her designee will review the appointee's charts in the context of on-going site peer review and CPC Quality & Utilization Management activities.

    c. When the Medical Director of a health center is the candidate to be proctored, the Chief of Service or Chief Medical Officer will designate a proctor.

    d. The Chief of Service will be reviewed by the Medical Director of a health center/clinical site at which he or she maintains a continuity primary care practice.

e. Proctoring activity will be documented. Other reviews and quality and utilization management activities based at the candidate's clinical site or within the CPC Service will be considered in the candidate's overall assessment.

f. A summary proctoring report will be sent by the health center/site Medical Director to the CPC Chief of Service. Notification of proctoring activities will be forwarded to the ZSFG Medical Staff Office.

g. Proctoring of equivalent clinical scope of service provided at another CPC, SFHN, or UCSF health center may satisfy proctoring requirements, per approval by the CPC Chief of Service.

3. REAPPOINTMENT

a. For **REAPPOINTMENT**, an evaluation of clinical competence will be performed prior to each reappointment. The Chief of Service will be responsible for this evaluation, which will include a review of the number of representative cases specified in the CPC privileging requirements.

b The clinical performance of the Chief of Service will be reviewed by a Medical Director of the clinical site at which he or she maintains a continuity primary care practice.

c. Reports of performance which are less than completely satisfactory will be reviewed and investigated by the Chief of Service.

d. Proctoring of equivalent clinical scope of service provided at another CPC, SFHN, or UCSF health center may satisfy proctoring requirements, per approval by the CPC Chief of Service.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Community Primary Care clinical service shall be in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Community Primary Care clinical service shall be in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

V. EDUCATION OF MEDICAL STAFF AND TRAINEES AT THE CPC HEALTH CENTERS

Each CPC health center is responsible for its own continuing medical education programs, including patient care conferences and invited outside speakers. In addition, each physician and affiliated professional member of the CPC service is accorded paid time for continuing medical education in accordance with Department of Public Health policy. CPC service members are encouraged to attend Primary Care Grand Rounds, co-sponsored by the Division of General Internal Medicine and Family & Community Medicine. Quarterly CPC Medical Staff meetings shall include 2 hours of CME activities each quarter.

The CPC Service supports and facilitates graduate and undergraduate education in the health centers and the Chief Medical Officer is responsible for approving and overseeing the conduct of medical education within the CPC service, in consultation with the appropriate officials of UCSF and the house staff training programs.

VI. COMMUNITY PRIMARY CARE CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. HOUSESTAFF TRAINING PROGRAMS IN THE CPC HEALTH CENTERS

Each CPC Health Center may participate in house staff training programs, if appropriate for that health center. As of May 1, 2023, the following CPC Health Center has ongoing house staff training programs for UCSF residents:

Castro Mission Health Center
Chinatown Public Health Center
Curry Senior Center
Maxine Hall Health Center
Ocean Park Health Center
Potrero Hill Health Center
Silver Avenue Family Health
Southeast Family Health Center
Tom Waddell Urban Health Center
Whole Person Integrated Care- Maria X Martinez Health Resource Center, Medical Respite and Sobering Center

Other health centers may accept house staff from UCSF and other accredited training programs under an approved MOU for time-limited rotations.

Each CPC health center which provides house staff training is responsible for meeting all residency program training requirements of the "parent" residency training program, including appropriate documentation of the attending physician supervision. The CPC Chief Medical Officer is responsible for supporting residency training programs at the health centers.

B. HOUSESTAFF SUPERVISION

Attending physicians shall supervise house staff in such a way that house staff assume progressively increasing responsibility for patient care according to their level of training, ability, and experience. The Medical Director of each health center involved in house staff training, or designee, shall consult with the residency program director, or designee, in evaluating the progress of each house staff member in assuming progressively independent roles in primary care activities.

C. HOUSESTAFF ROLES, RESPONSIBILITIES, & PATIENT CARE ACTIVITIES

House staff in the CPC service will function as primary care providers in training, assuming progressive responsibility for coordinating care for the primary care of patients assigned to them. An exception is any house staff member who is doing a rotation in a CPC health center in a specialty area (i.e., psychiatry, podiatry, or clinical psychology), in which case the role of such house staff will be according to the specialty area involved. Responsibilities include provision of primary care services, provision of urgent

care services, and coordination of medical care with appropriate specialty services and psychosocial services, all under the supervision of attending physicians.

D. HOUSESTAFF EVALUATION PROCESS

The Medical Director of each health center involved in house staff training is responsible for the evaluation process of all house staff members. The Medical Director or designee shall consult with the relevant residency program director, or designee, in developing evaluation criteria. Each house staff member is evaluated by the attending faculty who supervised that house staff member in a meaningful way, such evaluations to be coordinated by the health center Medical Director or designee. The patient care activities of each house staff member shall be closely scrutinized by the attending physician for quality of care. Clinical comments on patient care matters shall be shared with house staff members by attending physicians as the patient care is delivered and supervised.

E. PATIENT CARE ORDERS

As the CPC service is an outpatient service, all orders written by house staff in the CPC health centers shall be ambulatory care orders (e.g. orders to the nursing staff to administer an outpatient medication or injection, orders for diagnostic tests, orders for patient education, and so on). House staff may independently write patient care orders in accordance with ZSFG Medical Staff and residency program procedures (e.g. house staff may order diagnostic tests only if the attending physician's name and ~~CHN~~SFHN number is included, house staff may write prescriptions for outside pharmacies only if they are licensed by the State of California, house staff may write prescriptions for controlled substances only if they possess a DEA certificate, etc.).

VII. COMMUNITY PRIMARY CARE CLINICAL SERVICE CONSULTATION CRITERIA

Consultations may be made to the CPC health centers for the following reasons:

1. Referrals for primary care.
2. Referrals to a patient's primary care provider from a hospital-based service.
3. Referrals for specialty care (podiatry, psychiatry, psychology, social work, dental services, etc.)

Referrals for primary care may be made by calling per established protocols or electronically scheduling an appointment and should be accompanied by appropriate patient-related information. Referrals to a patient's primary care provider from a hospital-based service should be according to established protocols. Referrals for specialty care should be according to the protocols of each specialty.

Consultations made by the medical staff and affiliated professional staff in the CPC health centers for specialty, diagnostic, emergency, and acute care services at ZSFG shall be made in accordance with applicable ZSFG and SFHN policies (e.g. the consultation form or eConsult is filled out appropriately, the referring provider's name and ~~CHN~~SFHN number, health center telephone/fax number, and provider's pager number or cell phone are included, the reason for the consultation is clearly spelled out, etc.)

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital Medical Staff Bylaws and Rules and Regulations will govern all disciplinary actions for medical staff-related matters involving members of the Community Primary Care clinical service. Disciplinary action for administrative matters shall be according to Department of Public Health policies and procedures.

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

GOALS, OBJECTIVES

The Community Primary Care (CPC) service actively participates in the San Francisco Health Network Primary Care Performance Improvement Patient Safety Program with the following goals:

1) to monitor and evaluate the quality and appropriateness of patient care,
2) to pursue opportunities to improve patient care, and
3) to resolve identified problems.

Core components of the Primary Care Performance Improvement infrastructure will include Daily Management Systems.

In addition, Performance Improvement will be addressed at monthly SFHN Primary Care Management Team meetings and Primary Care Quality Improvement, Metric Orientation, Validation and Standardization (PC QI/MOVS) Committee meetings. Quality assurance is addressed primarily at health center specific meetings.

The objectives of the Primary Care Quality Improvement, Metrics , Orientation, Validation and Standardization PC QI/MOVS) Committee meetings and the Primary Care Management Teams:

1. Identification and assessment of problems in the delivery of patient care;
2. Development and implementation of plans designed to identify opportunities for improvement in patient care;
3. Creation and implementation of standardized monitoring systems that regularly evaluate indicators of clinical performance;
4. Maintenance of a database that documents the effectiveness of the aforementioned clinical performance indicators;
5. Use of relevant findings from quality reviews to appraise the effectiveness of medical care provided;
6. Engage PC leaders and managers in priority areas for improvement to promote standard practices, efficient use of central PI resources, and overall improvement in population health and care experience;
7. Efficiency in the delivery of service (to minimize morbidity and mortality as well as to avoid unnecessary delays in care).

To insure appropriate care and safety of all patients receiving care in the CPC service, it is understood that this care is provided chiefly in the CPC health centers and satellite locations, but care may also be provided in other relevant ambulatory areas (the home, community sites, etc.).

All quality and utilization management information and subsequent analyses, records, proceedings, and memoranda of decisions from the SFHN Primary Care Quality Improvement Metrics Orientation, Validation, and Standardization Committee meetings and SFHN Management Teams meetings shall be protected as confidential records under California law. Physicians and staff who have access to this information in the performance of their quality and utilization management activities shall be charged to take all appropriate steps to ensure the confidentiality of this information and to safeguard its legal protection.

RESPONSIBILITY

The CPC Chief of Service, SFHN Primary Care Chief Medical Officer, and Primary Care Director of Population Health and Quality are responsible for ensuring solutions to quality of care issues and to pursuing continuous quality improvement activities. As necessary, assistance is invited from other departments and committees e.g. the ZSFG Performance Improvement and Patient Safety Committee, Ambulatory Care Committee, Medical Executive Committee,).

The SFHN Primary Care Quality Improvement, Metrics Orientation, Validation and Standardization Committee and SFHN Primary Care Management Teams are responsible for coordinating quality improvement and quality assurance activities within Primary Care section of the San Francisco Health Network.

1. The organizational structure of the Primary Care Quality Improvement, Metrics Orientation, Validation,and Standardization Committee and the Primary Care Management Teams meeting are as follows:

a. **Composition**
Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee shall consist of the Primary Care Director of Population Health and Quality, at least one management team member from each primary care site, and the QI analysts. The committee will be chaired by the Primary Care Director of Population Health and Quality.

The Primary Care Management Team meetings are led by the SFHN Primary Care Leadership Team and shall consist of health center medical directors, nurse managers, operational, behavioral health leads and QI analysts. All SFHN Primary Care health centers will all be represented.

b. **Frequency of meetings**
The Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and . SFHN Primary Care Management Teams will each meet monthly and will meet no less than 9 times a year.

c. Responsibilities
The Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and Primary Care Management Teams will be responsible for monitoring the Performance Improvement and Quality Assurance activities of the Primary Care delivery sites. Each Primary Care health center will create its own health center Quality Improvement Committee, chaired or co-chaired by the health center Medical Director, which will direct QI activities at the health center and affiliated sites and will report to the Primary Care Leadership Team. Meetings of each of the health center QI Committees will take place monthly and will meet no less than 9 times a year. Written minutes of the meetings will be maintained at the health center in a confidential file. The scope of activities monitored by the health center QI Committees and/or Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee will include the following areas:

1. **Annual scorecard performance metric and dashboard review**
Regular review and analysis of opportunities and strategies for improvement of Primary Care Driver Metrics on the annual scorecard and other dashboards will take place both

within the Primary Care PI Review Committee and the Primary Care Management Teams meeting.

2. **Patient satisfaction surveys**
   There will be regular review of patient satisfaction survey quantitative and qualitative data. The survey administered will be the NRC Real-time survey or a paper- survey administered by the health center. Driver metrics will be reviewed at monthly Primary Care Management Team meetings.

3. **Peer review**
   Peer review will take place as ongoing chart reviews and yearly performance appraisal reports done by the health center Medical Directors and the CPC Chief of Service via an established peer review protocol.

4. **Review of unusual occurrence reports and patient concerns**
   All unusual occurrence reports regarding CPC providers will be forwarded to the appropriate health center manager and the SFHN Primary Care director responsible for overseeing the area of concern (i.e. behavioral health, nursing, medical, or front office/operations). Patient concerns are reviewed and addressed by the appropriate health center manager and the central Primary Care Experience team. Health center managers are responsible for documenting responses and resolution for UOs and patient concerns.

5. **Systems review**
   Systems problems brought to the attention of the health center Medical Directors regarding the performance of diagnostic consultation, emergency, acute, ancillary, and on-call services as they affect patient care will be submitted to the Primary Care Director or Deputy Director for review.

6. **Special program audits**
   All special programs operating within CPC which conduct audits and reviews (such as Family Planning, Perinatal Services, the Healthcare for the Homeless program, etc.) will submit findings of any review audits to the Primary Care Quality Improvement Metrics, Orientation, Validation, and Standardization Committee for incorporation into service-wide quality assurance and improvement planning.

7. **Problem analysis and resolution**
   Each health center QI Committee will be responsible for summarizing the results of the aforementioned activity areas reviewed, and documenting both an analysis and a plan for resolution of any problems identified.

