ZSFG JOINT CONFERENCE COMMITTEE MEETING

JULY 27, 2026

MEDICAL STAFF REPORT

Contents:

ZSFG CHIEF OF STAFF-OPEN SESSION ACTION ITEMS

Presented to the JCC-ZSFG July 27, 2026
July 2026 MEC Meetings

Clinical Service Report and Rules and Regulations: None

Credentials Committee-Privilege List/Standardized Procedures:

1. Neurosurgery Standardized Procedures and summary of changes
2. Cardiology Privilege List and summary of changes

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

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

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:Dan McGuire, NP	
Standardized Procedure Title:	Removal of Lumbar drain
Department:	Neurosurgery
Dept Chief:	Geoff Manley/Michael Huang
SP Author(s):	Dan McGuire
Update #1:	Deleted
Reason/Explanation for Revision:	No longer done by NP/PA
Standardized Procedure Title:	Surface Trauma and Wound
Department:	Neurosurgery
Dept Chief:	Geoff Manley/Michael Huang
SP Author(s):	Dan McGuire
Update #1:	Deleted
Reason/Explanation for Revision:	No longer done by NP/PA

Standardized Procedure Title:	C-Collar Clearance
Department:	Neurosurgery
Dept Chief:	Geoff Manley/Michael Huang
SP Author(s):	Dan McGuire
Update #1:	Deleted reference to shoulder/neck/intrascapular pain replaced with midline cervical pain or tenderness
Reason/Explanation for Revision:	No longer done by NP/PA

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 and Trauma Center
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Neurosurgery

I. Policy Statement

A. *It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators, and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.*

B. *All standardized procedures are to be kept electronically and on file in the Medical Staff Office; Department Chief, and ZSFG, Director of Nursing Office.*

Program	**Practice Location**
Neurosurgery	**Bldg 25; Bldg 5 4M Clinic**

II. Functions to be Performed

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

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

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every 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, utilization of standardized procedures and the Physician Assistant Practice Agreement (PAPA).

The NP/PA conducts physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care, 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* any staffed medical unit on the ZSFG campus**.
2. *Role in the outpatient and inpatient setting may include performing physical exams, diagnosing, and treating illnesses, ordering, and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications.*

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

   e. *Initiation or change of medication other than those in the formulary(ies).*
   f. *Problem requiring hospital admission or potential hospital admission.*

IV. Scope of Practice

Protocol #1	Health Care Management – Acute/Urgent Care
Protocol #2	Furnishing Medications/Drug Orders
Protocol #3	Discharge of Inpatients
Protocol #4	Procedure: Clinical Clearance of Cervical Spine Precautions
Protocol #5	Procedure: Removal of an Intracranial Pressure Device
Protocol #6	Removal of CSF from External Ventricular Drain (EVD) /Administration of Intracranial Medications
Protocol #7	Ordering Transfusion
Protocol #8	eConsult

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

1. *Active California NP/PA license.*
2. *Successful completion of a master's level or higher 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 from:*
   a. *American Nurses Credentialing Center (ANCC); or*
   b. *American Academy of Nurse Practitioners (AANP); or*
   c. *National Commission on the Certification of Physician Assistants (NCCPA) certification; or*
   d. *American Association of Critical Care Nurses; or*
   e. *Pediatric Nursing Certification Board; or*
   f. *National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties; or*
   g. *Addictions Nursing Certification Board.*
4. *Maintenance of certification of American Heart Association Basic Life Support for Health Care Providers (BLS-HCP)*
5. *Possession of a National Provider Identifier or must have submitted an application.*
6. *Copies of licensure and certificates must be kept electronically and on file in the Medical Staff Office.*
7. *Furnishing Number and DEA number if applicable.*

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

B. Specialty Training
   1. Specialty requirements
      a. NP specialty certification as an FNP, ACNP,AGACNP
      b. ____

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

   <u>Initial:</u> at the conclusion of the standardized procedure training, the Medical Director and supervising clinical provider(s) will assess the NP/PA's ability to practice clinically.

   a. *Clinical Practice*
      i. *Length of proctoring period will be up to three (3) months. The term may be shortened or lengthened at the discretion of the supervising clinical provider; however, the proctoring period shall not exceed the six (6) months CCSF probationary period.*
      ii. *The evaluator will be the Chief of Neurosurgery or designated clinical provider.*
      iii. *The method of evaluation in clinical practice will be those needed to demonstrate clinical competence*

   2. *Ongoing Professional Performance Evaluation (OPPE):*
   Affiliated staff will be monitored for compliance to department specific indicators and reports will be sent to the Medical Staff Office.

