City and County of San Francisco

Department of Public Health

London Breed
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Gabriel Ortiz, MD, PhD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

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

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I. ~~ORTHOPEDIC~~ORTHOPAEDIC SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

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

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

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF ~~ORTHOPEDIC~~ORTHOPAEDIC SURGERY CLINICAL SERVICE

Currently, the ~~Clinical Service of Orthopedic~~orthopaedic s~~S~~urgery clinical service at ~~San Francisco General Hospital~~Zuckerberg San Francisco General largely is staffed by ~~8~~

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

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

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

4. Current X-Ray Certificate

B. REAPPOINTMENTS

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

1. ~~Practitioners~~ Practitioners' Performance Profiles

Practitioner's performance profiles are determined and monitored in two ~~fashions~~ways. ~~Outpatient encounters are monitored by the hospital outpatient clinic services T~~he hospital outpatient clinic services monitor outpatient encounters, and statistics are available ~~by ICD9 and~~ via CPT codes. Inpatient services, including emergency room consultations, are monitored and counted according to different categories. Complications of all ~~nature are also compiled on a monthly basis and are kept on file by the Service as well as~~types are also compiled monthly and kept on file by the Service and in the Medical Staff Services Office.

2. Modification of Clinical Service

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

3. Staff Status Change

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

4. Modification/Changes to Privileges

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

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

The ~~Orthopedic~~Orthopaedic Surgery Clinical Service ~~fall into the same staff categories which are described in Article III – *Categories of the Medical Staff* of the SFGH~~ZSFG

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

III. DELINEATION OF PRIVILEGES (Refer to Attachment A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

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

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

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

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

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

A. SUPERVISION

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

B. EDUCATIONAL ACTIVITIES

Currently, there are eight ~~orthopedic~~orthopaedic residents on rotation at ~~SFGH~~ZSFG, two residents from every ~~Orthopaedic~~ Orthopaedic year PGY-2~~5~~ through -5~~2~~ at all times. There ~~are~~ is also a varying number of interns (2~~1~~-3~~0~~-4) at any point in time. There are two orthopaedic trauma ~~two~~ fellows on the ~~Orthopaedic~~ Orthopaedic Surgery Service, with periodic clinical support from the UCSF Spine, Hand, and Vascular Surgery fellows. ~~.~~These traineesy are divided into 2~~2~~ teams and are providing emergency room coverage.

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

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

Regular d~~Weekly di~~dactic sessions include~~are~~:

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

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

Medical students currently rotate at SFGHZSFG through Surgical Specialties 110 (1 week) and 4 week4-week optional electives.

C. EDUCATIONAL GOALS

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

D. GUIDELINES

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

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

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

E. DUTIES OF RESIDENTS (Specific Responsibilities):

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

1. Patient Care Responsibilities

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

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

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

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

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

7. Conference Responsibilities

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

VII. ~~ORTHOPEDIC~~ORTHOPAEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. RESPONSIBILITY

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

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

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

B. REPORTING

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

C. CLINICAL INDICATORS

The following clinical indicators are among those closely followed:

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

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

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

E. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

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

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1. Physicians/Affiliated Professionals

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

2. Housestaff

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

X. MEETING REQUIREMENTS

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

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

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

XI. ADOPTION AND ADMENDMENTAMENDMENT

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

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XII. PATIENT INFORMATION

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

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

ATTACHMENT A– ~~ORTHOPEDIC~~ORTHOPAEDIC SURGERY PRIVILEGES

Privileges for Zuckerberg San Francisco General

Requested Approved

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

OrthoSurg ORTHOPAEDIC SURGERY 2010
(MEC 08/10)

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

28.00 GENERAL PRIVILEGES

Core privileges directed at the treatment of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities, include the following treatments (other than those outlined for supplemental privileges):
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of ~~Orthopedic~~Orthopaedic Surgery.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.
REAPPOINTMENT: 20 operative procedures in the previous two years.

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

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Privileges for Zuckerberg San Francisco General

Requested Approved

X. Total joint surgery
Y. Tumor surgery
Z. Wound debridement
aa. Management of ~~orthopedic~~orthopaedic conditions for patients in SNF Units
bb. Major tumor resection

28.05 OUTPATIENT PRIVILEGES

Outpatient clinic privileges directed at the evaluation and diagnosis of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of ~~Orthopedic~~Orthopaedic Surgery.
PROCTORING: 5 observed visits and 15 retrospective reviews visits
REAPPOINTMENT: 20 visits in the previous two years.

28.10 SPECIAL PRIVILEGES: SPINAL SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery and has completed fellowship training in spinal surgery or possesses equivalent experience.
PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Orthopaedic Surgery or designee.
REAPPOINTMENT: 20 procedures in the previous two years.
Patient management includes the areas specified below:

A. Complex anterior and posterior cervical, thoracic, and lumbar spinal surgery
B. Open reduction and internal fixation of spine fractures
C. Intra-discal chemonucleolysis
D. Percutaneous disk excision

28.20 SPECIAL PRIVILEGES: HAND AND MICROVASCULAR SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microvascular surgery or possesses equivalent experience.
PROCTORING: Review of 5 operative procedures and 15 retrospective reviews of procedures
REAPPOINTMENT: 20 operative procedures in the previous two years.

A. Microsurgery and replacement, replantation of limbs and parts, including adjacent and free tissue transfer.
B. Complex Hand Surgery and Replantation of Limbs and Parts
C. Use of operating microscope, repair blood vessel/nerve, digit replantation
D. Free muscle/skin flap microvascualar anastamosis

28.30 GENERAL PODIATRIC PRIVILEGES

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

Privileges for Zuckerberg San Francisco General

Requested Approved

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

28.40. SURGICAL PODIATRIC PRIVILEGES

28.41. Category I: Podiatric Surgery

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.
PROCTORING: 5 observed cases and 15 retrospective reviews of procedures (Category I).
REAPPOINTMENT: 20 cases in the previous two years.

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

28.42. Category II: Podiatric Surgery

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00.
PROCTORING: 5 observed procedures and 15 retrospective reviews of procedures (Category 2).
REAPPOINTMENT: 20 procedures in the previous two years (Category 2).
Deep procedures of the forefoot including:

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

29.00. PHYSICAL MEDICINE & REHABILITATION

~~PREREQUITES~~PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.
PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation, with a recommendation to the Chief of the Orthopaedic Surgery Service.
REAPPOINTMENT: 20 procedures in the previous two years.
Performs basic procedures within the usual and customary scope of physical medicine and rehabilitation, including but not limited to diagnosis, management, treatment, and preventive care for adult and pediatric patients.
Procedures include:

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

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Privileges for Zuckerberg San Francisco General

Requested	Approved	
		C. Joint bursa aspiration
		D. Joint bursa injection
		E. Tendon sheath injection
		F. Trigger/Tender point injection
		G. Ganglion aspiration
		H. Nerve block
		I. Chemical neurolysis
		J. Neuromuscular junction block
		K. Autologous blood tendon injection
		L. Lumbar puncture
		M. Intrathecal pump management
		29.10 SPINAL INJECTION TECHNIQUES
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.
		PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.
		REAPPOINTMENT: 20 procedures in the previous two years.
		Procedures include:
		A. Transforaminal epidural injection (selected nerve root block)
		B. Interlaminar epidural injection
		C. Facet joint injection
		D. Facet nerve block
		E. Discography
		F. Epidurolysis
		G. Sympathetic nerve block
		H. Sacroiliac joint injection
		I. Epidural blood patch
		J. Radiofrequency nerve ablation
		29.20 SPINAL TECHNIQUES: SPECIAL PROCEDURES
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.
		PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.
		REAPPOINTMENT: 20 procedures in the previous two years.
		Procedures include:
		A. Spinal cord stimulation
		B. Percutaneous vertebroplasty/kyphoplasty
		C. Implanted drug delivery for pain or spasticity
		D. Intradiscal electrothermal therapy

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Privileges for Zuckerberg San Francisco General

Requested Approved

29.30 CLINICAL NEUROPHYSIOLOGY

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

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

REAPPOINTMENT: 20 procedures in the previous two years.

Procedures include:

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

29.40 EVOKED POTENTIAL TESTING

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

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

REAPPOINTMENT: 20 operative procedures in the previous two years

30.00 ACUTE TRAUMA SURGERY

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

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

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

REAPPOINTMENT: 20 operative procedures in the previous two years

31.00 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY

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

PROCTORING: Presentation of valid California Fluoroscopy certificate

REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.

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

Privileges for Zuckerberg San Francisco General

Requested	Approved		
		32.00	**PROCEDURAL SEDATION**
			PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of ~~Orthopedic~~Orthopaedics or a member of the Clinical Service prior to 10/17/00, and has completed at least one of the following: ·Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or, ·Management of 10 airways via BVM or ETT per year in the preceding 2 years or, ·Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association
			PROCTORING: Review of 5 cases (completed training within the last 5 years)
			REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following: ·Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or, ·Management of 10 airways via BVM or ETT per year for the preceding 2 years or, ·Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

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I hereby request clinical privileges as indicated above.

Applicant date

FOR DEPARTMENTAL USE:

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

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

CPR certification is required.
CPR certification is not required.

APPROVED BY:

Division Chief date

Service Chief date

PRINTED 6/24/2013

ATTACHMENT A – ORTHOPEDIC PRIVILEGE REQUEST FORM

Applicant: Please initial the privileges you are requesting in the Requested column.
Service Chief: Please initial the privileges you are approving in the Approved column.
FOR ALL PRIVILEGES: All complication rates, including problem transfusions, deaths, unusual occurrence reports, patient complaints and sentinel events, as well as Department quality indicators, will be monitored semiannually

Requested Approved

28 ORTHOPAEDIC SURGERY

28.00 GENERAL PRIVILEGES
Core privileges include procedures directed at the treatment of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopedic Surgery.
PROCTORING: Review of 3 cases.
REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.10 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopedic Surgery, Plastic Surgery, Podiatric Surgery, or the American Board of Physical Medicine & Rehabilitation. A current X-Ray/Fluoroscopy Certificate is required.
REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.20 PODIATRIC PRIVILEGES
Simple outpatient procedures, including nail avulsion, chemical, biopsy and
debridement of cutaneous lesions, and simple infection process relative to nails and skin. Evaluation and non-invasive treatment of common podiatric medical pathology.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery.
PROCTORING: Review of 3 cases.
REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.21 Category I – Podiatric Surgery
Superficial procedures including the treatment of cutaneous lesions, removal of foreign bodies, and superficial debridements.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery.
PROCTORING: Review of 3 cases.
REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

28.22 Category II – Podiatric Surgery.
Deep procedures of the forefoot, including the excision of soft tissue lesions, intermetatarsal neuromas, bunionectomies, capsulotomies, tenotomies, removal of foreign bodies of the forefoot, and amputation. Osseous procedures of the forefoot including sesamoidectomy, fusion of interphalangeal joints, and osteotomies.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified byThe American Board of Podiatric Surgery.
PROCTORING: Review of 3 cases.
REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

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

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Privileges for San Francisco General HospitalZuckerberg San Francisco General

Requested Approved

for adult and pediatric patients of all ages at the CHN facilities or in the patient's home.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation
PROCTORING: Review of 5 patient charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service
REAPPOINTMENT: Review of 5 patient charts by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service

29.02 SPINAL INJECTION TECHNIQUES

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

29.03 CLINICAL NEUROPHYSIOLOGY

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

29.031 EMG

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

29.032 EVOKED POTENTIAL TESTING

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

Requested Approved

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

30 ACUTE TRAUMA SURGERY

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

PREREQUISITES: Completion of ACGME-approved residency with
Board certification/eligibility in Orthopedic Surgery. Availability, clinical performance and continuing medical education consistent with current standards for orthopedic surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons.
PROCTORING: Review of 3 cases.
REAPPOINTMENT: Renewal of privileges requires the review of a minimum of 2 cases every 2 years.

31 SPECIAL PRIVILEGES

PATIENT MANAGEMENT INCLUDES THE AREAS SPECIFIED BELOW:

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

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

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PROCTORING: Review of 5 cases if training is completed through an ACGME program and 10 cases if the individual completed training through a non-ACGME training program.
REAPPOINTMENT: Review of 2 cases.

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

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PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microsurgery.
PROCTORING: Review of 5 cases if training is completed through an ACGME program and 10 cases if the individual completed training through a non-ACGME training program.

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REAPPOINTMENT: Review of 2 cases.

32 MODERATE SEDATION

The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department.
PROCTORING: Review of 5 cases.
REAPPOINTMENT: Review of 5 cases or completion of the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department. .

I hereby request clinical privileges as indicated above.

Applicant date

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

FOR DEPARTMENTAL USE:

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

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

CPR certification is required.
CPR certification is not required.

APPROVED BY:

Division Chief date

Service Chief date

Printed 10/19/2007 *Page 4*

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

ATTACHMENT B– ~~ORTHOPEDIC~~ORTHOPAEDIC SURGERY POLICIES AND PROCEDURES

A. EMERGENCY ROOM COVERAGE

~~1.~~ Representative, usually house staff, should respond~~spond~~ immediately~~IMMEDIATELY for~~ to ER consultation.

2. The Orthopaedic Surgery Service administration will c~~C~~onfirm that:
   a. ~~that~~ The~~your~~ name~~s~~ and contact information are~~beeper number are~~ listed correctly on the call schedule
   b. the contact information for those on call for resident (intern, junior, and senior), fellow, and faculty (general orthopaedic surgery/trauma, spine, and hand) is accurate (e.g.,~~at your~~ beeper, if applicable, and ~~,~~ cell phone) on the call schedule~~., Secure Chat and any other methods of clinical communications are~~is working~~.~~
3. The resident~~s~~ assigned to the ER on days should be available from 7:00 a.m. until 7:00 a.m. the following day, depending on their call assignment~~.~~..
4. The resident on call on holidays covers the ER during the day and night.
5. The attendings for general call will have call shifts that are for day coverage (attending of the day; AOD) and night coverage (attending of the night; AON), with shifts from 7:00 a.m. to 6:00 p.m and 6:00 p.m to 7:00 a.m., respectively.

5. PATIENT TREATMENT REGISTER:
   a. All outpatients must be recorded on the electronic "Patient ~~Case Log~~Treatment Register" ~~sheet~~ by the ~~Orthopedic~~Orthopaedic Emergency Room Resident. ~~Record name, MRB number, phone, address, diagnosis, treatment and clinic appointment date. Patients must have complete registry information placed on the registry information sheet.~~
   b. All admissions with ~~orthopedic~~orthopaedic problems (whether admitted to the Orthopaedic Surgery Service or other service~~not~~) must also be recorded on the appropriate patient list. ~~specifying assigned SFGH~~ZSFG ~~ward and admitting service if other than Ortho.~~
   ~~c. The Ortho Service administrative staff and nurse practitioners will obtain the list each morning and use it for service records.~~
   c~~d~~. Acute conditions (e.g., fractures, dislocations, infections, ~~etc.~~) shall be evaluated prior to given disposition discharge instructions from the ED. Orthopaedic Surgery residents should participate in the scheduling of outpatient follow-up scheduling of patients seen in the ED.~~not be given e-referral appointments~~.

6. EMERGENCY TREATMENT POLICIES:
   a. Junior orthopaedic surgery residents on call should c~~C~~onsult immediately with Chief Resident regarding any potential surgical case.
   b. T~~Unless he~~you ~~are~~ junior resident on call ~~certain of diagnosis and treatment, consult~~ should consult the Chief Resident prior to making disposition plans in which they are unsure~~.~~..
   c. The on-call junior resident should notify the Chief Resident immediately of all admissions to their service. The Chief Resident should notify the attending on call of all admissions to their service or cases scheduled~~.~~..
   d. R~~Save all youre~~sidents should ~~save all records, particularly the yellow copies of the consult forms (originals are to be left on the chart)~~document their consultation note in the medical record and ~~to~~ review all patient cases

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

e. When in doubt, the junior resident should ~~not hesitate to~~ ask the Chief Resident to personally see the patient and/or the imaging studies (e.g., compression fractures of the spine, patients unable to walk or care for themselves safely in casts, potential compartment syndromes, "disposition problems" whose diagnoses are ~~orthopedic~~orthopaedic~~, etc.~~).

f. ER ~~RECORDS~~Records: An orthopaedic surgery~~ORTHO~~ consult note must be written and signed in the medical record for each patient seen ~~using the standard template form~~. The records should include medications given and procedures done for patients admitted to the hospital or sent home with follow-up instructions (including clinic follow-up). ~~—~~For admissions, the attending of record must review the consult ~~and see the patient within 24 hours of admission,~~ see the patient within 24 hours of admission~~,~~, and complete an attending attestation ~~form~~ in the medical record.

g. Orthopaedic Surgery residents are responsible for the consultations in the ER.

h. ~~Orthopedic~~Orthopaedics & Neurosurgery should be called for consults~~by ER~~ according to the spine call schedule.

i. Orthopaedics & Plastics should be called for consults according to the hand call schedule.

7. Avoid "curbside" consultation--it is usually not optimal for the patient.

B. EMERGENCY ADMISSIONS

1. EMERGENCY ~~ORTHOPEDIC~~ORTHOPAEDIC ADMISSIONS

a. Emergency admissions are assigned to the service on call for that day, with the following exceptions:

1) Patients requiring emergency surgery will be cared for by the team performing the operation.

2) Re-admissions for the same problem will return to their previous team.

3) Patients seen from 6 p.m. to 7 a.m. the night prior will be reviewed by and admitted to the attending of the day (AOD), who will be covering the OR during the following day, unless otherwise arranged.

b. Residents should c~~C~~omplete ER admission ~~paperwork~~documentation at the time of admission~~,~~ including admission orders and a complete history and physical examination.

c. Direct admissions/transfers from other hospitals are welcome and encouraged. They must be approved first by an attending ~~who will arrange the transfer with the SFGHZSFG eligibility/transfer coordinator (if inpatient to inpatient transfer) or the ED attending (if ED to ED transfer,~~ who will arrange the transfer with the ZSFG eligibility/transfer coordinator (for inpatient-to-inpatient transfers) or the ED attending (for ED-to-ED transfers). Make note of ~~patient diagnosis, reason for transfer,~~

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

2. ADMISSIONS TO OTHER SERVICES

There must be:

a. A note in the medical record clearly defining the patient's ~~orthopedic~~orthopaedic problems and treatment, provided or recommended~~, and a legible signature with beeper number.. Times and dates are required on all notes and orders.~~

b. Clear ~~written~~ indication of which ~~orthopedic~~orthopaedic team is involved ~~with name of the chief resident and his/her beeper number~~.

c. Verbal communication with the responsible senior or chief resident of the admitting service to ensure proper communication and discussion of medical plans.

d. Patient admissions and transfers should adhere to the general guidelines established between the various services, ~~(~~including trauma and medicine~~)~~.

e. While on another service, ~~such "consult~~ the patients sonsulted on~~"~~ will be followed at least daily by the appropriate ~~orthopedic~~orthopaedic team, until the patient is stable for sign-off~~.~~.

f. Children with ~~orthopedic~~orthopaedic problems requiring hospitalization will be admitted to the p~~P~~ediatric ward~~Ward (6A)~~ under the primary care of the Pediatric Service who must be notified immediately about any admission and ~~(~~must see the patient in the ER~~in ER)~~. Orthopaedic Surgery Service ~~i~~house staff may~~nterns may~~ assist with the care of these~~such~~ patients~~, but need not do work-ups and ward care as these are provided by the Pediatric house staff~~.

C. NIGHT AND WEEKEND COVERAGE

1. The assigned junior resident and intern must stay in the hospital.
2. When a new junior resident assumes night/weekend call, the chief resident mayust also remain in the hospital to provide immediate back upbackup. —These requirementsis may be discontinued only by mutual agreement of the chief resident and service chief.
3. Before leaving for the day, interns will review sign out their patients with the intern and/or nurse practitioner on duty regarding pending problems, etc.
4. Night call is the responsibility of that the person on the call schedule. If you are illthe scheduled resident on call needs or need to be off for some other reason, it is your their responsibility to make sure thatany reason, it is their responsibility to ensure the time is covered by another house officerHO of the same level who agrees to coverwho agrees to cover for you. The chief residents must approve of a switch in night call. Other team members, orthopaedic surgery administrator, telephone operator and ER must be notified of any deviation from the printed scheduleorthopaedic surgery administrators, telephone operators, and the ER must be notified of any deviation from the Department's published schedule.
5. Do not "hassle" the administrative assistant about the call schedule. Questions regarding the call schedule should be directed to the Chief of Service.

D. VACATIONS

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

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

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

E. ORTHOPEDICORTHOPAEDIC TEAM ROUNDS

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

F. WARD PROCEDURES

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

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

2. ORDERS

a. All orders will be ~~written~~ entered completely~~, including time and date, and signed. All admission and postoperative orders **must be written** on the standing order forms~~.

b. Verbal orders ~~phone orders~~ must be countersigned within 24 hours.

~~c. Narcotics, anticoagulants and IV fluid orders will be carried out for up to 72 hours when they will stop automatically unless renewed.~~

c~~d~~. ~~GIVE ADEQUATE PAIN MEDICATION!~~Provide adequate pain medication. ~~Pre-medicate~~ pre-medicate before a painful procedure. Do not hesitate to consult the p~~P~~ain m~~M~~anagement s~~S~~ervice.

d~~e~~. All medication orders must be ~~renewed every 7 days~~reviewed regularly.

c~~f~~. All orders must be ~~re-established~~reconciled ~~are automatically stopped~~ at the time of surgery and on inter-service transfer. ~~They therefore must be re-written in these cases~~.

f~~g~~. X-rays and lab studies must be ordered in the medical ~~chart~~ record. ~~as well as requested on appropriate forms. (test 7 clinical information completed as requested on appropriate forms).~~ Practitioners should~~Do~~ not order unnecessary (routine) blood work or x-rays.

g~~h~~. All instructions for the cast technician or braces must be recorded in the medical record~~chart~~, just as any other order.

3. DISCHARGE RECORDS

a. The ~~chief resident~~ attending is responsible for the correctness of recorded discharge diagnoses.

b. ~~Complete, specific, final orthopedic diagnoses must be on the Patient Discharge Form (pink right margin) and on dictated summary.~~

c. A brief ~~(preferably one page only) dictatedd~~ischarge summary will be done for each patient. ~~This must record at least the patient's diagnoses, including date of injury, operations performed with dates, problems encountered, if any, and plans for further care and follow-up. (See section below on Laguna Honda transfers).~~

c. If a patient is transferred to another hospital or physician, a telephone conversation must occur between the receiving orthopedist and a senior ~~orthopedic~~orthopaedic team member to discuss the patient's diagnoses, condition, treatment undertaken and transfer arrangements. This conversation, including ~~name, address and phone number of receiving orthopedist~~the name, address, and phone number of the receiving orthopedist, must be recorded in a ~~progress~~ note within the medical record. A ~~dictated~~ discharge summary and pertinent x-rays or access to their medical record~~their copies~~ should accompany transferred patients~~patients so transferred~~.

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

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G. DISCHARGE PLANNING

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

H. COMPLETION OF MEDICAL RECORDS

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

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

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

I. INFECTION PREVENTION

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

J. PRESSURE SORES & CONTRACTURES

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

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

K. PLASTER

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

L. TRACTION SUPPLIES

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

M. ORTHOTICS AND PROSTHETICS

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

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

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

N. SURGERY

Phone: 415-206-8134 ~~or 8138:~~
Perioperative N~~N~~ursing Supervisor: Patty ~~Nichols~~Coggan~~Lawrence Nichols~~, R.N.

O. PREOPERATIVE PREPARATION

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

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

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

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

4. Attending-specific responsibilities:

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

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

c. The OR a~~A~~ttending of the day (the on-call attending or his designee) will be available to cover any emergency or trauma cases in OR 8, and be available for board management or patient-related questions. The AOD will ~~rounds~~round at the 6:30~~5~~ a.m. huddle.

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

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

3. Informed Consent

a. Disclosure:~~ISCLOSURE~~

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

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

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

b. ~~WRITTEN CONSENT FORM~~Consent form:

- Perform after~~AFTER~~ disclosure

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- Complete allALL relevant informationspaces (including date and time)
- Signed by patient (or legally appointed conservator)
- Signature witnessed by another M.D. or SFGHZSFG employee
- Translator The translator must sign
- Special rules for minors (see Hospital Policy Manual)

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

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

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

154. Preparation:~~REPARATION~~

a. Shave (in OR) only when and where hair will impede closure. Clipping should be performed when possible.

b. ~~If skin is intact, use iodophor~~Standard prep should be used (Prepadine, Betadine, Ioprep, etc.) ~~which can be painted directly on open wound~~. ~~Skin must be completely dry if adhesive drape is~~ The skin must be completely dry for the adhesive drape to stick reliably.

c. Drape according to standard sterile draping techniques.

15. ~~PROTECTION FOR SURGEONS~~Protection:

a. All surgeons must wear goggles, glasses, or a face shield for every case.

b. Double gloves must be worn for every case.

c. For cases with significant blood loss, each surgeon should~~must~~ wear:

1) Double shoe covers
2) ~~Knee high~~Knee-high disposable boots
3) Gowns with reinforced sleeves and front panel
4) Extra sleeves

d. The pulse lavage must be used with its splash shield. If none is available, the pulse lavage is not to be used. Irrigate with a bulb syringe.

e. S~~tackhouse s~~urgical helmet systems are available for use on all high-risk cases. When scheduling cases, ~~tell OR you~~communicate that you want to use the ~~Stackhouse~~ systems.

f. b. When operating on high-risk patients, the members of the surgical team should consider the use of~~wear~~ Kevlar gloves.

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

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

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

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

~~Grade III open fractures:~~

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

~~If gross dirt contamination:~~

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

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

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

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

~~18.~~20. The patient must be ~~site marked~~site-marked ~~prior to~~before surgery by a licensed practitioner who is capable of starting the case and will be present at the beginning of the case. ~~The attending must call in to the Operating Room by 7:15 the morning of the surgery.~~

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~~19.~~21. All hair and street clothing must be covered. A self-laundered scrub ~~-~~cap can be used if covered up by a clean, disposable cap. Use ~~hood, not cap alone~~a hood, not a cap alone, to cover all hair if exposed (a. ~~A~~ sweatband helps with sweat~~)~~..

~~20.~~22. ~~If you leave OR in greens, wear a long gown closed in the front. A short white jacket does not prevent contamination of the front of your greens. When in doubt, change your greens~~When in doubt, greens ~~-~~should be changed before beginning another case, particularly for ~~in~~ those cases that have been on contaminated or infected wounds or if the greens were worn outside of the operating room area. Greens should never leave the hospital campus (~~can be worn between~~ they can be worn between the hospital and ~~B~~other campus buildings).~~uilding 9).~~

2~~1~~3. The operating resident for the next case should stay in the assigned operating room between cases to expedite room turnover. ~~Patients in the pre-operative area should be checked by the surgical team~~The surgical team should check patients in the pre-operative area ~~for completion of paperwork, site marking, and desire to have additional questions answered prior to surgery in order to ensure no delay for~~to confirm paperwork completion, site marking, and any additional questions to be answered before surgery, to ensure the start of the next case is not delayed~~ the start of the next case~~. The surgical team in the OR ~~in which the patient is expected to enter will be notified by the holding area staff for patients with incomplete requirements so that this can be dealt with in order to avoid delays in room turn-overw~~here the patient is expected to enter will be notified by the holding area staff of patients with incomplete requirements, so this can be addressed to avoid delays in room turnover.

~~22.~~23. Masks should be changed between every case.

~~23.~~ Shoe covers must be worn in the OR at all times. If you leave the OR, remove your shoe covers and replace them upon return to the OR.

~~24.~~

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

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Age	NO FOOD*	CLEAR LIQUIDS ONLY**
Less than 6 months	4 hours before the procedure	2 hours
7 months to age 12	After midnight	2 hours
Age 13 and adjust	After midnight	4 hours
Age	**NO FOOD***	**CLEAR LIQUIDS ONLY****
Any age	4 hours (recommended light meal only)	Ad lib

* No food includes dairy products, infant formula, any unclear liquid, gum
** Clear liquids include water, filtered ~~apply~~ apple juice, cranberry juice, and breast milk

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~~DICTATIONS~~

OPERATIVE REPORTS

1. ~~1. Brief operative note A brief or or~~ full o~~O~~perative note must be completed and ~~signed in the~~placed in the medical record prior to the patient moving out of the p~~P~~erio-~~O~~perative c~~C~~are a~~A~~rea.

If a brief operative note is completed immediately after a procedure rather than a full o~~O~~perative note, then the full o~~O~~perative note ~~Must~~ must be ~~dictated~~ completed and signed within 24 hours of the intra-operative procedure. ~~on the Provations system~~

2. ~~2. All new fellows, residents, and interns who are unfamiliar with the system should be trained within the first week of~~prior to ~~their starting on the service.~~

3. At the time of surgery, the surgical team should identify the resident responsible for the surgical ~~dictation~~documentation. ~~The surgical resident responsible for the dictation should be identified on the operative note.~~

~~4. Attendings should submit the yellow copies to the Orthopaedic Department for billing purposes and monitoring the dictations.~~

~~5. Operative notes must be dictated within 24 hours of the surgical procedure. Any undictated note greater then 5 days will result in suspension of surgical privileges. Any unsigned note greater than 5 days after its dictation also will result in suspension of surgical privileges.~~

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

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

~~**FORMAT:**~~

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

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

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TO:	DIAL:
Listen	1
Dictate	2
Reverse (@15 words)	3
Pause	4
Fast forward	7
Rewind to beginning of report	6
End of report	5
Call operator	0 + 0
Insert*	0 + 6

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

4. After dictating the operative note, sign and dictate the blue sheet and place in box on 3B adjacent to resident boxes.

5. If an intern is the surgeon on a case, the op note must be dictated by the most senior resident on the case.

5. Do not sign any operative notes.

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

1. If indicated, obtain films in OR before breaking the OR before breaking the sterile shield or discontinuing anesthesia.

X-rays are not permitted in the PACU unless required for immediate monitoring.

2. Only those orthopaedic practitioners with a California fluoroscopy supervisors licenses may operate a fluoroscopy unit.

3. Prior toBefore the use of fluoroscopy, the operator must announce that this equipment will be used and must ensure that those exposed to potential radiation are protected with shielding, including the operator, the patient, and ancillary personnel.

3.

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P. Q. CLINIC RULES

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

~~Q. CLINIC PAPERWORK~~

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

R. ADMISSIONS FROM CLINIC

1. The nurse will assist with ~~arrangements for admission~~admission arrangements.
2. The c~~C~~hief r~~R~~esident and appropriate service attending should be notified of these admissions immediately.

S. EMERGENCY ADMISSIONS

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

T. ELECTIVE (FUTURE) ADMISSIONS

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

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3. ~~The TAR must be completed as early as possible for pre-admission financial approval if applicable.~~Complete the proper documentation and orders on the electronic medical record.

4. ~~—~~The patient should be evaluated ~~by~~for eligibility and may be appropriate for referral to the pre-operative clinic.~~Patient is then interviewed by eligibility worker.~~

3. ~~5. The patient should report to 1C1 immediately for pre-admit approval.~~be sent to the pre-operative clinic.

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

~~1. Same MediCal form as above. Note "Come and Stay."~~

~~2. Patients return to clinic and day before their surgery for 1) pre-op H&P, labs, disclosure and documentation, consent form and 2) preoperative instructions by nurse.~~

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

~~1. TAR patients as soon as possible.~~

~~2.~~ M.D./R.N. should~~must~~ schedule with the Surgi Center at least 3 days in advance~~advance.~~

2~~3~~. In general: Local anesthesia: Labs only if indicated. ~~—~~Need written H&P, disclosure, and consent.

4. General anesthesia: Same work-up and documentation as for Come and Stay.

V. CLINIC DISCHARGE CRITERIA

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

W. INFECTIONS

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

X. ~~ORTHOPEDIC~~ORTHOPAEDIC PEDIATRIC ADMISSIONS

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

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

Pediatics:

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

~~*Orthopedic*~~*Orthopaedics:*

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

Y. ~~ORTHOPEDIC~~ORTHOPAEDIC ~~FA~~MEDICINE~~MILY~~ INPATIENT SERVICE ADMISSIONS

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

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teams. ~~Later in the morning, the FIS Hospitalist will quickly round with the Ortho NPs and/or intern to set the plan of care for the Ortho-related problems for patients on the 3rd FIS team~~.

3. In accordance with the interservice agreements, for patients over 80 or with acute medical conditions warranting admission and management, the Medicine inpatient service will be the primary service with the Orthopaedic~~The FIS Hospitalist~~Medicine inpatient service will be the primary caregiver with Ortho Surgery Service serving as a ~~close~~ consulting service for patients on the Medicine inpatient service~~3rd FIS~~ team. Orthopaedic NPs ~~NPs~~ and interns will coordinate the disposition plan and follow-up for any o~~O~~rthopaedic-related medical issues. Otherwise, the ~~hospitalist~~Medicine inpatient service will manage all other aspects of care and discharge.
4. For overnight and weekend issues, the overnight medicine~~al~~ inpatient service~~FIS~~ Overnight h~~H~~ospitalist can be the first "go-to" person for any acute medical issues that arise on the o~~O~~rthopaedic s~~S~~ervice i~~n~~-patients.

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~~**V. PATIENTS WITH SPINE INJURIES**~~

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

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ATTACHMENT C -- —CLINICAL SERVICE CHIEF OF ORTHOPEDICORTHOPAEDIC SURGERY JOB DescriptionDESCRIPTION

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

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Chief of OrthopedicOrthopaedic Surgery Clinical Service

Position Summary:

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

Reporting Relationships:

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

Position Qualifications:

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

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

MajorMajor Responsibilities:

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

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

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

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

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

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

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

ORTHOPAEDIC SURGERY CLINICAL SERVICE RULES AND REGULATIONS 2026

Zuckerberg San Francisco General
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ORTHOPAEDIC SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
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I. ORTHOPAEDIC SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

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

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF ORTHOPAEDIC SURGERY CLINICAL SERVICE

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

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

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

B. REAPPOINTMENTS

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

1. Practitioners' Performance Profiles

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

2. Modification of Clinical Service

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

3. Staff Status Change

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

4. Modification/Changes to Privileges

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

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

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

III. DELINEATION OF PRIVILEGES (Refer to Attachment A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

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

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

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

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

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

VI. ORTHOPAEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. SUPERVISION

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

B. EDUCATIONAL ACTIVITIES

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

Resident teaching at ZSFG occurs in three ways:

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

Regular didactic sessions include:

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

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

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

C. EDUCATIONAL GOALS

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

D. GUIDELINES

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

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

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

E. DUTIES OF RESIDENTS (Specific Responsibilities):

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

1. Patient Care Responsibilities

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

5. Clinic Responsibilities

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

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

6. Surgical Responsibilities

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

7. Conference Responsibilities

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

VII. ORTHOPAEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. RESPONSIBILITY

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

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

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

B. REPORTING

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

C. CLINICAL INDICATORS

The following clinical indicators are among those closely followed:

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

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

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

E. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

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

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1. Physicians/Affiliated Professionals

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

2. Housestaff

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

X. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws, all Active Members are expected to show good-faith participation in the governance and quality evaluation processes of the Medical Staff by attending at least 50% of all assigned committee meetings, as well as clinical service meetings and the annual Medical Staff Meeting.