REPORTING

Each CPC health center Quality Improvement Committee reports to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and Primary Care Leadership Team. Annual Health Center reports shall include the following subject areas:

1. Annual PI scorecard plan, including identification of PI driver metrics with target goals for improvement. Primary Care-wide indicators reflecting SFHN performance improvement priorities each year are decided and apply to each health center.
2. Summary of clinic-specific prioritized quality improvement initiatives
3. Deliverables for health plan performance improvement Program activities

The Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee reports to the ZSFG Performance Improvement and Patient Safety Committee of the ZSFG Medical Staff. Annual summary reports of priority metrics and improvement activities will be submitted to the Performance Improvement and Patient Safety Committee. Performance improvement, patient safety, and utilization management activity records will be maintained by the CPC service and the SFHN Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee .

CLINICAL INDICATORS

The SFHN Primary Care section and CPC service, through the Chief of Service working in collaboration with the Primary Care Director of Population Health and Quality and Chief Medical Officer, shall establish clinical indicators of patient care which shall be monitored and evaluated as quality indicators. Periodic reports of such clinical indicators shall be made to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and Primary Care Management Teams.

Each CPC health center with an appropriate patient population shall participate in collecting and compiling the clinical indicators selected by the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee. In addition, each health center may elect to choose other clinical indicators that are appropriate to the patient population at that health center. Performance on clinical quality indicators which apply to specific special populations will be reviewed by special QI work groups, which will also lead QI efforts in these areas (ie chronic pain management, HIV, children's health, and prenatal). These clinical indicators will be reported to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee.

CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

CPC service providers' Medical Staff performance profiles are maintained by each health center Medical Director and reviewed by the CPC Chief of Service. In order to have clinical privileges renewed, each practitioner must demonstrate ongoing clinical competence, as demonstrated by chart reviews, peer review, twice yearly Ongoing Professional Performance Evaluation (OPPE), and yearly San Francisco Department of Public Health performance appraisals. (See Section II: Credentialing).

MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

Each CPC health center Medical Director monitors and evaluates each provider for appropriateness of patient care, and further monitors and evaluates the appropriateness of the range of patient services at that health center. The CPC Chief of Service reviews all provider evaluations and monitors the range of patient care services throughout the CPC service. Trends and recommendations for service improvement

and quality improvement are reported to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee.

MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Each CPC health center Medical Director is responsible for monitoring and evaluating the clinical and professional performance of all staff physicians and affiliated professionals at that health center. The CPC Chief Medical Officer is responsible for evaluating CPC health center Medical Directors. Performance appraisals are completed every year using SFDPH Performance Appraisal forms. Performance appraisal will include clinical performance appraisal, including OPPE results, administrative performance appraisal, and appraisal of participation in continuous quality improvement activities of the health center.

Relevant findings of the quality and utilization management activities of the CPC service, such as peer review appraisals, are considered as part of the appraisal and reappointment process of CPC service members. This information will also be used as part of the process of renewal and revision of clinical privileges of members of the CPC service.

X. MEETING REQUIREMENTS

CPC health center Medical Directors shall meet at least monthly to consider ongoing clinical and administrative issues of relevance to the CPC service, with such meetings to be convened by the Primary Care Chief Medical Officer. Monthly Primary Care Medical Director meetings are for both CPC and ZSFG-based Medical Directors. The entire CPC service (the CPC medical staff and affiliated professionals) shall meet at least quarterly; amendments to the Rules and Regulations and other matters requiring a vote of the entire service membership will be brought before these meetings. In addition, meetings of the entire CPC medical service shall be used to keep the members apprised of current developments and to solicit their input for ongoing service-related issues.

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

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

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. MEDICAL RECORDS

The medical staff of the CPC service will follow the medical records policies as defined in the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations (except as those policies pertain only to on-campus ZSFG sites).

B. CPR CERTIFICATION

CPR certification is recommended for all medical staff physicians, nurse practitioners, and physician assistants.

C. INFORMED CONSENT

Each clinical site shall maintain a list of procedures performed at that site that require informed consent. Informed consent shall be obtained in the manner described in the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

XII. ADOPTION AND AMENDMENT

The Community Primary Care clinical service Rules and Regulations will be adopted and revised by majority vote of all active CPC service members annually at a quarterly CPC service meeting. For purposes of such votes, active CPC service members will include all CPC members of the active medical staff, courtesy medical staff, affiliated professionals, and those medical staff members designated as active CPC service members by the Chief of Service.

APPENDIX A – COMMUNITY PRIMARY CARE PRIVILEGE DELINEATION FORM

Privileges for Zuckerberg San Francisco General Hospital

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.
Requested Approved

CPC COMMUNITY PRIMARY CARE 2008 (07/09 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.

Requested Approved

_____ _____ **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.

_____ _____ **8.30 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.
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.

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

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 Intrauterine Procedures
PREREQUISITES: Physicians must have CPC Basic Privileges (8.10 or 8.20).
PROCTORING: Review of 2 cases
REAPPOINTMENT: Review of 2 cases

a. Endometrial Biopsy
b. Insertion of Intrauterine Device (IUD)

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
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.

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 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.

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 include nail avulsion, chemical matrixectomies, 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 by CHIEF, ORTHOPEDIC SURGERY OR DESIGNEE REQUIRED:

_____

_____ _____ 8.52 CPC LICENSED 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.
SERVICE REVIEW: Initial approval and reappointment review and approval by CHIEF, PSYCHIATRY SERVICE OR DESIGNEE REQUIRED:

_____

_____ _____ 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 by CHIEF, PSYCHIATRY SERVICE OR DESIGNEE REQUIRED:

_____

_____ _____ 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 by CHIEF, NEUROLOGY OR DESIGNEE REQUIRED:

_____ _____ 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.
SERVICE REVIEW: Initial approval and reappointment review and approval by CHIEF, ORAL AND MAXILLOFACIAL SURGERY OR DESIGNEE REQUIRED:

_____

_____ _____ 8.56 CPC ACUPUNCTURE
Performs acupuncture, acupressure, and moxibustion in the SFHN facilities or in the patient's home.
PREREQUISITES: Current and valid license issued by the State of California Acupuncture Board of the Department of Consumer Affairs in accordance California Code Section 4938. Completion of a clean needle technique course.

PROCTORING: Direct observations and chart reviews on 5 different patients

by a medical staff member who maintains unproctored status for Acupuncture Privileges within the SFHN system. 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 SFHN 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 by CHIEF, OB & GYNECOLOGY OR DESIGNEE REQUIRED:
_____

_____ _____ 8.58 CPC REPRODUCTIVE HEALTH

Perform family planning, preconception counseling, STD prevention, IPV prevention, and other outpatient management related to sexual health, excluding pregnancy, for patients aged 12-24.
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
SERVICE REVIEW: Initial approval and reappointment review and approval by CHIEF, OB & GYNECOLOGY OR DESIGNEE REQUIRED:

_____ _____ **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)

Privileges for Zuckerberg San Francisco General Hospital

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

APPENDIX B – HOUSE STAFF COMPETENCIES

The house staff in the CPC service consist of house staff from UCSF/ZSFG residency programs and occasionally other accredited training programs under an approved MOU. There are no separate CPC house staff. The relevant house staff competencies of the Departments of General Internal Medicine and Family and Community Medicine are maintained by the residencies under the oversight of the UCSF Dean at Zuckerberg San Francisco General Hospital.

APPENDIX C – CHIEF OF SERVICE JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF COMMUNITY PRIMARY CARE SERVICE JOB DESCRIPTION

Chief of Community Primary Care
Position Summary:

The Chief of Community Primary Care is responsible for the credentialing and privileging of all CPC Service medical staff. He or she 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 Community Primary Care Service reports directly to the Director of Primary Care, if different, and to the Director of Ambulatory Care, if the Chief of CPC is the Director of Primary Care. The Chief of Service 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 Director of Health, the Director of SFHN Ambulatory Care, and the ZSFG Chief Executive Officer, 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 Community Primary Care is board certified in a primary care specialty and is a member of the active Medical Staff at ZSFG.

Major Responsibilities, in collaboration with the Primary Care Chief Medical Officer:

- 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, SFHN, and the DPH;

- In collaboration with the Chief Executive Officer and other ZSFG and SFHN leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the 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 San Francisco Health Network;

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

- Serving as a leader for the service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and

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

COMMUNITY PRIMARY CARE CLINICAL SERVICE RULES AND REGULATIONS

MEC Approval Date: September 2025

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

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I. COMMUNITY PRIMARY CARE CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Community Primary Care (CPC) service has direct responsibility for the conduct of medical care within all its ambulatory clinical sites. The purpose of the CPC service is to:

1. Ensure that all patients receive the highest quality health care and associated services. It is the mission of the CPC service to provide accessible, sustainable, high quality health care to San Franciscans who seek primary care medical services through SFDPH. The guiding philosophy is one of community-oriented primary care, which includes the following principles: a) integration of health and psychosocial services provided to individuals with public health services that focus on the health of the community as a whole; b) a commitment to working with the community as a partner, combining the professional expertise of the Department of Public Health and the CPC service with the experience and insight of the community, to develop comprehensive health needs assessments and plans to address those needs; and c) a multi-disciplinary model of care that can respond to the range of health and psychosocial problems experienced by the community.

2. Ensure that access to care is not adversely affected by race, sex, religion, national origin, immigration status, age, handicap, sexual orientation, diagnosis, ability to pay, or source of payment, subject to state and federal laws and regulations.

3. Ensure that all providers and staff in our clinics maintain high quality performance of their professional duties.

B. MEDICAL STAFF MEMBERSHIP REQUIREMENTS

Requirements for membership in the CPC service include:

1. A position as a clinician in one or more of the CPC health centers,

   Membership on the medical or affiliated professional staff of Zuckerberg San Francisco General Hospital (ZSFG) membership on the Medical Staff of Zuckerberg San Francisco General Hospital 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, Article II, Rules and Regulations and accompanying manuals.

C. ORGANIZATION and STAFFING OF THE COMMUNITY PRIMARY CARE CLINICAL SERVICE

1. Organization of the CPC service

The Community Primary Care (CPC) service is the clinical service of ZSFG comprised of the community-based primary care health centers and associated programs of the San Francisco Health Network, the health care delivery arm of the San Francisco Department of Public Health (SFDPH). The Community Primary Care (CPC) service is organized under the laws of the City and County of San Francisco through its governing body, the San Francisco Health Commission, and the Bylaws of the Medical Staff of Zuckerberg San Francisco General Hospital (ZSFG). The Rules and Regulations of the CPC Service have been created to further delineate the proper conduct of Medical Staff and affiliated professional staff professional activities within the Community Primary Care service's clinical sites.

Community Primary Care includes ten health centers and associated satellite locations operating under the jurisdiction and authority of the "parent" health center. In addition, the CPC service has jurisdiction and authority over the professional activities of its members at any other approved site where medical care may occur, such as home visits, visits to patients at ZSFG (except where the Bylaws of the ZSFG Medical Staff grant authority over professional activities at ZSFG to another clinical service), visits to patients in hospice or skilled nursing facilities, community-based nursing sites, and other such sites. The CPC service does not extend to any clinic or facility not operated by or affiliated with DPH.

2. CPC health centers

The member health centers/programs of Community Primary Care include:

1. Castro-Mission Health Center
2. Maxine Hall Health Center
3. Silver Avenue Family Health Center
4. Chinatown Public Health Center
5. Ocean Park Health Center
6. Potrero Hill Health Center
7. Southeast Health Center
8. Tom Waddell Urban Health Center

9. Curry Senior Center
10. Community Health Programs for Youth (Assisted Care/After Care (ACAC), Balboa Teen Health Center, Burton High School Wellness Center, CARECEN 2nd Chance Tattoo Removal Clinic, Cole Street Youth Clinic, Dimensions Clinic, Michael Baxter Larkin Street Clinic, 3rd Street Youth Center and Clinic, SPY Medical Clinic, , Willie Brown Middle School Health and Wellness Center, New Generation Health Center)
11. Whole Person Integrated Care (WPIC)
    - Tom Waddell Urgent Care
    - Street Medicine/Shelter Health
    - Medical Respite and Sobering Center
    - Permanent Supportive Housing Nursing

12. Community-based nursing sites which are considered satellites of health centers

3. CPC Chief of Service

The responsibilities of the CPC Chief of Service are as follows:

The Chief of Service of the Community Primary Care service shall be a licensed physician and member of the Medical Staff of ZSFG. The Chief of Service may also serve as Director of Primary Care and/or Primary Care Chief Medical Officer, San Francisco Health Network, Department of Public Health, City and County of San Francisco. In accordance with ZSFG Bylaws, the Chief of the CPC service shall be board certified in a primary care specialty.

The Chief of Service is responsible for all professional credentialing and privileging activities within the CPC Service, including the quality of medical care provided by the Medical Staff. The Chief of Service is responsible for enforcement of the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals, and these Rules and Regulations of the CPC Service. The Chief of Service organizes and oversees the conduct of graduate and undergraduate health science education within the CPC service in consultation with the Associate Dean and other appropriate officials of the University of California, San Francisco (UCSF) and the Primary Care Chief Medical Officer. The Chief or his/her designee represents the CPC Medical Staff on appropriate ZSFG, SFHN, DPH, San Francisco Health Plan, and other committees.