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

   4. *<u>Biennial Reappointment:</u> Medical Director and/or designated clinical provider must evaluate the NP/PA's clinical competence. The number of procedures and chart reviews will be done as noted in the specific procedure protocols.*

VI. Development and Approval of Standardized Procedure

A. *Method of Development*

Standardized procedures are developed collaboratively by the NPs/PAs, Physicians, and Administrators, and must conform to the eleven steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.

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

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

D. Revisions
The CIDP, Credentials, Medical Executive Committee, and Joint Conference Committee must approve all revisions to standardized procedures prior to implementation.

Protocol #1 Health Care Management – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions. Settings to include: Emergency Department, Inpatient Units, and Outpatient Clinics.

B. DATA BASE

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

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

C. DIAGNOSIS

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

D. PLAN

1. Therapeutic Treatment Plan
    a. Diagnostic tests for purposes of disease identification.
    b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    c. Referral to physician, specialty clinics, and supportive services, as needed.
    d. NP/PAs may also cosign Doctor's First Report of Occupational Injury or Illness (DFR) for a workers' compensation claim to receive time off from work for a period not to exceed three (3) calendar days. The "treating physician" must still sign the DFR and must be the one to make any determination of temporary disability.
    e. The pronouncement of cardiac death on admitted inpatients.

2. Patient Conditions Requiring Attending Consultation:

a. Acute decompensation of patient situation
b. Problem that is not resolved after reasonable trial of therapies
c. Unexplained historical, physical, or laboratory findings
d. Upon request of patient, nurse practitioner, physician assistant, or physician
e. Initiation or change of medication other than those listed in or approved by the formulary(ies)
f. Problem requiring hospital admission or potential hospital admission
g. Uncommon, unfamiliar, unstable, and complex patient conditions
h. Notification of the date and time of cardiac death
i. Patient visits involving workers' compensation claims for which patient requires more than three (3) calendar days off from work or determination of temporary disability.

3. Education
    a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling.
    b. Anticipatory guidance and safety education that is risk factor important.

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

E. RECORD KEEPING

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

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 a DEA number. . 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. Nurse practitioners may order Schedule II - V controlled substances when in possession of a DEA number. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies that will be used are: Zuckerberg San Francisco General Hospital and Trauma Center, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows ZSFG Administration policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (policy no. 13.5) & California AB1196 (Chapter 748)

B. DATA BASE

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

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
   c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the electronic record, or in the Medication Administration Record (MAR). The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, number of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      i. name of medication
      ii. strength
      iii. directions for use
      iv. name of patient
      v. name of prescriber and title
      vi. date of issue
      vii. quantity to be dispensed
      viii. license no., furnishing no., and DEA no. if applicable

2. Patient Conditions Requiring Consultation
   a. Problem which is not resolved after reasonable trial of therapies.
   b. Initiation or change of medication other than those in the formulary.
   c. Upon request of patient, NP, PA, or physician.
   d. Failure to improve pain and symptom management.

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

4. Follow-up

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

E. RECORD KEEPING

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

Protocol #3: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from Zuckerberg San Francisco General Hospital and Trauma Center. All patients discharged will have approval of an attending physician.

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

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

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

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

2. Patient Conditions Requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA or physician.
   c. Referral to Specialty Services not provided by DPH.

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

-discharge medications
-signs and symptoms of possible complications

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

E. RECORD KEEPING
All information from patient hospital stay will be recorded in the medical record (discharge summary, discharge order sheet, and progress notes).

Protocol #4: Procedure: Clinical Clearance of Cervical Spine Precautions

A. DEFINITIONS:

Cervical Spine Injury refers to a bony injury of the first through seventh cervical vertebrae. Cervical spine injury usually identified by plain film x-rays or cervical spine CT scan. For the purposes of this protocol, the patient with significant neck pain, sensory and/or motor deficits will be considered to have a spine/spinal cord injury until proven otherwise.