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

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

XI. ADOPTION AND AMENDMENT

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

XII. PATIENT INFORMATION

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

Zuckerberg San Francisco General
1001 Potrero Ave
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ATTACHMENT A– ORTHOPAEDIC SURGERY PRIVILEGES

Privileges for Zuckerberg San Francisco General

Requested Approved

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

OrthoSurg ORTHOPAEDIC SURGERY 2010
(MEC 08/10)

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

_____ _____ **28.00 GENERAL PRIVILEGES**

Core privileges directed at the treatment of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities include the following treatments (other than those outlined for supplemental privileges):
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopaedic Surgery.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.
REAPPOINTMENT: 20 operative procedures in the previous two years.

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

Privileges for Zuckerberg San Francisco General

Requested	Approved	
_____	_____	GG. Total joint surgery
_____	_____	HH. Tumor surgery
_____	_____	Z. Wound debridement
_____	_____	aa. Management of orthopaedic conditions for patients in SNF Units
_____	_____	bb. Major tumor resection
_____	_____	**28.05 OUTPATIENT PRIVILEGES**

Outpatient clinic privileges directed at the evaluation and diagnosis of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopaedic Surgery.
PROCTORING: 5 observed visits and 15 retrospective reviews visits
REAPPOINTMENT: 20 visits in the previous two years.

_____	_____	**28.10 SPECIAL PRIVILEGES: SPINAL SURGERY**

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery and has completed fellowship training in spinal surgery or possesses equivalent experience.
PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Orthopaedic Surgery or designee.
REAPPOINTMENT: 20 procedures in the previous two years.
Patient management includes the areas specified below:

_____	_____	A. Complex anterior and posterior cervical, thoracic, and lumbar spinal surgery
_____	_____	B. Open reduction and internal fixation of spine fractures
_____	_____	C. Intra-discal chemonucleolysis
_____	_____	D. Percutaneous disk excision
_____	_____	**28.20 SPECIAL PRIVILEGES: HAND AND MICROVASCULAR SURGERY**

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microvascular surgery or possesses equivalent experience.
PROCTORING: Review of 5 operative procedures and 15 retrospective reviews of procedures
REAPPOINTMENT: 20 operative procedures in the previous two years.

_____	_____	A. Microsurgery and replacement, replantation of limbs and parts, including adjacent and free tissue transfer.
_____	_____	B. Complex Hand Surgery and Replantation of Limbs and Parts
_____	_____	C. Use of operating microscope, repair blood vessel/nerve, digit replantation
_____	_____	D. Free muscle/skin flap microvascualar anastamosis
_____	_____	**28.30 GENERAL PODIATRIC PRIVILEGES**

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

Privileges for Zuckerberg San Francisco General

Requested	Approved	
_____	_____	A. Nail avulsion
_____	_____	B. Chemical Martisectomies
_____	_____	C. Biopsy and debridement of cutaneous lesions, and simple infection process relative to nails and skin.
_____	_____	**28.40 SURGICAL PODIATRIC PRIVILEGES**
_____	_____	28.41 Category I: Podiatric Surgery PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00. PROCTORING: 5 observed cases and 15 retrospective reviews of procedures (Category I). REAPPOINTMENT: 20 cases in the previous two years.
_____	_____	A. Treatment of cutaneous lesions
_____	_____	B. Removal of foreign bodies
_____	_____	C. Removal of superficial debridements
_____	_____	28.42 Category II: Podiatric Surgery PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Podiatric Surgery, or a member of the Clinical Services prior to 10/17/00. PROCTORING: 5 observed procedures and 15 retrospective reviews of procedures (Category 2). REAPPOINTMENT: 20 procedures in the previous two years (Category 2). Deep procedures of the forefoot including:
_____	_____	A. Excision of soft tissue lesions
_____	_____	B. Intermetatarsal neuromas
_____	_____	C. Bunionectomies
_____	_____	D. Capsulotomies
_____	_____	E. Tenotomies
_____	_____	F. Removal of foreign bodies of the forefoot
_____	_____	G. Amputation
_____	_____	H. Osseous procedures of the forefoot including sesamoidectomy
_____	_____	I. Fusion of interphalangeal joints
_____	_____	J. Osteotomies
_____	_____	**29.00 PHYSICAL MEDICINE & REHABILITATION**
		PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by
The		American Board of Physical Medicine and Rehabilitation. PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation, with a recommendation to the Chief of the Orthopaedic Surgery Service. REAPPOINTMENT: 20 procedures in the previous two years. Performs basic procedures within the usual and customary scope of physical medicine and rehabilitation, including but not limited to diagnosis, management, treatment, and preventive care for adult and pediatric patients. Procedures include:
_____	_____	A. Intra-articular joint injection
_____	_____	B. Intra-articular joint aspiration

Privileges for Zuckerberg San Francisco General

Requested	Approved	
_____	_____	C. Joint bursa aspiration
_____	_____	D. Joint bursa injection
_____	_____	E. Tendon sheath injection
_____	_____	F. Trigger/Tender point injection
_____	_____	G. Ganglion aspiration
_____	_____	H. Nerve block
_____	_____	I. Chemical neurolysis
_____	_____	J. Neuromuscular junction block
_____	_____	K. Autologous blood tendon injection
_____	_____	L. Lumbar puncture
_____	_____	M. Intrathecal pump management
_____	_____	**29.10 SPINAL INJECTION TECHNIQUES**

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.
PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.
REAPPOINTMENT: 20 procedures in the previous two years.
Procedures include:

_____	_____	A. Transforaminal epidural injection (selected nerve root block)
_____	_____	B. Interlaminar epidural injection
_____	_____	C. Facet joint injection
_____	_____	D. Facet nerve block
_____	_____	E. Discography
_____	_____	F. Epidurolysis
_____	_____	G. Sympathetic nerve block
_____	_____	H. Sacroiliac joint injection
_____	_____	I. Epidural blood patch
_____	_____	J. Radiofrequency nerve ablation
_____	_____	**29.20 SPINAL TECHNIQUES: SPECIAL PROCEDURES**

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation.
PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service.
REAPPOINTMENT: 20 procedures in the previous two years.
Procedures include:

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

Privileges for Zuckerberg San Francisco General

Requested	Approved		
_____	_____	**29.30**	**CLINICAL NEUROPHYSIOLOGY** PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required. PROCTORING: 5 observed procedures and 15 retrospective reviews of operative procedures by the Chief of Rehabilitation with a recommendation to the Chief of the Orthopaedic Surgery Service. REAPPOINTMENT: 20 procedures in the previous two years. Procedures include:
_____	_____		A. Electromyography
_____	_____		B. Nerve conduction study
_____	_____		C. Somatosensory evoked potential assessment
_____	_____		D. Electromyography/nerve conduction guided
_____	_____		E. Guided nerve block
_____	_____		F. Electromyography/nerve conduction guided junction nerve block
_____	_____	**29.40**	**EVOKED POTENTIAL TESTING** PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified in American Board of Physical Medicine and Rehabilitation. Additional training in Neurophysiological techniques from an AMA-Category 1 certified program (documentation required) or documentation of the type of procedures performed as part of residency training is required. PROCTORING: Review of 5 procedures and 15 retrospective reviews of procedures REAPPOINTMENT: 20 operative procedures in the previous two years
_____	_____	**30.00**	**ACUTE TRAUMA SURGERY** SCOPE: On-call trauma coverage for the comprehensive orthopaedic management of the acutely injured trauma patient. PREREQUISITES: Completion of ACGME-approved residency with Board certification/eligibility in Orthopaedic Surgery. Availability, clinical performance and continuing medical education consistent with current standards for orthopaedic surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons. PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures. REAPPOINTMENT: 20 operative procedures in the previous two years
_____	_____	**31.00**	**DIAGNOSTIC RADIOLOGY: FLUOROSCOPY** PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by The American Board of orthopaedic Surgery, Plastic Surgery, Podiatric Surgery, or the American Board of Physical Medicine & Rehabilitation, or a member of the Clinical Services prior to 10/17/00. A current x-Ray/Fluoroscopy Certificate is required. PROCTORING: Presentation of valid California Fluoroscopy certificate REAPPOINTMENT: Presentation of a valid California Fluoroscopy certificate.

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

Privileges for Zuckerberg San Francisco General

Requested	Approved		
_____	_____	**32.00**	**PROCEDURAL SEDATION**

PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopaedics or a member of the Clinical Service prior to 10/17/00, and has completed at least one of the following:
·Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
·Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
·Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association
PROCTORING: Review of 5 cases (completed training within the last 5 years)
REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:
·Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
·Management of 10 airways via BVM or ETT per year for the preceding 2 years or,
·Current Basic Life Support (BLS) certification (age appropriate) by the American Heart Association

I hereby request clinical privileges as indicated above.

_____ _____
Applicant date

FOR DEPARTMENTAL USE:

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

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

_____ CPR certification is required.
_____ CPR certification is not required.

APPROVED BY:

_____ _____
Division Chief date

_____ _____
Service Chief date

PRINTED 6/24/2013

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

A. EMERGENCY ROOM COVERAGE

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

follow-up). For admissions, the attending of record must review the consult, see the patient within 24 hours of admission, and complete an attending attestation in the medical record.

g. Orthopaedic Surgery residents are responsible for the consultations in the ER.

h. Orthopaedics & Neurosurgery should be called for consults according to the spine call schedule.

i. Orthopaedics & Plastics should be called for consults according to the hand call schedule.

7. Avoid "curbside" consultation--it is usually not optimal for the patient.

B. EMERGENCY ADMISSIONS

1. EMERGENCY ORTHOPAEDIC ADMISSIONS

a. Emergency admissions are assigned to the service on call for that day, with the following exceptions:

1) Patients requiring emergency surgery will be cared for by the team performing the operation.

2) Re-admissions for the same problem will return to their previous team.

3) Patients seen from 6 p.m. to 7 a.m. the night prior will be reviewed by and admitted to the attending of the day (AOD), who will be covering the OR during the following day, unless otherwise arranged.

b. Residents should complete ER admission documentation at the time of admission, including admission orders and a complete history and physical examination.

c. Direct admissions/transfers from other hospitals are welcome and encouraged. They must be approved first by an attending, who will arrange the transfer with the ZSFG eligibility/transfer coordinator (for inpatient-to-inpatient transfers) or the ED attending (for ED-to-ED transfers). Make note of the patient's diagnosis, the reason for transfer, the type of bed required (ICU, step-down, etc.), and the optimal timing for surgery. The attending of record should be consulted if patients are transferred out of the ED, including pediatric patients.

2. ADMISSIONS TO OTHER SERVICES

There must be:

a. A note in the medical record clearly defining the patient's orthopaedic problems and treatment, provided or recommended.

b. Clear indication of which orthopaedic team is involved.

c. Verbal communication with the responsible senior or chief resident of the admitting service to ensure proper communication and discussion of medical plans.

d. Patient admissions and transfers should adhere to the general guidelines established between the various services, including trauma and medicine.

e. While on another service, the patients sonsulted on will be followed at least daily by the appropriate orthopaedic team, until the patient is stable for sign-off.

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

C. NIGHT AND WEEKEND COVERAGE

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

D. VACATIONS

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

E. ORTHOPAEDIC TEAM ROUNDS

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

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

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

F. WARD PROCEDURES

1. MEDICAL RECORDS:
   a. A history and physical will be documented for each patient on admission by the intern or junior housestaff, who will enter orders after consulting with a senior resident.
   b. There must be a resident note for each patient confirming pertinent history, physical examination, lab and x-ray findings, and given clearly recorded diagnoses and plans completed and signed in the medical record.
   c. Any procedure (e.g., case change, closed reduction) must be recorded in the patient's medical record along with other notable findings (e.g., physical findings, post-reduction x-rays). Operative notes can be completed directly in the electronic health record or dictated as necessary.
   d. Progress notes by the residents should be completed daily on each patient, and dated and signed.
   e. There should be an interval history/preoperative note written in the medical record less than 24 hours before any elective procedure.

2. ORDERS
   a. All orders will be entered completely.
   b. Verbal orders must be countersigned within 24 hours.
   c. Provide adequate pain medication—pre-medicate before a painful procedure. Do not hesitate to consult the pain management service.
   d. All medication orders must be reviewed regularly.
   e. All orders must be reconciled at the time of surgery and on inter-service transfer.
   f. X-rays and lab studies must be ordered in the medical record. Practitioners should not order unnecessary (routine) blood work or x-rays.
   g. All instructions for the cast technician or braces must be recorded in the medical record, just as any other order.

3. DISCHARGE RECORDS
   a. The attending is responsible for the correctness of recorded discharge diagnoses.
   b. A brief discharge summary will be done for each patient. This must record at least the patient's diagnoses, including date of injury, operations performed with dates, problems encountered, if any, and plans for further care and follow-up.
   c. If a patient is transferred to another hospital or physician, a telephone conversation must occur between the receiving orthopedist and a senior

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

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

G. DISCHARGE PLANNING

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

H. COMPLETION OF MEDICAL RECORDS

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

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

I. INFECTION PREVENTION

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

J. PRESSURE SORES & CONTRACTURES

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

K. PLASTER

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

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

L. TRACTION SUPPLIES

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

M. ORTHOTICS AND PROSTHETICS

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

N. SURGERY

Phone: 415-206-8134
Perioperative Nursing Supervisor: Patty Coggan, R.N.

O. PREOPERATIVE PREPARATION

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

d. Elective operating schedules must be entered before general release times for the ORs, or 72 hours before surgery for the elective room, and 6:00 am the day of surgery for 8th Room Cases.
e. Non-urgent cases "added on" after that time will be scheduled in sequence by the OR as space and personnel permit.
f. Emergency cases must be scheduled incollaboration with the attending or service chief resident.
g. The consent form must be obtained before booking, and the booked case must match the booking form.

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

3. Informed Consent
   a. Disclosure:

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

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

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

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

4. Patient not competent to sign consent:
   Check or family or legal guardian (conservator)
   a. Emergency: If delay or non-treatment poses a significant risk to life, limb, or serious deterioration of the patient's condition, note this and the patient's non-lucidity in the record as justification for proceeding.
   b. Non-emergency:
      1. Obtain probate court order (slow--call Risk Management, x5125 to initiate).
      2. Alternative: If treatment cannot reasonably be delayed, one member of the medical staff must document in the medical record:
         a) nature of risk from the delay of treatment, and
         b) advantages of the proposed procedure.
5. Preoperative evaluation and note which must include indications for surgery as well as a list of potential complications. This will be written by the resident or attending most involved with the procedure whenever possible.
6. Appropriate anesthesia consultations should be obtained early enough to permit optimal patient preparation and to prevent last-minute cancellation by Anesthesia because of an "incompletely evaluated patient."
7. Early anesthesia consultations are routine for patients with complicated medical problems, including those with cardio-respiratory, hepatic, renal, or diabetic problems, as well as Jehovah's Witnesses.
8. All elective patients scheduled through the clinic should be referred to the anesthesia pre-operative clinic.
9. Preoperative planning must consider requirements for equipment, especially implants.
10. The operating resident will review the patient, including x-rays, with the OR attending so that both may be involved in preoperative planning. The operating resident must know the anatomy, surgical approach, operative procedure, indications, and alternative treatment methods.
11. Pre-operative notes should be written for inpatients the night before surgery.
12. Routine lab studies (CBS, UA, EKG, LFT's, Lytes, Creatinine, clotting studies, etc.) should be ordered as indicated. Blood should usually be typed and held, or

cross-matched if a transfusion is anticipated. X-rays must be pulled up in the OR before the case begins.

13. Essential instruments and implants must be selected and sterilized.
14. Cast materials must be ready and outside the operating room until wound closure.
15. Preparation:
    a. Shave (in OR) only when and where hair will impede closure. Clipping should be performed when possible.
    b. Standard prep should be used (Prepadine, Betadine, Ioprep, etc.). The skin must be completely dry for the adhesive drape to stick reliably.
    c. Drape according to standard sterile draping techniques.

15. Protection:
    a. All surgeons must wear goggles, glasses, or a face shield for every case.
    b. Double gloves must be worn for every case.
    c. For cases with significant blood loss, each surgeon should wear:
        1) Double shoe covers
        2) Knee-high disposable boots
        3) Gowns with reinforced sleeves and front panel
        4) Extra sleeves
    d. The pulse lavage must be used with its splash shield. If none is available, the pulse lavage is not to be used. Irrigate with a bulb syringe.
    e. Surgical helmet systems are available for use on all high-risk cases. When scheduling cases, communicate that you want to use the systems.
    b. When operating on high-risk patients, the members of the surgical team should consider the use of Kevlar gloves.
17. Prophylactic antibiotics are used for all clean surgical procedures when implant materials are used unless otherwise indicated:
    - 1 gram Kefzol IV with induction of anesthesia
    - 1 gram Kefzol IV in PAR

    Check for allergy and consult with the chief resident if needed.
18. Antibiotics for open fractures should be started in the ED per protocol.
19. A member of the surgical team should be in the OR by 7:30 a.m. If a member of the surgical team is not in the room, the procedure cannot start.
20. The patient must be site-marked before surgery by a licensed practitioner who is capable of starting the case and will be present at the beginning of the case.
21. All hair and street clothing must be covered. A self-laundered scrub cap can be used if covered up by a clean, disposable cap. Use a hood, not a cap alone, to cover all hair if exposed (a sweatband helps with sweat).
22. When in doubt, greens should be changed before beginning another case, particularly for those cases that have been on contaminated or infected wounds or if the greens were worn outside of the operating room area. Greens should never leave the hospital campus (they can be worn between the hospital and other campus buildings).
23. The operating resident for the next case should stay in the assigned operating room between cases to expedite room turnover. The surgical team should check patients in the pre-operative area to confirm paperwork completion, site marking, and any additional questions to be answered before surgery, to ensure the start of the next case is not delayed. The surgical team in the OR where the patient is expected to enter will be notified by the holding area staff of patients with incomplete requirements, so this can be addressed to avoid delays in room turnover.
23. Masks should be changed between every case.

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

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

Age	**NO FOOD***	**CLEAR LIQUIDS ONLY****
Less than 6 months	4 hours before the procedure	2 hours
7 months to age 12	After midnight	2 hours
Age 13 and adjust	After midnight	4 hours
Age	**NO FOOD***	**CLEAR LIQUIDS ONLY****
Any age	4 hours (recommended light meal only)	Ad lib

* No food includes dairy products, infant formula, any unclear liquid, gum
** Clear liquids include water, filtered apple juice, cranberry juice, and breast milk

OPERATIVE REPORTS

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

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

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

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

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

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

Q. CLINIC RULES

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

R. ADMISSIONS FROM CLINIC

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

S. EMERGENCY ADMISSIONS

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

T. ELECTIVE (FUTURE) ADMISSIONS

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

U. COME –AND-GO SURGERY IN SURGICENTER

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

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

V. CLINIC DISCHARGE CRITERIA

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

W. INFECTIONS

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

X. ORTHOPAEDIC PEDIATRIC ADMISSIONS

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

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

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

iii. Specific orthopaedic orders/requirements (i.e., limb elevation, icing).

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

Y. ORTHOPAEDIC MEDICINE INPATIENT SERVICE ADMISSIONS

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

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

Chief of Orthopaedic Surgery Clinical Service

Position Summary:

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

Reporting Relationships:

The Chief of Orthopaedic Surgery reports directly to the UCSF Associate Dean at ZSFG and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed at least every five years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the UCSF Associate Dean at ZSFG, the UCSF Department Chair, and the ZSFG Executive Administrator, upon approval of the Medical Executive Committee and the Governing Body. The Chief maintains working relationships with these individuals and groups, as well as with other clinical departments.

Position Qualifications:

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

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

Major Responsibilities:

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

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

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

In collaboration with the Executive Administrator and other ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting outside

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.

UCSF
University of California
San Francisco

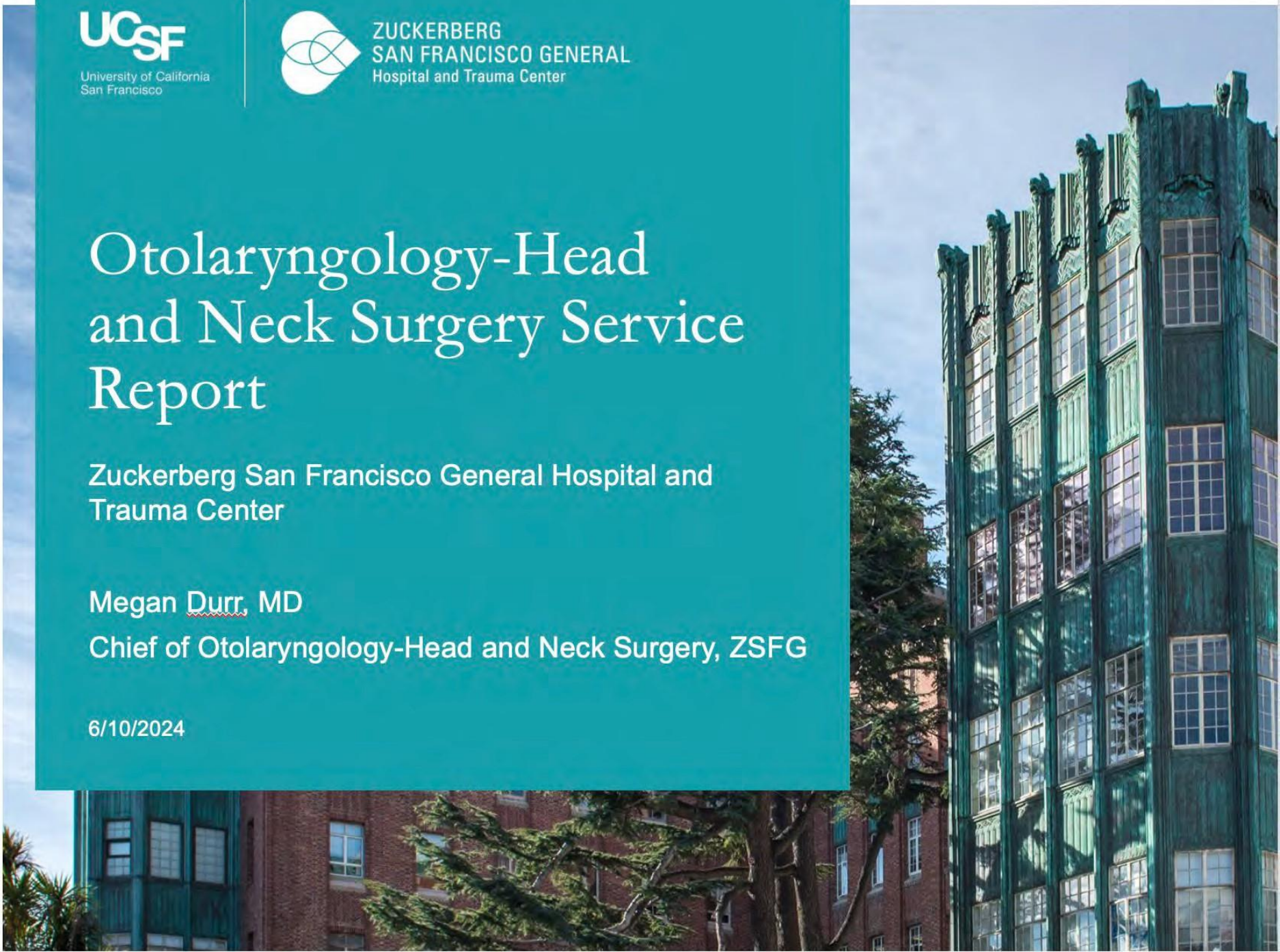
ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

Otolaryngology-Head and Neck Surgery Service Report

Zuckerberg San Francisco General Hospital and Trauma Center

Megan Durr, MD
Chief of Otolaryngology-Head and Neck Surgery, ZSFG

6/10/2024



Departmental Personnel and Structure

UCSF Departmental Structure

- Andrew Murr, MD, Chair

- Head and Neck Cancer and Skull Base Surgery (7)
  - Patrick Ha, MD
  - Ivan El-Sayed, MD
  - William Ryan, MD
  - Chase Heaton, MD
  - Jonathon George, MD
  - Katherine Wai, MD
  - Mary Jue Xu, MD
  - Michael Chow, MD
  - Ilya Likhterov, MD
  - Weston Niermeyer, MD (fellow)

- Otology/Neurotology (5)
  - Charles Limb, MD
  - Steven Cheung, MD
  - Aaron Tward, MD
  - Jeffrey Sharon, MD
  - Song Cheng, BM, BCh
  - Nicole Jiam, MD

- Laryngology and Voice Disorders (4)
  - Clark Rosen, MD
  - VyVy Young, MD
  - Yue Ma, MD
  - Tyler Crosby, MD
  - Jennifer Silver, MD (fellow)

- Facial Plastic and Reconstructive Surgery (3)
  - Daniel Knott, MD
  - Chase Heaton, MD
  - Andrea Park, MD
  - Autefeh Sajjadi, MD (fellow)

- Pediatric Otolaryngology (10)
  - Kristina Rosbe, MD
  - Anna Meyer, MD
  - Dylan Chan, MD
  - Garani Nadaraja, MD
  - Joanne Czechowicz, MD
  - Jordan Virbalas, MD
  - Jacqueline Weinstein, MD
  - Kimberly Luu, MD
  - Lia Jacobson, MD
  - Kara Brodie, MD
  - Scott Hirsch, MD
  - Rajas Tipnis, MD (fellow)

- Rhinology/Sinus Surgery and General Otolaryngology (9)
  - Tokunbo Ayeni, MD
  - Andrew N. Goldberg, MD
  - Andrew H. Murr, MD
  - Steven Pletcher, MD
  - Jolie Chang, MD
  - Megan Durr, MD
  - Patricia Loftus, MD
  - Jose Gurrola, MD
  - Anna Butrymowicz, MD
  - Caroline Schlocker, MD

ZSFG Otolaryngology

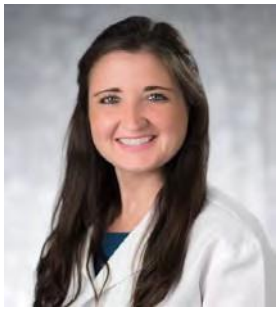
Our mission is to provide comprehensive and compassionate Otolaryngologic care to the diverse communities of San Francisco. We are dedicated to training the next generation of Otolaryngologists and ensuring that all patients have equitable access to the highest quality care

ZSFG Faculty and Residents

ZSFG OHNS Core Clinical Faculty

Megan Durr, MD (0.6 FTE)

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



Patricia Loftus, MD (0.49 FTE)

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

Mary Xu, MD (0.7 FTE)

- Head and Neck Oncologic Surgery
- Endocrine Surgery

Tokunbo Ayeni, MD (0.2 FTE)

- General Otolaryngology
- Facial Trauma Surgery

UCSF

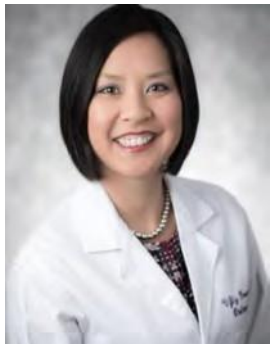
ZSFG OHNS Core Clinical Faculty

Song Cheng, MD (0.1 FTE)

- Otology/Neurotology

Anna Butrymowicz, MD (0.15 FTE)

- General Otolaryngology
- Facial Trauma Surgery



VyVy Young, MD (0.05 FTE)

- Laryngology

Andrew Goldberg, MD (0.05 FTE)

- General Otolaryngology
- Facial Trauma Surgery

UCSF

ZSFG OHNS APPs

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

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

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

- Outpatient OHNS 4J Clinic

UCSF OHNS Fellows, 2025-2026

- Autefeh Sajjadi, MD
  - Facial Plastic and Reconstructive Surgery

- Jennifer Silver, MD
  - Laryngology

- Rajas Tipnis, MD
  - Pediatric Otolaryngology

- Weston Niermeyer, MD
  - Head and Neck Oncological Surgery

ZSFG Audiologists

Emily Kidwell, AuD

Alison Lacey, AuD

Lauren Hudec, AuD

Celia Tow, AuD

ZSFG OHNS Volunteer Faculty

Adrian House, MD

Gerald Kangelaris, MD

Andrea Yeung, MD

ZSFG OHNS Clinical Faculty

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

ZSFG Administrative Staff

Lorel Hiramoto
Business Manager

Josephine Hermoso
Billing and Operations Analyst
Trainee Administrator

UCSF OHNS Residents

ZSFG Resident Rotation

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

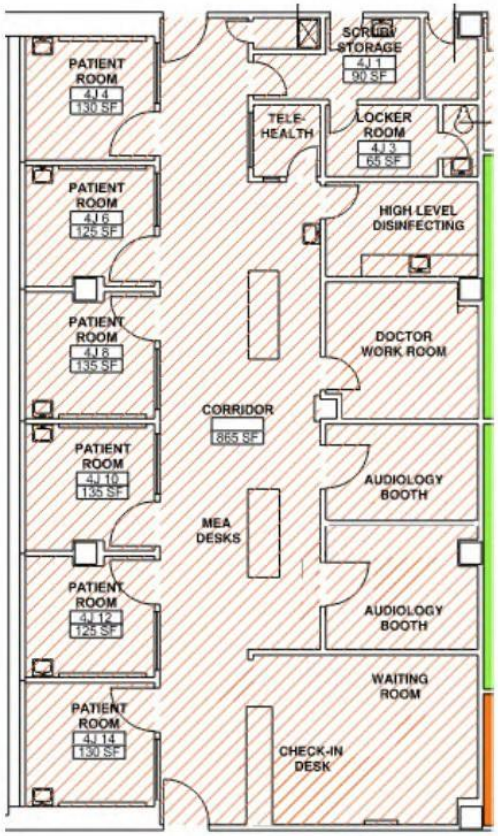
ZSFG Resident Rotation

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

Clinical Service

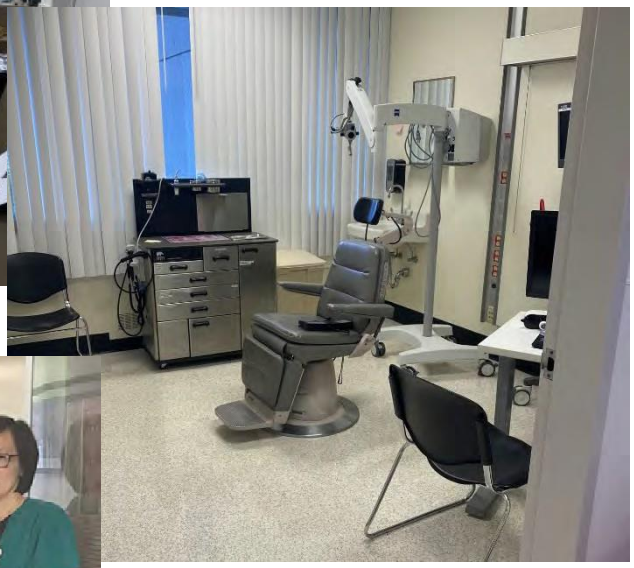
4J Clinic

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



Center hallway of 4J (exam rooms along left)