The Chief of Service is responsible for planning, organizing, and directing the clinical activities of Medical Staff within Community Primary Care. He or she participates in the planning, development, and implementation of primary care goals and strategies for care along with other DPH, SFHN and ZSFG staff. In addition, the CPC Chief of Service develops, implements, and monitors policies, procedures, systems, and standards for primary care medical services to ensure the effective delivery of medical services in compliance with local, state, and federal laws, rules, and regulations pertaining to the practice of medicine.

4. CPC health center Medical Directors

CPC health center Medical Directors are appointed by the SFHN Director of Primary Care and Primary Care Chief Medical Officer, with the approval of the Director of Ambulatory Care, Director of the San Francisco Health Network, and the Director of Health.

CPC Medical Directors are responsible for:

a. The overall clinical services of the health center.

b. The supervision and evaluation of clinical work performed by the Medical Staff and affiliated professional members of the CPC service who practice at the health center.

c. Assuring that the Medical Staff at their health center and affiliated ambulatory care sites practice medicine within the limits of the clinical privileges assigned to them.

d. Establish and maintain an effective Quality Improvement program at the health center, including gathering and evaluating data related to quality of care and professional standards regarding CPC Service members who practice at their health center, and taking action as may be appropriate. In the performance of these duties, the CPC health center Medical Directors report directly to the CPC Chief Medical Officer who reports to the Director of Primary Care.

5. Committees of the CPC Service

The members of the CPC Service shall have representatives on standing committees, subcommittees, and ad hoc committees of the ZSFG Medical Staff as appropriate and in accordance with Article VII of the ZSFG Medical Staff Bylaws.

In addition, SFHN Primary Care shall have the following standing committees and meetings:

- Primary Care Quality Improvement, Metric Orientation, Validation and Standardization Committee
- Primary Care Management Team Meetings

In addition, the Medical Staff of the CPC service may, from time to time, create its own ad hoc or standing committees, which shall assist in the maintenance of medical staff professional activities within the CPC service.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Community Primary Care service is in accordance with ZSFG Bylaws Article II, *Medical Staff Membership*, the Medical Staff Rules and Regulations, as well as these Clinical Service Rules and Regulations.

Appointment procedures for the CPC service, ZSFG Medical Staff and Affiliated Professionals are as follows:

1. An applicant for appointment to the CPC service shall complete the relevant DPH application form and submit to the Medical Director of the CPC health center to which the applicant is applying, who will review the DPH application with the CPC Chief Medical Officer. An applicant who wishes to work in multiple CPC health centers may submit his/her application directly to the CPC Chief Medical Officer. The application will be accompanied by documentation including, but not limited to: proof of training, proof of licensure, DEA certification (if applicable), resume, and letters of recommendation attesting to clinical competence and ethical character of the applicant.

2. Minimum training requirements are delineated in Section III - Delineation of Clinical Privileges.

3. An application for appointment to the Zuckerberg San Francisco General Hospital Medical Staff or Affiliated Professional will be submitted to the ZSFG Medical Staff Office for processing in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, and the CPC Rules and Regulations. Applications are reviewed and forwarded by the Chief of Service to the ZSFG Medical Staff Credentials Committee with a written recommendation for delineated privileges to be granted. Upon review and recommendation by the ZSFG Credentials Committee, the application is forwarded to the Medical Executive Committee. Final approval is received from the Health Commission.

4. Granting of clinical privileges within CPC is contingent upon successful completion of the application process for ZSFG Medical Staff or Affiliated Professional Staff. Initial staff

appointments are proctored for one year, during which time proctoring activity will occur as defined in Section IV. A.2.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Community Primary Care service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

1) Medical staff status change
The process for medical staff status change for members of the Community Primary Care clinical service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service rules and regulations.

2) Modification/changes to privileges
The process for modification/change to privileges for members of the Community Primary Care clinical service is in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

C. PRACTITIONER PERFORMANCE PROFILES

CPC service practitioner performance profiles are maintained by each CPC health center Medical Director and reviewed by the CPC Chief of Service. In order to have clinical privileges renewed, practitioners must demonstrate ongoing clinical competence, as demonstrated by chart reviews, peer review, Ongoing Provider Performance Evaluations (OPPE), and SFDPH performance appraisals.

D. AFFILIATED PROFESSIONALS

The process for appointment and reappointment for Affiliated Professionals through the Community Primary Care Clinical Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations. Affiliated professionals include nurse practitioners, nurse midwives, physician assistants, licensed acupuncturists, and clinical pharmacists. All affiliated professionals shall maintain a current job description at their clinical site, and shall operate under Standardized Procedures approved by the Committee on Interdisciplinary Practice and the Credentials Committee.

E. STAFF CATEGORIES

The Community Primary Care Clinical Service shall fall into the same staff categories, which are described in Article III of the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Community Primary Care 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.

B. ANNUAL REVIEW OF CLINCIAL SERVICE PRIVILEGE REQUEST FORM

The Community Primary Care Privilege Request Form shall be reviewed annually and modified as indicated.

C. CLINICAL PRIVILEGES and MODIFICATION/CHANGE TO PRIVILEGES

1. CPC clinical service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, and accompanying manuals. All requests for clinical privileges in the Community Primary Care service will be evaluated and approved by the CPC Chief of Service, the ZSFG Medical Staff Credentials Committee and the Governing Body. The granting of these privileges is subject to verification of proficiency based on the applicant's education, training, experience, and demonstrated competency. The applicant shall have the burden of establishing his or her qualifications and competency for the clinical privileges requested.

2. All requests for clinical privileges are proctored during a mandatory one-year period. During the proctoring period, the CPC member will be reviewed and evaluated, according to the guidelines laid out in the Rules and Regulations of the CPC service.

3. Community Primary Care service privileges permit practice within the community-based clinics of the San Francisco Department of Public Health and other approved locations where medical care is provided by CPC Medical Staff members.

4. Applicants and CPC members may request additional privileges or privileges in other ZSFG Clinical Services at any time. The CPC Chief of Service must be notified by the applicant of privileges requested of and granted by other ZSFG clinical services.

5. All CPC service members must be members of the ZSFG Medical Staff or Affiliated Professionals. Medical Staff membership will be Active for clinicians who work 50% or more time in CPC sites, and Courtesy for those who work less than 50% time in CPC sites.

6. All Active and Courtesy members of the CPC Service will have equal voting and membership rights within the CPC Service. Voting and membership rights within the ZSFG Medical Staff are as defined by the ZSFG Medical Staff Bylaws. The CPC Service membership is represented on the Medical Executive Committee of ZSFG by the CPC Chief of Service.

7. Applicants requesting clinical privileges in the CPC service shall fill out the CPC Privilege Request Form, newly revised July 2009, to include expanded special privileges for procedures no longer encompassed within core privileges. These special privileges require additional documentation of procedures performed within prior two years and if any complications occurred.

8. Successful applicants for limited privileges (i.e. Podiatry, Licensed Clinical Psychologist, Psychiatry) in the CPC service are subject to those policies adopted by the ZSFG Medical Staff clinical services which define conditions of practice for these specialties (e.g., the definition of an outpatient procedure), and are further subject to appropriate peer review within their specialty.

9. The process for modification/change to the privileges of members of the CPC service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

D. TEMPORARY PRIVILEGES

Temporary 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.

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

Monitoring and proctoring requirements for the Community Primary Care clinical service shall be the responsibility of the Chief of Service.

1. **INITIAL APPOINTMENT** will be made on the basis of demonstrated competence in the candidate's previous training and/or clinical practice.

    a. **PHYSICIANS** must demonstrate completion of residency training in a primary care specialty or prior experience in clinical primary care practice in the CPC health centers (prior to July 1, 2000) with demonstrated clinical competency equivalent to having completed a residency training program in a primary care specialty. Equivalent clinical competence will be demonstrated by proctoring outcomes, peer review, experience, letters of recommendation, and similar criteria.

    b. **NURSE PRACTITIONERS** must demonstrate completion of training in an appropriate primary care specialty and certification by the California Board of Registered Nurses as a Nurse Practitioner.

    c. **PHYSICIAN ASSISTANTS** must demonstrate completion of training in an appropriate primary care specialty and certification by the appropriate state-licensing agency.

    d. **DENTISTS, CLINICAL PHARMACISTS, PODIATRISTS, PSYCHOLOGISTS, LICENSED ACUPUNCTURISTS** must demonstrate completion of training in their respective field and certification/licensure by the appropriate state-licensing agency.

2. **PROCTORING**

    a. During the **PROCTORING** period (one [1] year), the number of representative cases specified in the CPC privileging requirements will be reviewed as part of the proctoring process.

    b. The Medical Directors of the CPC health centers/clinical sites are responsible for proctoring all providers based at their site or appointing a proctor for privileges which they do not hold. The site Medical Director or his/her designee will review the appointee's charts in the context of on-going site peer review and CPC Quality & Utilization Management activities.

    c. When the Medical Director of a health center is the candidate to be proctored, the Chief of Service or Chief Medical Officer will designate a proctor.

    d. The Chief of Service will be reviewed by the Medical Director of a health center/clinical site at which he or she maintains a continuity primary care practice.

e. Proctoring activity will be documented. Other reviews and quality and utilization management activities based at the candidate's clinical site or within the CPC Service will be considered in the candidate's overall assessment.

f. A summary proctoring report will be sent by the health center/site Medical Director to the CPC Chief of Service. Notification of proctoring activities will be forwarded to the ZSFG Medical Staff Office.

g. Proctoring of equivalent clinical scope of service provided at another CPC, SFHN, or UCSF health center may satisfy proctoring requirements, per approval by the CPC Chief of Service.

3. REAPPOINTMENT

a. For **REAPPOINTMENT**, an evaluation of clinical competence will be performed prior to each reappointment. The Chief of Service will be responsible for this evaluation, which will include a review of the number of representative cases specified in the CPC privileging requirements.

b The clinical performance of the Chief of Service will be reviewed by a Medical Director of the clinical site at which he or she maintains a continuity primary care practice.

c. Reports of performance which are less than completely satisfactory will be reviewed and investigated by the Chief of Service.

d. Proctoring of equivalent clinical scope of service provided at another CPC, SFHN, or UCSF health center may satisfy proctoring requirements, per approval by the CPC Chief of Service.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Community Primary Care clinical service shall be in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Community Primary Care clinical service shall be in accordance with ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

V. EDUCATION OF MEDICAL STAFF AND TRAINEES AT THE CPC HEALTH CENTERS

Each CPC health center is responsible for its own continuing medical education programs, including patient care conferences and invited outside speakers. In addition, each physician and affiliated professional member of the CPC service is accorded paid time for continuing medical education in accordance with Department of Public Health policy. CPC service members are encouraged to attend Primary Care Grand Rounds, co-sponsored by the Division of General Internal Medicine and Family & Community Medicine. Quarterly CPC Medical Staff meetings shall include 2 hours of CME activities each quarter.

The CPC Service supports and facilitates graduate and undergraduate education in the health centers and the Chief Medical Officer is responsible for approving and overseeing the conduct of medical education within the CPC service, in consultation with the appropriate officials of UCSF and the house staff training programs.

VI. COMMUNITY PRIMARY CARE CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. HOUSESTAFF TRAINING PROGRAMS IN THE CPC HEALTH CENTERS

Each CPC Health Center may participate in house staff training programs, if appropriate for that health center. As of May 1, 2023, the following CPC Health Center has ongoing house staff training programs for UCSF residents:

Castro Mission Health Center
Chinatown Public Health Center
Curry Senior Center
Maxine Hall Health Center
Ocean Park Health Center
Potrero Hill Health Center
Silver Avenue Family Health
Southeast Family Health Center
Tom Waddell Urban Health Center
Whole Person Integrated Care- Maria X Martinez Health Resource Center, Medical Respite and Sobering Center

Other health centers may accept house staff from UCSF and other accredited training programs under an approved MOU for time-limited rotations.

Each CPC health center which provides house staff training is responsible for meeting all residency program training requirements of the "parent" residency training program, including appropriate documentation of the attending physician supervision. The CPC Chief Medical Officer is responsible for supporting residency training programs at the health centers.

B. HOUSESTAFF SUPERVISION

Attending physicians shall supervise house staff in such a way that house staff assume progressively increasing responsibility for patient care according to their level of training, ability, and experience. The Medical Director of each health center involved in house staff training, or designee, shall consult with the residency program director, or designee, in evaluating the progress of each house staff member in assuming progressively independent roles in primary care activities.

C. HOUSESTAFF ROLES, RESPONSIBILITIES, & PATIENT CARE ACTIVITIES

House staff in the CPC service will function as primary care providers in training, assuming progressive responsibility for coordinating care for the primary care of patients assigned to them. An exception is any house staff member who is doing a rotation in a CPC health center in a specialty area (i.e., psychiatry, podiatry, or clinical psychology), in which case the role of such house staff will be according to the specialty area involved. Responsibilities include provision of primary care services, provision of urgent

care services, and coordination of medical care with appropriate specialty services and psychosocial services, all under the supervision of attending physicians.