Cervical Spinal Cord Injury refers to an injury to the spinal cord from the first through the eighth spinal root or to the cord itself, as in cord compression. Injuries to the cervical spinal cord are usually identified by physical examination during the trauma resuscitation and may be confirmed through MRI. Such findings would include sensory and/or motor changes in the dermatomes consistent with the level of injury.

Appropriate Mentation refers to the patient's ability to clearly and competently participate in an examination of the cervical spine and spinal cord function. This implies a Glasgow Coma Scale Score of 15 and the absence of drug/alcohol intoxication. In addition, there should be no evidence of head injury which would render an examination invalid.

1. Location to be Performed: For purposes of this protocol, the procedure may be completed in the Emergency Department, Inpatient Units, and Outpatient Clinics at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of Procedure:
   a. Indications:
      Patients who have sustained blunt trauma mechanism consistent with potential axial spine injury. Patients who meet ALL of the following criteria may be candidates for clinical exam clearance of the cervical spine:
      i. Appropriate mentation, cooperative and communicative (no language barrier)
      ii. No clinical evidence of CNS or focal neurological injury
      iii. No subjective complaints of midline cervical pain or tenderness.

   b. Precautions
      Patients at risk should always remain in a rigid cervical collar.
   c. Contraindications
      i. Inappropriate mentation
      ii. Clinical evidence of CNS or focal neurological injury relatable to a cervical spine injury
      iii. Distracting Injury
      iv. Intoxication or under the influence of drugs
      v. Midline cervical pain or tenderness

B. DATA BASE
1. Subjective Data
    a. The patient may complain of pain in the neck, specifically with tenderness to palpation of the cervical spine. The patient may also present with clear motor/sensory deficits.

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

C. DIAGNOSIS
Assessment of subjective and objective data to identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan
    a. Patient consent obtained consistent with hospital policy, before procedure is performed.
    b. Diagnostic tests/imaging for purposes of disease identification.
    c. Referral to physician as needed.

2. Patient Conditions Requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Unexplained physical findings
    c. Uncommon, unfamiliar, unstable, and complex patient conditions
    d. Radiologic abnormalities
    e. Midline cervical tenderness on palpation
    f. Neurological deficit found on physical examination
    g. Upon request of patient, NP, PA, or physician

3. Education
    a. Discharge information and instructions.
    b. The patient should be educated regarding the need for rigid immobilization, imaging, and treatment.

4. Follow-up
    a. As appropriate for procedure performed.
    b. The patient with suspected cervical trauma will be referred to the Spine Service of the day.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Prerequisites: Direct instruction, onsite training of procedure by the Chief of Neurological Surgery or clinical Supervising Physician designee. Cervical spine clearance will be based upon the Guidelines set forth by the Eastern Association for the Surgery of Trauma.
Proctoring Period a. A minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation. 1. Three procedures needed every 2 years. 2. Three chart reviews needed every 2 years.

Protocol #5: Procedure: Removal of an Intracranial Pressure Device

A. DEFINITION

Intracranial pressure device discontinuation is defined as the removal of a Camino Bolt and/or EVD.

1. Location to be Performed

   For purposes of this procedure, the protocol will be completed in the ICU at Zuckerberg San Francisco General Hospital Medical Center.

2. Performance of Procedure/minor Surgery:
   a. Indications

      Removal will be determined by the Neurosurgical team and in accordance with the Attending Neurological Surgeon.
   b. Precautions

      Coagulopathy
   c. Contraindications

      Coagulopathy

      Elevated Intracranial Pressure

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
      i. Normal coagulation values
      ii. Normal intracranial pressures ($\leq$ 20mmHg) for 24 hours or monitor deemed no longer necessary by Neurosurgery attending
      iii. Afebrile ($\leq$ 38.5) or with a documented source for febrile state
      iv. No evidence of medical treatment for elevated intracranial pressures for 48 hours or monitor deemed no longer necessary by Neurosurgery attending
      v. No evidence of infection or discharge from the bolt insertion site
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan
    a. Patient consent obtained consistent with hospital policy before procedure is performed.
    b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient Conditions Requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Development of uncontrolled bleeding or cerebrospinal fluid leak.
    c. Change in neurological exam following device discontinuation.
    d. Upon request of patient, NP, PA, or physician
    e. Initiation or adjustment of medication other than those in the formularies.