Patient exam room in 4J



4J clinic staff

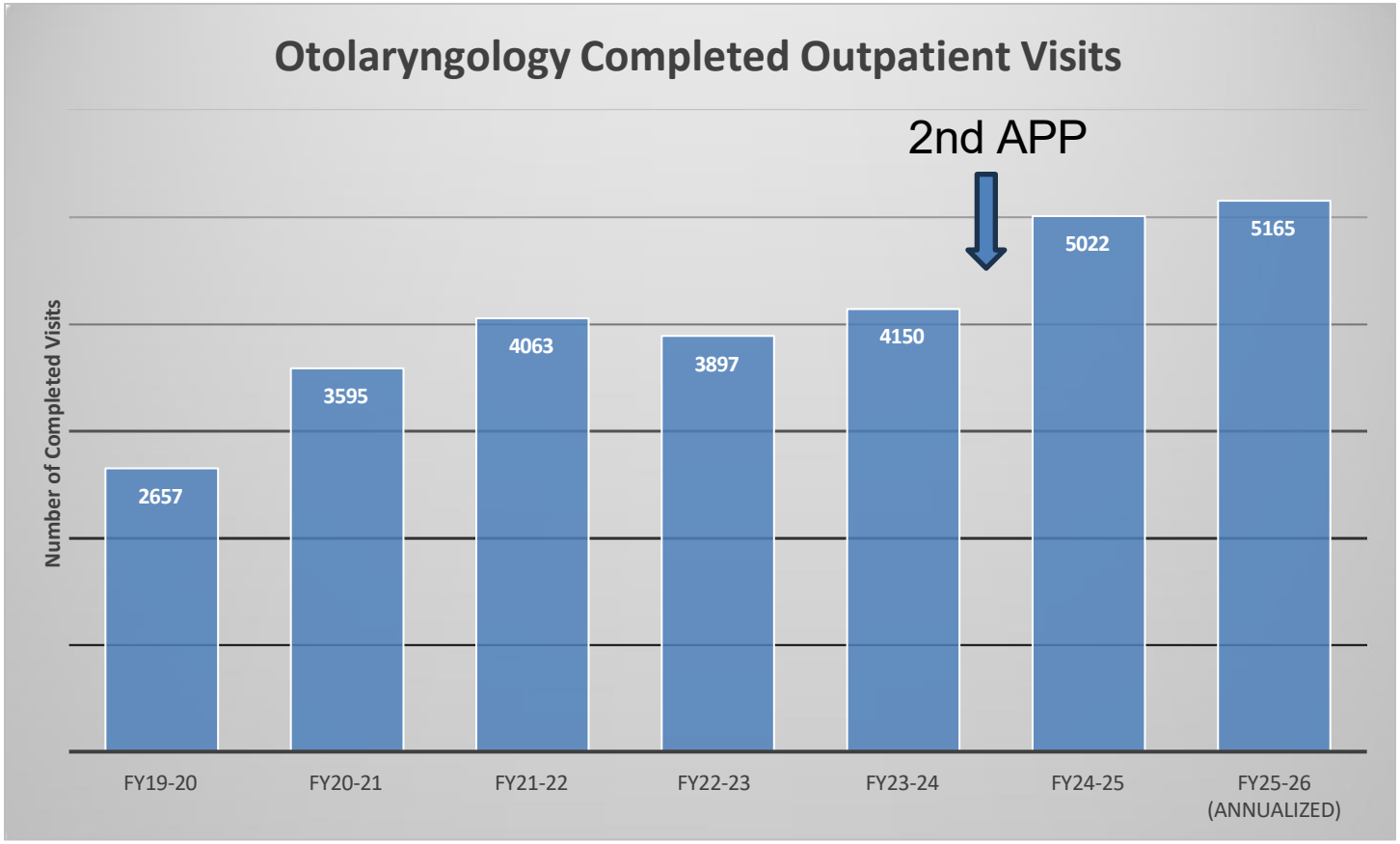
Clinical Scope of Service

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

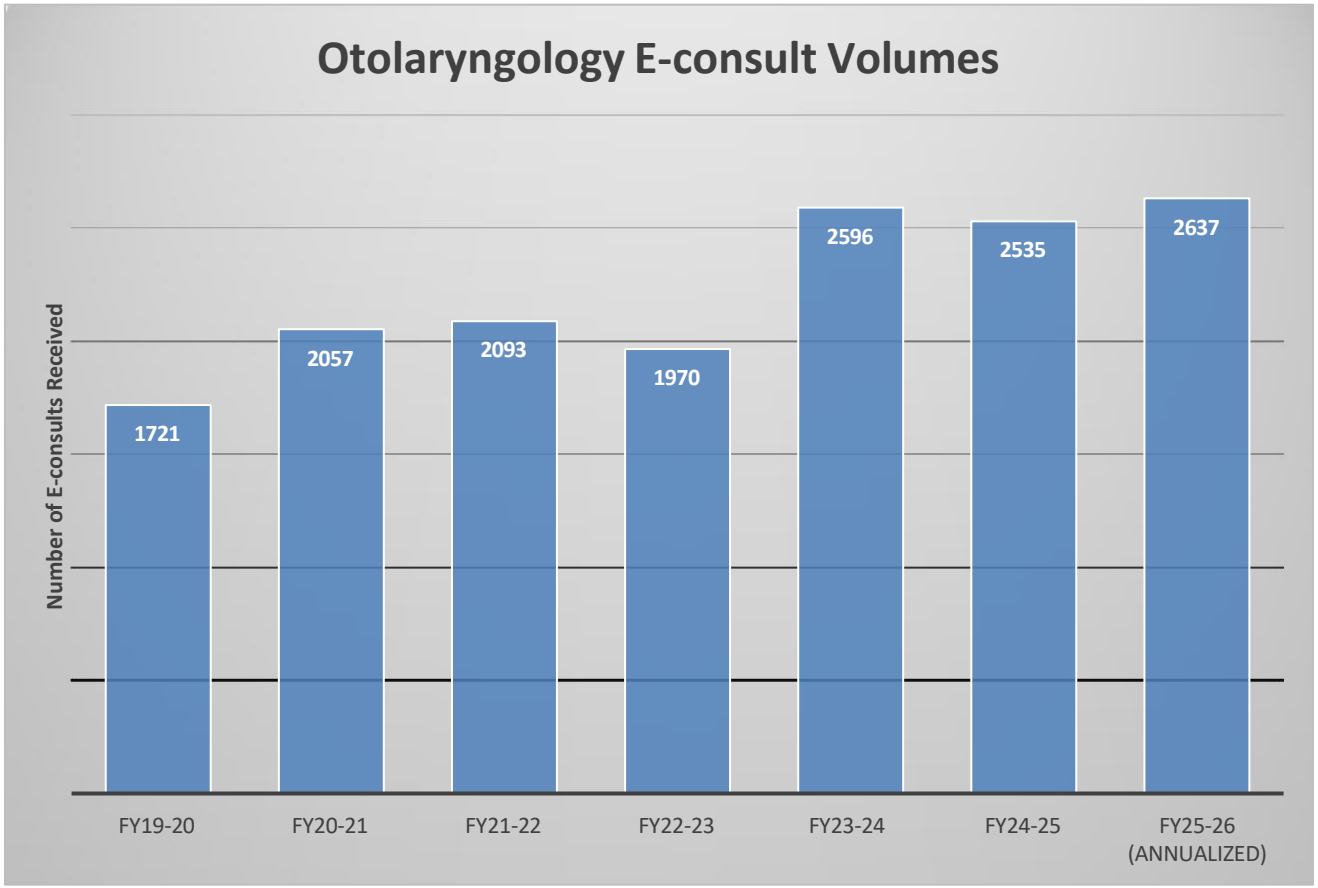
Clinical Schedule

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

Clinical Volume: Ambulatory Visits

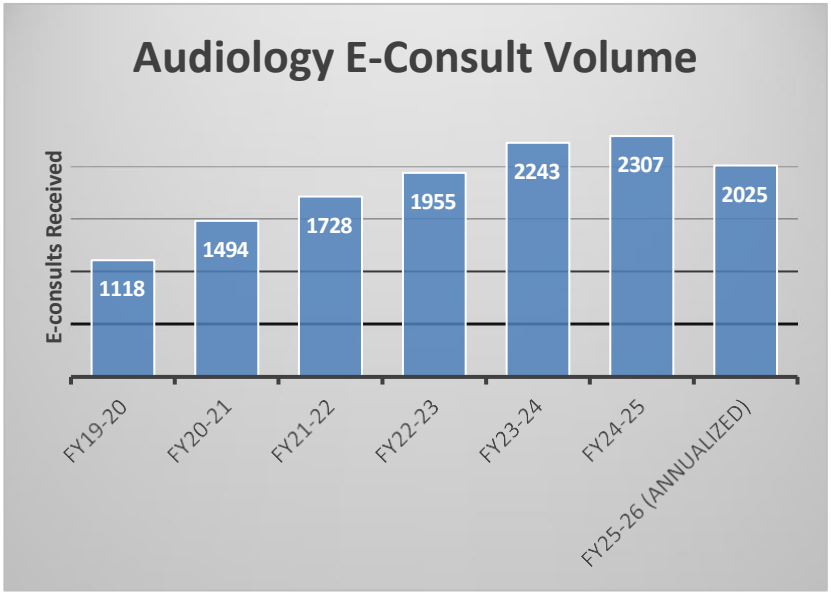


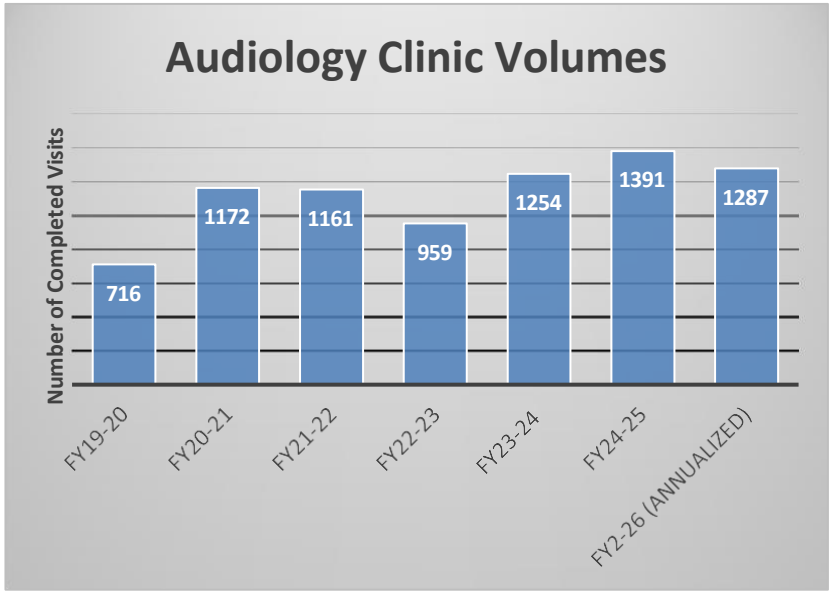
Clinical Volume: eConsult



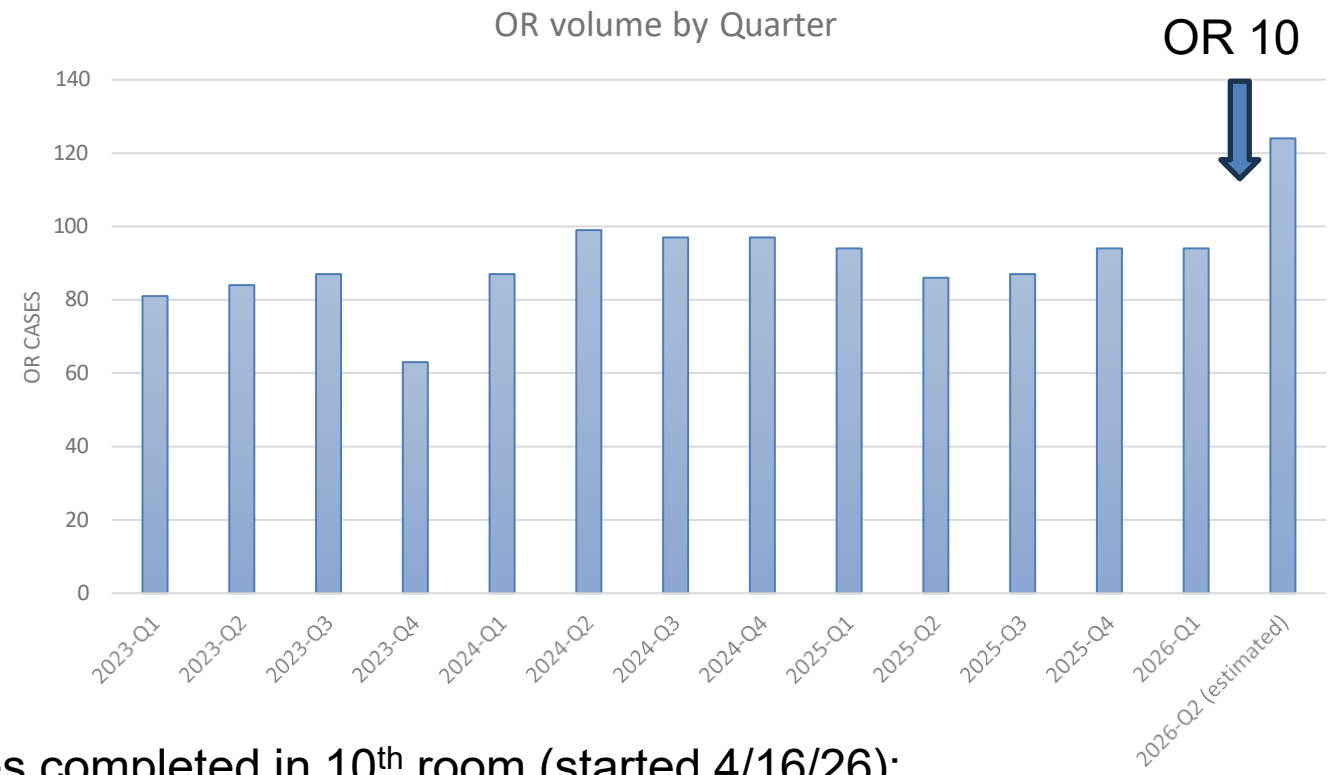
Audiology

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





OR Volume



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

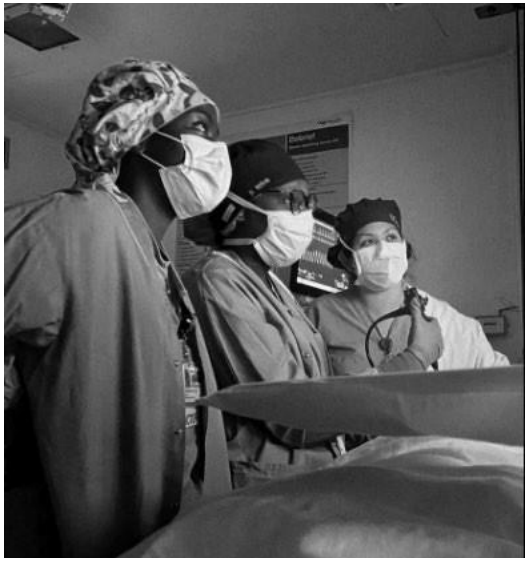
- Thyroidectomy x 2
- Cancer resection x 3
- Trauma surgery x 3
- Tracheotomy x 3
- Neck mass excision x 2
- Tonsillectomy
- Ear foreign body removal

OR Case Distribution

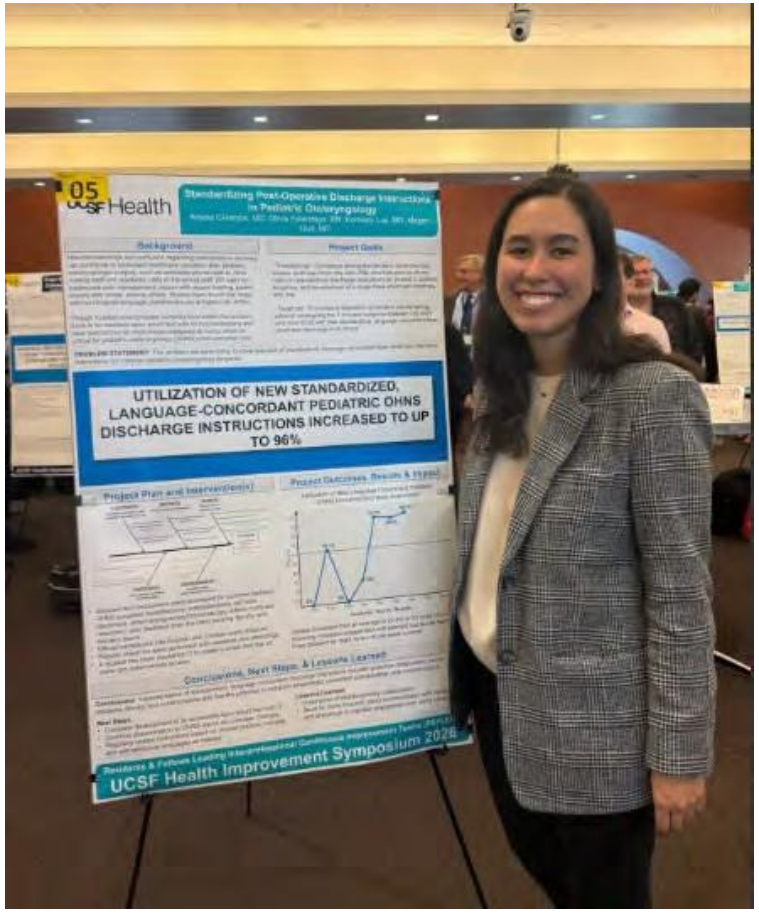
Surgery Type	Percent of Total Cases
FESS	15%
Cancer/neck mass	15%
Otology	15%
Rhinoplasty	12%
Trauma	10%
Tonsillectomy	8%
Endocrine Surgery	7%
Trach/revision/repair	7%
Laryngology	5%
Temporal artery biopsy	4%
Septoplasty	2%
Parotidectomy	2%

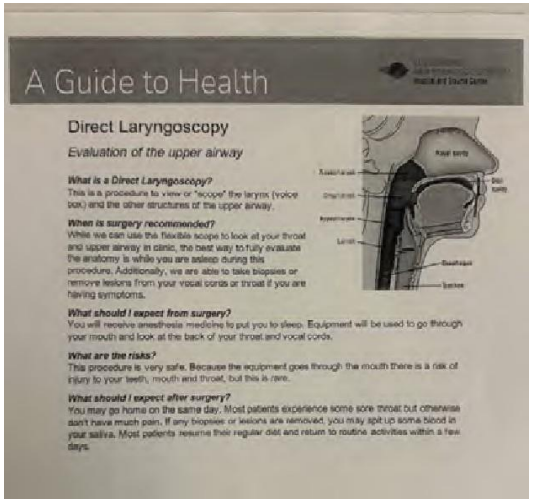
ZSFG Call

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



Performance Improvement and Patient Safety

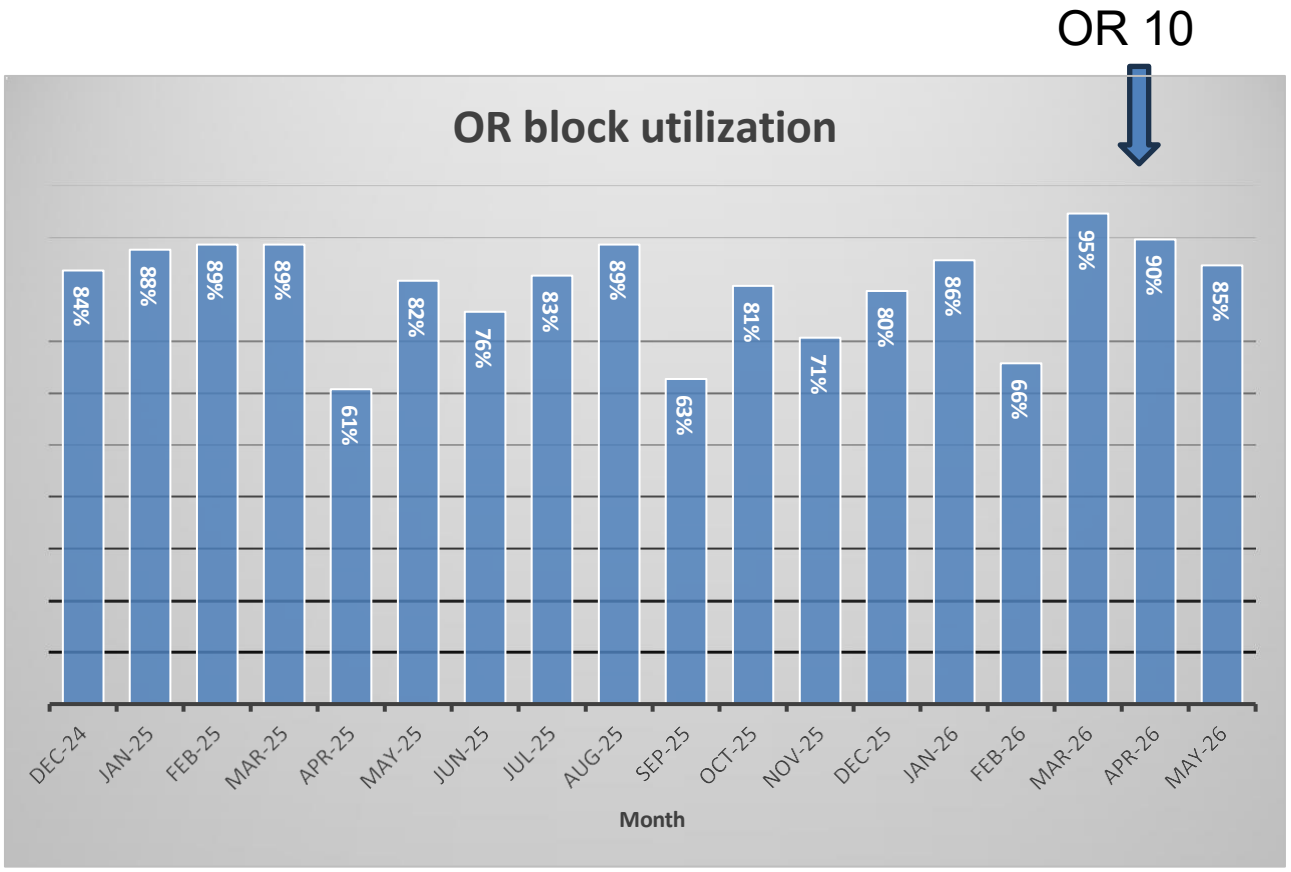




Post-procedure Patient Handouts

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

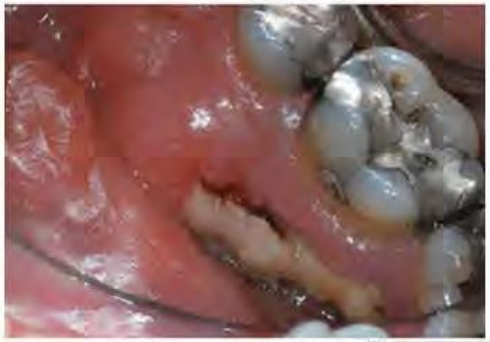
PIPS: OR Block Utilization

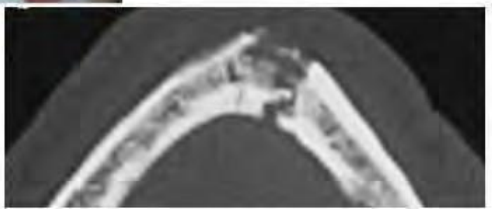


PIPS: Integrating Dental Preventative Care into OHNS cancer surveillance

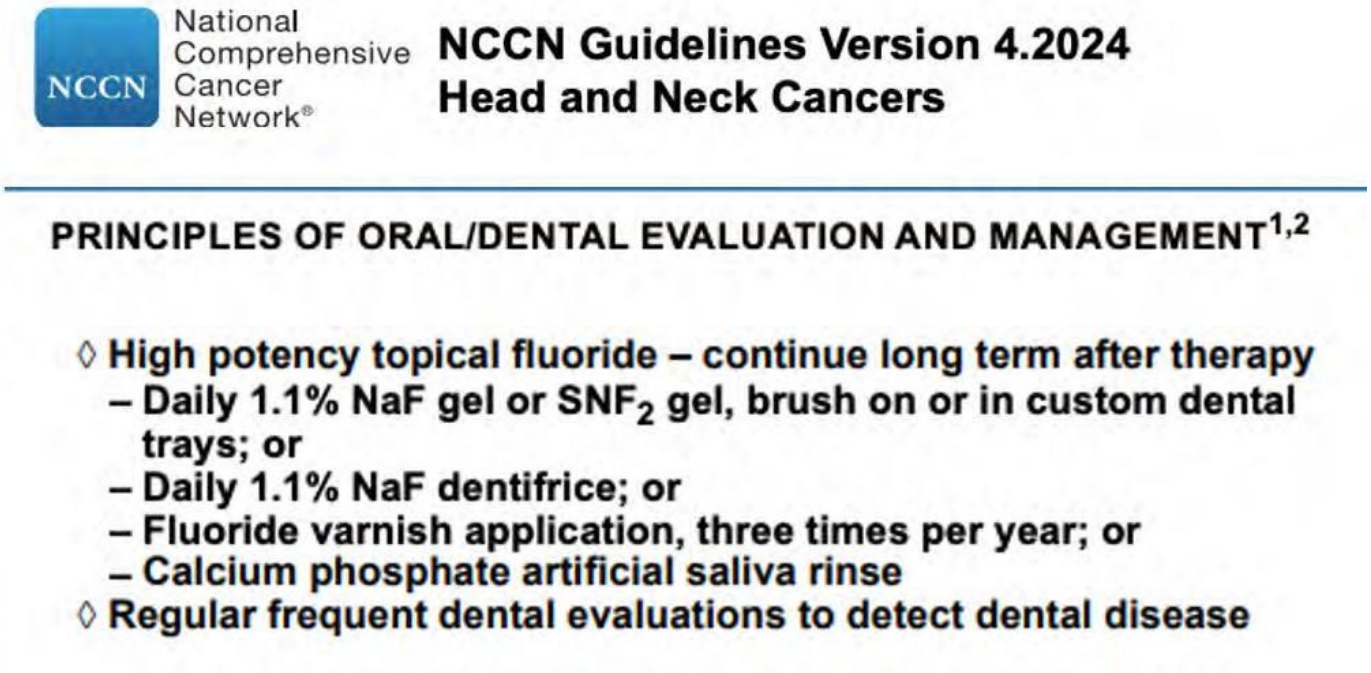
Why does dental care for head and neck cancer patients matter?

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

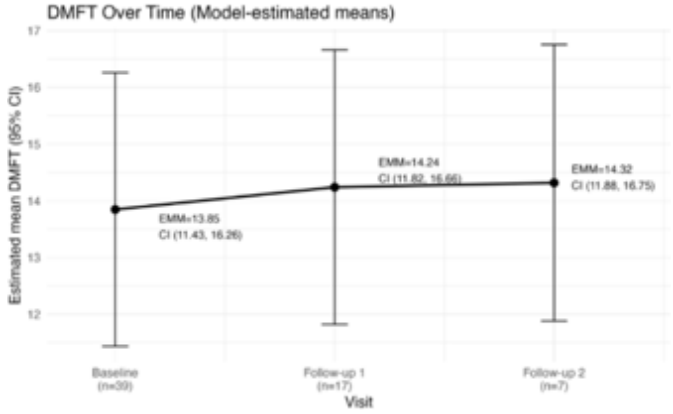




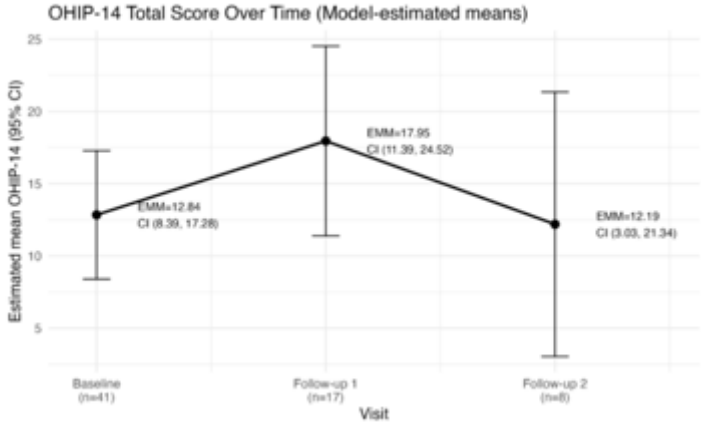
PIPS: Integrating Dental Preventative Care into OHNS cancer surveillance



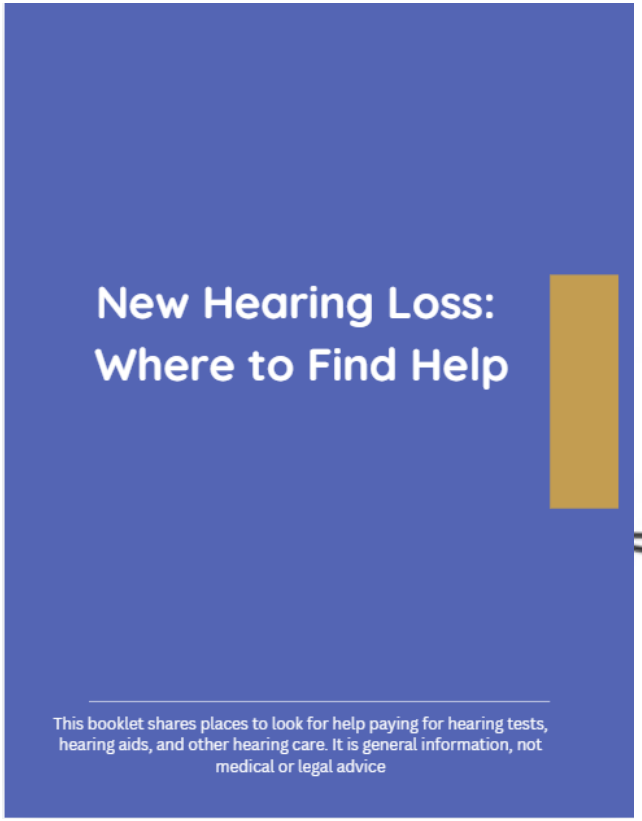
PIPS: Integrating Dental Preventative Care into OHNS cancer surveillance



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



PIPS: Hearing Screening



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

Authors: Armita Norouzi, BA[1,2,4,*] and Kevin Avelar, BS[3,*]; Emily Honzel, MD[1]; Ana Marija Sola, MD[1]; Kennedy Johnson, BS[5]; Nikhil Arora, MD[1]; Emily Kidwell, AuD[1,4]; Alison Lacey, AuD[1,4]; Lauren Hudec, AuD[1,4]; Ashley Carrington, AuD[1,4]; Lori Ross, PA-C[1,4]; Shauna Brodie, RN, MS, FNP[1,4]; Su Li, RN[4]; Yew Song Cheng, BM BCh[1,4]; Megan L. Durr, MD[1,4]

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

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

Authors: Armita Norouzi, BA[1,2,4]; Emily Honzel, MD[1]; Kevin Avelar, BS[3]; Ana Marija Sola, MD[1]; Kennedy Johnson, BS[5]; Nikhil Arora, MD[1]; Emily Kidwell, AuD[1,4]; Alison Lacey, AuD[1,4]; Lauren Hudec, AuD[1,4]; Ashley Carrington, AuD[1,4]; Lori Ross, PA-C[1,4]; Shauna Brodie, RN, MS, FNP[1,4]; Su Li, RN[4]; Yew Song Cheng, BM BCh[1,4]; Megan L. Durr, MD[1,4]

Performance Improvement: Administrative Service

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

Education

Education

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

ZSFG Resident Education

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

ZSFG Resident Education

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

ZSFG Resident Education

- Leadership Training Curriculum
  - Leadership Styles
  - Difficult Conversations
  - Public Speaking
  - Feedback

ORIGINAL REPORT

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

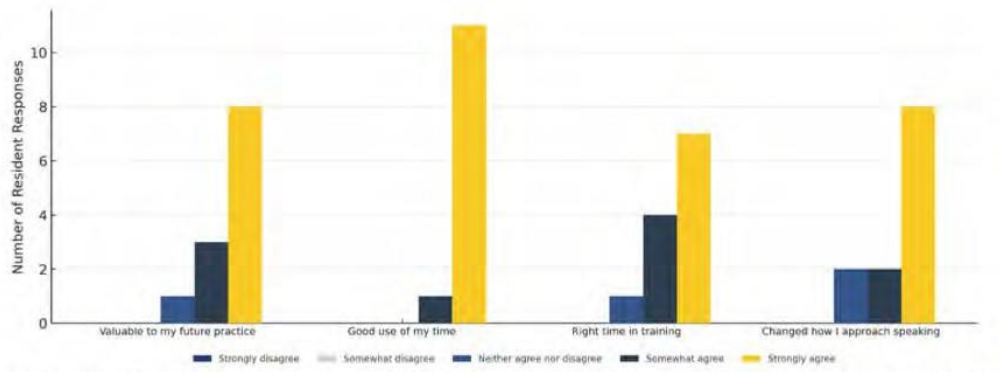


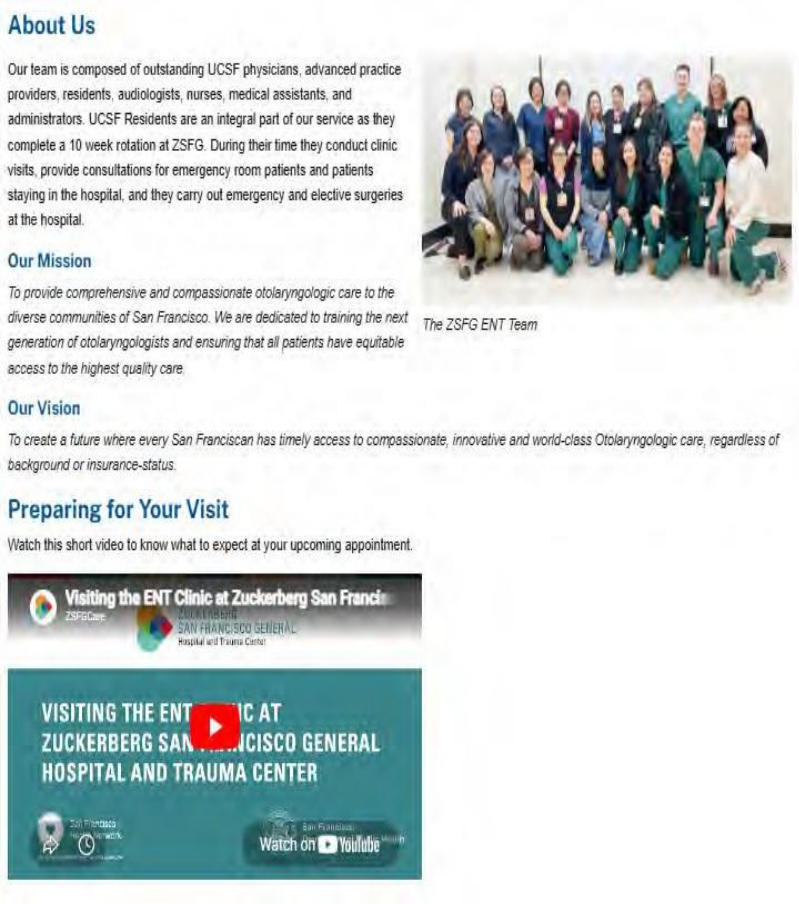
FIGURE 7 | Public speaking participant reactions. [Color figure can be viewed in the online issue, which is available at www.laryngoscope.com]

Resident Wellness

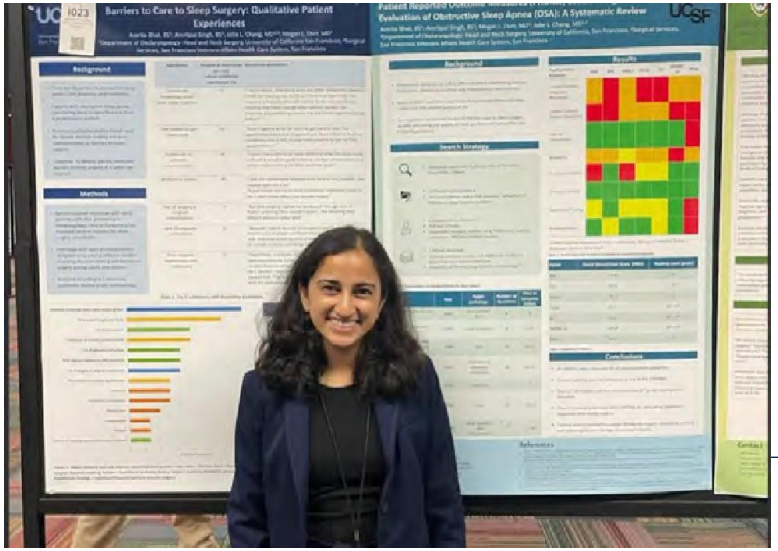
Faculty Wellness – Faculty Dinners

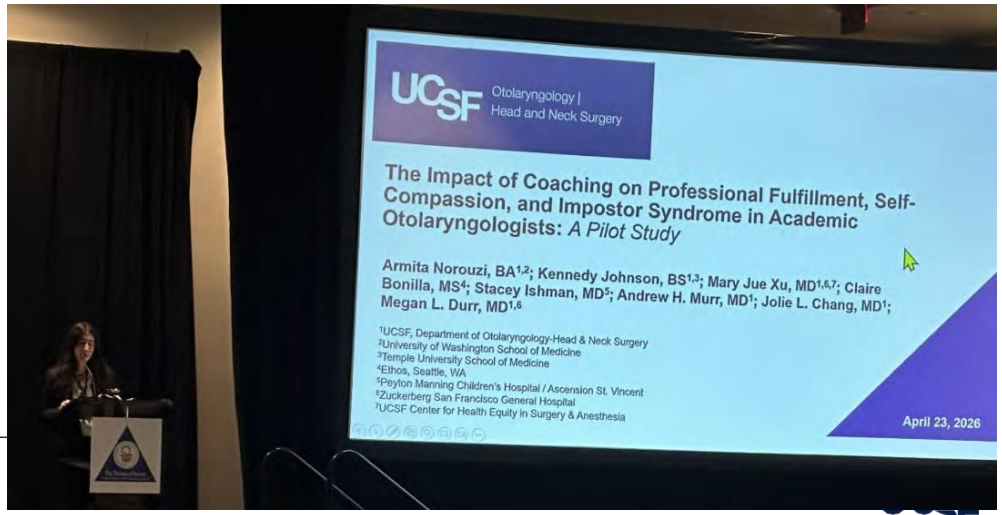
Department Wellness and Educational Events

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



Research


Barriers to Care to Sleep Surgery: Qualitative Patient Experiences
Evaluation of Obstructive Sleep Apnea (OSA): A Systematic Review
UCSF