D. HOUSESTAFF EVALUATION PROCESS

The Medical Director of each health center involved in house staff training is responsible for the evaluation process of all house staff members. The Medical Director or designee shall consult with the relevant residency program director, or designee, in developing evaluation criteria. Each house staff member is evaluated by the attending faculty who supervised that house staff member in a meaningful way, such evaluations to be coordinated by the health center Medical Director or designee. The patient care activities of each house staff member shall be closely scrutinized by the attending physician for quality of care. Clinical comments on patient care matters shall be shared with house staff members by attending physicians as the patient care is delivered and supervised.

E. PATIENT CARE ORDERS

As the CPC service is an outpatient service, all orders written by house staff in the CPC health centers shall be ambulatory care orders (e.g. orders to the nursing staff to administer an outpatient medication or injection, orders for diagnostic tests, orders for patient education, and so on). House staff may independently write patient care orders in accordance with ZSFG Medical Staff and residency program procedures (e.g. house staff may order diagnostic tests only if the attending physician's name and SFHN number is included, house staff may write prescriptions for outside pharmacies only if they are licensed by the State of California, house staff may write prescriptions for controlled substances only if they possess a DEA certificate, etc.).

VII. COMMUNITY PRIMARY CARE CLINICAL SERVICE CONSULTATION CRITERIA

Consultations may be made to the CPC health centers for the following reasons:

1. Referrals for primary care.
2. Referrals to a patient’s primary care provider from a hospital-based service.
3. Referrals for specialty care (podiatry, psychiatry, psychology, social work, dental services, etc.)

Referrals for primary care may be made by calling per established protocols or electronically scheduling an appointment and should be accompanied by appropriate patient-related information. Referrals to a patient’s primary care provider from a hospital-based service should be according to established protocols. Referrals for specialty care should be according to the protocols of each specialty.

Consultations made by the medical staff and affiliated professional staff in the CPC health centers for specialty, diagnostic, emergency, and acute care services at ZSFG shall be made in accordance with applicable ZSFG and SFHN policies (e.g. the consultation form or eConsult is filled out appropriately, the referring provider's name and SFHN number, health center telephone/fax number, and provider’s pager number or cell phone are included, the reason for the consultation is clearly spelled out, etc.)

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital Medical Staff Bylaws and Rules and Regulations will govern all disciplinary actions for medical staff-related matters involving members of the Community Primary Care clinical service. Disciplinary action for administrative matters shall be according to Department of Public Health policies and procedures.

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

GOALS, OBJECTIVES

The Community Primary Care (CPC) service actively participates in the San Francisco Health Network Primary Care Performance Improvement Patient Safety Program with the following goals:

1) to monitor and evaluate the quality and appropriateness of patient care,
2) to pursue opportunities to improve patient care, and
3) to resolve identified problems.

Core components of the Primary Care Performance Improvement infrastructure will include Daily Management Systems.

In addition, Performance Improvement will be addressed at monthly SFHN Primary Care Management Team meetings and Primary Care Quality Improvement, Metric Orientation, Validation and Standardization (PC QI/MOVS) Committee meetings. Quality assurance is addressed primarily at health center specific meetings.

The objectives of the Primary Care Quality Improvement, Metrics , Orientation, Validation and Standardization PC QI/MOVS) Committee meetings and the Primary Care Management Teams:

1. Identification and assessment of problems in the delivery of patient care;
2. Development and implementation of plans designed to identify opportunities for improvement in patient care;
3. Creation and implementation of standardized monitoring systems that regularly evaluate indicators of clinical performance;
4. Maintenance of a database that documents the effectiveness of the aforementioned clinical performance indicators;
5. Use of relevant findings from quality reviews to appraise the effectiveness of medical care provided;
6. Engage PC leaders and managers in priority areas for improvement to promote standard practices, efficient use of central PI resources, and overall improvement in population health and care experience;
7. Efficiency in the delivery of service (to minimize morbidity and mortality as well as to avoid unnecessary delays in care).

To insure appropriate care and safety of all patients receiving care in the CPC service, it is understood that this care is provided chiefly in the CPC health centers and satellite locations, but care may also be provided in other relevant ambulatory areas (the home, community sites, etc.).

All quality and utilization management information and subsequent analyses, records, proceedings, and memoranda of decisions from the SFHN Primary Care Quality Improvement Metrics Orientation, Validation, and Standardization Committee meetings and SFHN Management Teams meetings shall be protected as confidential records under California law. Physicians and staff who have access to this information in the performance of their quality and utilization management activities shall be charged to take all appropriate steps to ensure the confidentiality of this information and to safeguard its legal protection.

RESPONSIBILITY

The CPC Chief of Service, SFHN Primary Care Chief Medical Officer, and Primary Care Director of Population Health and Quality are responsible for ensuring solutions to quality of care issues and to pursuing continuous quality improvement activities. As necessary, assistance is invited from other departments and committees e.g. the ZSFG Performance Improvement and Patient Safety Committee, Ambulatory Care Committee, Medical Executive Committee,).

The SFHN Primary Care Quality Improvement, Metrics Orientation, Validation and Standardization Committee and SFHN Primary Care Management Teams are responsible for coordinating quality improvement and quality assurance activities within Primary Care section of the San Francisco Health Network.

1. The organizational structure of the Primary Care Quality Improvement, Metrics Orientation, Validation,and Standardization Committee and the Primary Care Management Teams meeting are as follows:

a. **Composition**
Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee shall consist of the Primary Care Director of Population Health and Quality, at least one management team member from each primary care site, and the QI analysts. The committee will be chaired by the Primary Care Director of Population Health and Quality.

The Primary Care Management Team meetings are led by the SFHN Primary Care Leadership Team and shall consist of health center medical directors, nurse managers, operational, behavioral health leads and QI analysts. All SFHN Primary Care health centers will all be represented.

b. **Frequency of meetings**
The Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and . SFHN Primary Care Management Teams will each meet monthly and will meet no less than 9 times a year.

c. Responsibilities
The Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and Primary Care Management Teams will be responsible for monitoring the Performance Improvement and Quality Assurance activities of the Primary Care delivery sites. Each Primary Care health center will create its own health center Quality Improvement Committee, chaired or co-chaired by the health center Medical Director, which will direct QI activities at the health center and affiliated sites and will report to the Primary Care Leadership Team. Meetings of each of the health center QI Committees will take place monthly and will meet no less than 9 times a year. Written minutes of the meetings will be maintained at the health center in a confidential file. The scope of activities monitored by the health center QI Committees and/or Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee will include the following areas:

1. **Annual scorecard performance metric and dashboard review**
Regular review and analysis of opportunities and strategies for improvement of Primary Care Driver Metrics on the annual scorecard and other dashboards will take place both

within the Primary Care PI Review Committee and the Primary Care Management Teams meeting.

2. **Patient satisfaction surveys**
   There will be regular review of patient satisfaction survey quantitative and qualitative data. The survey administered will be the NRC Real-time survey or a paper- survey administered by the health center. Driver metrics will be reviewed at monthly Primary Care Management Team meetings.

3. **Peer review**
   Peer review will take place as ongoing chart reviews and yearly performance appraisal reports done by the health center Medical Directors and the CPC Chief of Service via an established peer review protocol.

4. **Review of unusual occurrence reports and patient concerns**
   All unusual occurrence reports regarding CPC providers will be forwarded to the appropriate health center manager and the SFHN Primary Care director responsible for overseeing the area of concern (i.e. behavioral health, nursing, medical, or front office/operations). Patient concerns are reviewed and addressed by the appropriate health center manager and the central Primary Care Experience team. Health center managers are responsible for documenting responses and resolution for UOs and patient concerns.

5. **Systems review**
   Systems problems brought to the attention of the health center Medical Directors regarding the performance of diagnostic consultation, emergency, acute, ancillary, and on-call services as they affect patient care will be submitted to the Primary Care Director or Deputy Director for review.

6. **Special program audits**
   All special programs operating within CPC which conduct audits and reviews (such as Family Planning, Perinatal Services, the Healthcare for the Homeless program, etc.) will submit findings of any review audits to the Primary Care Quality Improvement Metrics, Orientation, Validation, and Standardization Committee for incorporation into service-wide quality assurance and improvement planning.

7. **Problem analysis and resolution**
   Each health center QI Committee will be responsible for summarizing the results of the aforementioned activity areas reviewed, and documenting both an analysis and a plan for resolution of any problems identified.

REPORTING

Each CPC health center Quality Improvement Committee reports to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and Primary Care Leadership Team. Annual Health Center reports shall include the following subject areas:

1. Annual PI scorecard plan, including identification of PI driver metrics with target goals for improvement. Primary Care-wide indicators reflecting SFHN performance improvement priorities each year are decided and apply to each health center.
2. Summary of clinic-specific prioritized quality improvement initiatives
3. Deliverables for health plan performance improvement Program activities

The Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee reports to the ZSFG Performance Improvement and Patient Safety Committee of the ZSFG Medical Staff. Annual summary reports of priority metrics and improvement activities will be submitted to the Performance Improvement and Patient Safety Committee. Performance improvement, patient safety, and utilization management activity records will be maintained by the CPC service and the SFHN Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee .

CLINICAL INDICATORS

The SFHN Primary Care section and CPC service, through the Chief of Service working in collaboration with the Primary Care Director of Population Health and Quality and Chief Medical Officer, shall establish clinical indicators of patient care which shall be monitored and evaluated as quality indicators. Periodic reports of such clinical indicators shall be made to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee and Primary Care Management Teams.

Each CPC health center with an appropriate patient population shall participate in collecting and compiling the clinical indicators selected by the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee. In addition, each health center may elect to choose other clinical indicators that are appropriate to the patient population at that health center. Performance on clinical quality indicators which apply to specific special populations will be reviewed by special QI work groups, which will also lead QI efforts in these areas (ie chronic pain management, HIV, children's health, and prenatal). These clinical indicators will be reported to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee.

CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

CPC service providers' Medical Staff performance profiles are maintained by each health center Medical Director and reviewed by the CPC Chief of Service. In order to have clinical privileges renewed, each practitioner must demonstrate ongoing clinical competence, as demonstrated by chart reviews, peer review, twice yearly Ongoing Professional Performance Evaluation (OPPE), and yearly San Francisco Department of Public Health performance appraisals. (See Section II: Credentialing).

MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

Each CPC health center Medical Director monitors and evaluates each provider for appropriateness of patient care, and further monitors and evaluates the appropriateness of the range of patient services at that health center. The CPC Chief of Service reviews all provider evaluations and monitors the range of patient care services throughout the CPC service. Trends and recommendations for service improvement

and quality improvement are reported to the Primary Care Quality Improvement, Metrics Orientation, Validation, and Standardization Committee.

MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Each CPC health center Medical Director is responsible for monitoring and evaluating the clinical and professional performance of all staff physicians and affiliated professionals at that health center. The CPC Chief Medical Officer is responsible for evaluating CPC health center Medical Directors. Performance appraisals are completed every year using SFDPH Performance Appraisal forms. Performance appraisal will include clinical performance appraisal, including OPPE results, administrative performance appraisal, and appraisal of participation in continuous quality improvement activities of the health center.

Relevant findings of the quality and utilization management activities of the CPC service, such as peer review appraisals, are considered as part of the appraisal and reappointment process of CPC service members. This information will also be used as part of the process of renewal and revision of clinical privileges of members of the CPC service.

X. MEETING REQUIREMENTS

CPC health center Medical Directors shall meet at least monthly to consider ongoing clinical and administrative issues of relevance to the CPC service, with such meetings to be convened by the Primary Care Chief Medical Officer. Monthly Primary Care Medical Director meetings are for both CPC and ZSFG-based Medical Directors. The entire CPC service (the CPC medical staff and affiliated professionals) shall meet at least quarterly; amendments to the Rules and Regulations and other matters requiring a vote of the entire service membership will be brought before these meetings. In addition, meetings of the entire CPC medical service shall be used to keep the members apprised of current developments and to solicit their input for ongoing service-related issues.

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

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

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. MEDICAL RECORDS

The medical staff of the CPC service will follow the medical records policies as defined in the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations (except as those policies pertain only to on-campus ZSFG sites).

B. CPR CERTIFICATION

CPR certification is recommended for all medical staff physicians, nurse practitioners, and physician assistants.

C. INFORMED CONSENT

Each clinical site shall maintain a list of procedures performed at that site that require informed consent. Informed consent shall be obtained in the manner described in the ZSFG Medical Staff Bylaws, Rules and Regulations, as well as these clinical service Rules and Regulations.

XII. ADOPTION AND AMENDMENT

The Community Primary Care clinical service Rules and Regulations will be adopted and revised by majority vote of all active CPC service members annually at a quarterly CPC service meeting. For purposes of such votes, active CPC service members will include all CPC members of the active medical staff, courtesy medical staff, affiliated professionals, and those medical staff members designated as active CPC service members by the Chief of Service.

APPENDIX A – COMMUNITY PRIMARY CARE PRIVILEGE DELINEATION FORM

Privileges for Zuckerberg San Francisco General Hospital

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.