3. Education
    a. Instruct patient on procedure prior to performance (As patient may be unable to comprehend provide nursing instruction prior to performance)
    b. Discharge information and instructions.

4. Follow-up
    a. As appropriate for procedure performed.
    b. Check suture/exit site for drainage 1-2 hours post removal
    c. Obtain report from nursing staff regarding level of consciousness post removal

E. RECORD KEEPING
    a. Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record as appropriate.
    b. The ICP reading before device removal will be documented in the above note

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

Prerequisites Completion of standardized procedure training on site.
Proctoring Period a. Minimum of 3 procedures and 3 chart reviews.
Reappointment Competency a. Evaluation will be done by the Medical Director or designated Physician. b. Ongoing competency evaluation.

1. Completion of three procedures every 2 years.
2. Three chart reviews needed every 2 years.

Protocol #6: Procedure: Removal of CSF from EVD/Administer Intrathecal Antibiotics/Administration of Intracranial TPA

A. DEFINITION

CSF Sampling from an EVD (external ventricular drain) is defined as removal of CSF for the purpose of culture, gram stain, cell count, and/or chemistry from a catheter located within the intraventricular space. Administration of intracranial medications is defined as injection of a specific medication and dosage, including antibiotics as determined by the Infectious Disease Service (for antibiotics) or Neurosurgical team (for Tissue Plasminogen Activator (tPA) and/or Normal Saline) into the intracranial space via an appropriate catheter.

1. Location to be Performed:
   For purposes of this procedure, the protocol will be completed in the inpatient units at Zuckerberg San Francisco General Hospital and Trauma Center.

2. Performance of Procedure:
   a. Indications
      Removal of CSF from an EVD will be determined by the Neurosurgical team and in accordance with the Attending Neurosurgeon. Administration of intrathecal antibiotics for the purpose of treatment of meningitis or ventriculitis will be determined in accordance with the Neurosurgical team/Attending and the Infectious Disease Service. Administration of intracranial tPA for the purpose of blood clot disruption will be determined in accordance with the Neurosurgical team/Attending. It may be indicated for a patient with a diagnosis of intracerebral hemorrhage, in whom a clot is causing hydrocephalus or increased intracranial pressure. NS may be administered with either of these, or by itself for the purpose of unclogging the catheter.
   b. Precautions
      Increased Intracranial Pressures
      Medication Allergies
      Immunocompromised State
      Coagulopathic state
   c. Contraindications
      Resistance met upon injection
      Absent waveform or Intracranial Pressure Measurement

B. DATA BASE

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

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
      i. Review of medication dosages
      ii. Laboratory review of microbiology results and white count if applicable, coagulation factors if applicable
      iii. Assessment for febrile ($\leq$ 38.5) state
      iv. Evaluation of the EVD insertion site for evidence of infection
      v. Performance of a neurological examination
      vi. Patient evaluation for signs of meningitis; including but not limited to; severe frontal/occipital headache, neck stiffness, light sensitivity, fever, rash
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained consistent with hospital policy before procedure is performed.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient Conditions Requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Upon request of patient, NP, PA, or physician
   c. Initiation or adjustment of medication other than those in the formularies.
   d. Resistance met upon withdraw of CSF and/or administration of sterile preservative free normal saline or antibiotics
   e. Noted leakage of fluid from the EVD catheter/tubing
   f. Presence of air noted within the EVD catheter/tubing
   g. Evidence of infection at the EVD insertion site
   h. Change in neurological status following CSF withdraw or antibiotic administration

i. Development of rash, hives, fever, tachycardia or change in respiratory status following antibiotic administration
j. Loss of waveform following drain manipulation

3. Education
Instruct patient to report symptoms of severe headache, fever, chills, numbness, tingling or weakness of extremities, impaired balance, incoordination, development of rash, hives, or shortness of breath

4. Follow-up
a. Assess EVD for evidence of effective functioning; presence of ICP waveform, active CSF drainage
b. Assess EVD and tubing for signs of loss of integrity including; leakage, breakage, presence of air
c. Assess for signs of site infection
d. Assess for symptoms of meningitis
e. Follow-up laboratory results on CSF samples and if appropriate catheter tip cultures and toxicology values
f. Assess for changes in neurological status