UCSF Otolaryngology | Head and Neck Surgery
The Impact of Coaching on Professional Fulfillment, Self-Compassion, and Impostor Syndrome in Academic Otolaryngologists: A Pilot Study
Armita Norouzi, BA[1,2]; Kennedy Johnson, BS[1,3]; Mary Jue Xu, MD[1,6,7]; Claire Bonilla, MS[4]; Stacey Ishman, MD[5]; Andrew H. Murr, MD[1]; Jolie L. Chang, MD[1]; Megan L. Durr, MD[1,6]
[1]UCSF, Department of Otolaryngology-Head & Neck Surgery
[2]University of Washington School of Medicine
[3]Temple University School of Medicine
[4]Ethos, Seattle, WA
[5]Peyton Manning Children's Hospital / Ascension St. Vincent
[6]Zuckerberg San Francisco General Hospital
[7]UCSF Center for Health Equity in Surgery & Anesthesia
April 23, 2026

Key Recent ZSFG OHNS Publications

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

Nicholas Correia[1] | Kennedy Johnson[2] | Megan Durr[2] | Barbara A. Grimes[3] | Ann A. Lazar[3] | Urmimala Sarkar[4] | Patrick K. Ha[2] | Laura Chen[1] | Katherine C. Wai[2] | Ilya Likhterov[2] | Sue S. Yom[5] | Jason W. Chan[5] | Alain P. Algazi[6] | Hyunseok Kang[6] | William R. Ryan[7] | Chase M. Heaton[2] | Ivan El-Sayed[2] | Jonathan George[2] | Mary Jue Xu[2,8]

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

Yasmin Eltawil[1] | Kennedy Johnson[2] | Yousef Alqasieer[3] | Armita Norouzi[2] | Yilin Piao[3] | Danielle Gillard[4] | Alyssa Civantos[2] | Kwang Kim[3] | Jason Chan[5] | Sue S. Yom[5] | Megan L. Durr[2] | Shauna Brodie[2] | Sydnee Chavis[6] | Michelle Chen[1] | Mary Jue Xu[2]

Original Research

AMERICAN ACADEMY OF OTOLARYNGOLOGY–HEAD AND NECK SURGERY FOUNDATION

OTO Open
2025, Vol. 9(3):e70152

DOI: 10.1002/oto2.70152
http://oto-open.org
WILEY

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

Alyssa M. Civantos, MD, MS[1], Kennedy Johnson, BS[1], Sultan Al Azzawi, BS[1], Phiroz E. Tarapore, MD[2], Steven W. Cheung, MD[1,3], Jennifer H. Sabes, AuD[1], Jolie L. Chang, MD[1,3], and Megan L. Durr, MD[1]

SCOPING REVIEW

Obstructive Sleep Apnea in Traumatic Brain Injury: A Scoping Review

Kennedy Johnson[1] | Nicholas Correia[1,2] | Jolie L. Chang[1] | Megan L. Durr[1]

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

ORIGINAL ARTICLE OPEN ACCESS

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

Rohith M. Bhethanabotla[1] | Nina Patel[1] | Reta Behnam[2] | W. John Boscardin[3] | Mary J. Xu[3] | Chase Heaton[1] | Katherine C. Wai[1] | Andrea M. Park[1] | P. Daniel Knott[1]

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

ORIGINAL REPORT OPEN ACCESS

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

Tiffany Husman[1] | Omeed Miraftab-Salo[1] | Alonn Ilan[2] | Shauna Brodie[2,3] | Alan Paciorek[4] | Megan L. Durr[2,3] | Jolie Chang[3] | Mary Jue Xu[2,3]

ORIGINAL REPORT

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

Amrita N. Bhat[1] | Amritpal Singh[1] | Philip Kurien[2] | George Su[1] | Jolie L. Chang[1,4] | Megan L. Durr[4]

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

Check for upda

Original Reports | Head and Neck Cancer

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

Aslam Nkya, MD, MMED[1]; Mary Jue Xu, MD, MAS[2]; Godfrey Sama Philipo, MD, MPH, MGSC[3,4]; Summaiya Haddadi, BMLS, MSc[4]; Dianna Ng, MD[5]; Beatrice Paul Mushi, MD, MPH[4]; Atuganile Edward Malango, MD, MMED[6]; Erick Philip Magorosa, BMLS, MSc[6]; Alan Paciorek, BS[7]; Li Zhang, PhD[7,8]; Sikudhani Muya, MD, MMED[9]; Patrick Ha, MD[2]; Edwin Liyombo, MD, MMED[1]; Enica Richard, MD, MMED[10]; Willybroad Massawe, MD, MMED[1]; Joel M. Palefsky, MD[11]; Sue S. Yom, MD, PhD[12]; Elia John Mmbaga, MD, PhD[4]; and Katherine Van Loon, MD MPH[8]

DOI https://doi.org/10.1200/GO-25-00596

Journal of the Colleges of Medicine of South Africa
ISSN: (Online) 2960-110X, (Print) 3105-4331

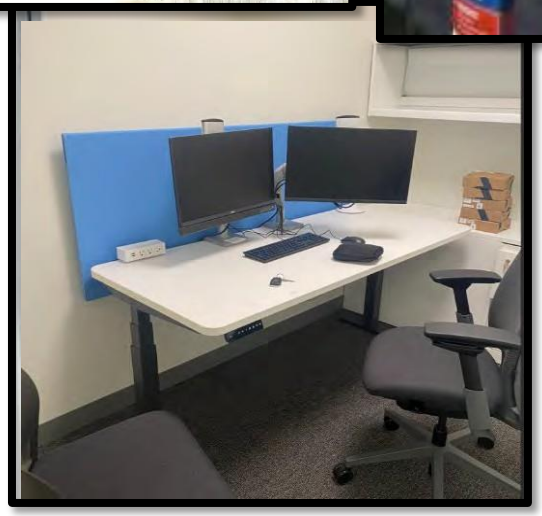
AOSIS

Page 1 of 9 Original Research

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

UCSF

Pride Hall



Community Outreach

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

OHNS

Demographics and feasibility of head and neck cancer screening in the San Franciso Chinatown community

Connie J. Zhou*, BS[1]; Brooke Warren*, MD[2]; Shauna Brodie, RN, MS, FNP[1], Katherine Wai, MD[1], Patrick K. Ha, MD[1], Megan L. Durr, MD[1], Mary Jue Xu, MD[1]

[1]Otolaryngology-Head & Neck Surgery, UC San Francisco, [2]Stanford Otolaryngology—Head & Neck Surgery *Co-first-authors

Abstract

In this pilot Head and Neck Cancer (HNC) screening, we conducted a cross-sectional study during the October 2023 San Francisco (SF) Chinatown Community Health Fair to describe the health fair's participants and assess the feasibility of community-based HNC screenings in this setting. Participants completed a questionnaire assessing socio-demographic information and relevant symptoms, followed by a head and neck exam. Cantonese was the most common primary language, and the majority of participants had Medicare or Medi-Cal insurance. Many participants reported at least one symptom, most commonly nasal obstruction and unilateral hearing loss with two participants with findings suspicious for HNC. We found that community-based HNC screenings in SF Chinatown are feasible with appropriate personnel including interpreters and providers, but additional work is needed to identify and screen high-risk individuals for HNC. Further outreach regarding hearing loss and nasal obstruction may be beneficial for this population.

Introduction

- 62% of households in SF's Chinatown live below 200% of the federal poverty and the median household is $21,000 compared to the city's average of $88,000, making Chinatown one of the most economically disadvantaged neighborhoods in SF[1]
- Race/ethnicity and socioeconomic status (SES) remain significant contributors to health inequities, making it particularly important to understand how these social determinants affect ear, nose, and throat conditions. More specifically, head and neck cancer incidence, stage at presentation, and mortality are known to be associated with SES and race/ethnicity[2-4]
- The purpose of this study is to **characterize the incidence of ear, nose, and throat conditions with a focus on head and neck cancer in San Francisco's Chinatown in order to understand the feasibility of screening and associated risk factors.**

Methods and Materials

- We conducted a cross-sectional study during the free October 2023 Chinatown Community Health Fair.
- Consenting participants completed a 34-item questionnaire in their primary language assessing socio-demographic information, smoking status, alcohol use, and relevant symptoms.
- Inspection and palpation of the oral cavity/oropharynx/neck, anterior rhinoscopy, and otoscopy were performed in participants' primary language.
- Descriptive statistics were performed.

Results

- 78 of 87 participants who completed the questionnaire received a head and neck exam (one participant preferred).
- Cantonese was the most common primary language (70%).
- Five percent of participants did not have health insurance, and 3.7% did not have dental insurance.
- No participants reported current tobacco use and 9 noted prior use. Of the four who reported their pack year history, the median was 9.5.
- Five reported current alcohol use and 5 reported previous use.
- Many participants (54%) reported at least one symptom, most commonly nasal obstruction (18%) and unilateral hearing loss (18%).
- Two participants (69M, 69M) without notable risk factors had history and physical exam findings suspicious for HNC (tongue ulceration and maxillary ridge swelling) and were provided resources for follow-up.

Participants	N = 87
Age, years	Mean = 62.9 (SD = 10.7)
	N (% Total)
Gender	
Male	24 (26.7%)
Female	63 (73.3%)
Race/Ethnicity	
Asian non-Hispanic	86 (98.9%)
Primary Language	
English	11 (12.6%)
Cantonese	68 (78.2%)
Mandarin	4 (4.6%)
Taiwanese	1 (1.1%)
Marital Status	
Single	10 (18.4%)
Married	36 (67.9%)
Divorced	3 (5.4%)
Widowed	3 (3.4%)
Insurance Type	
Medicare	35 (44.8%)
Medi-Cal/Medicaid	43 (49.4%)
VA	0 (0%)
Healthy SF	4 (4.6%)
Private/Purchased	8 (9.2%)
Other	9 (10.3%)
No insurance	4 (4.6%)
Has dental insurance	53 (60.9%)
Has seen dentist in last year	55 (63.2%)
Has a primary care provider	79 (67.4%)
Prior medical, surgical, or radiation treatment to head and neck region	1 (1.1%)
Family history for head and neck cancer	3 (3.4%)
Concerning lesion identified	3 (3.4%)
Tobacco Use	
Previous	9 (10.3%)
Current	0 (0%)
Alcohol Use	
Previous	5 (5.7%)
Current	5 (5.7%)

Table 1. Participant demographics and health-related behaviors

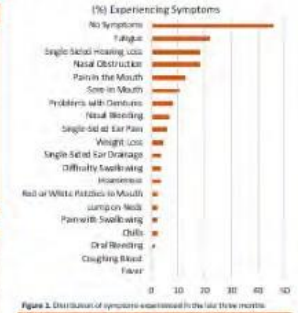


Figure 1. Distribution of symptoms experienced in the last three months

Discussion

- **Feasibility:** This study was limited in that the surveys were de-identified and we were unable to follow up with individuals to understand the impact of the screening and our recommendations. Though this was intentional as this was a pilot study to assess feasibility, from the data revealing 2% with clinical concern for HNC, it would be feasible in future studies to include a follow-up component to assist with connecting participants with the correct resources.
- **Importance of medical interpretation:** In the setting of health fairs, appropriate interpretation was of utmost importance in capturing participant engagement, assisting with survey questions, and explaining relevant clinical findings. We found that 3 interpreters paired with 3 providers were necessary to keep pace with 87 participants over the course of 5 hours.
- **Future outreach:**
  - Nasal obstruction and hearing loss were most commonly reported, which may be future areas of focus for community outreach.
  - Though feasible, additional studies are needed to identify, screen, and reach out to high-risk individuals.[4]

Conclusions

Community-based HNC screenings in SF Chinatown are feasible with appropriate personnel including interpreters and providers. While future targeted outreach may be more impactful for HNC prevention, further studies characterizing and implementing potential interventions for other otolaryngologic concerns may be meaningful for this population.

Contact

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2356 Post Street, 5th Floor, San Francisco, CA 94115
connie.zhou@ucsf.edu

References

Community Outreach Events

Global Health

AFRICAN HEAD AND NECK SOCIETY
AfHNS

THE GLOBAL OHNS INITIATIVE

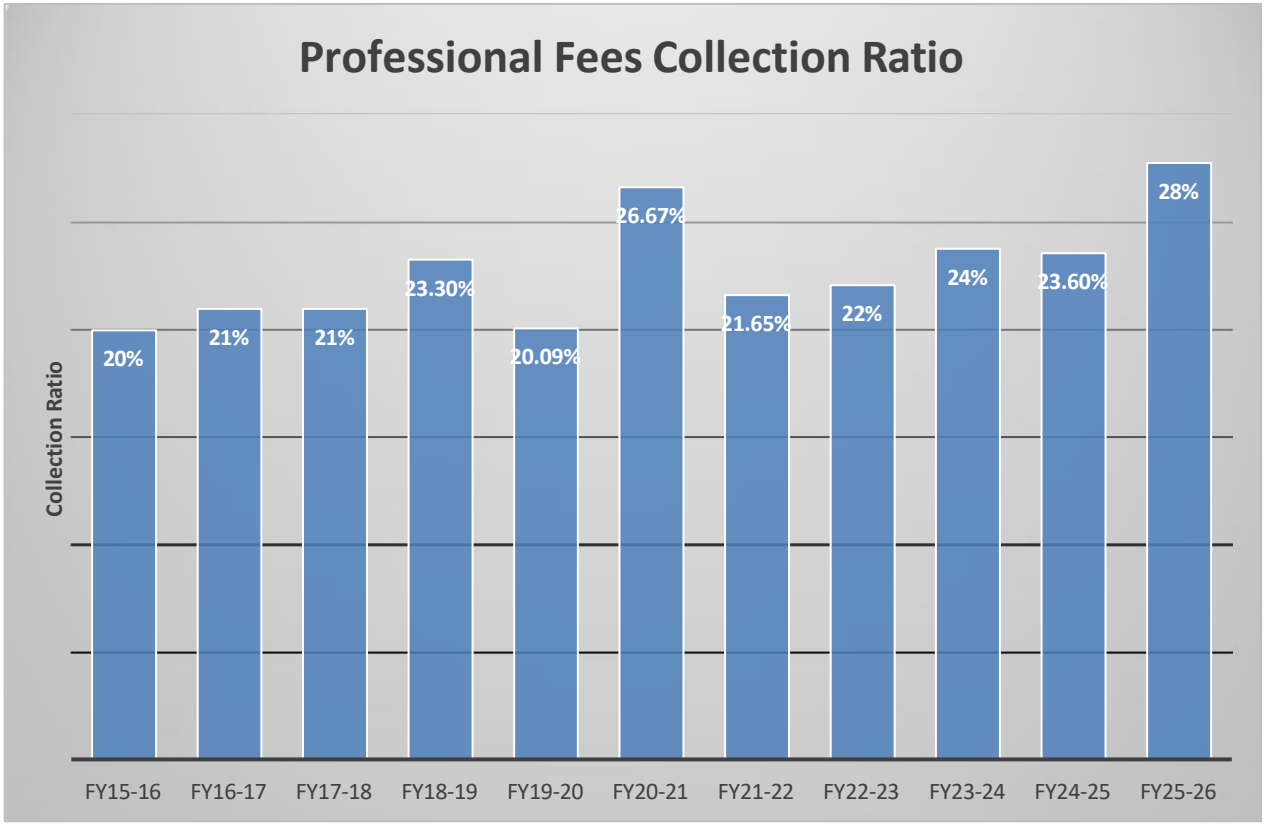
Towards universal access to high-quality, safe, timely, and affordable care for those with conditions of the head and neck

Finances

Professional Fee Collections

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

Professional Fee Collection Ratio



OHNS Revenue, FY 25-26

■ Laguna Honda Hospital Contract	$29,001 (10mo)
■ Pro Fee Collections	$505,934 (10mo)
■ Mng Care Capitated Payment	$52,189 (mid-year only)
■ PQP incentives	$27,393 (10mo)
Total (non-affiliation revenue)	$614,517 (10mo)
■ Affiliation Agreement	$1,481,666 (10mo)
Grand Total (with affiliation revenue)	$2,096,183 (10mo)

Affiliation Agreement

Clinical staffing

- Faculty: 2.1
- Staff 2.0

Strengths

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

Challenges

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

Future

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

Thank you!

City and County of San Francisco

Department of Public Health

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

OTOLARYNGOLOGY CLINICAL SERVICE
RULES AND REGULATIONS
~~**202**4~~ 2026

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

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

I. OTOLARYNGOLOGY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF OTOLARYNGOLOGY CLINICAL SERVICE

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

1. Guidelines for Appointment

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

DEA certification is required for active and courtesy staff.

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

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

2. Modification of Clinical Service

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

3. Staff Status Change

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

4. Modification/Changes to Privileges

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

5. On-Call Oversight

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

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

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

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

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

3. Appraisal of Patient Care
Evaluation of patient care will be by:

a. Observation of care provided during surgery.

b. Assessment of the appropriateness of care delivered as observed on ward rounds.

c. Review of minimum of 5 case files.

d. Review of Morbidity and Mortality Reports relevant to the particular practitioner.

4. Individual Responsibilities

a. Department Chief:

1. Review the above information and make a recommendation either to continue or drop the physician from the medical staff.
2. Make observations of patient care intraoperatively, on ward rounds and by assessment of patient complications or appointment of another physician to do the proctoring.

b. Administrative Assistant:

1. Review list of current hospital staff who require proctoring.
2. Assemble relevant information for review by Chief on an annual basis so that pertinent recommendations can be made.

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

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

VI. OTOLARYNGOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. RESIDENT EVALUATIONS

1. Individual Responsibilities

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

- Role, responsibility, and patient care activities of the house staff: The house staff have primary responsibility for the clinical care of patients on the wards, in the clinic, and in the operating room under the supervision of attending staff. It is the goal of the program to have the residents develop a formal therapeutic relationship with the patients and to have patients identify the housestaff as the primary care provider. This includes initial history and physical exams, medical test decision making, procedures, and analysis of care options and therapeutic interventions. This educational environment is consistently monitored by the real-time presence of the attending staff who closely monitor and supervise house staff interactions and decision making. It should be remembered that the house staff are all eligible for California State Licensure to practice independently as physicians and surgeons in the state of California by having completed ACGME approved surgical internships.

- The attending staff and program director make decisions about the extent to which the resident can practice independently by analyzing a variety of factors including in-service scores, rotation evaluations, semi-annual formal performance evaluations, ABO surgical experience data, and also by direct, daily contact and observation.

- Resident Evaluation Process: the residents are evaluated in accordance with ACGME requirements for Otolaryngology/Head and Neck Surgery. The residents participate in Grand Rounds, Morbidity and Mortality conference, regularly scheduled didactic lectures, journal clubs, textbook chapter readings, the annual in-service examination, and individual rotation evaluations on the MedHub system in accordance with Graduate Medical Education Committee guidelines. American Board of Otolaryngology/Head and Neck Surgery surgical experience reports are examined semi-annually in formal reviews with the Program Director and Chair. Clinical comments and evaluations are made to the house staff on a daily basis by the attending staff and Chief of Service.

- Patient Care Orders: house staff may independently write patient care orders.

2. Activities Reviewed

Observations of resident performance include those made:

- Intraoperatively
- On ward rounds

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

3. Reporting

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

VII. OTOLARYNGOLOGY CLINICAL SERVICE CONSULTATION CRITERIA

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

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

B. RESPONSIBILITY

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

Administrative Assistant:

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

C. RESIDENTPARTICIPATION

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

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

D. MONITORINGCOMPONENTS

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

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

E. EVALUATION

1. As clinical service problems, patterns, and trends are identified, appropriate assessments methodologies to determine the cause and extent of the problem will be selected and may include:

   a. Medical audit utilizing predetermined clinically valid criteria
   b. Experimental design and research
   c. Staff discussion
   d. Outside consultation

2. Action: Remedial actions may include:

   a. In-service education and training programs
   b. New/revised policies and procedures
   c. Staffing changes
   d. Equipment changes
   e. Counseling and proctoring
   f. Referral to outside committee for follow-up when appropriate

3. Reevaluation:

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

F. PERFORMANCE IMPROVEMENT DRIVER METRICS

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

G. REPORTING

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

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

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

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

H. PEER REVIEW

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

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

I. EVALUATION

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

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

J. REVIEW OF PATHOLOGY REPORTS

1. Objective

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

2. Responsibility

a. Service Chief:

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

3. Operations

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

4. Action

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

K. CLINICAL INDICATORS

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

L. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

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

M. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

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

N. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

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

X. MEETINGREQUIREMENTS

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

Otolaryngology Clinical Services shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Staff meetings are often held in conjunction with the UCSF Departmental Faculty meetings which are held approximately monthly. Minutes of the departmental meetings are ~~kept on file in the departmental office.~~stored electronically by the UCSF department.

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

XI. ADOPTION AND AMENDMENT

The Otolaryngology Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all full-time Active members of the Otolaryngology Service as often as necessary but at least every three years.

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ATTACHMENT A: JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF OTOLARYNGOLOGY SERVICE
JOB DESCRIPTION

Chief of Otolaryngology Clinical Service

Position Summary:

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

Reporting Relationships:

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

Position Qualifications:

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

Major Responsibilities:

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

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

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

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

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.

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ATTACHMENT B: OTOLARYNGOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM

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APPENDIX: ORGANIZATION - OTOLARYNGOLOGY CLINICAL SERVICE

1. OTOLARYNGOLOGY PROCEDURE CLINIC

a. Goals and Objectives

To establish guidelines for the safe and effective completion of procedures in the Otolaryngology Clinic

b. Procedures

All cases done require prior clearance by an otolaryngology attending who will assume responsibility for the case.

Under the guidance of an attending surgeon any case which may be safely accomplished under local anesthesia may be done as long as the attending surgeon has privileges for that type of procedure. Sedation may not be given for these procedures

The following procedures may be performed under these guidelines:

- Removal of intranasal ~~polyps~~lesions or crusting
- Incisional and excisional biopsies of non-vascular ~~nasal~~ masses or lesions of the head and neck
- Cauterization or radiofrequency ablation of nasal turbinates
- Incisional or excisional biopsies and removal of facial ulcerations, tumors, neck masses, skin, and skin anomalies.
- Repair of facial lacerations
- Myringotomy and insertion of pressure equalization tubes
- Irrigation of paranasal sinuses
- Removal of intermaxillary fixation, archbars and other oral appliances.
- Closed reduction of nasal fractures
- Diagnostic ultrasound of the head and neck and ultrasound-guided needle placement
- Botox injection
- Repair of tympanic membrane perforation
- Nasal cautery
- Removal of ear canal lesions, foreign bodies or cerumen including otomicroscopy
- Incision and drainage of abscess
- Salivary duct cannulation and flushing or saline or medications
- Tracheotomy tube changes and trachea-esophageal puncture changes
- Nasopharyngoscopy
-

c. Staffing

At least one physician and an attendant will be available for participation in all cases.

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Cases will be scheduled during designated clinic time or at other times only if it will not interfere with the normal functioning of the clinic, and that adequate nursing staffing can be available.

d. Equipment

Only those procedures for which equipment can be assembled preoperatively for the completion of the entire procedure will be undertaken in the clinic treatment room.

2. AUDIOLOGY SERVICE

a. **Objective**

To establish an audiology service to provide diagnostic evaluation, screening, testing and rehabilitation services for individuals with known or suspected hearing disorders with appropriate staff, space, equipment and supplies.

b. **General Requirements**

Policy & Procedure Manual:
Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with the Chief, Department of Otolaryngology-Head & Neck Surgery and a representative of the Director of Hospitals and Clinics, Zuckerberg San Francisco General.

1. Policies and procedures shall be approved by the Chief, Department Otolaryngology - Head & Neck Surgery and the Director of Hospitals and Clinics, Zuckerberg San Francisco General.

2. Policies and procedures shall be reviewed annually by the Chief, Otolaryngology - Head & Neck Surgery and Director of the Audiology Service and revised as necessary.

c. **Organization**

Director: A qualified audiologist will have overall responsibility for the audiology service.

A qualified audiologist must have at least a Master's Degree in Audiology, a Certificate of Clinical Competence (CCC) from the American Speech, Hearing and Language Association (ASHA) and a California State License in Audiology.

The audiologist who directs the section will be accountable to the Chief, Department of Otolaryngology - Head & Neck Surgery or his or her designee regarding patient care.

The audiologist who directs the section will be accountable to the Director of Hospital and Clinics regarding administrative matters.

d. **Responsibilities of the audiologist shall include:**

1. Development and implementation of pertinent policies and procedures.
2. Coordination of a system of scheduled inpatient and ambulatory care patient services.
3. Recommendation of the type and number of staff needed to perform the required services.
4. Recommendation of the type and amount of equipment and facilities needed to perform the required services.

5. Establishment of continuing educational opportunities for staff personnel.
6. Participation in the review and evaluation of the quality and appropriateness of patient care.
7. Preparation of all required reports.
8. Development of appropriate job description for additional staff personnel as they are available.
9. Insuring that routine maintenance and calibration of equipment is accomplished and properly documented.
10. Teaching audiometric techniques to medical students and housestaff.
11. Participation in multidisciplinary teaching conferences.

e. **Staffing**

Supervision:
All services will be provided by, or under the direction of, an audiologist who meets the qualifications specified above.

Under the direct supervision of a qualified audiologist, audiology services may be provided by an individual who has completed the academic requirements in audiology and is in the process of obtaining the required professional experience necessary for certification.

Audiologists will be provided from the UCSF Audiology Department per the University contract.

The Chief, Department of Otolaryngology - Head & Neck Surgery or his/her designee will be available during the hours which audiology services are provided to provide professional consultation as required by the audiologist.

f. **Equipment and Supplies**

At least the following equipment shall be provided:

Audiometers:
1. One clinical audiometer
2 Immittance audiometer

Additional Diagnostic Tests and Materials:
1. Appropriate toys for play audiometry
2. Loud speakers
3. An otoscope
4 Tape deck

Calibration:
All audiometers will be calibrated to ANSI standards two times a year by an outside contractor. A record of calibrations will be kept in the audiometric test suite.

g. **Physical Plant**

1. Audiologic evaluations will be conducted in an audiometric test suite, which meets ANSI standards for reduction of background noise.

2. The room will be large enough for sound field-testing and be equipped with two speakers.
3. The audiometric test suite will be accessible by wheelchair.
4. Counseling and treatment areas will be provided adjacent to the audiometric test suite by request to the clinic nurse.

h. **Services Provided**

Audiologic services will be provided for total age range population from children to geriatric patients. Specialty consultation for infants and special tests are available at UCSF. Audiologic evaluations appropriate to rule out, establish, or monitor the type and degree of auditory dysfunction in a wide variety of pathologies and conditions will be available. These will include but not be limited to:

1. Pathologies of the auditory system
2. Exposure to ototoxic drugs
3. Exposure to loud noise
4. Head trauma
5. Delayed language development
6. Vertigo of unknown etiology
7. Prenatal, perinatal and neonatal high risk factors

Comprehensive audiologic services will be administered to establish a patient's hearing threshold, to monitor a patient's hearing level, to assist in the identification of site of lesion of hearing loss, to assess communication abilities and disabilities, and to indicate potential benefit from surgery, use of a hearing aid and aural rehabilitation.

i. **Basic Audiometry**:

Baseline or monitoring audiologic evaluations must include but are not limited to the following:

1. Air conduction pure tone audiometry
2. Bone conduction pure tone audiometry

j. **Diagnostic Audiometry:**

Diagnostic audiology evaluations must include, but are not limited to the following:

1. Air and bone conduction pure tone audiometry.
2. Speech reception thresholds
3. Speech discrimination scores.

Site of lesion audiologic evaluations must include but are not limited to the following:

1. Air and bone conduction pure tone audiometry
2. Speech reception thresholds
3. Speech discrimination scores including PB roll-over testing.
4. Immittance audiometry including acoustic reflex decay when possible.

k. **Additional Tests**:

Other audiologic tests may be performed at UCSF at the discretion of the audiologist or physician performing or supervising the test procedure to include:

1. ABR
2. ENG
3. Otoacoustic

emissions.

l. **Hearing Aid Evaluations:**

Hearing aid evaluations and counseling are not provided.

m. **Aural Rehabilitation Services:**

1. Aurally disabled patients shall be referred to any appropriate source for aural rehabilitation services including auditory training, speech reading and hearing aid evaluation.
2. Counseling for parents of aurally disabled children shall be provided.

n. **High Risk Infants**

Screening for high-risk neonatal patients or infants will be provided by referral to the University of California, San Francisco, Department of Otolaryngology, for ABR audiometry.

o. **Case Management**

1. Patients seen for audiologic services may be referred by a physician or outside referral agency.
3. Audiometric test results will be recorded in the patient's medical record.
4. Notation will be made as to the audiologist's impression of the test results and any pertinent audiologic recommendations regarding necessity for further testing, need for amplification and/or aural rehabilitation services.
5. In addition to chart notes, copies of audiometric test results and recommendations will be sent to all outside referring physicians and agencies.

p. **Case Responsibility:**

1. Following audiologic evaluation, the patient will be returned to the referring physician for follow-up and continued medical management.
2. The audiologist will assume primary responsibility for the patient only when the referring physician requests that the audiologist assumes responsibility for a patient whose primary need is amplification and/or aural rehabilitation.
3. Patients for whom the audiologist has assumed primary responsibility will be referred back to his physician for consultation if significant changes are noted in auditory or vestibular status.

3. OTOLARYNGOLOGYCLINIC

a. **Objectives**

To establish guidelines for the safe and effective diagnosis and outpatient treatment of otolaryngologic conditions.

b. **General Requirements**

The otolaryngology clinic will be organized and run in the 4J clinic area. ~~Rooms 1 and 6 are~~ Many rooms are equipped with an operating microscope to use for otologic clinic procedures. All rooms have adequate lighting to be used for diagnosis and otolaryngology procedures as itemized in the protocol for the otolaryngology treatment room.

c. **Personnel**

1. DEPARTMENTAL CHIEF: Responsible for the overall management of the physician staff of the otolaryngology clinic. Responsible for setting policy for management of the clinic in consultation with the Nurse Manager.
2. NURSE MANAGER, 4J CLINIC: Responsible for the overall supervision of the nursing staff of the otolaryngology clinic.
3. SENIOR RESIDENT: Responsible for the coordination of resident attendance and resident and medical student teaching in the otolaryngology clinic.
4. JUNIOR RESIDENT/MEDICAL STUDENT: Patient Care as directed by the senior resident.
5. NURSE PRACTITIONER(S) and/or PHYSICIAL ASSISTANT(S): Responsible for e-referral as needed and other clinical duties as approved by ZSFG Affiliated Professional Staff Standardized Procedures and Protocols.
6. CLINICAL NURSE: Responsible for effective operation of the clinic as indicated below.
7. LICENSED VOCATIONAL NURSE/MEA: Responsibilities as listed below.
8. CLERICAL PERSONNEL: Responsible for making appointments and registering patients into the clinic.

d. **Schedule**

The Otolaryngology Clinic will run on the following schedule:

Monday:	8:15a.m. -5:00 p.m.
Tuesday:	No formal clinic
Wednesday:	8:15a.m.- 5:00 p.m.
Thursday:	8:15-12:00p.m.
Friday:	1:00 - 5:00 p.m.

e. **Appointments**

Patients may be referred by the emergency room or by other clinic/hospital physicians. Patients may also be scheduled in response to e-referral.

f. **Patient Visits**

Patients will be classified into the following categories:

1. NEW PATIENTS: These patients will routinely be scheduled for appointment time slots as indicated by templates approved by the OHNS chief of service.
2. FOLLOW-UP PATIENTS: These patients will routinely be scheduled as above.

3. DROP-IN PATIENTS: These patients do not have previous appointments that have been cleared by the clinic nurse or physicians. These patients will be seen after scheduled patients unless earlier evaluation is required for their condition.
4. INPATIENT CONSULTATIONS: These patients will be scheduled as acuity dictates.
5. OTOLARYNGOLOGY INPATIENTS: These patients will be seen, as required, when treatment requires use of clinic facilities.
6. AFTER HOURS CONSULTATIONS: Clinic rooms will be available for resident and attending evaluation of patients who are seen after normal clinic hours. Only patients who require specific equipment and facilities of the otolaryngology clinic should be seen in these areas.

A. **Patient Processing**

1. REGISTRATION: All patients will register per the current hospital policy.
2. ORDER OF PATIENT TREATMENT: Patients will be seen in the order of their arrival and based upon appointment time. This may be altered in the event of conditions requiring urgent treatment.
3. LAB AND X-RAY DATA: Prior to the patient being seen, the nursing staff will review the patient's record from the previous visit and ensure that laboratory and x-ray data previously ordered are available for review by the physician. He/she will attempt to locate these results if they are not in the electronic medical record.
4. HEAD AND NECK EXAM: On initial evaluation, patients will have a complete otolaryngology exam. The completeness of the exam will be modified as indicated on subsequent visits.
5. CLINICAL RECORDS: Providers will complete the outpatient clinical record immediately after seeing the patient. All outpatient encounters will be documented medical record system.
   The face sheet will be completed by the provider prior to patient departure and the MEA will schedule other appointments and return visits.
   .
6. AUDIOMETRIC EXAMS: Audiometric exams will be scheduled as outlined in the chapter on Audiology in the Clinical Service's Policy and Procedure Manual.

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I. OTOLARYNGOLOGY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF OTOLARYNGOLOGY CLINICAL SERVICE

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

1. Guidelines for Appointment

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

DEA certification is required for active and courtesy staff.

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

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

2. Modification of Clinical Service

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

3. Staff Status Change

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

4. Modification/Changes to Privileges

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

5. On-Call Oversight

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

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

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

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

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

3. Appraisal of Patient Care
Evaluation of patient care will be by:

a. Observation of care provided during surgery.

b. Assessment of the appropriateness of care delivered as observed on ward rounds.

c. Review of minimum of 5 case files.

d. Review of Morbidity and Mortality Reports relevant to the particular practitioner.

4. Individual Responsibilities

a. Department Chief:

1. Review the above information and make a recommendation either to continue or drop the physician from the medical staff.
2. Make observations of patient care intraoperatively, on ward rounds and by assessment of patient complications or appointment of another physician to do the proctoring.

b. Administrative Assistant:

1. Review list of current hospital staff who require proctoring.
2. Assemble relevant information for review by Chief on an annual basis so that pertinent recommendations can be made.

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

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

VI. OTOLARYNGOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. RESIDENT EVALUATIONS

1. Individual Responsibilities

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

- Role, responsibility, and patient care activities of the house staff: The house staff have primary responsibility for the clinical care of patients on the wards, in the clinic, and in the operating room under the supervision of attending staff. It is the goal of the program to have the residents develop a formal therapeutic relationship with the patients and to have patients identify the housestaff as the primary care provider. This includes initial history and physical exams, medical test decision making, procedures, and analysis of care options and therapeutic interventions. This educational environment is consistently monitored by the real-time presence of the attending staff who closely monitor and supervise house staff interactions and decision making. It should be remembered that the house staff are all eligible for California State Licensure to practice independently as physicians and surgeons in the state of California by having completed ACGME approved surgical internships.