Requested Approved

CPC COMMUNITY PRIMARY CARE 2008 (07/09 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.

Requested Approved

_____ _____ **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.

_____ _____ **8.30 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.
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.

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

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 Intrauterine Procedures
PREREQUISITES: Physicians must have CPC Basic Privileges (8.10 or 8.20).
PROCTORING: Review of 2 cases
REAPPOINTMENT: Review of 2 cases

a. Endometrial Biopsy
b. Insertion of Intrauterine Device (IUD)

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
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.

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 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.

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 include nail avulsion, chemical matrixectomies, 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 by CHIEF, ORTHOPEDIC SURGERY OR DESIGNEE REQUIRED:

_____

_____ _____ 8.52 CPC LICENSED 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.
SERVICE REVIEW: Initial approval and reappointment review and approval by CHIEF, PSYCHIATRY SERVICE OR DESIGNEE REQUIRED:

_____

_____ _____ 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 by CHIEF, PSYCHIATRY SERVICE OR DESIGNEE REQUIRED:

_____

_____ _____ 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 by CHIEF, NEUROLOGY OR DESIGNEE REQUIRED:

_____ _____ 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.
SERVICE REVIEW: Initial approval and reappointment review and approval by CHIEF, ORAL AND MAXILLOFACIAL SURGERY OR DESIGNEE REQUIRED:

_____

_____ _____ 8.56 CPC ACUPUNCTURE
Performs acupuncture, acupressure, and moxibustion in the SFHN facilities or in the patient's home.
PREREQUISITES: Current and valid license issued by the State of California Acupuncture Board of the Department of Consumer Affairs in accordance California Code Section 4938. Completion of a clean needle technique course.

PROCTORING: Direct observations and chart reviews on 5 different patients

by a medical staff member who maintains unproctored status for Acupuncture Privileges within the SFHN system. 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 SFHN 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 by CHIEF, OB & GYNECOLOGY OR DESIGNEE REQUIRED:
_____

_____ _____ 8.58 CPC REPRODUCTIVE HEALTH

Perform family planning, preconception counseling, STD prevention, IPV prevention, and other outpatient management related to sexual health, excluding pregnancy, for patients aged 12-24.
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
SERVICE REVIEW: Initial approval and reappointment review and approval by CHIEF, OB & GYNECOLOGY OR DESIGNEE REQUIRED:

_____ _____ **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)

Privileges for Zuckerberg San Francisco General Hospital

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

APPENDIX B – HOUSE STAFF COMPETENCIES

The house staff in the CPC service consist of house staff from UCSF/ZSFG residency programs and occasionally other accredited training programs under an approved MOU. There are no separate CPC house staff. The relevant house staff competencies of the Departments of General Internal Medicine and Family and Community Medicine are maintained by the residencies under the oversight of the UCSF Dean at Zuckerberg San Francisco General Hospital.

APPENDIX C – CHIEF OF SERVICE JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF COMMUNITY PRIMARY CARE SERVICE JOB DESCRIPTION

Chief of Community Primary Care
Position Summary:

The Chief of Community Primary Care is responsible for the credentialing and privileging of all CPC Service medical staff. He or she 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 Community Primary Care Service reports directly to the Director of Primary Care, if different, and to the Director of Ambulatory Care, if the Chief of CPC is the Director of Primary Care. The Chief of Service 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 Director of Health, the Director of SFHN Ambulatory Care, and the ZSFG Chief Executive Officer, 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 Community Primary Care is board certified in a primary care specialty and is a member of the active Medical Staff at ZSFG.

Major Responsibilities, in collaboration with the Primary Care Chief Medical Officer:

- 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, SFHN, and the DPH;

- In collaboration with the Chief Executive Officer and other ZSFG and SFHN leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the 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 San Francisco Health Network;

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

- Serving as a leader for the service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs; and

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

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	Ambulatory Care Standing Order Protocol Update September 2025
Clinical Service:	Primary Care and Specialty Care
Date of last approval:	September 2024
Summary of SOP updates:	New and updated SOPs
Update #1:	*Updated Procedure* Adult Primary Care: Cervical Cancer Screening • Current: For patients with a cervix aged 21-65 who have been sexually active • Proposed: For patients with a cervix aged ≥21
Update #2:	*Updated Procedure* Adult Primary Care: COLORECTAL CANCER SCREENING • Current: For a patient aged 45-75, authorized staff members with appropriate training will do the following: 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. If colonoscopy > 10 yrs OR if FOBT/FIT >10 months OR if No FOBT/FIT → Order and offer FIT If No colonoscopy AND if (FOBT/FIT >10 months or No FOBT/FIT) → Order and offer FIT Proposed: For a patient aged 45-75, authorized staff members with appropriate training will review the care gap for guidance and do the following: 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.

	If colonoscopy > 10 yrs OR if FOBT/FIT >10 months OR if No FOBT/FIT → Order and offer FIT If No colonoscopy AND if (FOBT/FIT >10 months or No FOBT/FIT) → Order and offer FIT
Update #3:	*Updated Procedure* <u>Adult Primary Care: DIABETES MANAGEMENT</u> Current: 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) Proposed: Appropriate training will also include: 4. <u>Review CareGap active for Teleretinal Screening</u> 5. <u>If clinic has a TRS camera, and no future appointment already scheduled with 4M, place order and complete teleretinal imaging.</u> 6. <u>If clinic does not have a TRS camera, refer to 4M for teleretinal screening.</u> 7. If last foot exam > 10 months: a. Perform Monofilament Test. b. Record MFT test results in EHR. If result is abnormal, refer to Podiatry
Update #4:	*Updated Procedure* <u>Adult Primary Care and Specialty Care: HEPATITIS B SCREENING</u> Proposed ADD: Authorized staff members with appropriate training will do the following: 1. 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. CurrentAuthorized staff members with appropriate training will do the following: ~~1.~~ If a patient meets criteria[3] for HBV screening, AND EHR does not contain any result for "HEPATITIS B HBV SURFACE ANTIGEN", order "HEPATITIS B HBV SURFACE ANTIGEN" and "HEPATITIS B HBV SURFACE ANTIBODY" 2.

Update #5:	*New Procedure* Adult Primary Care: PREGNANCY INTENTION SCREENING Proposed: Add: For a woman aged ~~18-501,~~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.
Update #6:	*Updated Procedure* Adult Primary Care: Prostate Cancer Screening 1. Proposed: Remove
Update #7:	*Updated Procedure* Adult Primary Care: STI SCREENING Current: a: If male and aged 35 and older b: If male aged 20-35 or female 20 or older AND with one of the following cardiovascular risk factors… Proposed: a. If male and aged 35 and older and women 45 and older b. If male aged 20-35 or female 20-45, AND with one of the following cardiovascular risk factors…
Update #8:	*Updated Procedure* Adult Primary Care: STI Testing Proposed: 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 ≥ 15 - ≤ 44 years of age:* • Syphilis if no record of prior test *All sexually active people ≥ 12 - ≤ 64 years of age* • HIV if no record of prior test *Sexually active women ≤24 years of age:*

	• Urine or vaginal gonorrhea (GC) and chlamydia (CT) if last done >10 mo *Sexually active men who have sex with women **and** women who have sex with men, and at increased risk of 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 **Sex with a man who has sex with men (for women), 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.* *Sexually active men who have sex with men* • HIV if last done > 5 mo • Syphilis if last done > 5 mo • GC and CT from all sites of exposure if last tested > 5 mo o Urine if insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o Rectal swab if receptive anal sex in the last 12 months *Sexually active transgender people* • HIV if last done > 5 mo • Syphilis if last done > 5 mo • Offer GC and CT screening based on current anatomy and sites of exposure if last tested > 5 mo o Urine if has a penis and insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o Rectal swab if receptive anal sex in the last 12 months o 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 o Urine if has a penis and insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o Rectal swab if receptive anal sex in the last 12 months o Vaginal swab or urine if has a cervix and had receptive

	vaginal (front hole) sex in last 12 months • For women: vaginal swab (clinician or self-collected) for trichomoniasis if last done >10 mo ***Consider more frequent testing if patient at increased risk of STIs**
Update #9:	1. Ambulatory Specialty Care: Cardiology Management Current: Perform ECG on the following patients: a. New Cardiology Clinic patients at initial visit b. Established Cardiology Clinic patients every 6 months for monitoring c. Patients with a history of atrial fibrillation d. Patients with new complaint of acute chest pain Proposed: 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 d. Annually for all patients with heart failure to screen for left bundle branch block
Update #10:	Ambulatory Specialty Care: CHRONIC KIDNEY DISEASE SCREENING Current: 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 With an estimated glomerular filtration rate (eGFR) < 60: a urine microalbuminuria if not completed within the prior 10 months Proposed: For all patients (remove "for patients aged 18 and older")
Update #11:	Ambulatory Specialty Care: CONTRACEPTION COUNSELING Current: For a woman aged 18-50, authorized staff members with appropriate training will 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 Proposed: 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 1.
Update #12:	Ambulatory Specialty Care: Immunizations Current: The RN/LVN or delegated MEA under the supervision of a provider administers immunization per CDC's Adult Immunization Schedule as found on www.cdc.gov. All nursing staff are expected to operate within scope of practice and know the contraindications of all immunizations offered at Zuckerberg San Francisco General. The RN/LVN or delegated MEA will complete the following steps before administering immunizations: a. Reviews vaccination summaries in the Electronic Health Record (EHR). b. Verifies vaccinations to be administered. c. Gives patient Vaccination Information Sheet (VIS). d. Checks chart, immunization card, EHR to verify patient's immunization history. e. Completes the Screening Questionnaire for Adults Reviews the completed Screening Questionnaire for contraindications Proposed: Delete
Update #13:	Ambulatory Specialty Care: PREGNANCY TESTING Current: 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. If the patient is being seen in Reproductive Endocrinology and Infertility (REI) Clinic. Proposed: Authorized staff members with appropriate training will order a urine pregnancy test for patients under the following circumstances: a) Requested by the patient (women of all ages). b) If the patient is missing monthly menses. c) If the patient is scheduled for dental surgery with anesthesia

	d) If the patient is starting or continuing a teratogenic drug. e) If the patient is having a uterine or cervical procedure f) before initiating contraception, unless healthcare provider reasonably certain patient is not pregnant. g) If the patient is being seen in Reproductive Endocrinology and Infertility (REI) Clinic.
Update #14:	*Ambulatory Specialty Care: STI Screening* *Current:* 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 ≥ 18 - ≤ 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) • Syphilis 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 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 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.* *Proposed:* *Remove*
Update 15:	*SFHN Pediatric Primary Care: ASQ 3 Screening* *Current:* The authorized staff with the appropriate training will provide age-appropriate **Ages and Stages Questionnaire (ASQ-3) screening** in the preferred language of the caregiver at 9 months, 18 months and 24/30 month well child visits. *Proposed:* *Remove (Deemed to be more appropriate as standard work)*
Update 16:	*SFHN Pediatric Primary Care: Autism Screening* *Current:* The authorized staff with the appropriate training will provide MCHAT or other approved **Autism Spectrum Disorder screening** in the preferred language of the caregiver at 2 separate well child visits between 16 and 24 months of age. *Proposed:* *Remove*
Update 17:	*SFHN Pediatric Primary Care: Blood Pressure* *Current:* The authorized staff with appropriate training measures blood pressure beginning at the 3 year well child visit and at every annual well child visit thereafter, and records measurements in EHR and on required paper forms. *Proposed:* *Remove*

Update 18:	*SFHN Pediatric Primary Care: Depression Screening* *Current:* The authorized staff with the appropriate training will provide Edinburgh or PHQ-2 depression screening in the preferred language of the caregiver to primary caregivers at every visit for infants up to 6 months old *Proposed:* *Remove*
Update 19:	*SFHN Pediatric Primary Care:Handouts* *Proposed:* The authorized staff with the appropriate training will give age specific handout, immunization handout, car seat safety age 0-8 years. *Current:* *Remove*
Update 20:	*SFHN Pediatric Primary Care: Height/ Weight* *Current:* The authorized staff with appropriate training (e.g. RN/LVN or delegated MEA or HW) measures height and weight at all well child visits, and records measurements in electronic health record and on required paper forms for that visit (CHDP form, WIC, School/Daycare forms, etc.). *Proposed:* *Remove*
Update 21:	*SFHN Pediatric Primary Care: Head Circumference* *Current:* The authorized staff with appropriate training measures the head circumference at all well child visits, 24 months and under, and records measurements in EHR and on required paper forms *Proposed:* *Remove*
Update 22:	*SFHN Pediatric Primary Care: Hearing Screening* *Current:* Starting at age 4 years old, the authorized staff with appropriate training completes

	formal **hearing screening** annually or at next visit if previous screen was documented as a fail and documents the results in the medical record and on required paper forms. o 25 Db, (<11 years old) 500, 1000, 2000 and 4000 Hz 25 Db (11+ years old) 500, 1000, 2000, 4000, 6000, and 8000 Hz *Proposed:* *Remove*
Update 23:	*SFHN Pediatric Primary Care: Lead* *Current:* The authorized staff with the appropriate training will screen for **lead** once after the first birthday and once again between the 2nd and 5th birthdays. *Proposed:* Screen for **lead** once after the first birthday (typically at 12mo WCC visit) and once again between the 2nd and 5th birthdays.
Update 24:	*SFHN Pediatric Primary Care: Teen Screening/ STI Screening* *Current:* Teen Screening: 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: Obtain and document a confidential phone number. - 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. 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. Additional STI screening per provider discretion *Proposed:*