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites Completion of standardized procedure training on site
Proctoring Period a. Minimum of 3 successful observed demonstrations b. Minimum of 3 chart reviews
Reappointment Competency a. Evaluation will be performed by Supervising Physician and/or his or her designee b. Ongoing competency evaluation. 1. Completion of three procedures every 2 years. 2. Three chart reviews needed every 2 years

Protocol #7: Ordering Blood Transfusions

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

1. Location to be performed: Emergency Department, Inpatient Units, and Outpatient Clinics.

2. Performance of procedure:
   a. Indications
      1. Anemia
      2. Thrombocytopenia or platelet dysfunction
      3. Coagulation factor or other plasma protein deficiencies <u>not</u> appropriately correctable by other means.
   b. Precautions
      1. Blood and blood components must be given according to ZSFG guidelines.
      2. <u>Emergency</u> exchange transfusion orders are not covered by this standardized procedure – these must be countersigned by the responsible physician.
      3. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.
   c. Contraindications
      1. Absolute: none
      2. Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenia purpura (TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and reason for transfusion.
   b. Transfusion history, including prior reactions, minor red cell antibodies and allergies.

2. Objective Data
   a. Physical exam relevant to the decision to transfuse.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

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

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

2. Patient Conditions Requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Problem requiring hospital admission or potential hospital admission.

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

4. Follow-up
   As appropriate for patient condition and reason transfusions were given.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:
a. Successful completion of the Zuckerberg San Francisco General Hospital Transfusion Training course.

b. Successful completion of Transfusion Training course test on blood ordering and informed consent. c. Must have an 80% test score on both examinations.
Proctoring Period: a. Read and Sign the ZSFG Administrative Policy and Procedure 2.3 “Informed Consent Prior to Blood Transfusion and Counseling of Patients about Autologous and Designated Blood Donation Options”. b. Read ZSFG Transfusion Guidelines in Laboratory manual. c. Documentation of 1 countersigned transfusion order and review of documentation in the patient medical record.
Reappointment Competency Documentation: a. Completion of the two education modules and completion of the two examinations with a passing score of 80%. b. Performance of 1 transfusion order per year and 1 medical record review per 2 years. c. Review of any report from the Transfusion Committee. d. Evaluator will be the medical director or other designated physician.

PROTOCOL #8: eConsult Review

A. DEFINITION

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

1. Prerequisites:
    a. Providers reviewing eConsults will have six months experience with patients in the specific specialty area provided at Zuckerberg San Francisco General Hospital and Trauma Center or elsewhere before allowed to review 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 of the algorithms or referral guidelines developed and approved by the Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.

3. Proctoring: A concurrent review of the first 20 eConsult consultation decisions will be performed by the Chief of Service or designee in the first three months.

4. Reappointment: 5 chart reviews will be needed for reappointment 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, and intensity, aggravating and alleviating factors, current and previous treatments.

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

C. DIAGNOSIS

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

D. PLAN

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

2. Patient Conditions Requiring Attending Review
   a. Upon request of the referring NP, PA, or physician
   b. Problem requiring hospital admission or potential hospital admission
   c. When recommending complex imaging studies or procedures for the referring provider to order
   d. Problem requiring emergent/urgent surgical intervention
   e. As indicated per the algorithms developed by the Chief of Service

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

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

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

E. RECORD KEEPING

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

Summary of Changes

Current	Revision	Explanation for Revision
N/A	50.26 ENDOMYOCARDIAL BIOPSY PREREQUISITES: Currently Board Eligible, Certified, or Re-Certified by the American Board of Internal Medicine in Advanced Heart Failure and Transplant Cardiology (AHFCT). PROCTORING: Review of 2 cases REAPPOINTMENT: Review of 2 cases	New Privilege
N/A	50.27 RIGHT HEART CATHETERIZATION PREREQUISITES: Currently Board Eligible, Certified, or Re-Certified by the American Board of Internal Medicine in Advanced Heart Failure and Transplant Cardiology (AHFCT). PROCTORING: Review of 2 cases REAPPOINTMENT: Review of 2 cases	New Privilege

Delineation Of Privileges
Medicine Cardiology 2020

Provider Name:

Privilege	Status	Approved

MedCardio CARDIOLOGY 2020
(0920 MEC)

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

50.00 CORE PRIVILEGES ___
Evaluate, diagnose, consult, treat, and interpret clinical findings of adolescent and adult patients in the ambulatory and inpatient settings with cardiovascular disease. Core privileges also include electrocardiography interpretation, cardioversion, treadmill testing, ambulatory rhythm monitoring, clinical interpretation of transthoracic and stress echocardiography, central venous line placement, pericardiocentesis, temporary transvenous pacemaker insertion, and pulmonary artery line placement.