- The attending staff and program director make decisions about the extent to which the resident can practice independently by analyzing a variety of factors including in-service scores, rotation evaluations, semi-annual formal performance evaluations, ABO surgical experience data, and also by direct, daily contact and observation.

- Resident Evaluation Process: the residents are evaluated in accordance with ACGME requirements for Otolaryngology/Head and Neck Surgery. The residents participate in Grand Rounds, Morbidity and Mortality conference, regularly scheduled didactic lectures, journal clubs, textbook chapter readings, the annual in-service examination, and individual rotation evaluations on the MedHub system in accordance with Graduate Medical Education Committee guidelines. American Board of Otolaryngology/Head and Neck Surgery surgical experience reports are examined semi-annually in formal reviews with the Program Director and Chair. Clinical comments and evaluations are made to the house staff on a daily basis by the attending staff and Chief of Service.

- Patient Care Orders: house staff may independently write patient care orders.

2. Activities Reviewed

Observations of resident performance include those made:
- Intraoperatively
- On ward rounds

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

3. Reporting

Each resident's ZSFG performance is evaluated by faculty and discussed at the Departmental clinical competency committee meetings by a ZSFG representative.

VII. OTOLARYNGOLOGY CLINICAL SERVICE CONSULTATION CRITERIA

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

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

B. RESPONSIBILITY

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

Administrative Assistant:

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

C. RESIDENTPARTICIPATION

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

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

D. MONITORINGCOMPONENTS

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

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

E. EVALUATION

1. As clinical service problems, patterns, and trends are identified, appropriate assessments methodologies to determine the cause and extent of the problem will be selected and may include:

    a. Medical audit utilizing predetermined clinically valid criteria
    b. Experimental design and research
    c. Staff discussion
    d. Outside consultation

2. Action: Remedial actions may include:

    a. In-service education and training programs
    b. New/revised policies and procedures
    c. Staffing changes
    d. Equipment changes
    e. Counseling and proctoring
    f. Referral to outside committee for follow-up when appropriate

3. Reevaluation:

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

F. PERFORMANCE IMPROVEMENT DRIVER METRICS

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

G. REPORTING

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

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

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

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

H. PEER REVIEW

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

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

I. EVALUATION

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

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

J. REVIEW OF PATHOLOGY REPORTS

1. Objective

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

2. Responsibility

a. Service Chief:

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

3. Operations

Reports of operations performed by the service are maintained in departmental electronic files,

4. Action

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

K. CLINICAL INDICATORS

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

L. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

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

M. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

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

N. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

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

X. MEETINGREQUIREMENTS

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

Otolaryngology Clinical Services shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Staff meetings are often held in conjunction with the UCSF Departmental Faculty meetings which are held approximately monthly. Minutes of the departmental meetings are stored electronically by the UCSF department.

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

XI. ADOPTION AND AMENDMENT

The Otolaryngology Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all full-time Active members of the Otolaryngology Service as often as necessary but at least every three years.

ATTACHMENT A: JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF OTOLARYNGOLOGY SERVICE
JOB DESCRIPTION

Chief of Otolaryngology Clinical Service

Position Summary:

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

Reporting Relationships:

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

Position Qualifications:

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

Major Responsibilities:

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

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

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

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

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.

ATTACHMENT B: OTOLARYNGOLOGY CLINICAL SERVICE PRIVILEGE REQUEST FORM

APPENDIX: ORGANIZATION - OTOLARYNGOLOGY CLINICAL SERVICE

1. OTOLARYNGOLOGY PROCEDURE CLINIC

a. Goals and Objectives

To establish guidelines for the safe and effective completion of procedures in the Otolaryngology Clinic

b. Procedures

All cases done require prior clearance by an otolaryngology attending who will assume responsibility for the case.

Under the guidance of an attending surgeon any case which may be safely accomplished under local anesthesia may be done as long as the attending surgeon has privileges for that type of procedure. Sedation may not be given for these procedures

The following procedures may be performed under these guidelines:

- Removal of intranasal lesions or crusting
- Incisional and excisional biopsies of non-vascular masses or lesions of the head and neck
- Cauterization or radiofrequency ablation of nasal turbinates
- Incisional or excisional biopsies and removal of facial ulcerations, tumors, neck masses, skin, and skin anomalies.
- Repair of facial lacerations
- Myringotomy and insertion of pressure equalization tubes
- Irrigation of paranasal sinuses
- Removal of intermaxillary fixation, archbars and other oral appliances.
- Closed reduction of nasal fractures
- Diagnostic ultrasound of the head and neck and ultrasound-guided needle placement
- Botox injection
- Repair of tympanic membrane perforation
- Nasal cautery
- Removal of ear canal lesions, foreign bodies or cerumen including otomicroscopy
- Incision and drainage of abscess
- Salivary duct cannulation and flushing or saline or medications
- Tracheotomy tube changes and trachea-esophageal puncture changes
- Nasopharyngoscopy
-

c. Staffing

At least one physician and an attendant will be available for participation in all cases.

Cases will be scheduled during designated clinic time or at other times only if it will not interfere with the normal functioning of the clinic, and that adequate nursing staffing can be available.

d. Equipment

Only those procedures for which equipment can be assembled preoperatively for the completion of the entire procedure will be undertaken in the clinic treatment room.

2. AUDIOLOGY SERVICE

a. **Objective**

To establish an audiology service to provide diagnostic evaluation, screening, testing and rehabilitation services for individuals with known or suspected hearing disorders with appropriate staff, space, equipment and supplies.

b. **General Requirements**

Policy & Procedure Manual:
Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with the Chief, Department of Otolaryngology-Head & Neck Surgery and a representative of the Director of Hospitals and Clinics, Zuckerberg San Francisco General.

1. Policies and procedures shall be approved by the Chief, Department Otolaryngology - Head & Neck Surgery and the Director of Hospitals and Clinics, Zuckerberg San Francisco General.

2. Policies and procedures shall be reviewed annually by the Chief, Otolaryngology - Head & Neck Surgery and Director of the Audiology Service and revised as necessary.

c. **Organization**

Director: A qualified audiologist will have overall responsibility for the audiology service.

A qualified audiologist must have at least a Master's Degree in Audiology, a Certificate of Clinical Competence (CCC) from the American Speech, Hearing and Language Association (ASHA) and a California State License in Audiology.

The audiologist who directs the section will be accountable to the Chief, Department of Otolaryngology - Head & Neck Surgery or his or her designee regarding patient care.

The audiologist who directs the section will be accountable to the Director of Hospital and Clinics regarding administrative matters.

d. **Responsibilities of the audiologist shall include:**

1. Development and implementation of pertinent policies and procedures.
2. Coordination of a system of scheduled inpatient and ambulatory care patient services.
3. Recommendation of the type and number of staff needed to perform the required services.
4. Recommendation of the type and amount of equipment and facilities needed to perform the required services.

5. Establishment of continuing educational opportunities for staff personnel.
6. Participation in the review and evaluation of the quality and appropriateness of patient care.
7. Preparation of all required reports.
8. Development of appropriate job description for additional staff personnel as they are available.
9. Insuring that routine maintenance and calibration of equipment is accomplished and properly documented.
10. Teaching audiometric techniques to medical students and housestaff.
11. Participation in multidisciplinary teaching conferences.

e. **Staffing**

Supervision:
All services will be provided by, or under the direction of, an audiologist who meets the qualifications specified above.

Under the direct supervision of a qualified audiologist, audiology services may be provided by an individual who has completed the academic requirements in audiology and is in the process of obtaining the required professional experience necessary for certification.

Audiologists will be provided from the UCSF Audiology Department per the University contract.

The Chief, Department of Otolaryngology - Head & Neck Surgery or his/her designee will be available during the hours which audiology services are provided to provide professional consultation as required by the audiologist.

f. **Equipment and Supplies**

At least the following equipment shall be provided:

Audiometers:
1. One clinical audiometer
2 Immittance audiometer

Additional Diagnostic Tests and Materials:
1. Appropriate toys for play audiometry
2. Loud speakers
3. An otoscope
4 Tape deck

Calibration:
All audiometers will be calibrated to ANSI standards two times a year by an outside contractor. A record of calibrations will be kept in the audiometric test suite.

g. **Physical Plant**

1. Audiologic evaluations will be conducted in an audiometric test suite, which meets ANSI standards for reduction of background noise.

2. The room will be large enough for sound field-testing and be equipped with two speakers.
3. The audiometric test suite will be accessible by wheelchair.
4. Counseling and treatment areas will be provided adjacent to the audiometric test suite by request to the clinic nurse.

h. **Services Provided**

Audiologic services will be provided for total age range population from children to geriatric patients. Specialty consultation for infants and special tests are available at UCSF. Audiologic evaluations appropriate to rule out, establish, or monitor the type and degree of auditory dysfunction in a wide variety of pathologies and conditions will be available. These will include but not be limited to:

1. Pathologies of the auditory system
2. Exposure to ototoxic drugs
3. Exposure to loud noise
4. Head trauma
5. Delayed language development
6. Vertigo of unknown etiology
7. Prenatal, perinatal and neonatal high risk factors

Comprehensive audiologic services will be administered to establish a patient's hearing threshold, to monitor a patient's hearing level, to assist in the identification of site of lesion of hearing loss, to assess communication abilities and disabilities, and to indicate potential benefit from surgery, use of a hearing aid and aural rehabilitation.

i. **Basic Audiometry**:

Baseline or monitoring audiologic evaluations must include but are not limited to the following:

1. Air conduction pure tone audiometry
2. Bone conduction pure tone audiometry

j. **Diagnostic Audiometry:**

Diagnostic audiology evaluations must include, but are not limited to the following:

1. Air and bone conduction pure tone audiometry.
2. Speech reception thresholds
3. Speech discrimination scores.

Site of lesion audiologic evaluations must include but are not limited to the following:

1. Air and bone conduction pure tone audiometry
2. Speech reception thresholds
3. Speech discrimination scores including PB roll-over testing.
4. Immittance audiometry including acoustic reflex decay when possible.

k. **Additional Tests**:

Other audiologic tests may be performed at UCSF at the discretion of the audiologist or physician performing or supervising the test procedure to include:

1. ABR
2. ENG
3. Otoacoustic emissions.

l. **Hearing Aid Evaluations:**

Hearing aid evaluations and counseling are not provided.

m. **Aural Rehabilitation Services:**

1. Aurally disabled patients shall be referred to any appropriate source for aural rehabilitation services including auditory training, speech reading and hearing aid evaluation.
2. Counseling for parents of aurally disabled children shall be provided.

n. **High Risk Infants**

Screening for high-risk neonatal patients or infants will be provided by referral to the University of California, San Francisco, Department of Otolaryngology, for ABR audiometry.

o. **Case Management**

1. Patients seen for audiologic services may be referred by a physician or outside referral agency.
3. Audiometric test results will be recorded in the patient's medical record.
4. Notation will be made as to the audiologist's impression of the test results and any pertinent audiologic recommendations regarding necessity for further testing, need for amplification and/or aural rehabilitation services.
5. In addition to chart notes, copies of audiometric test results and recommendations will be sent to all outside referring physicians and agencies.

p. **Case Responsibility:**

1. Following audiologic evaluation, the patient will be returned to the referring physician for follow-up and continued medical management.
2. The audiologist will assume primary responsibility for the patient only when the referring physician requests that the audiologist assumes responsibility for a patient whose primary need is amplification and/or aural rehabilitation.
3. Patients for whom the audiologist has assumed primary responsibility will be referred back to his physician for consultation if significant changes are noted in auditory or vestibular status.

3. OTOLARYNGOLOGY CLINIC

a. **Objectives**

To establish guidelines for the safe and effective diagnosis and outpatient treatment of otolaryngologic conditions.

b. **General Requirements**

The otolaryngology clinic will be organized and run in the 4J clinic area. Many rooms are equipped with an operating microscope to use for otologic clinic procedures. All rooms have adequate lighting to be used for diagnosis and otolaryngology procedures as itemized in the protocol for the otolaryngology treatment room.

c. **Personnel**

1. DEPARTMENTAL CHIEF: Responsible for the overall management of the physician staff of the otolaryngology clinic. Responsible for setting policy for management of the clinic in consultation with the Nurse Manager.
2. NURSE MANAGER, 4J CLINIC: Responsible for the overall supervision of the nursing staff of the otolaryngology clinic.
3. SENIOR RESIDENT: Responsible for the coordination of resident attendance and resident and medical student teaching in the otolaryngology clinic.
4. JUNIOR RESIDENT/MEDICAL STUDENT: Patient Care as directed by the senior resident.
5. NURSE PRACTITIONER(S) and/or PHYSICIAL ASSISTANT(S): Responsible for e-referral as needed and other clinical duties as approved by ZSFG Affiliated Professional Staff Standardized Procedures and Protocols.
6. CLINICAL NURSE: Responsible for effective operation of the clinic as indicated below.
7. LICENSED VOCATIONAL NURSE/MEA: Responsibilities as listed below.
8. CLERICAL PERSONNEL: Responsible for making appointments and registering patients into the clinic.

d. **Schedule**

The Otolaryngology Clinic will run on the following schedule:

Monday:	8:15a.m. -5:00 p.m.
Tuesday:	No formal clinic
Wednesday:	8:15a.m.- 5:00 p.m.
Thursday:	8:15-12:00p.m.
Friday:	1:00 - 5:00 p.m.

e. **Appointments**

Patients may be referred by the emergency room or by other clinic/hospital physicians. Patients may also be scheduled in response to e-referral.

f. **Patient Visits**

Patients will be classified into the following categories:

1. NEW PATIENTS: These patients will routinely be scheduled for appointment time slots as indicated by templates approved by the OHNS chief of service.
2. FOLLOW-UP PATIENTS: These patients will routinely be scheduled as above.

3. DROP-IN PATIENTS: These patients do not have previous appointments that have been cleared by the clinic nurse or physicians. These patients will be seen after scheduled patients unless earlier evaluation is required for their condition.
4. INPATIENT CONSULTATIONS: These patients will be scheduled as acuity dictates.
5. OTOLARYNGOLOGY INPATIENTS: These patients will be seen, as required, when treatment requires use of clinic facilities.
6. AFTER HOURS CONSULTATIONS: Clinic rooms will be available for resident and attending evaluation of patients who are seen after normal clinic hours. Only patients who require specific equipment and facilities of the otolaryngology clinic should be seen in these areas.

G. **Patient Processing**

1. REGISTRATION: All patients will register per the current hospital policy.
2. ORDER OF PATIENT TREATMENT: Patients will be seen in the order of their arrival and based upon appointment time. This may be altered in the event of conditions requiring urgent treatment.
3. LAB AND X-RAY DATA: Prior to the patient being seen, the nursing staff will review the patient's record from the previous visit and ensure that laboratory and x-ray data previously ordered are available for review by the physician. He/she will attempt to locate these results if they are not in the electronic medical record.
4. HEAD AND NECK EXAM: On initial evaluation, patients will have a complete otolaryngology exam. The completeness of the exam will be modified as indicated on subsequent visits.
5. CLINICAL RECORDS: Providers will complete the outpatient clinical record immediately after seeing the patient. All outpatient encounters will be documented medical record system.
   The face sheet will be completed by the provider prior to patient departure and the MEA will schedule other appointments and return visits.

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6. AUDIOMETRIC EXAMS: Audiometric exams will be scheduled as outlined in the chapter on Audiology in the Clinical Service's Policy and Procedure Manual.

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

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

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:	
Standardized Procedure Title:	Anesthesia
Department:	
Dept Chief:	
SP Author(s):	
Update #1:	Added Protocol #9: Consent & Ordering Blood Products for Transfusion
Reason/Explanation for Revision:	Reflect current practice
Update #2:	
Reason/Explanation for Revision:	

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below.

Preamble	• The Preamble is the portion of the SP that precedes the Protocols, the first pages of the SP, outlined I-VII, includes sections "Policy Statement, Functions to be Performed," etc. • The Preamble was updated in 2023 to include changes in legislation, regulations, and practice. (CIDP, 10/2023)
Equity	Ensure language within the SP is inclusive. Examples include but are not limited to: • Do not use race/ethnicity descriptors unless necessary • Do not use sex assigned at birth unless necessary • Use "their" rather than "him/her" (CIDP, 8/2022)
ZSFG	Change "San Francisco General Hospital" to "Zuckerberg San Francisco General Hospital" and SFGH to ZSFG (CIDP, 10/2016) · "Community Health Network" change to "**San Francisco Health Network**" · "CHN" change to "**SFHN**"
Qualified Provider	Insert the following after every use of words "qualified provider:" who has completed proctoring and subsequently maintained their eligibility for performing the procedure. *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 Procedures

Nurse Practitioner/Physician Assistants

2026

Title: Department of Anesthesia

PREAMBLE

I. Policy Statement

A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in 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 4J Preoperative and Pain Clinic, the Pre-Op Clinic Medical Director's Office and on file in the Medical Staff Office.

II. Functions to Be Performed

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

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

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specific conditions requiring the Nurse Practitioner to seek physician consultation.

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

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

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is in the Anesthesia Pre-operative Clinic, the Anesthesia Pain Management Clinic, and any other part of the hospital where pre-operative assessment and optimization, or acute/chronic pain assessment and management are required.

B. Supervision
   1. Overall Accountability:
      The NP/PA is responsible and accountable to the respective Medical Directors of the Preoperative Clinic and Pain Clinic, as well as the Anesthesia attending assigned to supervise the Anesthesia Pre-Op Clinic, Anesthesia Pain Management Clinic, or Anesthesia Acute Pain Service.
   2. A consulting physician (Anesthesia attending) will be available to the NP/PA, by phone, in person, or by other electronic means at all times.

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

   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical, or laboratory findings
   d. Upon request of patient, affiliated staff, or physician
   e. Initiation or change of medication other than those in the formulary(ies)
   f. Problem requiring hospital admission or potential hospital admission
   g. Acute, severe respiratory distress
   h. An adverse response to respiratory treatment, or a lack of therapeutic response

IV. Scope of Practice

Protocol #1: Health Care Management: Primary Care/Specialty Clinics/Inpatient Units
Protocol #2: Pre-Op Screening of Adults
Protocol #3: Pre-Op Screening of Children
Protocol #4: Furnishing Medications and Drug Orders
Protocol #5: Electronic Consult (eConsult) Review
Protocol #6: Management of Neuraxial/Nerve Catheters for Pain Control
Protocol #7: Trigger Point Injections
Protocol #8: Botox Injections for Migraines
Protocol #9: Consent & Ordering Blood Products for Transfusion

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V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

1. Active California Registered Nurse/ Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
5. Possession of a National Provider Identifier or must have submitted an application.

6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA number if applicable.

B. Specialty Training
   1. Degree needed for adults: Adult Nurse Practitioner (ANP), Family Nurse Practitioner (FNP) or Physician Assistant (PA)
   2. Degree needed for children less than 18 years of age: FNP, PA or Pediatric Nurse Practitioner (PNP)

VI. Evaluation

A. Evaluation of NP/PA Competence in performance of standardized procedures.
   1. Initial: At the conclusion of the standardized procedure training, the Medical Directors and/or designated physician and other supervisors, as applicable, will assess the NP/PA's ability to practice.

      a. Clinical Practice
         1. Length of proctoring period will be three months which can be shortened or lengthened.
         2. The evaluator will be the Medical Directors and/or designated supervising physician or peer reviewers as applicable.
         3. The method of evaluation in clinical practice will be a minimum of 5 cases for each core category. One case may apply to multiple categories including core and special procedures demonstrate clinical competence or as noted in each special protocol.
   2. Follow-up: Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Directors, and/or designated physician, at appropriate intervals.
   3. Ongoing Professional Performance Evaluation (OPPE): Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.
   4. Biennial Reappointment: Medical Directors, and/or designated physician must evaluate the NP/PA's clinical competence. For reappointment, 5 chart reviews every 2 years or as noted in each special protocol. Charts can include reviews completed for special procedure reviews.

VII. Development and Approval of Standardized Procedure

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

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

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

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

Protocol #1: Health Care Management – Specialty Clinics/Inpatient Units (Core)

A. DEFINITION

This protocol covers the procedure for age appropriate health care management in specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses within outpatient clinics, Emergency Department, Inpatient units, ICU.

B. DATABASE

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

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

C. DIAGNOSIS

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

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical or laboratory findings.
   d. Uncommon, unfamiliar, unstable and complex patient conditions.
   e. Upon request of patient, NP, PA, or physician
   f. Problem requiring hospital admission or potential hospital admission.

3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. smoking cessation, diet, exercise).
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.
   c. Discharge information and instructions.

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

E. RECORD KEEPING

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

Protocol #2: Pre-Op Screening of Adults (Core)

A. Definition

This protocol covers the assessment and management of adults prior to the administration of anesthesia. This will include a directed history and physical.

1. Proctoring
    a. Length of proctoring period will be three months which can be shortened or lengthened.
    b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
    c. The method of evaluation in clinical practice will be presentation of 5 adult cases to either the Medical Director or designated physician during the proctoring period with a chart review of the same 5 cases

2. Reappointment:
    a. The period of review will be every 2 years
    b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
    c. Evaluation will be the review of 3 adult medical record cases

B. Data Base

1. Subjective Data:
    a. Screening: appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems.
    b. Historical information relative to the presenting illness (past health history, family history, occupational history, personal/social history, review of systems;
    c. Status of relevant symptom(s), e.g. present or stable

2. Objective Data:
    a. Physical examination appropriate to the disease process
    b. Review of appropriate laboratory / diagnostic studies
    c. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

C. Diagnosis

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

D. Plan

1. Diagnostic Plan
   a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification
   b. Referral to specialty clinics and supportive services, as needed

2. Treatment Plan
   a. Physical and/or occupational therapy and/or speech therapy, if appropriate
   b. Diet and exercise prescription as indicated by the disease process and the patient condition
   c. Management of medications as appropriate

3. Patient conditions requiring Attending Consultation
   a. With emergent conditions requiring prompt medication attention
   b. With acute decompensation of the patient situation
   c. When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings
   d. Upon request of the patient, NP, PA, or Physician
   e. When ordering expensive and/or unusual diagnostic studies
   f. When prescribing medications not within the clinical expertise of the NP/PA
   g. Patient conditions that may require physician consultation in addition to the ones mentioned in the preamble including but not limited to:
      - Significant abnormal lab values
      - New carotid bruits
      - New cardiac murmurs or other cardiac symptoms
      - Current uncompensated heart failure
      - New ECG changes
      - Other acute or chronic conditions which will benefit from treatment and stabilization prior to surgery.
      - Patients evaluated for surgery who have unusual and/or unanticipated findings.

4. Patient / Family Education
   In verbal and/or written format, the Nurse Practitioner explains to the pertinent party or parties involved the disease process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up.

5. Follow-up and Referral
   Performed in accordance with the standard of practice and/or with the consulting physician's recommendation.

E. Record Keeping

Patient contacts and visits are to be documented in accordance with standard practice and institutional policy. All information relevant to patient care will be recorded in the medical record.

A. Clinical Definition

This protocol covers the assessment and management of children less than 18 years of age prior to the administration of anesthesia. This will include a directed history and physical.

1. Proctoring
    a. Length of proctoring period will be three months in length which can be shortened or lengthened.
    b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
    c. The method of evaluation in clinical practice will be presentation of 5 pediatric cases to either the Medical Director or designated physician during the proctoring period with a chart review of the same 5 cases.

2. Reappointment:
    a. The period of review will be every 2 years
    b. The evaluator will be the Medical Director of the Anesthesia Pre-Op Clinic
    c. Evaluation will be the review of 3 pediatric medical record cases.

B. Database

1. Subjective Data:
    a. Screening: age appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems.
    b. Historical information relative to the presenting illness (past health history, family history, occupational history, personal/social history, review of systems
    c. Status of relevant symptom(s), e.g. present or stable

2. Objective Data:
    a. Physical examination appropriate to the disease process
    b. Review of appropriate laboratory / diagnostic studies
    c. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.

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

D. Plan

1. Diagnostic Plan
    a. Age appropriate screening tests, and/or diagnostic tests for purposes of disease identification
    b. Referral to specialty clinics and supportive services, as needed

2. Treatment Plan
    a. Physical and/or occupational therapy and/or speech therapy, if appropriate
    b. Diet and exercise prescription as indicated by the disease process and the patient condition
    c. Management of medication as appropriate.

3. Patient conditions requiring Attending Consultation
    a. With emergent conditions requiring prompt medication attention
    b. With acute decompensation of the patient situation
    c. When there is a problem that is not resolving as anticipated with unexplained, historical, physical and/or laboratory findings
    d. Upon request of the patient, NP/PA, or Physician
    e. When ordering expensive and/or unusual diagnostic studies;
    f. When prescribing medications not within the clinical expertise of the NP/PA
    g. Patient conditions that may require physician consultation in addition to the ones mentioned in the preamble including but not limited to:
        - Significant abnormal lab values
        - Congenital heart disorders
        - Severe neuromuscular disease
        - Cranio-facial malformations
        - Other acute or chronic conditions which will benefit from treatment and stabilization prior to surgery
        - Patients evaluated for surgery who have unusual and/or unanticipated findings

4. Patient / Family Education
    a. In verbal and/or written format, the NP/PA explains to the pertinent party or parties involved the disease process, pertinent signs and symptoms, therapeutic modalities and appropriate follow-up.
    b. The NP/PA will provide age appropriate verbal and/or written information to prepare a child and/or their family for the operative experience.

5. Follow-up and Referral
   Performed in accordance with the standard of practice and/or with the consulting physician's recommendation.

E. Record Keeping
1. Patient contacts and visits are to be documented in accordance with standard practice and institutional policy.
2. All information relevant to patient care will be recorded in the medical record.

Protocol #4: Furnishing Medications/Drug Orders (Core)

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license. Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, Anesthesia Services, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies to be used are: ZSFG, Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

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

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment
    a. Initiate, adjust, discontinue, and/or renew drugs and devices.
    b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
    c. Nurse Practitioners/Physician Assistants may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the electronic health record, or in the Medication Administration Record (MAR). The protocol will include the following:
        1. location of practice
        2. diagnoses, illnesses, or conditions for which medication is ordered
        3. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
    d. To facilitate patient receiving medications from a pharmacist the following information must be provided:
        i. name of medication
        ii. strength
        iii. directions for use
        iv. name of patient
        v. name of prescriber and title
        vi. date of issue
        vii. quantity to be dispensed
        viii. license no., furnishing no.(NP only), and DEA no.
    e. Limitations
        1. A prescription for a Schedule II or III controlled substance shall be limited to the number of tablets needed until the next scheduled follow-up clinic appointment.
        2. No refills will be allowed for lost or stolen narcotic prescriptions.

2. Patient conditions requiring Attending Consultation
    a. Problem which is not resolved after reasonable trial of therapies.
    b. Unexplained historical, physical or laboratory findings.
    c. Upon request of patient, NP, PA, or physician.
    d. Failure to improve pain and symptom management.
    e. Acute, severe respiratory distress

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

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

E. RECORD KEEPING

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

Protocol #5: Electronic Consult (eConsult) Review

A. DEFINITION

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

1. Prerequisites:
   a. Providers reviewing eConsults will have six months experience with patients in the specific specialty area provided at ZSFG or elsewhere before allowed to do electronic referrals independently.
   b. Providers reviewing eConsults will be licensed as stated in the Standardized Procedure NP/PA Preamble.
   c. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
   d. Providers reviewing eConsults will have expertise in the specialty practice for which they are reviewing.

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Medical Director which will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.

3. Proctoring: Concurrent review of the first 20 eConsult consultation decisions will be performed by the Medical Director or designee concurrently for the first three months.

4. Reappointment: A review of five eConsults every two years.

B. DATABASE

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

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

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

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

C. DIAGNOSIS

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

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation in patient condition.
   b. Unexplained historical, physical or laboratory findings.
   c. Upon request of the referring NP, PA, or physician.
   d. Problem requiring hospital admission or potential hospital admission.
   e. When recommending complex imaging studies or procedures for the referring provider to order.
   f. Problem requiring emergent/urgent surgical intervention.
   g. As indicated per the algorithms developed by the Chief of Service.

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

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

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

E. RECORD KEEPING

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

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

Protocol #6: Management of Neuraxial and Peripheral Nerve Catheters

A. Definition

Management of in situ neuraxial and peripheral nerve catheters for the purpose of optimizing pain control including assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter after use is no longer indicated.

1. Location of procedure may include Emergency Department, Inpatient Units, Perioperative Area, and Intensive Care Units

a. Indications - Patients with in situ neuraxial or peripheral nerve catheters who require catheter management.

b. Precautions/Contraindications that require physician consultation:

- Patients who are acutely hypotensive or predisposed to hypotension such as elderly patients, patients with heart failure, or hypovolemic patients.
- New focal neurologic findings or severe back pain.
- Patients with signs of neuraxial or peripheral nerve catheter infection or risk factors for contamination of such catheters including fever or elevated white blood cell count; catheter site tenderness, erythema, swelling, discharge, or bleeding; non-intact catheter dressing or catheter disconnection.
- Patients with documented allergy to medication or medication in same class as catheter infusion medication.
- Patients with coagulopathy or taking antithrombotic medications not consistent with joint UCSF/ZSFG "Guidelines For The Use of Antithrombotic Agents In The Setting Of Neuraxial Procedures"[1].

B. Data Base

1. Subjective Data

a. History and review of symptoms relevant to the presenting complaint, pain presentation, and catheter placement procedure

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-containing products, anticoagulants, anti-platelet agents,

[1] https://anesthesia.ucsf.edu/clinical-resources/guidelines-use-antithrombotic-agents-setting-neuraxial-procedures-0

and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents and opioids.

2. Objective Data

   a. Physical exam to include vital signs review, inspection and palpation of the catheter site, sensory level of the neuraxial or nerve block, extremity motor and sensory function as appropriate

   b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

C. Diagnosis

Assessment of data from the subjective and objective findings to gauge effectiveness of pain control and determine the presence of complications related to pain management therapies

D. Plan

1. Therapeutic Treatment Plan
   a. Explain to the patient, if possible, the availability, risks, and benefits of relevant pain treatment modalities.

   b. Determine, in consultation with the attending physician, the consulting team, and the patient, which pain treatment modalities will be initiated, adjusted or discontinued

   c. Set up catheter medication infusion pump, initiate/adjust infusion medication, or remove catheter as appropriate

   d. Initiate, adjust, or discontinue other pharmacologic and non-pharmacologic pain modalities as indicated

2. Patient conditions requiring attending physician consultation

   a. Acute hypotension, allergic reaction, and any decompensation of patient.

   b. New neurologic findings or severe back pain

   b. Unexplained physical or laboratory findings

   c. Catheter requires removal/replacement due to inadequate function, loss of sterility, or signs of infection

d. Upon request of patient, NP, PA or physician

3. Education

   Provide patient and provider education related to catheter purpose, signs of malfunction/complication, and the patient controlled analgesia function

4. Follow-up

   While on service, NP/PA will perform daily subjective/objective evaluation as described in section B) Data Base while catheter is in situ.

E. Record Keeping

1. Patient contacts are to be documented in the medical record in accordance with standard practice and institutional policy.
2. All information relevant to patient care will be recorded in the medical record

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of onsite training by a qualified anesthesia provider.
Proctoring a. A minimum of 2 observations by a qualified anesthesia attending of each of the following: clinical assessment of patient in relation to pain management, assessment of catheter site, setup of infusion pump, selection/administration of infusion medications, and removal of catheter
Reappointment a. The evaluator will be the Medical Director of the Anesthesia Acute Pain Service b. Management of 2 cases and 1 chart review every 2 years.

Protocol #7: Procedure: Trigger Point Injection

A. DEFINITION:
A trigger point is defined as a focal area of soft tissue hyperirritability that is painful on palpation and/or elicits a twitch response. Trigger point injection is the insertion of a needle into a

trigger point, with or without injection of solution (e.g. saline, steroids, and anesthetics) into the region of the trigger point.

1. Indications:
    - Pain attributed to a trigger point or a taut area of skeletal muscle
2. Precautions/contradictions:
    - Allergy to injectable medication
    - Close proximity to vital organs (e.g. potential risk of pneumothorax)

B. DATA BASE

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

2. Objective Data
    a. Physical exam appropriate to the procedure to be performed.

    b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
    c. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes such as myofascial pain with trigger points.

D. PLAN

1. Therapeutic Treatment Plan
    a. Explain the procedure to the patient.
    b. Patient consent obtained per hospital policy before procedure is performed.
    c. Time Out performed per hospital policy.
    d. The procedure is performed following standard medical technique according to the departmental guidelines.

    e. Diagnostic tests for purposes of disease identification.
    f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    g. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Allergic reaction
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP/PA, or physician
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Patient will be informed that pain relief may occur immediately if anesthetics or steroids are injected. Baseline pain may recur upon clearance ("wearing out") of the medications from the area of injection. Patient will be instructed in signs and symptoms of infection or allergy and procedures to follow if they occur.

4. Follow-up
   Patients will be seen in follow up within 4-6 weeks if clinically indicated.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be documented in electronic medical record.

F. Summary of Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Training by 3 direct observations of a qualified anesthesia attending performing trigger point injections will occur. Standardized Training will include NP/PA being able to demonstrate knowledge of the following for all noted injection sites: 1. Indications for procedure and treatment 2. Risks and benefits of procedure and medication 3. Related anatomy and physiology 4. Consent process 5. Wound infection and wound healing mechanisms 6. Use of required equipment 7. Steps in performing procedures 8. Ability to interpret results and formulate follow-up plans 9. Documentation and CPT and ICD-10 coding 10. Ability to recognize complication
Proctoring:

a. New practitioners to procedure will have a minimum of 2 successful observed demonstrations of the procedure b. Experienced practitioners to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstrations of the procedure. c. Chart review of all observed cases.
Reappointment Competency a. Performance of at least 2 injections every 2 years. b. 1 chart review every 2 years.

Protocol #8: Botox injections

A. DEFINITION

Administration of Botox (Onabotulinum toxin A) for the treatment of chronic migraine.

1. Location to be performed: ~~Neurology Service~~Anesthesia Pain Clinic

2. Performance of Botox Administration
   a. Indications
      1. Prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer)
   b. Precautions
      1. Potency units of Botox are not interchangeable with other preparations of botulinum toxin products.
      2. Spread of toxin effects: swallowing and breathing difficulties can lead to death. Seek immediate medical attention if respiratory, speech, or swallowing difficulties occur.
      3. Concomitant neuromuscular disorders, including peripheral motor neuropathic diseases, amyotrophic lateral sclerosis, or neuromuscular junction disorders (e.g., myasthenia gravis or Lamber-Eaton syndrome) may exacerbate clinical effects of treatment. Patients with known or unrecognized neuromuscular or neuromuscular junction disorders should be monitored when given Botox. They may be at increased risk of clinically significant effects including generalized muscle weakness, diplopia, ptosis,

dysphonia, dysarthria, severe dysphagia, and respiratory compromise.

4. Use with cautions in patients with compromised respiratory function.

5. Bronchitis and upper respiratory infections may occur in patients treated for spasticity.

6. Patients receiving concomitant treatment of Botox and aminoglycosides or other agents interfering with neuromuscular transmission (e.g., curare-like agents), or muscle relaxants, should be observed closely because the effect of Botox may be potentiated.

c. Contraindications
1. Allergy or hypersensitivity to Botox or any other botulinum toxin preparation or to any components in the preparation.