	Teen Screening (aged 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: Obtain and document a confidential phone number. - 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. 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. Additional STI screening per provider discretion
Update 25:	*SFHN Pediatric Primary Care: Vision Testing* *Current:* Starting at age 3 years old, the authorized staff with appropriate training completes formal **vision testing** with the Snellen Wall chart (preferred) or the Vision Screener (if the child is unable to complete the Snellen) annually or at next visit if previous screen was documented as a fail. The authorized staff with appropriate training documents the results in the medical record and on required paper forms. *Proposed:* *Remove*

Summary of Changes – Ambulatory Care Standing Order Protocol (September 2025 Update)

Update #	Clinical Area	Previous Version	Proposed / Updated Version	Summary of Change
1	Adult Primary Care – Cervical Cancer Screening	For patients with cervix aged 21–65 who have been sexually active	For patients with cervix aged ≥21	Broadened eligibility; removed sexual activity requirement
2	Adult Primary Care – Colorectal Cancer Screening	Age 45–75; detailed colonoscopy/FIT protocols	Age 45–75; guidance via care gap review plus same screening protocols	Added 'review care gap' step
3	Adult Primary Care – Diabetes Management	A1c, metabolic panel, UACR monitoring	Added teleretinal screening steps, foot exam/monofilament test	Expanded screening procedures
4	Adult Primary & Specialty Care – Hepatitis B Screening	Screen only if criteria met	Screen all adults >18 with full HBV panel	Expanded universal HBV screening
5	Adult Primary Care – Pregnancy Intention Screening	Not included	New screening for women 12–50 (post-menarche, pre-menopause)	New procedure added
6	Adult Primary Care – Prostate Cancer Screening	Included	Removed	Screening procedure eliminated
7	Adult Primary Care – STI Screening	Men ≥35; men 20–35 or women ≥20 with risk factors	Men ≥35 and women ≥45; men 20–35 or women 20–45 with risk factors	Adjusted age ranges
8	Adult Primary Care – STI Testing	Not specified in detail	Detailed multi-population STI protocols (age, risk, MSM, transgender, HIV+, etc.)	Major expansion of STI testing guidance
9	Ambulatory Specialty Care – Cardiology Management	ECG at baseline, q6mo, Afib, acute chest pain	ECG at baseline, EP visits, acute chest pain, annually for HF	Adjusted ECG use; removed q6mo Afib monitoring

10	Ambulatory Specialty Care – CKD Screening	Adults ≥18 with diabetes, HTN, or eGFR <60	All patients with those conditions (removed age qualifier)	Broader eligibility
11	Ambulatory Specialty Care – Contraception Counseling	Women 18–50	Women 12–50 (post-menarche, pre-menopause)	Expanded eligibility
12	Ambulatory Specialty Care – Immunizations	CDC-based RN/LVN workflow	Deleted	Procedure removed
13	Ambulatory Specialty Care – Pregnancy Testing	Patient request, missed menses, dental anesthesia, teratogenic drugs, REI clinic	Added cervical/uterine procedure, pre-contraception initiation	Expanded circumstances for testing
14	Ambulatory Specialty Care – STI Screening	Extensive population-specific protocols	Deleted	Procedure removed
15	Pediatric Primary Care – ASQ-3 Screening	Ages 9, 18, 24/30 months	Removed	Procedure moved to standard work
16	Pediatric Primary Care – Autism Screening	MCHAT at 16–24 months	Removed	Procedure removed
17	Pediatric Primary Care – Blood Pressure	Start at age 3, annually	Removed	Procedure removed
18	Pediatric Primary Care – Depression Screening	PHQ-2/Edinburgh for caregivers of infants <6mo	Removed	Procedure removed
19	Pediatric Primary Care – Handouts	Immunization, car seat, age-specific handouts	Removed	Procedure removed
20	Pediatric Primary Care – Height/Weight	At all well child visits	Removed	Procedure removed
21	Pediatric Primary Care – Head Circumference	≤24 months	Removed	Procedure removed
22	Pediatric Primary Care –	Start at age 4, annual	Removed	Procedure removed

	Hearing Screening			
23	Pediatric Primary Care – Lead Screening	Once after age 1, again age 2–5	At 12mo WCC + again age 2–5	Minor clarification
24	Pediatric Primary Care – Teen Screening/STI Screening	Teen protocols starting age 12; STI testing ≥15	Clarified protected teen screening (12–17) with similar STI testing	Updated age range and confidentiality emphasis
25	Pediatric Primary Care – Vision Testing	Start at age 3, annual	Removed	Procedure removed

San Francisco Health Network (SFHN) Clinics
Date Adopted: July 2019
Last Review Date: September 2024~~February 2021~~
Revised: ~~June 2022; August 2023; September 2024;~~ May 2025

TITLE: SFHN Ambulatory Care Clinics Combined Standing Order Protocols for Health Care Maintenance and Chronic Disease Management

PROCEDURE FOR SFHN ADULT PRIMARY CARE:
PROCEDURE FOR SFHN AMBULATORY SPECIALTY CARE:
PROCEDURE FOR SFHN PEDIATRIC PRIMARY CARE:
PROCEDURE FOR SFHN PERINATAL CARE:

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 ~~aged~~ > 21~~-65 who have been sexually active~~, authorized staff members with appropriate training will do the following: 1. For patients aged 21-29, if last cytology test (PAP) ~~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 ~~aged~~ > age 30~~-65~~, 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~~HPV co-test~~." 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.

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	~~4. If last diabetes retinal eye exam > 10 months, place order for referral for diabetic retinal screen.~~ ~~5.~~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: ~~1. If a patient meets criteria[3] for HBV screening, AND EHR does not contain any result for "HEPATITIS B HBV SURFACE ANTIGEN", order "HEPATITIS B HBV SURFACE ANTIGEN" and "HEPATITIS B HBV SURFACE ANTIBODY"~~ ~~1.~~ If a patient is age > 18 years old order "HEPATITIS B HBV

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	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 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 ~~summaries~~ 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

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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 ~~18-501,~~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.
~~**PROSTATE CANCER SCREENING**~~	~~For patients with a prostate, and no known history of prostate cancer, authorized staff members with appropriate training will do the following:~~ ~~1. For patients aged 45-60, order "PSA total" if no PSA on file or 1) last PSA total <1 and >5 years, 2) last PSA total 1-2 and >1 year.~~ ~~2.~~1. ~~For patients aged 61-75, order "PSA total" if no PSA on file or 1) last PSA total <1 and >5 years, 2) last PSA total 1-3 and >1 year.~~
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~~8~~ - ≤ 50 years of age who could become pregnant:* • Syphilis if no record of prior test (if at increased risk*, test if

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	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 o Urine if insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o 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 o Urine if has a penis and insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o Rectal swab if receptive anal sex in the last 12 months o 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.

APPROVAL

Ambulatory Care Committee	June 2025 ~~July 2017, July 2019, Sept 2020~~
Medical Executive Committee	~~Oct 2017~~

~~**Date Originally Adopted: Oct 2017**~~

~~**Reviewed: March 2019**~~

~~**Revised: June 2019**~~

~~**Revised: September 2020**~~

~~**Reviewed: February 2021**~~

~~**Revised: June 2022**~~

~~**Revised: July 2023**~~

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. ~~SFDPH Viral Hepatitis B Screening Guidelines:~~
   ~~Who should be screened for HBV?~~
   - ~~Persons born in regions of high and intermediate HBV endemicity (HBsAg prevalence ≥ 2%): Asia, Pacific Islands, Middle East, Eastern Europe, Russia, Sub-Sahara Africa, Amazon Basin, Arctic Populations~~
   - ~~U.S. born persons not vaccinated as infants whose parents were born in regions with high HBV endemicity (HBsAg prevalence ≥ 8%): Asia, Pacific Islands, Africa, Amazon Basin, Arctic Populations~~
   - ~~Intravenous drug users (current and past)~~
   - ~~Men who have sex with men~~
   - ~~Persons who require immunosuppressive therapy~~
   - ~~Persons with elevated ALT/AST of unknown etiology~~
   - ~~Donors of blood, plasma, organs, tissues or semen~~
   - ~~All pregnant women~~
   - ~~Infants born to HBsAg-positive mothers~~
   - ~~Household, needle-sharing or sex contacts of persons known to be HBsAg positive~~
   - ~~Persons who are infected with HIV or HCV, who are on hemodialysis~~
   - ~~Persons who are incarcerated~~
   - ~~Persons who are the source of blood or body fluids exposures that might require post-exposure prophylaxis (e.g., needle stick, sexual assault)~~
4. 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
5. American Diabetes Association 2020
6. *Final Update Summary: Lipid Disorders in Adults (Cholesterol, Dyslipidemia): Screening*. U.S. Preventive Services Task Force. July 2015.
7. Protocols for Hormonal Reassignment of Gender, Tom Waddell Health Center, 05/07/13

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PROCEDURE FOR SFHN AMBULATORY SPECIALTY CARE:

In addition to Standing Order Protocols for Primary Care, the following may apply to specific specialty care clinics.

~~ZSFG Specialty Clinics~~
~~Date Adopted: July 2019~~
~~Review Date: June 2020~~
~~Revised: November 2020~~
~~Revised: June 2022~~
~~Revised: July 2023~~

~~TITLE: Standing Order Protocols for Disease Management in ZSFG Specialty Care Clinics (Urgent Care Clinic, 1N, 1M, Ward 92, 3M, 4M, 5M, 4C, Ward 86)~~

~~STATEMENT OF POLICY:~~
~~The ZSFG Medical Staff policy regarding Standing Order Protocols (SOPs) for Disease Management in Specialty Clinics is renewed annually by the designated Specialty Care provider. Specifically, SOPs enable authorized staff members with appropriate training to apply SOPs applicable to the patient's visit type and care delivery site/setting, to facilitate disease management for patients 18 years and older.~~

~~When a patient meets guideline criteria as specified by demographics and medical history, which are accessible in the medical record, appropriately trained clinical staff can independently order and complete all specified tests and services.~~

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 ~~a.~~b. All visits in Electrophysiology Clinic ~~b. Established Cardiology Clinic patients every 6 months for monitoring~~ ~~c. Patients with a history of atrial fibrillation~~ c. Patients with new complaint of acute chest pain ~~d.~~ Annually for all patients with heart failure to screen for left bundle branch block 3. Order 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 ~~for patients aged 18 and older~~:

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Commented [SP1]: JP what do you think?

Commented [SP2]: Per Jonathan Davis: Would not do an ECG every 6 months for monitoring for all patients unless there aer symptoms. would not have this be part of standard workflow.

Commented [SP3]: Per Jonathan Davis: Would not get an ECG for all patients with afib just because they have afib

	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~~8~~-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
~~**IMMUNIZATIONS**~~	~~The RN/LVN or delegated MEA under the supervision of a provider administers immunization per CDC's Adult Immunization Schedule as found on www.cdc.gov. All nursing staff are expected to operate within scope of practice and know the contraindications of all immunizations offered at Zuckerberg San Francisco General. The RN/LVN or delegated MEA will complete the following steps before administering immunizations:~~ ~~a. Reviews vaccination summaries in the Electronic Health Record (EHR).~~ ~~b. Verifies vaccinations to be administered.~~ ~~c. Gives patient Vaccination Information Sheet (VIS).~~ ~~d. Checks chart, immunization card, EHR to verify patient's immunization history.~~ ~~e. Completes the Screening Questionnaire for Adults~~ ~~f. Reviews the completed Screening Questionnaire for contraindications~~

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	~~before administering immunizations.~~ ~~g. Obtains patient's oral agreement prior to administering immunizations after VIS given.~~ ~~h. If any questions or concerns about administering immunizations, contacts Charge Nurse or provider.~~ ~~i.~~a. ~~Delegated MEA/HW has licensed clinician verify immunizations prior to administering per clinic workflows.~~
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 ~~4.~~6. before initiating contraception, unless healthcare provider reasonably certain patient is not pregnant. ~~5.~~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.
~~**STI SCREENING**~~	~~Authorized staff members with appropriate training will do the following:~~ ~~Obtain and document a confidential phone number for any patient age <25~~

Commented [AA5]: CDC SPR "How To Be Reasonably Certain that a Patient Is Not Pregnant"

https://www.cdc.gov/contraception/hcp/usspr/not-pregnant.html#:~:text=In%20most%20cases%2C%20a%20detailed%20history%20provides,about%20to%20start%20using%20a%20contraceptive%20method.&text=Although%20pregnancy%20tests%20often%20are%20performed%20before,menses%2C%20recent%20sexual%20intercourse%2C%20or%20recent%20pregnancy.