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Internal Medicine in Cardiovascular Disease.

PROCTORING: Review of 5 cases that include any of the elements listed under core privileges.

REAPPOINTMENT: Review of 3 cases that include any of the elements listed under core privileges.

50.01 NON-INVASIVE ELECTROPHYSIOLOGY PRIVILEGE ___
Interpretation and reporting of electrocardiograms, treadmill exercise tests, and continuous ambulatory electrocardiographic monitors

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by American Board of Internal Medicine in Cardiovascular Disease

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

50.05 CORE PRIVILEGES IN INTERVENTIONAL CARDIOLOGY ___
Under these core privileges, the interventional cardiologist will be able to perform interventional cardiology procedures that are now considered routine and basic in this field. The Core Privileges category should include the following:Right and left heart catheterization; Diagnostic coronary angiography; Percutaneous coronary interventions, including coronary angioplasty, coronary stent implantation, thrombectomy, intravascular ultrasound, fractional flow reserve measurements; Valvuloplasty; Intra-aortic balloon pump placement; Trans-aortic continuous flow axial pump placement; Placement of intravenous cooling catheters; Myocardial biopsy.

PREREQUISITES: Currently Board Admissible, Certified, or Re-certified by the American Board of Internal Medicine in Interventional Cardiology.

PROCTORING: Review of 5 cases that include any of the elements listed under core privileges.

REAPPOINTMENT: Review of 3 cases that include any of the elements listed under core privileges.

50.10 SPECIAL PRIVILEGES ___

50.15 PROCEDURAL SEDATION ___

Provider Name:

Privilege	Status	Approved

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Cardiology and has completed at least one of the following:
- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

PROCTORING: Review of 5 cases (completed training within the last 5 years)

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:
- Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
- Management of 10 airways via BVM or ETT per year for the preceding 2 years or,
- Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

50.21 TRANSEOPHAGEAL ECHOCARDIOGRAPHY ___
(Color Doppler, Spectral Doppler, and Two Dimensional modalities)

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Medical Specialties in Cardiology. Moderate sedation privileges, Level 2 American Society of Echocardiology training, 3 additional months to Level 1 American Society of Echocardiology training fellowship or equivalent including 50 supervised transesophageal studies.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 2 cases

50.25 PERMANENT PACEMAKER INSERTION ___

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Medical Specialties in Cardiology.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 2 cases

50.26 ENDOMYOCARDIAL BIOPSY ___

PREREQUISITES: Currently Board Eligible, Certified, or Re-Certified by the American Board of Internal Medicine in Advanced Heart Failure and Transplant Cardiology (AHFCT).

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases

50.27 RIGHT HEART CATHETERIZATION ___

PREREQUISITES: Currently Board Eligible, Certified, or Re-Certified by the American Board of Internal Medicine in Advanced Heart Failure and Transplant Cardiology (AHFCT).

PROCTORING: Review of 2 cases

REAPPOINTMENT: Review of 2 cases

50.31 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY ___

Privilege	Status	Approved

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by the American Board of Medical Specialties in Cardiology and current X-Ray/Fluoroscopy Certificate.

PROCTORING: Presentation of valid California Fluoroscopy certificate;

REAPPOINTMENT: Presentation of valid California Fluoroscopy certificate

50.34 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.

Fecal Occult Blood Testing (Hemoccult®) ___

Vaginal Ph Testing (Ph Paper) ___

Urine Chemistrip® Testing ___

Urine Pregnancy Test (Sp® Brand Rapid Test) ___

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

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

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

________________________________ ____________________
CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

________________________________ ____________________
Applicant Date

APPROVED BY

________________________________ ____________________
Division Chief Date

________________________________ ____________________
Service Chief Date

Delineation Of Privileges

Medicine Cardiology 2020

Provider Name:

Privilege	Status	Approved