2. Infection at proposed injection site.

3. Patient refusal

B. DATA BASE

1. Subjective Data
a. History and review of symptoms relevant to the presenting complaint or procedure to be performed including but not limited to presence of headache and motor/sensory deficits.
b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aminoglycosides and other agents interfering with neuromuscular transmission, anticholinergic drugs, other botulinum neurotoxin products, and muscle relaxants, and allergies.

2. Objective Data
a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination and integrity of the skin at the proposed injection site.
b. The procedure is performed following standard medical technique according to the PREEMPT trial and Manual of Botulinum Toxin Therapy, Second Edition.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes. Differential diagnoses would include but not limited to tension type headache or other primary headache disorders, intracerebral hemorrhage, aneurysmal subarachnoid hemorrhage, meningitis, space occupying lesion, idiopathic intracranial hypertension, cerebral venous thrombosis, spontaneous internal carotid artery dissection, or giant cell arteritis.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent, consistent with hospital policy, obtained before procedure is performed.
   b. Timeout conducted consistent with hospital policy.
   c. Diagnostic tests might include blood work such as C-Reactive Protein (CRP) and Erythrocyte sedimentation rate (ESR); CT or MRI only if patient symptoms do not meet criteria for migraine.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. All patients requiring this procedure will receive Anesthesiology or Neurology Consultation with attending input confirming the need for the procedure.

Commented [DJ(1]: Neuro provides consultation for these patients as well.

3. Education
   a. Discharge instructions and patient education material will be provided.

4. Follow-up
   As appropriate for procedure performed.
   a. Assess for side effects including a sensation of tightness across the forehead, inability to frown, eyebrow asymmetry eyelid ptosis, shoulder weakness or pain. Side effects typically self-resolve within 1-3 months.
   b. Assess for allergic reaction.

E. COMPETENCY ASSESSMENT

1. Initial Competence

a. The Nurse Practitioner or Physician Assistant will be instructed on the procedure, efficacy and the indication of this therapy and demonstrate understanding of such.

b. The Nurse Practitioner or Physician Assistant will receive training and demonstrate competency in the following:
    i. Medical indications and contraindications of the procedure.
    ii. Benefits and potential side effects of the procedure.
    iii. Related anatomy and physiology.
    iv. Consent process (if applicable).
    v. Steps in performing the procedures.
    vi. Documentation of the procedure.

c. An Allergan certificate of completion of the Professional Education and Injection Paradigm Simulation Training for Botox will be required to certify that training is completed.

d. The Nurse Practitioner or Physician Assistant will observe the supervising physician/designee perform each procedure three times. The Nurse Practitioner or Physician Assistant will then perform the procedure three times under direct supervision.

e. The supervising physician will document the Nurse Practitioner or Physician Assistant's competency prior to allowing that individual to perform the procedure without supervision.

f. The Nurse Practitioner or Physician Assistant will ensure the completion of competency sign off documents.

2. Continued Proficiency
    a. The Nurse Practitioner or Physician Assistant will demonstrate competency by successful completion of the initial competency.

    b. Each candidate will be initially proctored and signed off by the supervising physician/designee. The Nurse Practitioner or Physician Assistant must perform this procedure at least three times every two years. In cases where this minimum is not met, the supervising physician or designee must again sign off the procedure for the Nurse Practitioner or Physician

Assistant. The Nurse Practitioner or Physician Assistant will be signed off after demonstrating 100% accuracy in completing the procedure.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency Documentation

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

Protocol #9: Consent & Ordering Blood Products for Transfusion

A. DEFINITION

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

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

2. Performance of procedure:

a. Indications

1. Anemia
2. Thrombocytopenia or platelet dysfunction
3. Coagulation factor or other plasma protein deficiencies not appropriately correctable by other means.

b. Precautions

1. Blood and blood components must be given according to ZSFG guidelines.
2. Emergency exchange transfusion orders are not covered by this standardized procedure – these must be countersigned by the responsible physician.
3. If (relative) contraindications to transfusion exist (see below) the decision whether to transfuse or not must be discussed with the responsible physician.

c. Contraindications

1. Absolute: none
2. Relative: Immune cytopenias, such as autoimmune hemolytic anemia, idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenia purpura (TTP), heparin-induced thrombocytopenia (HIT). In these conditions transfusions should be withheld, unless necessitated by serious bleeding, deteriorating medical condition attributable to anemia, or high risk of either condition occurring.
3. Patient Declination for blood products for transfusion after informed consent discussion.

B. DATA BASE

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

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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.

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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.

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ZSFG 2020 Anesthesia Service NP/PA Standardized Procedures
Medical Director or Division Chief Approval or Service Chief Approval
Marc Steurer, MD
Author Name: Arthur Wood, MD Anesthesia Service Standardized Procedures
CIDP Approval Date: 5/06/2020
Credentials Approval Date: 6/01/2020
MEC Approval Date: 6/08/2020
Gov. Body Approval Date: 6/23/2020

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MS.08.01.03: Summary of Changes

Current	Revision	Explanation for Revision
All references to credentialing and primary source verifications performed within 180 days	All references to credentialing and primary source verifications performed within 120 days	NCQA shortened the primary source verification window from 180 to 120 days (effective July 1, 2025) to ensure provider credentials are up-to-date at the time of credentialing
N/A	V. Procedure (page 3) In accordance with ZSFG Medical Staff Bylaws, the Credentials Committee includes an interdisciplinary group representation of peer-review-qualified practitioners and designated physicians who hold direct responsibility, expertise, and active involvement in credentialing decisions. The committee uses a peer-review process to thoroughly evaluate credentialing information and make informed recommendations. The Medical Staff Services Department supports the credentialing process by providing comprehensive information for both initial credentialing and recredentialing reviews. Credentialing criteria are formally reviewed and approved by the Credentials Committee, its Chair, or designated members. Cases that do not meet the established eligibility criteria are escalated to the Credentials Committee for decision-making.	NCQA requires that policies (1) define the criteria used to make credentialing decisions and (2) state that these criteria are reviewed and approved by the Credentialing Committee, Medical Director, or another designated peer review body.
N/A	H. Non-Discriminatory Credentialing and Recredentialing v. The San Francisco Department of Public Health (SFDPH), including the San Francisco Health Network (SFHN) and ZSFG, credentialing applications may	Health Plan requirement, in response to NCQA Health Plan Accreditation standard **CR 3, Element C, factor 6** requires non-discrimination statement be included on both the application and policy. Questions on race,

	request demographic information such as race, ethnic or national identity, gender, age, sexual orientation, language, and other related details. Providing this information is entirely optional and not required for credentialing. Any demographic data voluntarily disclosed by an applicant will not be used in any discriminatory manner and will have no impact on the review, evaluation, or approval of credentialing applications. This information is collected solely for purposes such as compliance with reporting requirements, promoting diversity, and improving health equity initiatives.	ethnicity, and language capabilities are optional and will not be used in credentialing decisions.
N/A	H. Non-Discriminatory Credentialing and Recredentialing vi. The San Francisco Department of Public Health (SFDPH), including SFHN and ZSFG, is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or professional disciplinary action from another state when that action is based exclusively on the application of a law from that state that restricts or penalizes care that is lawful in California. (§1375.61, SB-487)	Health Plan requires that a written policy that delegates do not automatically deny or terminate a provider solely because of an out-of-state judgment/conviction/discipline when the reason for that out-of-state action is only tied to another state's law restricting care that is legal in California.
J. System Control Measures	J. Credentialing Information Integrity Appendix G: SFHN Credentialing Information Integrity Policy and Procedure.	System Control Measures have been updated to NCQA's 2025 Credentialing Information Integrity standard (CR-2), requiring organizations to implement policies and procedures that define the scope of credentialing data, responsible staff, documentation and audit processes.
Appendix B – Verification Methods License to Practice in California Includes information on licensure sanctions and expirables.	Appendix B – Verification Methods License to Practice in California Includes information on licensure sanctions and expirables that are monitored monthly.	Health Plan requirement on the occurrence to which expirables are monitored.

ZSFG HOSPITAL & TRAUMA CENTER

Medical Staff Organization

Credentialing Manual

Office of Origin: Medical Staff Services, (628) 206-2342

I. PURPOSE:

Zuckerberg San Francisco General Hospital (ZSFG) and Clinics ensure that licensed health care providers meet the minimum credentials standards for Medical Staff or Affiliate Staff membership. This Credentialing Manual (with accompanying policies and procedures) and the Appendix, will be reviewed and approved each year by the ZSFG Credentials Committee and Medical Executive Committee.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- Joint Commission Medical Staff Standards
- NCQA Credentialing Standards
- CMS Conditions of Participation
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

III. DEFINITIONS:

Practitioner: Any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, unless otherwise expressly limited.

Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures or privileges: Advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, or CRNA – certified registered nurse anesthetist), PA – physician assistant, PharmD, Optometrists, Genetic Counselor, Acupuncturist and other categories as approved by the Governing Body.

Provider: For purposes of this document, provider means practitioners and affiliates.

Complete Application:

A complete application, at the point that verifications are finished, means the following:

- all information was verified and any missing information is explained or accounted for;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by ZSFG have been resolved.

IV. POLICY:

The Medical Staff Office conducts credentialing with confidentiality for all clinical venues within ZSFG and will only delegate credentialing to any outside entities if needed. Credentialing is performed prior to appointment and reappointment to the ZSFG Medical Staff.

A. Each provider has a confidential credentials file, which contains verification documents. For Medical Staff members, the credentials file includes quality information as described in Appendix A. These files are re-verified at least every two (2) years. Expirable documents are updated on an ongoing basis. All required verifications must be no more than 120 days old at the time of Governing Body review.

B. Credential files are treated as confidential and are kept within file cabinets with access by Medical Staff Office personnel only. These files are protected from discovery pursuant to Evidence Code Section 1156, et seq. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Section 1156, et seq.

1. The credentials file may be reviewed by contracting health plan representatives (pursuant to delegated credentialing agreements), except that information determined to be confidential.

   A provider has the right to review the items in their credentials file, except the following elements: National Practitioner Databank Reports and Letters of Reference. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the credentials file.

2. The quality information may be reviewed by contracting health plan representatives for the following elements: malpractice claims history, disciplinary actions by hospitals, managed care organizations or State Medical Boards and outcomes of those actions. Other quality items are subject to review pursuant to delegated quality agreements or the National Commission on Quality Assurance (NCQA) credentialing standards.

   A provider has the right to review the items in their quality file, except letters of reference or documents related to peer review activities. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the quality file.

C. Provider Rights to obtain Status of Application
Upon request, providers will be notified of the status of their application during the credentialing process.

D. Provider Rights to Amend Application
The provider attests that all information submitted for the credentialing process is accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the provider will be asked (via phone, letter or email) to resolve this discrepancy. The provider will be given opportunity to resolve the discrepancies, with response to the Credentials Committee Chair. Any attempts to intentionally hide or misrepresent information are addressed during the Credentials Committee review.

E. Notification of Provider Rights: Pursuant to the Medical Staff Bylaws, providers are notified of their rights to:

- review information submitted to support their credentialing application;
- correct erroneous information; and
- be informed of the status of their application upon request.

F. Erroneous Information: The applicant for appointment, reappointment, and/or clinical privileges will be notified by credentialing staff of any conflicting information found in the provider's application and/or any supporting documentation.
Notice will occur by telephone or written request within 10 days of discovery, and will be documented in the provider's credentials file.

- The provider will have 30 days to reconcile and return the application and/or

supporting documentation to the credentialing staff

- Acceptable format will be the corrected and signed credentialing application and, as applicable, a written and signed explanation for any discrepancies in the original application
- The Credentials Committee or Credentials Committee Chair will receive a report of any corrected information submitted by the provider.
- The documentation provided by the applicant and any other related documents will be placed in the provider's credentials file along with notation as to the date received.

G. Upon delegation of credentialing activities, audits may be performed by health plan representatives and other payers, based upon the following guidelines:

1. Audits must be scheduled in advance at a time mutually agreed upon by ZSFG and the auditing entity.
2. Selected documents regarding peer review may not be subject to auditing.
3. Auditors may not photocopy or remove documents.

If credentialing is not delegated, the health plan/payer is responsible for credentialing providers for their health plan.

V. PROCEDURE

In accordance with ZSFG Medical Staff Bylaws, the Credentials Committee includes an interdisciplinary group representation of peer-review-qualified practitioners and designated physicians who hold direct responsibility, expertise, and active involvement in credentialing decisions. The committee uses a peer-review process to thoroughly evaluate credentialing information and make informed recommendations**.**

The Medical Staff Services Department supports the credentialing process by providing comprehensive information for both initial credentialing and recredentialing reviews. Credentialing criteria are formally reviewed and approved by the Credentials Committee, its Chair, or designated members. Cases that do not meet the established eligibility criteria are escalated to the Credentials Committee for decision-making.

A. Initial Appointments

1. The following information is required to begin the Initial Appointment process:
    - Request from Department
    - Applicant Name
    - Curriculum Vitae/Resume including all professional work history
    - Faculty Appointment (if applicable)
    - Requested Privileges/Protocols (Standardized Procedures), (when applicable)
    - Requested Start Date for Temporary Privileges/Credentials only
    - ID attestation per Joint Commission guidelines

2. Providers must complete the following items:
    - Application for Medical Staff or Affiliate Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges, or for Affiliate, Standardized Procedures.
    - Agreement to abide by the Medical Staff Bylaws, Rules and Regulations
    - Health Plan Attestation form (as applicable)
    - Environmental Safety form

3. In addition to returning the above documents, providers also must submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not

limited to:

- Copy of California License(s) (an on-line query is acceptable)
- Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
- Evidence of Current Malpractice Coverage, if applicable
- Fluoroscopy Certificate as appropriate
- Current Photo
- CPR, BLS/ACLS, PALS, NALS, if applicable
- Current Curriculum Vitae (CV)

4. The Medical Staff Office reviews the documents as follows:
   a. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges. The applicant confirms the correctness and completeness of the application.
   c. Clinical venues are specified and appropriate.
   d. Complete addresses, phone and fax numbers as listed for:
      - Medical school, Internships, Residencies, Fellowships;
      - Hospitals and affiliations;
      - Peer references; and
      - Malpractice insurance company(ies)
   e. Privileging forms or Standardized Procedures are completed as appropriate.
   f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
   g. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

5. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

   Verification of provider enrollment screening in the Medicaid Fee-For-Service program. Completion of the Medi-Cal related acknowledgements for health plan specific trainings are required to begin within 10 working days of a new provider becoming active, and may be completed up to 120 days prior to the new being activated/approved.

6. File Triaging:
   Once all of the information is gathered, the applicant's file is triaged by the Medical Staff Office and flagged for potentially adverse information to be carefully evaluated during the Credentials Committee review.

7. Temporary Privileges for Initial Appointments:
   For Initial Appointments involving clinical urgency, a Service Chief may request temporary privileges up to 120 days. Request for Temporary Privileges/Credentials must be approved by the

CEO (or authorized designee) on the recommendation of the Chief of Staff (or authorized designee).

Actions on temporary privileges/credentials are updated in the Medical Staff Office database upon approval and appropriate areas are notified. The Medical Staff Office database updates the applicant's status and privileges/protocols are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

8. Applicants must complete the credentialing process with privileges or standardized procedures (as appropriate) prior to the provision of patient care to ZSFG patients.

B. Reappointments

1. Reappointment Application Packet
   At least five (5) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:
   - Preprinted Reappointment Application
   - Copy of current clinical privileges

2. The provider is required to return the application and supporting documents within thirty (30) days, and include the following:
   - Copy of current DEA Certificate as appropriate
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current CV

3. If the application is not returned within the designated time period, the provider and Department Chair will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment may be deemed to be a voluntary resignation from the Medical Staff, and the provider will be submitted as "resigned" to the Credentials Committee.

   Practitioners/Affiliates who automatically resign shall be required to complete a reinstatement form to reapply for membership. Reinstatement shall be processed in a manner parallel to the reappointment process. Reinstatement application forms shall be accepted within one (1) month from the date the practitioner membership expires.

   All Practitioners/Affiliates whose membership has expired more than one (1) month shall be required to complete the initial appointment process.

4. The Medical Staff Office reviews the documents as follows:
   a. All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant confirms the correctness and completeness of the application.
   c. Privileging forms and Standardized Procedures are completed as appropriate.
   d. Clinical venues are specified and appropriate.

e. Completed addresses, phone and fax numbers as listed for:
   - Hospitals and affiliations
   - Peer references; and
   - Malpractice insurance company(ies)

f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.

g. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy) are current.

5. Verification of Information

   Verification of information begins as soon as the application appears complete, and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed. Verification of provider enrollment screening in the Medicaid Fee-For-Service program

6. Reappointment Performance Improvement

   The results of performance monitoring, evaluation, and identified opportunities to improve care and service are documented in this file. Data Summary sheets are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership.

7. Pre-Credentials Committee Meeting

   A meeting shall be convened prior to the Credentials Committee meeting date which shall be attended by the Chair of the Credentials Committee and the credentialing staff to discuss files of concern and the agenda.

C. Evaluation And Approval Process

1. Clinical Services Evaluation Process

   If an issue is identified, the related documentation is flagged for the Service Chief to review. The complete file - including application, supportive documents, privileges request form, practitioner sanctions, complaints, and adverse events –is sent to the appropriate Service Chief for review and recommended to the Credentials Committee. For any flagged files, the Service Chief must document sufficient review to support their recommendation for appointment or reappointment.

   If the Service Chief is disinclined to make a favorable recommendation due to:
   - concerns indicating the potential for a provider's conduct to be detrimental to patient safety or care, or
   - concerns related to professional competence or behavior that could adversely affect patient welfare;

   the Service Chief drafts a report outlining these concerns for the Credentials Committee.

   After the Service Chief's recommendation is completed, the file is prepared for discussion at the next monthly Credentials Committee meeting, and the applicant is placed on the Credentials Committee Summary Report.

2. Credentials Committee Evaluation Process

The Credentials Committee reviews the Summary Report and all applicable credentialing criteria—such as practitioner sanctions, complaints, and adverse events identified through ongoing monitoring—before approving credentialing decisions and issuing its formal recommendation for appointment or reappointment. Files are evaluated in accordance with the File Triaging categories (see Appendix C).

Applications categorized as '*green'* do not require committee discussion and are approved on the consent agenda. Applications categorized as '*yellow'* or *'red*' are discussed in detail by the Credentials Committee.

Applications requiring additional information/clarification may be tabled until sufficient information is gathered to support a recommendation. Discussion is documented in the committee meeting minutes. The report with Credentials Committee recommendations is then sent to the Medical Executive Committee (MEC).

3. Medical Executive Committee and Governing Body Evaluation Process
   The Credentials Committee Summary Report is reviewed by the Medical Executive Committee, then the Joint Conference Committee, and then referred to the Health Commission as the Governing Body.

   Actions on credentialing and recredentialing are updated in the Medical Staff Office database within 10 days of Governing Body approval, and these updates are made available on designated intranet sites for inquiry by the applicant or authorized staff. Notification of the Governing Body's decision is forwarded to the applicant within 30 days.

4. Provider Enrollment
   Upon Governing Body approval, formal notification of the finalized Credentials Committee Summary Report is sent to the contracted Health Plans, to ensure timely notification of all credentialing and recredentialing decisions, including changes in provider status, approved privileges, or conditions placed on participation.

D. Visiting Privileges

1. In circumstances involving clinical necessity when clinical services require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, visiting privileges may be granted on a case-by-case basis.

2. The following information is required to begin the Visiting Privileges process:
   - Completed Application
   - Curriculum Vitae/Resume including all professional work history
   - Faculty Appointment (if applicable)
   - Service Chief Recommendation
   - Requested Privileges
   - Requested Start Date

3. Providers must complete the following items:
   - Visiting Application including Confidentiality Statement and Consent to Release Information and Privileges.
   - Review the Medical Staff Bylaws, Rules and Regulations

4. In addition to returning the above documents, providers must also submit any relevant

licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:

- Copy of California License(s) (an on-line query is acceptable)
- Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
- Evidence of Current Malpractice Coverage
- Fluoroscopy Certificate as appropriate
- CPR, BLS/ACLS, PALS, NALS, if applicable
- Current Curriculum Vitae (CV)

5. The Medical Staff Office reviews the documents as follows:
   - All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   - Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges.
   - Clinical urgency and venues are specified and appropriate.
   - Complete addresses, phone and fax numbers as listed for:
     - Hospitals and affiliations;
     - Peer references; and
     - Malpractice insurance company(ies)
   - Privileging forms are completed as appropriate.
   - California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

6. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

7. The Chief of Staff and the Executive Administrator (or authorized designees) may grant Visiting privileges for a specified period of time after the above information has been evaluated by the applicable service chief and he/she has made an affirmative recommendation.

E. Expirables/Ongoing Monitoring

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods.

F. Resignations

The effective date of the resignation will be the last day of the month in which the provider states that he/she is resigning, or a date indicated by the Chief of Service, and can occur before the Governing Body date. Notice of resignation to the Medical Staff Office may be submitted by the resigning provider or by the Department Chief, or Chief's designee, provided that the resigning provider is copied on the notice.

H. Non-Discriminatory Credentialing and Recredentialing.

The Medical Staff Office monitors and prevents discriminatory credentialing through the following process:

i. Tracking and trending of reasons for denial and / or termination.

ii. Semi-annual audits of files in process for more than 120 days.

iii. All Credentialing Committee members, staff, and guests are required to sign the Statement of Confidentiality annually, which includes a non-discrimination statement. Committee members must also sign a standing non-discrimination agreement that remains in effect for the duration of their service. By signing, members attest that all credentialing decisions—whether related to approval, denial, or termination—are based solely on objective applicant qualifications and established network participation criteria, and never on factors such as age, gender, sexual orientation, race, ethnic or national identity, specialization, or the type of services provided.

iv. Credentials Committee agenda must include a non-discrimination statement. All documents and information presented for committee review must exclude any references to a practitioner's race, ethnic or national identity, gender, age, sexual orientation, or to specific procedures or types of patients the practitioner serves. This ensures that credential decisions remain unbiased, equitable, and compliant with the organization's non-discrimination standards.

v. The San Francisco Department of Public Health (SFDPH), including the San Francisco Health Network (SFHN) and ZSFG, credentialing applications may request demographic information such as race, ethnic or national identity, gender, age, sexual orientation, language, and other related details. Providing this information is entirely optional and not required for credentialing. Any demographic data voluntarily disclosed by an applicant will not be used in any discriminatory manner and will have no impact on the review, evaluation, or approval of credentialing applications. This information is collected solely for purposes such as compliance with reporting requirements, promoting diversity, and improving health equity initiatives.

vi. The San Francisco Department of Public Health (SFDPH), including SFHN and ZSFG, is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or professional disciplinary action from another state when that action is based exclusively on the application of a law from that state that restricts or penalizes care that is lawful in California. *(§1375.61, SB-487)*

I. Primary Source Verification (within 120 days prior to decision) - *ongoing monthly monitoring* ***(****see Appendix B - Verification Methods)*

- National Practitioner Data Bank (NPDB)
- State Medical Board licensure
- Medi-Cal and Medicaid Suspended and Ineligible List
- Medicare and Medicaid exclusions/sanctions
- Office of Inspector General (OIG) Exclusion List
- SAM.gov debarment checks
- Board Certification
- Work History
- Malpractice insurance coverage and professional liability claim history
- Attestation questions answered in the application

J. Credentialing Information Integrity - *(see Appendix G: SFHN Credentialing Information Integrity Policy and Procedure)* The purpose of this section is to ensure compliance with *CR 8, Element A,* National Committee for Quality Assurance (NCQA) standards.

A. CREDENTIALS FILE

(available for provider review)

The following documents are kept current and maintained in the Credentials file (as applicable):

1. Application for membership.
2. Delineation of privileges, recommended by the Service Chief in the service which privileges are being requested.
3. Current California State Medical (or other professional) License
4. Valid DEA certification, as applicable
5. Current X-ray Supervisor and Operator Certificate, as applicable
6. Verification of graduation from medical (or other professional) school and completion of residencies and fellowships
7. Verification of previous affiliations prior to SFGH Medical Staff appointment
8. Curriculum Vitae that includes a comprehensive work history
9. Evidence of current, adequate malpractice insurance
10. Professional liability claims history
11. Verification of Board Status Certification or Candidacy, as applicable
12. National Practitioner Data Bank Query Report (which includes Medicare and Medicaid Sanctions activity)
13. California Medical Board Status check for validation of license and sanction activity
14. Continuing Medical Education Compliance
15. Consent to release relevant information
16. Copies of the Governing Body Approval letters confirming Medical Staff appointment and/or approved privileges
17. For Affiliate Staff only: CPR (BLS/ACLS) certification

B. QUALITY FILE

(not available for provider review)

The quality files contain the following historical and current documents (as applicable):

1. Any action taken as a result of a malpractice claim within the previous three (3) years.
2. Reports of disciplinary actions and the outcome of those actions.
3. Results of internal and health plan quality management review such as Peer Review, Surgical Case and Hospital Mortality Review, Transfusion Committee reviews, patient complaints, clinical activity reports, and other quality indicators.
4. State Medical Board reports on any state sanction activity (e.g. 805 reports).
5. Any supplemental information or documentation regarding quality of care including, but not limited to, letters of reference or service.
6. Letters of Reference that attests to clinical competence and ethical character of the applicant.

APPENDIX B – Verification Methods

			CREDENTIALING EVENT				
	CREDENTIALING ITEM	METHOD OF VERIFICATION	INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINT-MENT	UPDATE AS EXPIRES	VISITING / TEMP. PRIVILEGE
1	**License to Practice in California** Includes information on licensure sanctions and expirables that are monitored monthly.	Website as available for the type of provider. If website that is considered primary source verification is not available, credentialer confirms in writing. Whenever a Member's license or other legal credential authorizing practice in this state is revoked, limited, suspended, or expires, the Member's Medical Staff membership and Privileges shall be automatically suspended as of the date such action or expiration becomes effective.	X	X	X	X	X
2	**DEA Registration** Provider attests if DEA is not applicable to scope of practice.	Obtain online verification. If website that is considered primary source verification is not available, credentialer confirms in writing.	X	X	X	X	X
3	**Fluoroscopy Certificate** Provider attests if certificate is not applicable to scope of practice.	Obtain online verification. If website that is considered primary source verification is not available, credentialer confirms in writing.	X	X	X	X	X
4	**Medical School (Domestic Graduates) or Other Professional Schools (non- physician applicants)**	May be obtained (in writing or orally) from the institution(s) where medical school/other professional school completed or the AMA or AOA profile service, as applicable.	X				
5	**ECFMG (Foreign Graduates)** For physicians who enter USA- based internship/ residency programs.	www.ecfmg.org or in writing from ECFMG	X				
6	**Internship /other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X				
7	**Residency/other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or the AMA or AOA profile service, as applicable.	X		X *If any new training during the previous appointment period*		
8	**Fellowship/ other professional training**	May be obtained (in writing or orally) from the institution(s) where training completed or	X		X *If any new*		

APPENDIX B – Verification Methods

			CREDENTIALING EVENT				
	CREDENTIALING ITEM	**METHOD OF VERIFICATION**	**INITIAL APPOINTMENT**	**NEW PRIVILEGES**	**REAPPOINT-MENT**	**UPDATE AS EXPIRES**	**VISITING / TEMP. PRIVILEGE**
		the AMA or AOA profile service, as applicable.			*training during the previous appointment period*		
9	**Board Certification or other professional certification or registration**	CertiFACTS, ABMS compendium, query of the ABMS database, AMA or AOA profile or confirmation (orally or in writing) directly from the certifying organization.	**X**	**X**	**X**	**X**	**X**
10	**Healthcare Organization Affiliations**	Confirm in writing or by telephone with affiliation. Confirm dates of affiliation, scope of privileges, restrictions and any disciplinary actions taken during the affiliation. If verification of an affiliation is not obtained after two requests (including a phone call to the facility), this will be noted in the file and the file may then move through the evaluation process without verification of the affiliation.	**X** *Verify all affiliations within the last five years after Medical/ Professional School*	**X** *Verify as necessary to obtain information related to competency*	**X** *Verify current affiliation(s)*		**X** *Verify current affiliation(s)*
11	**Work History (Looking for gaps in training and work history)**	Applicant provides information on application form or curriculum vitae. Additional investigation occurs for 3 months month gaps in work history. Gaps will be documented in the file.	**X** *Verify all affiliations within the last five years after Medical/ Professional School*				**X** *Temps: the last five years Visiting: current affiliation*
12	**Professional Liability Insurance**	Obtain information related to coverage and amounts of coverage directly with carrier. Minimum insurance: $2/million per claim and $6/million annual aggregate coverage.	**X**		**X**		**X**
13	**Professional Liability Claims History:**	Applicant provides information about current and past claims, settlements and judgments; AND write to current carrier; AND request NPDB report.	**X**	**X**	**X**		**X**
14	**Continuing Medical Education**	License attestation	**X**		**X**		
15	**National Practitioner Data**	Enrolled in Continuous Query. Notified of new disclosures as	**X**	**X**	**X**		**X**

APPENDIX B – Verification Methods

			CREDENTIALING EVENT				
	CREDENTIALING ITEM	METHOD OF VERIFICATION	INITIAL APPOINTMENT	NEW PRIVILEGES	REAPPOINT-MENT	UPDATE AS EXPIRES	VISITING / TEMP. PRIVILEGE
	Bank (NPDB)	reported, along with monthly report.					
16	**Medicare Sanctions**	OIG Sanction Report	**X**	**X**	**X**	**Monthly**	**X**
17	**Peer/Professional References/ Recommendations** Peer means an individual in the same professional discipline (same type of license) or MD for Affiliated Staff as appropriate.	Peer references must be from individuals who have recently worked with the applicant, have directly observed his or her professional performance over a reasonable period of time, and who can and will provide reliable information regarding current clinical ability, ethical character, health status and ability to work with others. If the applicant has recently completed professional training (resident, fellowship, etc.), a reference from the program director must be requested and references from supervising Attending physicians, rather than co-residents, must be obtained.	**X** *Obtain 3 Peer References, with at least one from each professional position held in the last two years*	**X** *As necessary to obtain confirmation of clinical competency*	**X** *Obtain 2 Peer References; If Courtesy appt. with no data summary sheet, one reference must be from a Supervisor at external primary hospital*		**X** *One peer reference*
18	**Social Security Death Master File verification** Verification of the SSDMF from NTIS via MD- Staff is required for all initial applicants and then to be verified on an ongoing monthly basis for all actively credentialed providers	Verification of the SSDMF is conducted through the MD-Staff credentialing database and	**X**			**Monthly**	**X**
19	**SAM (GSA/EPLS)**	System for Award Management	**X**		**X**	**Monthly**	**X**
20	**CA DHCS (S&I)**	California Department of HealthCare Services; Sanctions and Ineligible List	**X**		**X**	**Monthly**	**X**

APPENDIX C – File Triaging Categories

TRIAGING CATEGORY	INITIAL APPOINTMENT	REAPPOINTMENT
Green	No issues have been identified with the provider's application, and the file meets the following criteria: • Satisfactory References • No record of malpractice payment or current pending claims • No disciplinary actions • No licensure restrictions • No unexplained time gaps in work history • Current licensure • No problems verifying information • No indication of investigations or potential problems Information is returned in a timely manner and contains nothing that suggests the practitioner is anything but highly qualified	No issues have been identified with the provider's reappointment, and the file meets the following criteria: • Satisfactory References • No record of malpractice payments since the last appointment or current pending claims • No disciplinary actions • No licensure restrictions • Current licenses • No problems verifying information • No indications of investigations or potential problems • Information is returned in a timely manner and contains nothing that suggests the practitioner is anything by highly qualified • Applicant is not requesting new privileges • Applicant is not requesting a status change • Applicant meets all criteria for privileges requested • Activity levels are appropriate • CME relates to privilege requests • QA data includes no Peer Review or Quality of Care issues • No health problems identified
Yellow	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • Malpractice claims • Criteria for Privileges requested is not met. • International Medical Graduate	The provider's file may include questionable information, such as: • Peer references and prior affiliations indicate potential problems. • Malpractice claims in past 3 years • Health problem identified which will likely have impact on exercise of clinical privileges or standardized procedures. • Lack of clinical activity or difficulty in obtaining monitoring reports
Red	The provider's file shows potentially adverse information, including: • Unsatisfactory peer references or prior affiliations • Disciplinary actions or reports filed by any verification	The provider's file shows potentially adverse information, including: • Disciplinary actions or reports filed by any verification organization (NPDB, Federations, MBC, Medicare Sanctions, AMA)

	organization (NPDB, Federations, MBC, Medicare Sanctions, AMA) • Clinical privileges revoked, diminished or altered by another Healthcare organization • Any existing information shows a quality of care or competency issue	• Clinical privileges revoked, diminished or altered by another Healthcare organization • New privileges requested outside of normal scope of specialty • Any existing information shows a quality of care or competency issue

APPENDIX D – Sources of Performance Improvement Data

When available, information from these sources is integrated into the credentialing process:

1. **Patient Complaints and Grievances:** The Office of Patient Experience (OPEX) monitors all grievances and provides bi-annual reports to the Governing Body, by way of Performance Improvement & Patient Safety (PIPS) Committee and Medical Executive Committee (MEC). Bi-annual monitoring reports are sent to Medical Staff Services and added to the agenda for discussion at the next Credentials Committee meeting. Significant issues are forwarded to Quality Improvement and/or Risk Management for further analysis with communication to the Service Chief. If the Service Chief determines immediate action is required, the Chief of the Medical Staff is notified and initiates appropriate resolution.

2. **Adverse Events**: Risk Management monitors all adverse events and provides bi-annual reports to the Governing Body, by way of Performance Improvement & Patient Safety (PIPS) Committee and Medical Executive Committee (MEC). The monthly monitoring reports are sent to Medical Staff Services and added to the agenda for discussion at the next Credentials Committee meeting. Significant issues are communicated to the Service Chief. If the Service Chief determines immediate action is required, the Chief of the Medical Staff is notified and initiates appropriate resolution.

3. **Clinical Activity Reports:** For monthly reappointment cycles, physician volume statistics and comparative data are gathered by the Medical Staff Office. Providers with no clinical activity may provide supporting information for consideration by the Service Chief to ensure appropriate recommendation of membership/privileges.

4. **Quality Measures:** Physician specific quality data identified for Credentials Committee review as appropriate.

5. **Peer Review:** Individualized profiling information is assessed by the Service Chief.

6. **Medical Record Delinquencies**: The Service Chief reviews and notates as appropriate.

7. **Risk Management/Malpractice Claims:** Risk Management entities report UC Regents and San Francisco City and County claims history. Providers are obligated to disclose past and pending liability actions and provide further details regarding these actions, including specific discussion with the Service/Division Chief. Claims histories also are requested from external professional liability insurance companies, as applicable. Providers with one or more claims are flagged for review by the Service Chief and the Credentials Committee.