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	~~*All sexually active people ≥ 18 - ≤ 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)~~ ~~• Syphilis 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 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 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.*

REFERENCES

1. 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

~~**APPROVAL**~~

~~MUSS~~	~~March 2019~~
~~P&T~~	~~March 2019~~
~~Ambulatory Care Committee~~	~~March 2019, September 2020~~

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.

~~San Francisco Health Network (SFHN) Clinics~~
~~Date Adopted: December 2016~~
~~Review Due: November 2017~~
~~Date Revised: November 2020~~
~~Date Revised: September 2024~~

~~TITLE: Standing orders for Well Child Care in SFHN Clinics~~

~~STATEMENT OF POLICY: Nurses, LVNs, MEAs, and HWs are to record measurements and sensory (hearing/vision) screening to children prior to physician or nurse practitioner visits, and MEAs/RNs/LVNs may order and administer immunizations and PPDs where appropriate in conjunction with primary care visits, scheduled vaccine visits, or during drop-in immunization periods.~~

~~CROSS REFERENCE: Admin Policy 9.17 INFLUENZA AND PNEUMOCOCCAL VACCINATION OF INFANT AND PEDIATRIC PATIENTS AT ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER http://in-sfghweb03.in.sfdph.net/CHNPolicies/production/Administrative/I-9/9-17.htm?9/9/201610:42:26%20AM~~

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) ~~should~~ can be performed annually for participants of the WIC program (ie 3-5yo).
~~**ASQ-3 SCREENING**~~	~~The authorized staff with the appropriate training will provide age-appropriate **Ages and Stages Questionnaire (ASQ-3) screening** in the preferred language of the caregiver at 9 months, 18 months and 24/30 month well child visits.~~
~~**AUTISM SCREENING**~~	~~The authorized staff with the appropriate training will provide MCHAT or other approved **Autism Spectrum Disorder screening** in the preferred language of the caregiver at 2 separate well child visits between 16 and 24 months of age.~~
~~**BLOOD PRESSURE**~~	~~The authorized staff with appropriate training measures blood pressure beginning at the 3 year well child visit and at every annual well child visit thereafter, and records measurements in EHR and on required paper forms.~~
~~**DEPRESSION SCREENING**~~	~~The authorized staff with the appropriate training will provide Edinburgh or PHQ-2 depression screening in the preferred language of the caregiver to primary caregivers at every visit for infants up to 6 months old~~

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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.
~~**HANDOUTS**~~	~~The authorized staff with the appropriate training will give age specific handout, immunization handout, car seat safety age 0-8 years.~~
~~**HEIGHT/WEIGHT**~~	~~The authorized staff with appropriate training (e.g. RN/LVN or delegated MEA or HW) measures height and weight at all well child visits, and records measurements in electronic health record and on required paper forms for that visit (CHDP form, WIC, School/Daycare forms, etc.).~~
~~**HEAD CIRCUMFERENCE**~~	~~The authorized staff with appropriate training measures the head circumference at all well child visits, 24 months and under, and records measurements in EHR and on required paper forms~~
~~**HEARING SCREENING**~~	~~Starting at age 4 years old, the authorized staff with appropriate training completes formal **hearing screening** annually or at next visit if previous screen was documented as a fail and documents the results in the medical record and on required paper forms.~~ ~~• 25 Db, (<11 years old) 500, 1000, 2000 and 4000 Hz~~ ~~25 Db (11+ years old) 500, 1000, 2000, 4000, 6000, and 8000 Hz~~
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 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	~~The authorized staff with the appropriate training will s~~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

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	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**: ○ Obtain and document a confidential phone number. ○ 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. ○ 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. ○ 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.
~~**VISION TESTING**~~	~~Starting at age 3 years old, the authorized staff with appropriate training completes formal **vision testing** with the Snellen Wall chart (preferred) or the Vision Screener (if the child is unable to complete the Snellen) annually or at next visit if previous screen was documented as a fail. The authorized staff with appropriate training documents the results in the medical record and on required paper forms.~~

Commented [SP9]: · At all well child visits for children 12yo or older, the authorized staff will administer standardized depression or Adolescent Behavioral Health Vital Signs screening and document the patient response in the chart.

Documentation:

1. Record measurements in kilograms and centimeters in electronic medical record and on any appropriate forms.

2. Record BMI on any appropriate forms.

3. Record immunizations and vision/hearing screening in the electronic medical record and on any appropriate forms.

4. Log immunizations including lot number in the electronic medical record or per Downtime protocols if appropriate.

5. Log patient refusal of recommended immunization/test into the electronic record.

6. Record application of Fluoride varnish in the electronic record.

Patient Education and Instructions:

- Give VIS and record as given anytime administering vaccines.
- Give instruction sheet, "After the Shots…" anytime administering vaccines
- Give age-appropriate education packets per clinic protocol.

APPROVAL

Ambulatory Care Committee	Nov 2016, September 2020
Medical Executive Committee	Dec 2016

PROCEDURE FOR SFHN PERINATAL CARE:

In addition to Standing Order Protocols for Primary Care, the following applies to clinics providing perinatal care.

~~San Francisco Health Network (SFHN) Clinics~~
~~Date Adopted: _December 2016~~
~~Reviewed: November 2017~~
~~Revised: March 2019, November 2020, June 2022~~

~~TITLE: Standing orders for Routine Perinatal Care~~

~~POLICY: The following Zuckerberg San Francisco General OMG,Medical Policy is renewed annually by the designated primary care provider. It enables nursing staff (e.g. Registered Nurse and Medical Evaluation Assistant) to complete health care maintenance panel management to prenatal patients. As relates to administration of vaccines, per Administration Policy # 9.16, "The Medical Evaluation Assistant (MEA) may administer vaccinations under supervision of a Primary Care Provider (MD, DO, NP, PA) or RN. The RN, LVN, LPT and MEA will be required to complete a vaccine administration competency module ."~~

~~When the patient meets guideline criteria as specified in the history and physical examination section of the visit note, nursing staff can independently order and complete all the specified tests and services outlined in these standing orders prior to her visit without requiring a direct provider order.~~

~~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.~~

~~CROSS REFERENCES: Admin Policy 9.16 Adult Influenza & Pneumococcal Vaccination of patients at ZSFG http://in-sfghweb03/chnpolicies/production/administrative/i-9/9-16.htm?7/20/201610:20:10%20AM~~

~~AUTHORIZED BY: SFGH MSO~~

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 B Surface Antigen and Antibody~~ ○ 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) ~~and~~	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 Dou Referral ○ Refer to RD if initial A1c 5
	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	

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		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 infecti ~~gestational age if Hep A non-immune~~	
	Hepatitis B series	At any gestational age if Hep B non-immune~~At any gestational age if Hep B non-immune~~	
	Influenza	Prenatal specific vaccine, during flu season yearly	

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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-2 (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 infecti~~gestational age if Hep A non-immune~~	
	Hepatitis B series	At any gestational age if Hep B non-immune~~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)

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	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	○ 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
	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 ~~gestational age if Hep A non-immune~~	
	Hepatitis B series	At any gestational age if Hep B non-immune~~At any gestational age 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	

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	Vaccinations:		
	COVID-19	At any gestational age if not up to date	
	Hepatitis A series	At any gestational age if Hep A non-immune~~At any gestational age if Hep A non-immune~~	
	Hepatitis B series	At any gestational age if Hep B non-immune~~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~~Complete series if Hep non-immune and not up to date~~	
	Hepatitis B series	At any gestational age if Hep B non-immune~~Complete series if Hep non-immune and not up to date~~	
	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	

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~~APPROVAL~~

~~Ambulatory Care Committee~~	~~Nov 2016, September 2020~~
~~Medical Executive Committee~~	~~Dec 2016~~

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.

San Francisco Health Network (SFHN) Clinics
Date Adopted: July 2019
Last Review Date: September 2024
Revised: May 2025

TITLE: SFHN Ambulatory Care Clinics Combined Standing Order Protocols for Health Care Maintenance and Chronic Disease Management

PROCEDURE FOR SFHN ADULT PRIMARY CARE:
PROCEDURE FOR SFHN AMBULATORY SPECIALTY CARE:
PROCEDURE FOR SFHN PEDIATRIC PRIMARY CARE:
PROCEDURE FOR SFHN PERINATAL CARE:

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: ~~1. If a patient meets criteria[3] for HBV screening, AND EHR does not contain any result for "HEPATITIS B HBV SURFACE ANTIGEN", order "HEPATITIS B HBV SURFACE ANTIGEN" and "HEPATITIS B HBV SURFACE ANTIBODY"~~ 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 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	Authorized staff members with appropriate training will do the following:

Prophylaxis) LABS	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 ~~18-501,~~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.
	1.
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 o Urine if insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o 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 o Urine if has a penis and insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o Rectal swab if receptive anal sex in the last 12 months o 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 o Urine if has a penis and insertive anal sex or received oral sex in the last 12 months o Pharyngeal swab if performed oral sex on a penis in the last 12 months o Rectal swab if receptive anal sex in the last 12 months o 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.

APPROVAL

Ambulatory Care Committee	June 2025
Medical Executive Committee	

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. ~~SFDPH Viral Hepatitis B Screening Guidelines:~~
   ~~Who should be screened for HBV?~~
   - ~~Persons born in regions of high and intermediate HBV endemicity (HBsAg prevalence ≥ 2%): Asia, Pacific Islands, Middle East, Eastern Europe, Russia, Sub-Sahara Africa, Amazon Basin, Arctic Populations~~
   - ~~U.S.-born persons not vaccinated as infants whose parents were born in regions with high HBV endemicity (HBsAg prevalence ≥ 8%): Asia, Pacific Islands, Africa, Amazon Basin, Arctic Populations~~
   - ~~Intravenous drug users (current and past)~~
   - ~~Men who have sex with men~~
   - ~~Persons who require immunosuppressive therapy~~
   - ~~Persons with elevated ALT/AST of unknown etiology~~
   - ~~Donors of blood, plasma, organs, tissues or semen~~
   - ~~All pregnant women~~
   - ~~Infants born to HBsAg-positive mothers~~
   - ~~Household, needle-sharing or sex contacts of persons known to be HBsAg positive~~
   - ~~Persons who are infected with HIV or HCV, who are on hemodialysis~~
   - ~~Persons who are incarcerated~~
   - ~~Persons who are the source of blood or body fluids exposures that might require post-exposure prophylaxis (e.g., needle stick, sexual assault)~~
4. 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
5. American Diabetes Association 2020
6. *Final Update Summary: Lipid Disorders in Adults (Cholesterol, Dyslipidemia): Screening*. U.S. Preventive Services Task Force. July 2015.
7. 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	Authorized staff members with appropriate training will do the following:

MANAGEMENT	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
	a.
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. 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

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 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:
	  o 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
	  o Has had a household member with confirmed active TB since the last screening
	  o Confirmed HIV positive
	  o Starting or currently on immunosuppression therapy
	• If the TB SCREENING is positive, authorized staff will:
	  o 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. o 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 infect
	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	~~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	
	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 infect
	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
	Urine dip (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	

	Urine dip Chem 7	disease, autoimmune disorder (lupus, APLS), thyroid disease, sickle cell anemia UTI symptoms, diabetes, or h/o recurrent UTI	○ Offer L&D tour ○ PPTL consent papers to be signed by 35 6/7 weeks
	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. 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.

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

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

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP: 9/3/25	
Person completing this form: Erika Kiefer	
Standardized Procedure Title:	OB/GYN SP
Department:	OB/GYN
Dept Chief:	Rebecca Jackson, MD
SP Author(s):	Kara Myers, CNM
Update #1:	Added 5B/CTSI as a Location

*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)

Zuckerberg San Francisco General Hospital
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE NURSE PRACTITIONER / PHYSICIAN ASSISTANT/ CERTIFIED NURSE-MIDWIFE

PREAMBLE

Title: OBSTETRICS AND GYNECOLOGY

I. Policy Statement

A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse-Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, Clinical Psychologists 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 all appropriate sites within the OB/GYN service.

II. Functions to Be Performed

Each practice area will vary in the functions that will be performed, such as primary care in a specialty clinic care setting or inpatient care in a unit-based hospital setting. The NP/CNM/PA conducts physical exams, diagnoses, and treats illnesses, orders and interprets tests, counsels on preventative health care, performs invasive procedures and furnishes medications/issue drug orders as established by state law.

A Certified Nurse-Midwife (CNM) is a registered nurse with additional training in midwifery and who has met the requirements of Section 1460 of the Nurse Practice Act. The scope of practice of the CNM includes the care of people during the antepartum, intrapartum, postpartum, and interconceptual periods. A CNM provides family planning, conducts deliveries and cares for the newborn and infant.

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (document supervising agreement between supervising physician and PA).