8. **Suspensions/Sanctions**: Physicians may be suspended for non-compliance with policies as outlined in the Medical Staff Bylaws, and for infractions, such as a license revocation or other action by the Medical Board or Governing Body (please see the Medical Staff Bylaws for further information). These suspensions are monitored by the Medical Staff Office and identified for Service Chief and Credentials Committee review.

9. **Reporting of Adverse Action to Authorities and Contracted Health Plans**: Adverse action that has been taken against a practitioner which falls under the reporting guidelines for state and federal agencies will be reported as appropriate to the National Practitioner Data Bank, the California Medical or Nursing Board, to the SFDPH Office of Managed Care and to contracted Health Plans. (refer to the ZSFG Medical Staff Bylaws for activities or professional conduct that constitutes a request for investigation).

10. **Service Quality Indicators:** Each clinical service establishes and monitors quality indicators. The Service Chief considers applicable indicators when recommending appropriate membership/privileges and indicates any issues for Credentials Committee consideration.

11. **Provider Directories**: All information required to be published in the practitioner directories of managed healthcare plans per the contractual agreement will be consistent with the information required for the credentialing process.

I. PURPOSE

Ongoing Professional Practice Evaluation (OPPE) is designed to support quality patient care activities and can identify outliers related to clinical performance at Zuckerberg San Francisco General Hospital (ZSFG). OPPE is intended to ensure consistency and to foster a more efficient evidence-based privilege renewal process. The OPPE process focuses on the collection of practitioner-specific, professional practice data related to clinical activities of Medical Staff and Affiliated Medical Staff practitioners at ZSFG. OPPE improves the delivery of quality patient care and is conducted regularly, in accordance with The Joint Commission Medical Staff Standard MS.08.01.03. ZSFG Chiefs (or their designees) are expected to review the data metrics and sign-off the data. When necessary, intervention by the organized medical staff may be required, including but not limited to development and implementation of a Focused Professional Practice Evaluation (FPPE) to address practice that is considered marginal or unacceptable.

II. PROCEDURE

The ZSFG Medical Staff Services Department is required to coordinate the collection, validation, and assessment of practitioner-specific, professional practice data that is relevant to the clinical practices approved by the ZSFG organized medical staff. Continuous monitoring of practitioner's clinical competence metrics will support the ZSFG organized medical staff in the provision of high-quality, safe patient care that is compassionate, appropriate, and effective.

Each practitioner's professional practice metrics will be reviewed by each service Chief or their designee(s) in keeping with the goal of providing high-quality and safe patient care and in accordance with The Joint Commission Standard MS.08.01.03. The practitioner's professional practice evaluation will be documented in the Professional Performance (OPPE) by the Medical Staff Services Department and the timeframe for review of the data cannot exceed 12 months. Management of OPPE is the responsibility of the Medical Staff Services Department. Practitioner's Ongoing professional practice data (OPPE) is privileged, facility specific information protected by California Evidence Codes 1156 and 1157.

Categories of metrics may include the following groups, in accordance with the Accreditation Council for Graduate Medical Education (ACGME) core competencies: Patient Care, Medical/Clinical Knowledge, Practice- Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism and Systems- Based Practice. Examples of individual metrics may specifically include data from:

- Administrative Activity
- Case Characteristics and Volume
- Core Competencies
- Inpatient Utilization
- Outpatient Utilization
- Patient Safety and Quality
- Patient Satisfaction
- Patient Relations
- Risk Management

A. DEFINITIONS

Chief of Service – Physician with the ultimate responsibility to review and sign-off on the professional practice information of each practitioner in his/her department. If needed, the Chief of Service may designate a faculty member to review and sign-off on records.

Credentials Committee – The ZSFG Medical Staff Committee is responsible for recommending appointments and reappointments to the Medical Staff, delineation of staff privileges, and application of corrective actions where indicated.

Designee – Physician leader identified by the Service Chief to review a set of practitioners.

OPPE – the Ongoing Professional Performance Evaluation system is designed to aggregate practitioner-specific data from a variety of sources and display this information on a secure password protected website. All the information is stored on the city's secure network under ZSFG IT Security Policy.

Practitioner – Member of the ZSFG Medical Staff or Affiliate Medical Staff

B. CONFIDENTIALITY

Professional practice evaluation information is privileged and confidential in accordance with ZSFG Medical Staff Bylaws and California state evidence codes (including 1157) pertaining to confidentiality and non- discoverability.

All staff, committee members, and other practitioners involved in review and evaluation of performance will hold information in strict confidence, make no voluntary disclosures of such information, and agree to complete a confidentiality acknowledgement related to their handling of Professional Practice Evaluation information under this procedure.

A confidentiality acknowledgment will be completed at initial participation and at least every two years thereafter.

Security practices must be maintained to protect the integrity and confidentiality of OPPE at ZSFG. As OPPE reports are facility-specific, the information contained within are considered proprietary and thus only intended to be viewed by those directly involved in the OPPE process at ZSFG.

OPPE data may be directly shared with other facilities outside of ZSFG (1) Upon special request to the current Chief of Staff, or (2) as requested by another facility under a current, executed Memorandum of Understanding or Peer Review Sharing Agreement.

C. CONFLICTS OF INTEREST

A medical staff member asked to perform professional practice evaluation may have a conflict of interest if they might not be able to render an unbiased evaluation due to:

- Involvement in the patient's care
- Relationship to patient or patient family
- Relationship with the involved practitioners as a partner or direct

competitor It is the responsibility of the reviewer to disclose potential conflicts.

It is the responsibility of the Credentials Committee to determine whether a conflict would prevent the individual from participating and the extent of that participation if allowed.

Individuals determined to have a conflict may be present during group discussion (if approved by Credentials Committee) but are required to recuse themselves prior to final deliberation and vote.

III. PROCEDURE

The OPPE will be updated with the latest available data every 12 months focusing on collection of metrics between July 1 and June 30 each year. Departmental OPPE data is coordinated between each clinical service and the ZSFG Medical Staff Services Team as detailed within the timeline table in the section below. Internal (ZSFG defined) benchmark data will be provided by the clinical services for specified metrics with each clinical service. Each clinical service will be responsible to review and validate the OPPE data for providers within their service.

Submission of OPPE data related to the clinical practice of each service Chief shall be reviewed/validated by someone other than the service Chief such as a senior faculty member in the department with the same clinical privileges.

A. TIMING & RECURRING SCHEDULE

The calendar below outlines the timeframes that the various parts of OPPE are carried out each cycle:

MONTH	DESCRIPTION	RESPONSIBLE PARTIES
July	1. On July 1st, run retrospective master roster of credentialed providers from the credentialing database which lists provider holding an appointment/privileges through the ZSFG Medical Staff during the previous July 1 thru June 30 OPPE cycle. 2. Run the Board Certification Issues Report & the Suspensions Report from MD-STAFF for the previous July 1 thru June 30 OPPE cycle. 3. Obtain copy of the Hydra ZSFG Compliance Report from Dean's Office 4. Sort/edit the roster to create department-specific list of providers. 5. Sort/edit the roster again to identify providers with privileges in the department but whose home department is elsewhere. These are referred to as the "add-on" providers for the department for purposes of OPPE. They are listed at the end of each department's OPPE spreadsheet. 6. Reconcile the provider count against the original master roster to assure quality with no names overlooked throughout the data sorting process. 7. Copy the finalized department-specific OPPE spreadsheets as templates from the previous OPPE cycle. This involves deleting the provider names/metric data/comments, add/delete/revise metrics as directed by notes from Chiefs/approved by Chair, Credentials Committee to create the OPPE spreadsheets for the current OPPE cycle. 8. Copy/paste the provider names, including the "add-on" providers, from the department sections of the final edited master roster to the department-specific spreadsheet templates. (**Note:** *Totaled 47 spreadsheets for 30 OPPE departments last OPPE cycle.)* 9. Update/revise the instructions for completing the OPPE spreadsheet. 10. Update the Chief/Credentials Committee annual OPPE email language directed to Chiefs & designees. Save a copy to Outlook drafts folder. 11. Obtain note closure report data from IT/OPPE workgroup. Add board certification, license, & note closure data to the OPPE spreadsheet templates	OPPE Coordinator/ MSSO Chief, Creds Committee with OPPE IT workgroup UCSF Deans Office

August	1. Complete any remaining steps from July list. 2. Aim towards a mid-August target for issuing OPPE lists to Chiefs & designees. 3. Use the department-specific annual OPPE email language indicating the due-date deadline within 60 days. Attach a copy of the department-specific OPPE spreadsheets along with a copy of the instructions for completion. 4. Repeat step #3 for each department or clinical service specialty. 5. Create a Tracking Log of Spreadsheets Returned by Due Date & Finalized which lists the departments or clinical service specialties who have received the OPPE email outreach requests. Use this log to track the response and versions returned.	OPPE Coordinator/ MSSO
September	1. Complete outreach to any remaining departments regarding remaining steps from August. 2. Send out reminders as 6 weeks, 4 weeks, and 2 weeks to services that have not responded. 3. Review/return spreadsheets back to Chiefs/designees with replies/requests for clarification/comments /finalization with cc to Chair/Creds Committee & Manager/MSSO Update Tracking Log of M&U OPPE Evals as indicated by reviews	OPPE Coordinator /MSSO Chair/Creds Committee Manager/ MSSO
October - November	1. Update & issue the Tracking Log of Spreadsheets Returned by Due Date & Finalized biweekly to Chair/Credentials Committee for his updates to Creds Committee, MEC, etc. 2. Continue spreadsheet reviews/replies/requests for clarification/comments/ working towards finalization for all clinical services remaining. Continue updating Tracking Log of M&U OPPE Evals as indicated by reviews.	OPPE Coordinator /MSSO Chair/Creds Committee
December	1. Finalize any remailing reviews of departments or clinical service specialties OPPEs spreadsheets. 2. Finalize the Tracking Log of M&U OPPE Evals Finalize the Tracking Log of Spreadsheets Returned by Due Date & Finalized	OPPE Coordinator / MSSO
January	1. When all spreadsheet reviews are finalized, meet with Credentials Committee Chair to review all marginal & unacceptable OPPE ratings identified. 2. Ensure that each marginal & unacceptable has commentary and has been appropriately addressed.	OPPE Coordinator /MSSO
May - June	Prepare Prep file folders and structure on T Drive for the next cycle of OPPE	OPPE Coordinator/ MSSO

B. Marginal and Unacceptable OPPE Evals:

1. During the review of the annual department OPPE spreadsheets, the Medical Staff Services Coordinator updates the Tracking Log of Marginal & Unacceptable OPPE Evals by department/provider and advises the respective Service Chief regarding providers whose OPPE evals may trigger a Focused Professional Practice Evaluation (FPPE) based on the following frequency thresholds:
   a. Two (2) consecutive Unacceptable (U) evals for the same OPPE metric, OR
   b. Three (3) consecutive Marginal (M) evals for the same OPPE metric, OR
   c. One (1) Unacceptable and two (2) Marginal evals consecutively for the same OPPE metric
2. Marginal and Unacceptable OPPE ratings require the Chief to enter a comment in the COMMENTS column of the department's OPPE spreadsheet for providers whose data for any OPPE metric falls within the Marginal or Unacceptable threshold range for the metric. The Service Chief will consult with the Chair/Credentials Committee regarding the need for a for-

cause FPPE plan.

3. The Chief or designee will discuss any Marginal or Unacceptable OPPE evals with the provider. The Medical Staff Services Coordinator will confirm and document through use of a DocuSign form signed by both the service chief and subject provider.
4. Following completion of the annual OPPE spreadsheet reviews and finalization, the OPPE Coordinator and the Chair of the Credentials Committee meet to review the Tracking Log of M&U OPPE Evals to ensure that all have been reported to/addressed by the Chief.

C. RESPONSIBILITIES

1. Service Chief's Responsibilities:
   a. Review, validate each practitioner's OPPE data within 60 days of posting by the ZSFG Medical Staff Services Department.
   b. Comment on performance metrics that have not met the established thresholds or address identified clinical practice irregularities.
   c. Sign-off on the data provided for each practitioner within the department, per OPPE review period.
   d. Forward identified concerns or clinical practice irregularities to the ZSFG Medical Staff Services Department immediately, for further review by the ZSFG Credentials Committee.
   e. May opt to assign a designee with the primary responsibility to review practitioners within the department. The Chair must keep the Medical Staff Services Department advised of any changes or updates.
   f. Arrange for appropriate coverage to review OPPE data performance metrics reports during periods of planned absences.

2. Practitioner
   a. May request to review their OPPE data.
   b. May add supplemental information/comments for the Service Chief or designee to review as part of periodic validation and sign-off of the OPPE metrics.
   c. May communicate with Service Chief or designee regarding any concerns regarding the content of the OPPE data.

D. OVERSIGHT & DATA RETENTION

1. The Medical Staff Services Department will be notified by the Chief or designee upon completion of the annual review/sign-off of OPPE clinical practice metrics. The Medical Staff Services Department will retain electronic copies of the individual practitioner's data for inclusion in the credentials file to be reviewed by the Credentials Committee as part of each provider's credentialing reappointment.

E. PROCEDURE REVIEW AND REVISION

The Ongoing Practitioner Practice Evaluation Procedure will be reviewed on an annual basis. Compliance with The Joint Commission and functionality will be evaluated as well as the continued relevance of the indicators chosen.

Appropriate revisions will be recommended by the Medical Executive Committee and/or the Credentials Committee.

APPENDIX F – Credentialing of HIV/AIDS Specialists Procedure

I. PURPOSE

Zuckerberg San Francisco General Hospital (ZSFG) provides members with access to qualified specialists for HIV care. This procedure defines the additional qualifications for designating practitioners with an HIV/AIDS specialty at ZSFG. All practitioners are credentialed, recredentialed, and enrolled according to the National Committee for Quality Assurance (NCQA) policy and procedure CR-06.

II. PROCEDURE

REQUIRED QUALIFICATIONS: Practitioners can be designated as an HIV specialist if both of the following requirements are met.

1. Valid unrevoked and unsuspended California state medical license
2. Meets one of the 3 qualifications below:
    a. Credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM)
    b. Board certified in the field of Infectious Diseases by a member board of the American Board of Medical Specialties (ABMS)
    c. Long-standing HIV provider (5 years or greater) with at least 25 ongoing patients with HIV under their care
3. For qualifications in (2) above, the following requirements should also be met:
    a. In the immediately preceding 12 months has clinically managed care to a minimum of 25 HIV patients; and
    b. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV patients, including a minimum of five (5) hours related to antiretroviral therapy per year.

III. AFFILIATED PROFESSIONALS (NP, PA)

Nurse practitioners and physician assistants may be designated with HIV/AIDS specialty if they are under the supervision of an HIV/ AIDS physician specialist, are credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (AAHIVM) or have provided ongoing care to at least 25 patients with HIV infection with the additional requirements in #3 above.

IV. CREDENTIALING PROCEDURE

1. Any practitioner who wants to serve as an HIV/AIDS specialist must request to be credentialed as one using the HIV/AIDS Specialist Designation form in the credentialing packet.
2. HIV/AIDS Specialist applicants will be subjected to the credentialing requirements and process described in policy and procedure CR-06 Initial Credentialing, Recredentialing, Screening, and Enrollment of Practitioners. (NCQA)
3. HIV/AIDS Specialist applicants attest that they meet licensure, board certification, and work experience requirements established in Section IIS of this policy.
4. Physician Advisory/Peer Review/Credentialing Committee (PAC) reviews and approves all HIV/AIDS Specialist credentialing applications as described in policy and procedure CR-06.
5. A list of HIV/AIDS Specialists is kept current in the provider directory according to policy PR-21 and is searchable based on the HIV specialist designation.

V. MONITORING

Monitoring: ZSFG Medical Staff Services ensures HIV/AIDS Specialists' board certification or specialty certification are monitored for their qualifications as part of the recredentialing process every 24

months, at minimum. The ZSFG/UCSF Division of HIV, Infectious Diseases & Global Medicine is responsible for monitoring the minimum amount of hours is met, if applicable

Committee Review: The Credentials Committee review all cases for approval or denial and provide feedback or request additional information or corrections as needed at regularly scheduled Credentials Committee meetings.

VI. DEFINITIONS

Continuing Medical Education:

1) For physicians, continuing medical education courses recognized as qualifying for Category 1 credit by the Medical Board of California;
2) For nurse practitioners, continuing education contact hours recognized by the California Board of Registered Nursing;
3) For physician assistants, continuing education units approved by the American Association of Physician Assistants or those described in either subsection (1) or (2), above.

Credentialing: a process of reviewing and evaluating licenses, permits, training, and other qualifications of licensed practitioners and organizational providers.

Initial Credentialing: initial review of a practitioner or organizational provider credentials

Credentials Committee: (a) Review the credentials of Applicants and make recommendations for membership and delineation of Clinical Privileges in compliance with these Bylaws; (b) Make a report to the MEC on each Applicant for Medical Staff membership and privileges, which shall include recommendations from the appropriate Clinical Service Chief; (c) Review all information available regarding the competence of Medical Staff Members and as a result of such review makes recommendations for the granting of Privileges, reappointments, and the assignment of Applicants to the various Clinical Services as provided in theses Bylaws.

Practitioner: a licensed or certified professional who provides medical or behavioral healthcare services (source NCQA).

Recredentialing: process of reevaluating Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical Staff and the continuation of Clinical Privileges.

APPENDIX G – SFHN Medical Staff Services Credentialing Information Integrity Policy and Procedure

I. PURPOSE

The San Francisco Health Network Medical Staff Services Department meets regulatory and accreditation agency standards by instituting policies and procedures that describe the type of information reviewed, responsibility of each Staff member, process for documenting updates, types of inappropriate documentation and how that information is protected, monitored, and reported. SFHN Medical Staff Services ensures that each Staff member is trained on safeguarding credentialing information by taking an annual Credentialing Information Integrity Training to protect credentialing information from inappropriate modifications.

The purpose of this policy is to provide guidance to the San Francisco Network Health Plan Medical Staff Services Department in fulfilling its delegated Managed Care Plans responsibilities for auditing of credentialing information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues. SFHN demonstrates its commitment to protecting the integrity of credentialing information used in the credentialing process. Credentialing information integrity refers to maintaining and safeguarding the information used in the initial credentialing and recredentialing process against inappropriate documentation and updates.

II. REFERENCES

NCQA Credentialing Standards CR 8: Credentialing Information Integrity

III. POLICY

A. Scope of Credentialing Information

SFHN Medical Staff Services credentialing staff are responsible for protecting all credentialing-related information. The following categories of information shall be maintained in a secure manner at all times:

1. Practitioner Application Materials
   All application and attestation documents submitted by the practitioner shall be securely stored within the ASM platforms MD App and MD Staff.
2. Primary Source Documentation
   Any credentialing documents received directly from a primary source or authorized agent shall be maintained in one of the following secure formats:
   • A locked, access restricted cabinet; or
   • The password protected MD Staff electronic credentialing system.
   These measures ensure prevention of unauthorized access, modification, or disclosure.
3. Credentialing Activity Records
   The following documentation related to credentialing activities shall be maintained accurately and securely:
   • Primary source verifications (PSV) verification dates and verifier identification, electronic or wet signature or initials
   a. Email - Verifications received by email will be from an approved source and verify a provider's name, type of information being verified, and relevant start/end/expiration dates, if applicable.
   b. Verbal - Verifications from verbal sources are recorded electronically and will note the source, date of verification, type of verification, name of the individual verifying the information, their position and any relevant dates (certification, licensure, training,

educations, etc.)
- Dates of required reports, including sanctions and adverse event logs
- Credentialing checklist

4. Committee Documentation
   Ensure that all documentation related to Credentialing Committee actions is properly recorded, finalized, and maintained
   - Credentialing decision and decision date
   - Clean file approval documentation, when applicable
   - Credentialing Committee minutes

B. Staff Responsibilities

1. SFHN Medical Staff Services Credentialing Coordinators, Specialists, Supervisors, Managers, and Directors are all responsible for documenting credentialing activities. The following staff may also have read access to the system on an as needed basis but do not have the ability to make any modifications or deletions: Network Managers, Contracting Specialists, as well as Directors and CQO directly involved in the credentialing process (Credentialing Staff). Credentialing Staff will have read/write ASM MD Staff user access as appropriate to their specific responsibilities.
2. Credentialing Staff are assigned user roles based on areas of responsibility as defined in their job description. Each user role is assigned specific read/write system access as needed to perform their duties which may include modifying or archiving information. Credentialing information within MD Staff should not be deleted without first consulting a manager.
3. Oversight of credentialing information integrity function is performed by SFHN Medical Staff Services during the annual audit to ensure that information meet established policies. Credentialing files are audited by the SFHN Medical Staff Services Manager and documented on the "Cred Info Integrity Audit Analysis Tool". The credentialing information integrity results are presented to the SFHN Medical Staff Services Credentialing Committee for review, approval, and /Patient Safety & Performance Improvement Committee (PIPS) if corrective action is necessary.
4.

Role	Access Level	Permissions	Staff Positions
Administrator *(all facilities)*	Full System Access	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit logs.	SFHN CQO; SFHN Director; ZSFG Manager
Administrator *(respective facility)*	Full Access – individual facility	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit	SFHN CQO: SFHN Director; ZSFG Manager; ZSFG Medical Staff Analysts; HR Managers/ Senior Analysts

		logs.	
General Users ***(respective facility)***	General Access	View and modify provider information; document credentialing activities; upload documents; no deletion rights.	ZSFG/LHH/BHS Medical Staff Specialists; HR Analysts/Clerks
Read-Only User	View Only	View provider profiles and non-sensitive documents; no rights to modify or delete	DPH IT; DPH Patient Financial Services; DPH provider Enrollment; CPG; OPPE Coordinator

IV. PROCEDURE

A. **Documentation Standards and Recording of Credentialing Activities** (CR1 Factor 13)

1. Documentation Requirements
    a) A signed (or initialed) and dated credentialing document completed by the verifier; or a printed verification document with the verifier's handwritten or electronic initials and the date verification was performed.
    b) A verification checklist may be used in lieu of signing each document. When a checklist is used, it must include:
    • The source used for each verification
    • The date the verification was completed
    • The signature or initials of the verifier
    • The report date, if applicable (e.g., NPDB, OIG, sanctions lists)
    • Typed initials are acceptable when the checklist is part of the organization's electronic system (e.g., MD Staff) and the system contains a unique electronic signature or identifier tied to the Credentialing Staff person who performed the verification.
2. Standards for Recording Activities in Credentialing Files
   For each verification, Credentialing Staff must either upload a copy of the source document or enter a system note that includes the verification source, method (online, written, oral), completion date, verifier's initials, and any required follow up. All documentation is maintained in the provider's electronic file in MD Staff.
3. Documenting Credentialing Information Updates
    a) Authorized Modifications
       Credentialing information may be updated by Credentialing Staff whenever existing information changes, renews, or needs correction. Staff make updates using their secure, password protected MD Staff accounts, and all changes are automatically logged in the provider's electronic credentialing record.
    b) Appropriate Modifications include, but not limited to:
    • Updates to expired licensure or other documents
    • Changes, updates, or renewals of education, training, insurance, or privileges
    • Corrections of data entry errors
    • Resolution of duplicate provider profiles
    • Reassignment or correction of documents previously appended to the incorrect provider profile

4. Updates to Primary Source Verification (PSV) Documents
   For updates to PSV information, Credentialing Staff document what was changed, why it was changed, and include their initials and the date. A brief supporting note or email is added to the credentialing file or recorded in the MD Staff comments or checklist.
5. System Tracking Requirements
   Electronic system automatically logs the date of any change and the username of the Credentialing Staff member who made it. Staff must ensure each entry accurately reflects the update and that all supporting documentation is included.
6. Documentation of Modifications
   Credentialing Staff document each modification in the provider's electronic file by noting the date of the change, what was modified, why it was modified, and who made the update.

B. Types of Inappropriate Documentation & Updates

Inappropriate modifications to credentialing include but are not limited to:

1. Falsifying any credentialing dates, including verification, approval, or ongoing monitoring dates
2. Creating documentation without conducting the required verification or activity
3. Fraudulently altering existing documents such as credentialing minutes, clean-file reports, or monitoring reports
4. Attributing verification or review to an individual who did not perform it
5. Altering or "whiting out" dates or signatures on hard-copy documents
6. Unauthorized or unsanctioned deletion of provider files or supporting documentation

C. Monitoring the Information Integrity Process

1. An annual audit of credentialing staff documentation and associated updates is conducted as part of the health plan delegate audit. Files are randomly selected for the audits and reviewed for any inappropriate documentation and updates on the "Cred Info Integrity Audit Analysis Tool" reporting assessment.
2. The Credentialing Information Integrity Audit Results and Analysis Tool will be used to collect and evaluate the audit results which are then presented at the next Credentialing Committee for review and approval and Patient Safety & Performance Improvement Committee (PIPS) for quality-focused process recommendations.
3. If any files are found to have inappropriate documentation and/or updates, the SFHN Medical Staff Services Director or SFHN Chief Quality Officer will document the errors and track subsequent corrections, as well as issue a notice of corrective action and training to the identified group and/or individual system user.
4. If fraud or misconduct are found, the SFHN Medical Staff Services Director or SFHN Chief Quality Officer will report the findings to facility-specific Compliance Officer as well as NCQA through email or the NCQA website. Examples of fraud or misconduct include, but are not limited to:
   a) Falsifying credentialing dates (e.g., licensure dates, credentialing decision dates, staff verifier dates, ongoing monitoring dates).
   b) Creating documents without performing the required activities.
   c) Fraudulently altering existing documents (e.g., credentialing minutes, clean-file reports, ongoing monitoring reports).
   d) Attributing verification or review to an individual who did not perform the activity.

e) Updates to information by unauthorized individuals.

5. Consequences for inappropriate documentation or updates may include but are not limited to the following, in accordance with union rules & disciplinary requirements:
    a) Revocation of user account login credentials
    b) Corrective action memo issued to the individual user
    c) Disciplinary action, up to termination of staff member.

D. Follow-Up and Corrective Actions based on Non-Compliance

1. The Credentialing Director or Credentialing Manager will document any actions taken to address modifications that do not meet policy standards and issue a corrective action to the affiliated group or specific individual.
2. The Credentialing Director will review corrective actions 3-6 months after it was issued to assess the effectiveness of these actions and may continue to monitor corrective actions if deemed necessary.
3. Results will be reported to the Credentialing Committee review & approval and Patient Safety & Performance Improvement Committee (PIPS) for quality-focused process recommendations.

E. Auditing and Analysis of Modifications to Credentialing Information

1. SFHN Medical Staff Services will use the Credentialing Information Integrity Assessment Reporting Tool to evaluate overall performance against this policy. The Credentialing Information Integrity Audit Results and Analysis Tool will be the audit and analysis tool.
2. A random sampling of 5% or 50 files (whichever is less) will be reviewed. Files (25 initial and 25 recredentialing files) will be reviewed annually and documented in the above tools. The report will include files for the previous 12 months.
3. Any inappropriate documentation or updates are documented and will be evaluated using a qualitative analysis to determine the cause.

F. Improvement Actions

1. Any corrective action or subsequent training ordered by the SFHN Medical Staff Services Director or SFHN Chief Quality Officer will be documented and included with the Analysis Tool.
2. The effectiveness of corrective actions will be reviewed 3-6 months after it was issued using a random sample of credentialing files process within that time period.
3. A conclusion as to the effectiveness of the corrective action will be determined by a based on the results of the reevaluation.

G. Staff Training

1. All staff involved in the credentialing or practitioners that are part of the San Francisco Health Network and affiliated San Francisco Department of Public Health entities will complete annual training on this policy, focused on the protection of credentialing information from inappropriate documentation or modification.
2. Training will include:
    • the role of staff in protecting information,
    • the types of information requiring protection,
    • the process for appropriately documenting updates to credentialing information,
    • what constitutes inappropriate updates or modifications and the prevention of falsification and fraud.

3. Staff will also be educated on the auditing process and methodology used to audit credentialing files including the process for documenting inappropriate documentation and reporting instances of fraud and misconduct.

V. REVIEW & APPROVAL

JCC / Governing Body	
MEC	
Credentials Committee	

POLICY & PROCEDURE WITH ALL APPENDICIES (A, B, C, D, F, G)

Added appendix G
Approved by Medical Executive Committee – May 11, 2026
Approved by Credentials Committee – May 4, 2026

Added appendix F
Approved by Medical Executive Committee – November 13, 2025
Approved by Credentials Committee – November 3, 2025

Added appendix F (changed to appendix E – 11/3/2025)
Approved by Medical Executive Committee – October 17, 2024
Approved by Credentials Committee – September 30, 2024

Added appendices C & D
Approved by Medical Executive Committee – February 15, 2024
Approved by Credentials Committee – February 5, 2024

Added appendices A & B
Approved by Medical Executive Committee – December 15, 2022
Approved by Credentials Committee - December 5, 2022

Approved by Medical Executive Committee – December 16, 2021
Approved by Credentials Committee – December 6, 2021

Approved by JCC – October 22, 2019
Approved by Medical Executive Committee – October 17, 2019
Approved by Credentials Committee – October 8, 2019

ZSFG HOSPITAL & TRAUMA CENTER
Medical Staff Organization
Credentialing Manual

Office of Origin: Medical Staff Services, ~~Office~~ (628) 206-2342

I. PURPOSE:

Zuckerberg San Francisco General Hospital (ZSFG) and Clinics ensure that licensed health care providers meet the minimum credentials standards for Medical Staff or Affiliate Staff membership. This Credentialing Manual (with accompanying policies and procedures) and the Appendix, will be reviewed and approved each year by the ZSFG Credentials Committee and Medical Executive Committee.

II. REFERENCES:

- Medical Staff Bylaws, Rules and Regulations
- Joint Commission Medical Staff Standards
- NCQA Credentialing Standards
- CMS Conditions of Participation
- Committee on Interdisciplinary Practice (CIDP) Policy and Procedures

III. DEFINITIONS:

Practitioner: Any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, unless otherwise expressly limited.

Affiliate Health Professional: Categories include the following clinical professionals with standardized procedures or privileges: Advanced practice registered nurses (NP – nurse practitioner, CNM – certified nurse midwife, or CRNA – certified registered nurse anesthetist), PA – physician assistant, PharmD, Optometrists, Genetic Counselor, Acupuncturist and other categories as approved by the Governing Body.

Provider: For purposes of this document, provider means practitioners and affiliates.

Complete Application:
A complete application, at the point that verifications are finished, means the following:

- all information was verified and any missing information is explained or accounted for;
- all gaps in time of three months or more are accounted for;
- any discrepancies between information provided by the applicant and the information verified by ZSFG have been resolved.

IV. POLICY:

~~A.~~ The Medical Staff Office conducts credentialing with confidentiality for all clinical venues within ZSFG and will only delegate credentialing to any outside entities if

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needed. Credentialing is performed prior to appointment and reappointment to the ZSFG Medical Staff.

~~B.~~ A. Each provider has a confidential credentials file, which contains verification documents. For Medical Staff members, the credentials file includes quality information as described in Appendix A. These files are re-verified at least every two (2) years. Expirable documents are updated on an ongoing basis. All required verifications must be no more than ~~180~~ 120 days old at the time of Governing Body review.

~~C.~~ B. Credential files are treated as confidential and are kept within file cabinets with access by Medical Staff Office personnel only. These files are protected from discovery pursuant to Evidence Code Section 1156, et seq. Documents in these files may not be reproduced or distributed, except as permitted pursuant to State Law, including Section 1156, et seq.

1. The credentials file may be reviewed by contracting health plan representatives (pursuant to delegated credentialing agreements), except that information determined to be confidential.

   A provider has the right to review the items in their credentials file, except the following elements: National Practitioner Databank Reports and Letters of Reference. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the credentials file.

2. The quality information may be reviewed by contracting health plan representatives for the following elements: malpractice claims history, disciplinary actions by hospitals, managed care organizations or State Medical Boards and outcomes of those actions. Other quality items are subject to review pursuant to delegated quality agreements or the National Commission on Quality Assurance (NCQA) credentialing standards.

   A provider has the right to review the items in their quality file, except letters of reference or documents related to peer review activities. The provider may submit a signed addendum offering additional information about documents, indicators or events included in the quality file.

~~D.~~ C. Provider Rights to obtain Status of Application

Upon request, providers will be notified of the status of their application during the credentialing process.

~~E.~~ D. Provider Rights to Amend Application

The provider attests that all information submitted for the credentialing process is accurate and agrees to immediately report any changes in information. If any submitted items differ substantially from documentation disclosed throughout the verification process, the provider will be asked (via phone, letter or email) to resolve this discrepancy. The provider will be given opportunity to resolve the discrepancies, with response to the Credentials Committee Chair. Any attempts to intentionally hide or misrepresent information are addressed during the Credentials Committee review.

~~F.~~ E. Notification of Provider Rights: Pursuant to the Medical Staff Bylaws, providers are notified of their rights to:

- review information submitted to support their credentialing application;

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- correct erroneous information; and
- be informed of the status of their application upon request.

~~G.~~ F. Erroneous Information: The applicant for appointment, reappointment, and/or clinical privileges will be notified by credentialing staff of any conflicting information found in the provider's application and/or any supporting documentation.
Notice will occur by telephone or written request within 10 days of discovery, and will be documented in the provider's credentials file.

- The provider will have 30 days to reconcile and return the application and/or supporting documentation to the credentialing staff
- Acceptable format will be the corrected and signed credentialing application and, as applicable, a written and signed explanation for any discrepancies in the original application
- The Credentials Committee or Credentials Committee Chair will receive a report of any corrected information submitted by the provider.
- The documentation provided by the applicant and any other related documents will be placed in the provider's credentials file along with notation as to the date received.

~~H.~~ G. Upon delegation of credentialing activities, audits may be performed by health plan representatives and other payers, based upon the following guidelines:

1. Audits must be scheduled in advance at a time mutually agreed upon by ZSFG and the auditing entity.
2. Selected documents regarding peer review may not be subject to auditing.
3. Auditors may not photocopy or remove documents.

If credentialing is not delegated, the health plan/payer is responsible for credentialing providers for their health plan.

V. PROCEDURE

In accordance with ZSFG Medical Staff Bylaws, the Credentials Committee includes an interdisciplinary group representation of peer-review-qualified practitioners and designated physicians who hold direct responsibility, expertise, and active involvement in credentialing decisions. The committee uses a peer-review process to thoroughly evaluate credentialing information and make informed recommendations.

~~V.~~ The Medical Staff Services Department supports the credentialing process by providing comprehensive information for both initial credentialing and recredentialing reviews. Credentialing criteria are formally reviewed and approved by the Credentials Committee, its Chair, or designated members. Cases that do not meet the established eligibility criteria are escalated to the Credentials Committee for decision-making.