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

A. Setting

1. Location of practice is all sites within the OB/GYN service and 5B/CTSI. If indicated for patient and/or provider safety, sites may also include the patient's home, a community location, or another safe, private location.

B. Supervision

2. Overall Accountability:
   The NP/CNM/PA is responsible and accountable to the Medical Director of the Obstetric, Midwifery, and Gynecology Clinic, Medical Director of Obstetrics, and the Medical Director of 6G.
3. A consulting physician, who may be an attending, senior resident, or fellow, will be available to the NP/CNM/PA, by phone, in person, or by other electronic means at all times.
4. 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. Uncommon, unfamiliar, unstable, and complex patient conditions.
   e. Upon request of patient, affiliated staff, or physician.
   f. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.

IV. Scope of Practice

1. Health Care Management: Acute/Urgent Care
2. Health Care Management: Well Woman Care
3. Health Care Management: Prenatal Care
4. Furnishing Medications/Drug Orders
5. Discharge of Inpatients
6. eConsult Review
7. Colposcopy and Cryotherapy
8. Endocervical Polyp Removal
9. Endometrial Biopsy
10. Episiotomy and Perineal Laceration Repair
11. Contraceptive Implant Insertion
12. Contraceptive Implant Removal
13. Intrauterine Device Insertion
14. Intrauterine Devise Removal: Non-visualized Strings
15. Pre-op Evaluation for Second Trimester Abortion
16. Trigger Point Injections for Pelvic Pain
17. Limited Obstetric Ultrasound: <14 Weeks Gestational Age
18. Limited Obstetric Ultrasound: >14 Weeks Gestational Age Assessment
19. Limited Obstetric Ultrasound: Third Trimester Assessment of Cardiac Activity, Presentation, and Amniotic Fluid
20. Waived Testing
21. First-Trimester Aspiration Abortion
22. Procedural Sedation
23. Vulvar Skin Biopsy
24. CNM First-Assist for Cesarean-Section

MS.08.01.03: Summary of Changes

Title: Management of Benign and Malignant Breast Conditions

Current	Revision
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 ZSFG 5M Obstetric, Midwifery & Gynecology Clinic (5M OMG), 3M Breast Surgery & Oncology Clinic, and on file in the Medical Staff Office.	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 ZSFG 5M Obstetric, Midwifery & Gynecology Clinic (5M OMG), 3M Breast Surgery & Oncology Clinic, 4C Oncology Clinic and on file in the Medical Staff Office.
C. 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 ZSFG 5M Obstetric, Midwifery & Gynecology Clinic (5M OMG), 3M Breast Surgery & Oncology Clinic, and on file in the Medical Staff Office.	C. 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 ZSFG 5M Obstetric, Midwifery & Gynecology Clinic (5M OMG), 3M Breast Surgery & Oncology Clinic, 4C Oncology Clinic and on file in the Medical Staff Office.
III. Circumstances Under Which NP/PA May Perform Function A. Setting 1. Location of practice is at ZSFG 5M Obstetric, Midwifery Gynecology Clinic, and 3M Breast Surgery & Oncology Clinic.	III. Circumstances Under Which NP/PA May Perform Function A. Setting 1. Location of practice is at ZSFG 5M Obstetric, Midwifery Gynecology Clinic, 3M Breast Surgery & Oncology Clinic, and 4C Oncology Clinic.

Community Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Management of Benign and Malignant Breast Conditions

I. Policy Statement

A. It is the policy of the Community Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, 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 ZSFG 5M Obstetric, Midwifery & Gynecology Clinic (5M OMG), 3M Breast Surgery & Oncology Clinic, 4C Oncology Clinic and on file in the Medical Staff Office.

C. The Breast and Cervical Cancer Initiative is a Public Health initiative implemented in 1997. One goal of the initiative is to assure access to breast and cervical cancer diagnosis and treatment for low income women in San Francisco with particular attention to the elderly, the homeless, and other underserved populations in San Francisco. This Standardized Procedure covers clinical care provided by a Nurse Practitioner and/or Physician Assistant in 5M Breast Clinic, ~~and~~ 3M Breast Surgery & Oncology Clinic, and 4C Oncology Clinic and addresses breast care due to the complexities associated with breast care/cancer care. Pap smear screening is a fundamental function of primary care and covered by NP/PA practice and is not addressed in this SP. The goal of the Initiative is to increase access to underserved women for both breast and cervical cancer screening/care.

II. Functions To Be Performed

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

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician consultation.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination ever ten years (6 year recertification cycle prior to 2014, 10 year recertification cycle starting in 2014 and thereafter). Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (documents supervising agreement between supervising physician and PA).

The NP/PA conduct 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

A. Setting
   1. Location of practice is at ZSFG 5M Obstetric, Midwifery Gynecology Clinic, ~~and~~ 3M Breast Surgery & Oncology Clinic and 4C Oncology Clinic.

B. Supervision
   1. Overall Accountability:
      The NP/PA is responsible and accountable to the Medical Director of 3M Breast Surgery & Oncology Clinic.
   2. A consulting physician, which will be one of the Breast Clinic Attending's in 3M will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
      a. Acute decompensation of patient situation
      b. Problem that is not resolved after reasonable trial of therapies.
      c. Unexplained historical, physical, or laboratory findings for example, including but not limited to: breast mass rapidly increasing in size, lack of response of abscess to usual antibiotic treatment, complex presentation of bloody nipple discharge, unusual family/genetic history.
      d. Upon request of patient, affiliated staff, or physician.
      e. Problem requiring hospital admission or potential hospital admission.
      .

Commented [MK1]: This would stay the same for 4C Oncology

IV. Protocols
1. Management of Benign and Malignant Breast Conditions
2. Furnishing Medications/Drug Orders
3. Procedure: eConsult Review

V. Requirements for the Nurse Practitioner /Physician Assistant

A. Basic Training and Education
   1. Active California Registered Nurse/ Certified Nurse-Midwife/Physician Assistant license.
   2. Successful completion of a program, which conforms to the Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.
   3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants

(NCCPA) certification.
4. Possession of a National Provider Identifier or must have submitted an application.
5. Copies of licensure and certificates must be on file in the Medical Staff Office.
6. Furnishing Number.
7. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Practice Agreement
8. Board Certification will be grandfathered for all staff hired prior to January 2003.

B. Specialty Training
1. Specialty requirements: Physician Assistant, ANP, FNP, Women's Health Practitioner, Geriatric Nurse Practitioner or PNP.
2. Six months of experience in providing health care to women which includes but is not limited to clinical breast examination.
3. Knowledge and use of guidelines set forth by nationally recognized organizations such as the National Comprehensive Cancer Network (NCCN) and the American College of Obstetricians and Gynecologists (ACOG).

VI. Evaluation

A. Evaluation of NP/PA Competence in performance of standardized procedures.
1. Initial: at the conclusion of the standardized procedure training, the Medical Director or designated physician/peer will assess the NP/PA's ability to practice.
a. Clinical Practice
- Length of proctoring period will be three months.
- The evaluator will be the 3M Medical Director or other designated physician/peer.
- The method of evaluation in clinical practice will be 5 chart reviews for each protocol and clinical consultation and direct observation during the proctoring period.

2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician/peer, at appropriate intervals.

3. Biennial Reappointment: Medical Director, and/or designated physician/peer must evaluate the NP/PA's clinical competence with 5 chart reviews and for each protocol as listed in the procedure protocols.

VII. Development and Approval of Standardized Procedure

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

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

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

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

Protocol #1: Management of Benign and Malignant Breast Conditions

A. DEFINITION

This protocol covers the procedures related to the management of benign and malignant breast conditions. Scope of care includes management of symptoms related to breast changes and referral for appropriate diagnostic testing and treatment as indicated from ZSFG 5M Breast Clinic, ZSFG 3M Breast-Oncology Clinic, 4C Oncology Clinic and the ZSFG AVON Breast Center.

B. DATA BASE

1. Subjective Data
   a. Ongoing/Continuity: review of symptoms and history relevant to the disease process or presenting complaint.
   b. Pain history to include onset, location, and intensity.
   c. Risk assessment- family history of cancer.

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Laboratory and breast diagnostic imagining procedures including, but not limited to mammography, breast ultrasound, MRI, fine needle aspiration, ultrasound core biopsy, stereotactic biopsy, MRI guided biopsy and CT bone scans, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the ZSFGMC POCT policy and procedure 16.20.

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Initiation or adjustment of medication
   b. Referral to specialty clinics and supportive services, as needed.
   c. Referral to cancer risk counseling and testing.

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 for example, including but not limited to: breast mass rapidly increasing in size, lack of response of abscess to usual antibiotic treatment, complex presentation of bloody nipple discharge, unusual family/genetic history.
d. Upon request of patient, NP, PA, or physician
e. Problem requiring hospital admission or potential hospital admission.

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

4. Follow-up
   Track patients who are high risk who are breast cancer gene mutation positive, have a strong family history of breast or ovarian cancer, have family history of any cancer.

E. RECORD KEEPING
All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes).

Protocol #2*:* Furnishing Medications/Drug Orders

A. DEFINITION

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

B. DATA BASE

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

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

to history and exam.

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the EMR or in the Medication Administration Record (MAR). The protocol will include the following:
      1. location of practice
      2. diagnoses, illnesses, or conditions for which medication is ordered
      3. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      1. name of medication
      2. strength
      3. directions for use
      4. name of patient
      5. name of prescriber and title
      6. date of issue
      7. quantity to be dispensed
      8. license no., furnishing no., and DEA no. if applicable

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. Failure to improve pain and symptom management.
   f. Problem requiring hospital admission or potential hospital admission.

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

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

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the electronic medical record (EMR) as appropriate

Protocol #3: Procedure: eConsult Review- Nurse Practitioner/PA review eConsults to the 5M Breast Clinic.

A. DEFINITION

eConsult review is defined as the review of new outpatient consultation requests via the online eConsult system. A new outpatient is defined as a patient that has neither been consulted upon by the specialty service, admitted to the specialty service nor seen in the specialty clinic within the previous two years.

1. Prerequisites:
    a. Providers reviewing eConsults will have six months experience with patients in the specific specialty area provided at Zuckerberg San Francisco General Hospital and Trauma Center or elsewhere before being allowed to do eConsults independently.
    b. Providers reviewing eConsults will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
    c. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
    d. Providers reviewing eConsults will have expertise in the specialty practice for which they are reviewing.
2. Educational Component: Providers will demonstrate competence in understanding fundamentals of breast care in order to facilitate screening, triaging and prioritizing of patients in the eConsult system.
3. Proctoring: A review of at least 20 of the eConsult consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.
4. Ongoing reappointment: Review of 5 consultations every 2 years.

B. DATA BASE

1. Subjective Data
    a. History: age appropriate history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems relevant to the presenting disease process as provided by the referring provider on the electronic referral. eConsult review will be confined to data found in the submitted eConsult form. Data contained in the paper or electronic medical record, but not in the eConsult, is specifically excluded from the eConsult review. The

reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

b. Pain history to include onset, location, intensity, aggravating and alleviating factors, current and previous treatments.

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient as provided by the referring provider.
   b. Laboratory and imaging evaluation as obtained by the referring provider relevant to history, physical exam, and current disease process will be reviewed. Further evaluation will be requested from the referring provider if indicated.

C. DIAGNOSIS

A diagnosis will not be determined at the time of eConsult review. Differential diagnosis will be provided at the time the patient is seen in clinic by the consulting provider. Assessment of the subjective and objective data as performed by the consulting provider in conjunction with identified risk factors will be evaluated in obtaining a diagnosis.

D. PLAN

1. Review of eConsult

   a. Algorithms or referral guidelines developed and approved by the Medical Director in conjunction with the NP/PA will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.
   b. All data provided via the eConsult consultation request will be reviewed and assessed for thoroughness of history, adequacy of work up, and urgency of condition.
   c. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient conditions requiring Attending Review

   a. Acute decompensation in patient condition
   b. Unexplained historical, physical or laboratory findings
   c. Upon request of the referring NP, PA, or physician
   d. Problem requiring hospital admission or potential hospital admission

e. When recommending complex imaging studies or procedures for the referring provider to order
f. Problem requiring emergent/urgent surgical intervention
g. As indicated per the algorithms or referral guidelines.

3. Education
   a. Provider education appropriate to the referring problem including disease process, additional diagnostic evaluation and data gathering, interim treatment modalities and lifestyle counseling (e.g. diet, exercise).

4. Scheduling of Appointments
   a. Dependant upon the urgency of the referral, the eConsult will be forwarded to the scheduler for either next available clinic appointment scheduling or overbook appointment scheduling.

5. Patient Notification
   a. Notification of the patient will be done by the referring provider if the appointment is scheduled as next available. If the appointment is scheduled as an over book within two weeks of the eConsult, the consulting scheduler is responsible for notifying the patient.

E. RECORD KEEPING

All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the EMR upon scheduling or after a period of six months.

During the proctoring period, the eConsult consultation request will be printed and the provider recommendations will be written on the print out. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into the EMR and forwarded to the scheduler.