A. Initial Appointments

1. The following information is required to begin the Initial Appointment process:
   - Request from Department
   - Applicant Name
   - Curriculum Vitae/Resume including all professional work history
   - Faculty Appointment (if applicable)
   - Requested Privileges/Protocols (Standardized Procedures), (when applicable)
   - Requested Start Date for Temporary Privileges/Credentials only
   - ID attestation per Joint Commission guidelines

2. Providers must complete the following items:

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- Application for Medical Staff or Affiliate Staff appointment including Confidentiality Statement and Consent to Release Information, Privileges, or for Affiliate, Standardized Procedures.
- Agreement to abide by the Medical Staff Bylaws, Rules and Regulations
- Health Plan Attestation form (as applicable)
- Environmental Safety form

3. In addition to returning the above documents, providers also must submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
   - Copy of California License(s) (an on-line query is acceptable)
   - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
   - Evidence of Current Malpractice Coverage, if applicable
   - Fluoroscopy Certificate as appropriate
   - Current Photo
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current Curriculum Vitae (CV)

4. The Medical Staff Office reviews the documents as follows:
   a. All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges. The applicant confirms the correctness and completeness of the application.
   c. Clinical venues are specified and appropriate.
   d. Complete addresses, phone and fax numbers as listed for:
      - Medical school, Internships, Residencies, Fellowships;
      - Hospitals and affiliations;
      - Peer references; and
      - Malpractice insurance company(ies)
   e. Privileging forms or Standardized Procedures are completed as appropriate.
   f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
   g. California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

5. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

   Verification of provider enrollment screening in the Medicaid Fee-For-Service program. Completion of the Medi-Cal related acknowledgements for health plan specific trainings are required to begin within 10 working days of a new provider becoming active, and may be completed up to ~~180~~ 120 days prior to the new being activated/approved.

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6. File Triaging:
   Once all of the information is gathered, the applicant's file is triaged by the Medical Staff Office and flagged for potentially adverse information to be carefully evaluated during the Credentials Committee review.

7. Temporary Privileges for Initial Appointments:
   For Initial Appointments involving clinical urgency, a Service Chief may request temporary privileges up to 120 days. Request for Temporary Privileges/Credentials must be approved by the CEO (or authorized designee) on the recommendation of the Chief of Staff (or authorized designee).

   Actions on temporary privileges/credentials are updated in the Medical Staff Office database upon approval and appropriate areas are notified. The Medical Staff Office database updates the applicant's status and privileges/protocols are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification is forwarded to the applicant within 10 days of the decision on the request for temporary privileges.

8. Applicants must complete the credentialing process with privileges or standardized procedures (as appropriate) prior to the provision of patient care to ZSFG patients.

B. —Reappointments

B.

1. Reappointment Application Packet
   At least five (5) months prior to the end of the two (2) year appointment period, the provider is mailed an application for reappointment. Previously submitted information is queried to produce the reappointment application. The reappointment packet includes:
   - Preprinted Reappointment Application
   - Copy of current clinical privileges

2. The provider is required to return the application and supporting documents within thirty (30) days, and include the following:
   - Copy of current DEA Certificate as appropriate
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current CV

3. If the application is not returned within the designated time period, the provider and Department Chair will be notified for a delinquent reappointment and will receive a (15) day extension to complete the paperwork. Failure to submit a reappointment application at least 45 days before the expiration date of the current appointment may be deemed to be a voluntary resignation from the Medical Staff, and the provider will be submitted as "resigned" to the Credentials Committee.

   Practitioners/Affiliates who automatically resign shall be required to complete a reinstatement form to reapply for membership. Reinstatement shall be processed in a manner parallel to the reappointment process. Reinstatement application forms shall be accepted within one (1) month from the date the practitioner membership expires.

   All Practitioners/Affiliates whose membership has expired ~~longer~~ more than one (1) month shall be required to complete the initial appointment process.

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4. The Medical Staff Office reviews the documents as follows:
   a. All items on application form. This includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanations for any irregularities on certain questions about practice issues, legal matters and health status.
   b. Applicant's signature is present and dated on all forms. The applicant confirms the correctness and completeness of the application.
   c. Privileging forms and Standardized Procedures are completed as appropriate.
   d. Clinical venues are specified and appropriate.
   e. Completed addresses, phone and fax numbers as listed for:
      - Hospitals and affiliations
      - Peer references; and
      - Malpractice insurance company(ies)
   f. Continuing Medical Education (CME) materials document any courses relevant to specific privileges requested.
   g. California License(s) and applicable certificates (e.g. DEA, Fluoroscopy) are current.

5. Verification of Information
   Verification of information begins as soon as the application appears complete, and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Verbal verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

   Verification of provider enrollment screening in the Medicaid Fee-For-Service program

6. Reappointment Performance Improvement
   The results of performance monitoring, evaluation, and identified opportunities to improve care and service are documented in this file. Data Summary sheets are collected and provided as evidence of the practitioner's current competence and suitability for medical staff membership.

7. Pre-Credentials Committee Meeting
   A meeting shall be convened prior to the Credentials Committee meeting date which shall be attended by the Chair of the Credentials Committee and the credentialing staff in order toto discuss files of concern and the agenda.

C. Evaluation And Approval Process

C.

1. Clinical Services Evaluation Process

1.

If an issue is identified, the related documentation is flagged for the Service Chief to review. The complete file (including application, supportive documents, and privileges request form, practitioner sanctions, complaints, and adverse events) is sent to the appropriate Service Chief for review andand recommendedation to the Credentials Committee. If the applicant's file wasFor any flagged files, the Service Chiefreviewer must document sufficient review to support making

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~~a~~their recommendation for appointment or ~~/~~reappointment.

If the Service Chief is disinclined to make a favorable recommendation ~~based on~~due to:

- concerns indicating the potential for a provider's conduct to be detrimental to patient safety or care, or
- concerns related to professional competence or behavior that could adversely affect patient welfare;

- the Service Chief drafts a report outlining these concerns for the Credentials Committee.~~a perceived medical disciplinary cause or reason, indicating the potential for a provider's conduct to be detrimental to patient safety or to the delivery of patient care; or~~

~~perceived conduct or professional competence which affects or could adversely affect the health or welfare of a patient or patients, the Service Chief drafts a report to the Credentials Committee indicating concerns with the appointment/reappointment~~.

After the Service Chief's recommendation is completed, the file is prepared for discussion at the next monthly Credentials Committee meeting, and the applicant is placed on the Credentials Committee Summary Report.~~After the Service Chief's recommendation, the file is prepared for the monthly Credentials Committee and the applicant is added to the next monthly Credentials Committee Summary Report.~~

2. Credentials Committee Evaluation Process

The Credentials Committee reviews the Summary Report and all applicable credentialing criteria—such as practitioner sanctions, complaints, and adverse events identified through ongoing monitoring—before approving credentialing decisions and issuing its formal recommendation for appointment or reappointment.~~The Credentials Committee reviews the Summary Report and Committee makes a recommendation for appointment/reappointment.~~ ~~F~~Files are ~~reviewed~~ evaluated in accordance with the File Triaging categories (see Appendix C).

Applications ~~deemed~~ categorized as '*green*' do not require committee discussion and are approved on the consent agenda.~~do not require committee discussion and are approved on the consent agenda.~~ Applications ~~deemed~~ categorized as '*yellow*' or '*red*' are discussed in detail by the Credentials Committee.~~ for review and recommendation.~~

Applications requiring additional information/clarification may be tabled until sufficient information is gathered to support a recommendation. Discussion is documented in the committee meeting minutes. The report ~~-~~with Credentials Committee recommendations is then sent to the Medical Executive Committee (MEC).

3. Medical Executive Committee and Governing Body Evaluation Process

The Credentials Committee Summary Report is reviewed by the Medical Executive Committee, then the Joint Conference Committee, and then referred to the Health Commission as the Governing Body.

~~Actions on appointments/reappointments are updated in the Medical Staff Office database within 10 days of Governing Body approval. The Medical Staff Office database updates are displayed on intranet websites for inquiry by the applicant or other Medical Center staff. Notification of the Governing Body decision is forwarded to the applicant within 30 days~~.
Actions on credentialing and recredentialing are updated in the Medical Staff Office database

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within 10 days of Governing Body approval, and these updates are made available on designated intranet sites for inquiry by the applicant or authorized staff. Notification of the Governing Body's decision is forwarded to the applicant within 30 days.

4. Provider Enrollment
   Upon Governing Body approval, formal notification of the finalized Credentials Committee Summary Report is sent to the contracted Health Plans, to ensure timely notification of all credentialing and recredentialing decisions, including changes in provider status, approved privileges, or conditions placed on participation.~~.~~

D. Visiting Privileges

1. In circumstances involving clinical necessity when clinical services require the services of a physician, dentist, podiatrist or clinical psychologist who is not a member of the Medical Staff, visiting privileges may be granted on a ~~case by case~~case-by-case basis.

2. The following information is required to begin the Visiting Privileges process:
   - Completed Application
   - Curriculum Vitae/Resume including all professional work history
   - Faculty Appointment (if applicable)
   - Service Chief Recommendation
   - Requested Privileges
   - Requested Start Date

3. Providers must complete the following items:
   - Visiting Application including Confidentiality Statement and Consent to Release Information and Privileges.
   - Review the Medical Staff Bylaws, Rules and Regulations

4. In addition to returning the above documents, providers must also submit any relevant licensure/certificates as applicable to the requested privileges or clinical activity, including but not limited to:
   - Copy of California License(s) (an on-line query is acceptable)
   - Copy of DEA Certificate and/or Furnishing certificate as appropriate (a query is acceptable)
   - Evidence of Current Malpractice Coverage
   - Fluoroscopy Certificate as appropriate
   - CPR, BLS/ACLS, PALS, NALS, if applicable
   - Current Curriculum Vitae (CV)

5. The Medical Staff Office reviews the documents as follows:
   - All items on the application form, which includes answering all questions on the application, enclosing copies of requested documentation, and providing attachments or written explanation for any irregularities on certain questions about practice issues, legal matters and health status.
   - Applicant's signature is present and dated on all forms. The applicant must have signed the application and request for clinical privileges.
   - Clinical urgency and venues are specified and appropriate.
   - Complete addresses, phone and fax numbers as listed for:
     - Hospitals and affiliations;
     - Peer references; and

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- Malpractice insurance company(ies)

- Privileging forms are completed as appropriate.
- California License(s), DEA Certificate, and Fluoroscopy Certificate are current.

6. Verification of information begins as soon as the application appears complete and is conducted as specified in Appendix B – Verification Methods. Verification for some items must be obtained from primary sources and are received in writing from the primary sources, although oral verification may be done. Oral verification requires a dated, signed note in the credentialing file stating who at the primary source verified the item, the date and time of verification, and how it was verified.

   Many primary sources have on-line access available, which is the preferred method of verification for primary source items. When an automated verification system is used, the documentation notes the date the query was performed.

7. The Chief of Staff and the Executive Administrator (or authorized designees) may grant Visiting privileges for a specified period of time after the above information has been evaluated by the applicable service chief and he/she has made an affirmative recommendation.

E. Expirables/Ongoing Monitoring

Sanctions and expirables are monitored on a monthly basis as indicated in Appendix B - Verification Methods.

F. Resignations

The effective date of the resignation will be the last day of the month in which the provider states that he/she is resigning, or a date indicated by the Chief of Service, and can occur before the Governing Body date. Notice of resignation to the Medical Staff Office may be submitted by the resigning provider or by the Department Chief, or Chief's designee, provided that the resigning provider is copied on the notice.

H. Non-Discriminatory Credentialing and Recredentialing.

The Medical Staff Office monitors and prevents discriminatory credentialing through the following process:

i. Tracking and trending of reasons for denial and / or termination.

ii. Semi-annual audits of files in process for more than ~~six (6) months~~120 days.

iii. ~~The presence of a non-discrimination statement on the Statement of Confidentiality to be signed by members, staff and guests of the Credentials Committee on an annual basis.~~All Credentialing Committee members, staff, and guests are required to sign the Statement of Confidentiality annually, which includes a non-discrimination statement. Committee members must also sign a standing non-discrimination agreement that remains in effect for the duration of their service. By signing, members attest that all credentialing decisions—whether related to approval, denial, or termination—are based solely on objective applicant qualifications and established network participation criteria, and never on factors such as age, gender, sexual orientation, race, ethnic or national identity, specialization, or the type of services provided.

~~iii.~~

iv. ~~The presence of a non-discrimination statement on the Credentials Committee agenda.~~Credentials Committee agenda must include a non-discrimination statement. All documents and information presented for committee review must exclude any references to a practitioner's race, ethnic or national

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identity, gender, age, sexual orientation, or to specific procedures or types of patients the practitioner serves. This ensures that credential decisions remain unbiased, equitable, and compliant with the organization's non-discrimination standards.

~~iv.~~ v. The San Francisco Department of Public Health (SFDPH), including the San Francisco Health Network (SFHN) and ZSFG, credentialing applications may request demographic information such as race, ethnic or national identity, gender, age, sexual orientation, language, and other related details. Providing this information is entirely optional and not required for credentialing. Any demographic data voluntarily disclosed by an applicant will not be used in any discriminatory manner and will have no impact on the review, evaluation, or approval of credentialing applications. This information is collected solely for purposes such as compliance with reporting requirements, promoting diversity, and improving health equity initiatives.

~~v. Documents and / or information, submitted to the Credentials Committee for approval, denial or termination do not designate a practitioner's race, ethnic / national identify, gender, age, sexual orientation or the type of procedure or patient in which the practitioner specializes. The Credentialing Committee members will sign a non-discrimination agreement that remains in effect during their term as a Committee member. The statement attests that all decisions made by the committee are based on the applicant's credentials and network participation criteria and not the applicant's age, gender, sexual orientation, race, ethnic/national identity, specialization or special services the applicant may provide.~~

vi. The San Francisco Department of Public Health (SFDPH), including SFHN and ZSFG, is prohibited from discriminating against a licensed provider solely on the basis of a civil judgment, criminal conviction, or professional disciplinary action from another state when that action is based exclusively on the application of a law from that state that restricts or penalizes care that is lawful in California. *(§1375.61, SB-487)*

~~The Medical Staff Office monitors complaints alleging discrimination. Results are reported to the Credentialing Committee bi-annually.~~

I. ~~Queries: Verification of the following within 180 days of the Governing Body decision date:~~Primary Source Verification (within 120 days prior to decision) - *ongoing monthly monitoring (see Appendix B - Verification Methods)*

- National Practitioner Data Bank (NPDB) ~~(required for all applicants)~~
- ~~The~~ State Medical Board ~~responsible for issuing the provider l~~licensure
- Medi-Cal and Medicaid Suspended and Ineligible List~~Provider Reports~~
- Medicare and Medicaid exclusions/sanctions
- Office of Inspector General (OIG) Exclusion List
- SAM.gov debarment checks
- Board Ce~~r~~tification
- Work History
- Malpractice insurance coverage and professional liability ~~claims~~claim history
- Attestation questions answered in the application

J. ~~System Control Measures (CR 1C & D)~~ Credentialing Information Integrity - *(see Appendix G: SFHN Credentialing Information Integrity Policy and Procedure)*

The purpose of this section is to ensure compliance with ~~the~~ *CR 8, Element A*, National Committee for Quality Assurance (NCQA) standards.

~~Part C – System Controls~~	
~~1. How~~	~~Credentialing applications are received via MD Staff credentialing database.~~

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primary source verification information is received, dated and stored.	Supporting documentation such as primary source verifications (PSVs) are either uploaded into the MD Staff credentialing database or queried directly through the database. All primary source verifications (PSVs) collected as part of the ZSFG credentialing process for initial and reappointment applications are reviewed by the ZSFG credentialing team. Primary source verifications (PSVs) include but are not limited to the following; State licensure, DEA, DEA-X, OIG, SAM/GSA, NPDB, AMA, NPI, Certifacts. PSVs are received or obtained by primary source websites, email, or verbally (over the phone): a. Primary Source Websites – Verifications from primary source websites will show the name of the source, the provider(s) being verified, the type of verification (license, certificate, etc.), and expiration date if applicable. b. Email – Verifications received by email will be from an approved source and verify a provider's name, type of information being verified, and relevant start/end/expiration dates if applicable. c. Verbal – Verifications from verbal sources are recorded electronically and will note the source, date of verification, type of verification, name of the individual verifying the information, their position and any relevant dates (certification, licensure, training, educations, etc.) PSVs are dated automatically via the MD Staff credentialing database and the dates cannot be changed/modified. PSVs are stored in the MD Staff Credentialing database hosted by the vendor.
2. How modified information is tracked and dated from its initial verification:	PSVs uploaded into the MD Staff Credentialing database cannot be modified. The ZSFG credentialing team is oriented not to attempt to modify any type of PSV prior to upload within MD Staff Credentialing database. If a verification contains discrepant information that requires additional clarification, the credentialing team may include additional information to supplement the original PSV. Supplemental information should include the credentialing team member's name and date additional information was obtained.
3. Staff who are authorized to review, modify and delete information, and circumstances when modificati	All users are authorized to review information. No users have ability to modify PSVs uploaded into MD Staff. Authorized users are instructed to use good judgement and even consult a team member whenever a question arises regarding a need to remove/delete information in MD Staff. Access to MD Staff is role based and granted based on job function within the Medical Staff Services department or ZSFG facility. Access is reviewed quarterly and adjusted as needed. **Role** | **Acces** | **Permissio** | **Staff**

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on or deletion is appropriate.		s Level	ns	Positions
	Administrator (all facilities)	Full System Access	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit logs.	SFHN Director; ZSFG Manager
	Administrator (respective facility)	Full Access	View, add, modify, and delete information; manage user roles; workflows; oversight of credentialing information integrity functions and audit logs.	SFHN Director; ZSFG Manager; ZSFG Medical Staff Analysts; HR Managers/ Senior Analysts
	General Users (respectiv	Gene ral Acce	View and modify provider	ZSFG/LHH/B HS Medical Staff

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~~*e facility)*~~	~~ss~~	~~information; document credentialing activities; upload documents; no deletion rights.~~	~~Specialists; HR Analysts/Clerks~~
~~**Read-Only User**~~	~~View Only~~	~~View provider profiles and non-sensitive documents; no rights to modify or delete.~~	~~DPH Information Technology; DPH Patient Financial Services; DPH Provider Enrollment; ZSFG QPPE Coordinator~~

~~**Data Deletion Protocols**~~

~~Authorized users are encouraged to check with their direct manager when a need to delete information presents itself. This includes instances when a PSV may need to be re-run for a provider's profile.~~

~~**Examples of appropriate modifications to credentialing information include but are not limited to:**~~

- ~~**Erroneous Data Entry**: Updates to expired licensure or other documents (*updating the database data fields to reflect current/accurate information*)~~
- ~~Changes/updates to education, training, or privileges when supporting PSVs are obtained~~
- ~~Correcting/rectifying any data entry errors~~
- ~~Addressing/identifying duplicative provider profiles~~
- ~~**Misfiled Documents:** Documents uploaded to incorrectly (*e.g. wrong provider profile)*~~
- ~~**Duplicate Provider Records**: When duplicate profiles are identified, data is consolidated into the correct profile.~~

~~**Examples of inappropriate modifications to credentialing information include but are not limited to:**~~

- ~~Altering credentialing approval dates unsanctioned by the Joint Conference Committee (JCC) or prior to temporarily approval by the ZSFG clinical leadership while awaiting JCC final approval~~
- ~~Altering dates on verifications cannot be performed~~
- ~~Whited out of dates or signatures on hard copy documents~~

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	• Unauthorized/inappropriate deletion of provider files or supporting documentation
4. The security controls in place to protect the information from unauthorized modification.	An excerpt from the City of San Francisco Employee Handbook is detailed below (pg 54 of the New Employee Handbook. **Work Site Security** To prevent and discourage unauthorized access to your work site, do not leave your office area unattended. Do not prop open doors or windows that are normally kept locked. Lock all office doors after business hours or when you leave. Prevent and discourage theft by securing your valuables. Work-site keys and passes may not be shared, may not be duplicated without permission and must be returned upon separation. Access to credentialing information is limited to authorized users only. Only authorized users are granted access to the MD Staff credentialing database based on business need. Authorized users are required to complete Annual Compliance and Privacy Training (DPH) along with Cybersecurity Training to ensure safeguard of credentialing database information. Authorized users should: • Use strong passphrases containing unique combinations of uppercase letters, lowercase letters, numerals and symbols • Refrain from writing down passwords • Only use a unique password for any of their accounts, and not use a password more than once • Update/change their passwords periodically, including when appropriate such as when passwords may be compromised Authorized user's accounts are inactivated upon separation from the organization, and every 30 days from their last login. The MD Staff credentialing database is only accessible via hospital intranet or VPN access. When the organization inactivates the user's active directory account, the user will no longer have a mechanism/pathway to log in to MD Staff for access to credentialing information.
5. The policies and procedures describe the organization's audit process for identifying and assessing risks and	Monitoring of our processes must occur at least annually. The audits of our process will be performed by a director in conjunction with selected members of the medical staff office team. The audits may include but are not limited to the following: 1. A description of the system functionality that prevents or disallows modifications of credentialing information. 2. If the CR system allows modifications only under specific circumstances, an annual process for identifying all changes to established policies within the past 12 months and then updating the system controls accordingly. 3. A review of automatic system alerts or flags for modifications or events in real time and a separate process for annually testing the performance of the system's automatic alerts or flags.

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ensuring that specified policies and procedures are followed. At a minimum, the description includes: • the audit elements include: • methodology used; • including sampling; • individuals involved in the audit; and • audit frequency. ➢ Oversight of the department responsible for the audit.	Primary source documentation uploaded into our MD-Staff credentialing database cannot be modified. An annual review sampling 5% of active records or 50 files will be reviewed at random from our monthly health plan roster (provider universe) and conducted by department management/senior staff to ensure that the provider records are complete and possesses accurate information. When auditing is used as the method for monitoring, sampling using the "5% or 50 files" audit method, with a minimum of 10 credentialing files and 10 recredentialing files shall occur. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits will audit 100% of the credentialing and recredentialing files. Annual review of job roles and current user access to ensure system access is still appropriate for the role requirements. Monthly, quarterly, semiannual, or annual review of all modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system's audit trail function reporting capability. Credentialing, privileging, and enrollment are paperless processes that have very limited paper documents due to requirements for wet signatures. For paper documents/files, leadership conducts periodic walk-throughs of the department to ensure confidential/sensitive documents are being handled and stored properly during and after business hours – i.e., in locked drawers/filing cabinets, not left on workstations, etc. Incorporate review of data modifications/changes/updates to credentialing data (both electronic and paper as applicable) into file Q&A process. Assess for accuracy, appropriateness, compliance with policies. Findings will be documented and stored in a network folder. Credentialing staff and anyone who has access to credentialing information is required to sign an annual confidentiality form. These forms will be stored in a Medical Staff Services folder.

Part D – Oversight	
1. Identify all modifications to credentialing and recredentialing information that	At a minimum, an annual monitoring report will be required to show compliance with our Credentialing System Controls policies, procedures shall be reported to the ZSFG MSO and AH Credentials Committee and Medical Executive Committee. The report will need to include:

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did not meet the organizations policies/procedures for modifications as described in CR 1, Element C, Credentialing System Controls.	a. A review of all modifications that did not meet the policies and procedures i. Conduct a qualitative and quantitative analysis of all modifications that did not meet policies. ii. Actions taken to address any modifications that did not meet established policy. iii. Implement quarterly monitoring when there are elements that did not meet the policies and procedures and provide written documentation in a report of this review. b. The report shall include the person/role/title of the person performing the monitoring. c. The report shall include the person/role/title of the person who has oversight of the monitoring process if different from who performs monitoring.
2. Document and analyze all modifications that did not meet standards by doing a qualitative and quantitative analysis of all modifications.	i. **Credentialing System Controls Oversight Report** – this template will be included in the request for documents at the time of the annual oversight assessment. ii. **Monitoring and Reporting of Inappropriate Modifications** this template will be included in the request for documents at the time of the annual oversight assessment. ZSFG MSO would need to submit this report if inappropriate modifications were identified. MSS will continue to monitor the report until it demonstrates improvement for three consecutive quarters. If improvement isn't demonstrated for at least one finding, all quarterly reports will be submitted to the MSS Director.
3. Acting on all findings. (Not applicable if no findings above.)	Findings will be acted upon by the ZSFG MSO, if any are identified.

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POLICY & PROCEDURE WITH ALL APPENDICIES (A, B, C, D, F, G)

Added appendix G
Approved by Medical Executive Committee – May 11, 2026
Approved by Credentials Committee – May 4, 2026

Added appendix F
Approved by Medical Executive Committee – November 13, 2025
Approved by Credentials Committee – November 3, 2025

Added appendix F (changed to appendix E – 11/3/2025)
Approved by Medical Executive Committee – October 17, 2024
Approved by Credentials Committee – September 30, 2024

Added appendices C & D
Approved by Medical Executive Committee – February 15, 2024
Approved by Credentials Committee – February 5, 2024

Added appendices A & B
Approved by Medical Executive Committee – December 15, 2022
Approved by Credentials Committee - December 5, 2022

Approved by Medical Executive Committee – December 16, 2021
Approved by Credentials Committee – December 6, 2021

Approved by JCC – October 22, 2019
Approved by Medical Executive Committee – October 17, 2019
Approved by Credentials Committee – October 8, 2019

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Implementation of Provisional Status for Newly Appointed Medical Staff

> **3.3. Provisional Medical Staff**
>
> The Provisional Medical Staff shall consist of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have yet to complete initial proctoring requirements. Provisional Medical Staff Members shall be appointed to a specific Clinical Service and may serve on Medical Staff Committees. Provisional Medical Staff Members shall not be eligible to hold Medical Staff Offices or to vote on amendments to these

Situation

Newly appointed practitioners at ZSFG are currently assigned directly to Active or Courtesy status, which obscures the need for timely FPPE (initial proctoring). This has led to inconsistent proctoring completion, delayed evaluations, and potential regulatory vulnerabilities.

Practitioners granted full privileges between 13-24 months — and in some cases acting as proctors themselves before completing their own FPPE — puts us at risk of a survey finding.

Background

The Medical Staff Bylaws state that new practitioners enter a *provisional appointment period* prior to advancement. Provisional status is intended to provide a structured, time-limited oversight framework for FPPE and early competency evaluation.

TJC requires organizations to define, track, and evaluate FPPE for all new practitioners—lack of structure puts the hospital at risk during surveys.

Assessment

The absence of a clear Provisional designation creates operational, quality, and compliance risks. The Medical Staff Office have identified potential contributing factors to not using Provisional status:

- Departments have varying practices and inconsistently follow through on proctoring.
- FPPE reminders to practitioners are not automated.
- Some providers and service Chiefs are unclear on expectations regarding FPPE.
- Currently, providers show as “Active (P)” or “Courtesy (P),” which does not clearly convey their provisional status or FPPE responsibilities.
- Outstanding proctoring cases span 6–24 months for more than 170 practitioners.
- Early performance issues may be missed when evaluation timelines drift past the 1-year mark.
- Providers may be called on to proctor before completing their own evaluations, conflicting with bylaws requiring proctors to have unrestricted privileges.
- Other hospitals routinely use Provisional status to ensure standardization of oversight and

competency evaluation. It is considered an industry best practice and supports both FPPE tracking and regulatory readiness.

Recommendation

1. **Adopt Provisional Status as the default initial appointment category** for new privileged practitioners, replacing Active (P)/Courtesy (P) status.

2. **Standardize Provisional advancement criteria**, requiring:
   - Completion of required proctoring cases
   - Identify proctor that reviewed cases
   - Satisfactory peer review and OPPE indicators
   - Department Chief attestation

3. **Use Provisional status as a formal accountability mechanism** to ensure FPPE is completed within expected timeframes and support early identification of performance concerns. Provisional status does not limit or restrict practice or the privileges granted.

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	Standardized procedure - Nurse Practitioner/Physician Assistant
Clinical Service:	CHN Primary Care
Date of last approval:	2023
Summary of SOP updates:	Updated language and removed redundant phrases, added protocols and deleted protocols no longer in practice, updated requirements for proctoring and reappointment based on FCM SP, removed 3 forms of supervision no longer required for PAs, expand consultation and proctoring to include other credentialed/qualified providers and not just MDs or the supervising physician, and edit format of document
Update #1:	Updated Protocol <u>Protocol #1 Health care management – Prenatal Care</u> • Current: Reviews routine prenatal care of essentially healthy women • Proposed: Update plan to match current prenatal care guidelines and removed section on "Management of HIV-infected Pregnant Women at The Bay Area Perinatal Aids Center (BAYPAC)
Update #2:	Updated Protocol - Protocol #4 Furnishing Medications/Drug Orders • Current: Reviews NP and PA routine ordering of drugs including controlled substances and that all controlled substances must be approved by supervision physician before being issued or carried out. Further updates included language to match code 2836.1 so that controlled substances shall be furnished or ordered in accordance with patient-specific protocols approved by the treating or supervision physician. • Proposed Further updated language in accordance with AB1196: "<u>Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, Surgical Services, scope of</u>

	practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol."</u>
Update #3:	Updated Protocol Protocol #5 Arthrocentesis and Intraarticular Injections • Current: protocol covered arthrocentesis of knee and elbow only • Proposed: Update language to include all joints for arthrocentesis and intraarticular injections to match current FCM SP – i.e. language now covers trigger finger and shoulder joints.
Update #4:	Added Protocol Protocol #6 Musculoskeletal Soft Tissue Injections/Aspirations • Proposed ADD: Covers the aspiration of and/or injection of medications into soft tissue structures such as bursa, tendon sheaths, cysts, trigger points and carpal tunnel, for therapeutic or diagnostic purposes. • Adapted from current FCM SP
Update #5:	Updated Protocols Protocol #10 Contraceptive Implant Removal & #9 Contraceptive Insertion • Current: Initially proctoring period required minimum of 6 removals for new provider, updated to 3 • Proposed: update to a minimum of 2 procedures for new provider • Current: Reappointment requires performance of 4 removals and 1 chart reviews very 2 years. • Proposed: update to a minimum of 2 case reviews every 2 years for removals and 1 case review for insertions. (In line with current "Standardized procedures Initial and Reappointment Criteria" document)
Update #6:	Added Protocol Protocol #16 Nail Debridement • Proposed ADD: Covers removal of elongated overgrown nail material • Adapted from current FCM SP
Update #7:	Added Protocol Protocol #17 Nail Removal/Mastrisectomy • Proposed ADD: Covers complete removal or partial removal of the nail bed and nail plate • Adapted from current FCM SP
Update #8:	Added Protocol

	Protocol #18 Skin biopsy • Proposed ADD: Covers removal of a small portion of abnormal skin to be tested in a laboratory • Adapted from current FCM SP

San Francisco Health Network

Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER /PHYSICIAN ASSISTANT

These standardized procedures are for the following Primary Care Clinics:

Castro Mission Health Center
Chinatown Public Health Center
Community Health Programs for Youth
Curry Senior Center
Maxine Hall Health Center
Medical Respite and Sobering Center
Ocean Park Health Center
Potrero Hill Health Center
Silver Avenue Health Center
Southeast Health Center
Special Programs for Youth
Tom Waddell Urban Health

PREAMBLE

Title: Community Primary Care

I. Policy Statement

A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Certified Nurse Midwives, Physician

Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in 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 individual clinical sites within the Community Primary Care Clinical Service and on file in the Medical Staff Office.*

II. *Functions To Be Performed*

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

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

A Certified Nursing Midwife (CNM) is a registered nurse who has had additional training in midwifery and who has met the requirements of Section 1460 of the Nurse Practice Act. The Scope of Practice of the CNM includes the care of women during the antepartal, intrapartal, postpartal, inteoconceptual periods, provides family planning, conducts deliveries and cares for the newborn and infant.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education

for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every ten years. Graduation from an accredited physician assistant program and passage of the national certifying exam are required for state licensure. While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and practice agreement.

The NP/CNM/PA conduct physical exams, diagnoses and treats illness, order and interpret tests, counsel on preventative health care, assists in surgery, performs invasive procedures and furnish medications/issue drug orders as established by state law.

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

A. Setting

1. Location of practice is the various clinical sites within the Community Primary Care Service.
2. Role in each setting may include primary and urgent care in all settings.

B. Supervision

1. Overall Accountability:
   The NP/CNM/PA is responsible and accountable to: the clinic Medical Director, Chief of Service, supervising physician and other supervisors as applicable.
2. A consulting attending physician, will be available to the NP/CNM/PA, by phone, in person, or by other electronic means at all times.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies.

c. Unexplained historical, physical, or laboratory findings.
d. Upon request of patient, affiliated staff, or physician.
e. Initiation or change of medication other than those in the formulary (ies).
f. Problem requiring hospital admission or potential hospital admission.

IV. Scope of Practice

Protocol #1 Health Care Management: Primary Care
Protocol #2 Health Care Management: Acute and Urgent Care
Protocol #3 Health Care Management: Prenatal Care
Protocol #4 Furnishing Medications and Drug Orders
Protocol #5 Procedure: Arthrocentesis and Intraarticular Injections
Protocol #6 Procedure: Musculoskeletal Soft Tissue Injections/Aspirations
Protocol #7 Procedure: Endometrial Biopsy
Protocol #8 Procedure: Incision and Drainage of Skin Abscesses
Protocol #9 Procedure: Insertion of Contraceptive Implant
Protocol #10 Procedure: Removal of Contraceptive Implant
Protocol #11 Procedure: Insertion of Intrauterine Device
Protocol #12 Procedure: Surface Trauma and Wound Care
Protocol #13 Procedure: Splinting
Protocol #14 Procedure: Waived Testing
Protocol #15 Procedure: Tattoo Removal
Protocol #16: Procedure: Nail Debridement
Protocol #17: Procedure: Nail Removal/Matrisectomy
Protocol #18: Procedure: Skin Biopsy

V. Requirements for the Nurse Practitioner /Certified Nurse Midwife/Physician Assistant

A. Basic Training and Education

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

(NCCPA) certification.

4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center ~~s~~. Copies of ~~DSA~~ Practice Agreement must be kept at each practice site for each PA.

B. Specialty Training

1. Specialty requirements: FNP, CNM, ANP, PNP.
   Note:
   Pediatric Nurse Practitioners may treat all patients up to age 21 years.
   Adult Nurse Practitioners may treat all patients from age 13 and above.
   Family Nurse Practitioners and Physician Assistants can treat patients of all ages.

2. At least two (2) years of Clinical Experience in specialty area desired.

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

1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and/or other supervisors, as applicable will assess the NP/CNM/A's ability to practice.
   a. Clinical Practice
      - Length of proctoring period will be 3 months and will include 5 chart reviews and 1 case of direct observation.
      - The evaluator will be the Medical Director, Chief of Service or physician designee.

2. Biennial Reappointment: Medical Director, and/or designated physician and/or supervisor must evaluate the NP/CNM/PA's appropriate clinical competency for the setting by review of 5 charts and direct observation as determined by the evaluator.

3. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician and/or supervisor at appropriate intervals until acceptable skill level is achieved.

VI. *Development and Approval of Standardized Procedure*

A. Method of Development

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

B. Approval

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

C. Review Schedule

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

D. Revisions

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

Protocol #1: Health Care Management – Primary Care

A. DEFINITION

This protocol covers the procedure for age-appropriate health care management in primary care, clinics within the Community Primary Care Clinical Service including health centers, health center satellite locations, and the Ambulatory Care Call Center. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses.

B. DATA BASE

1. Subjective Data
   a. Screening: age-appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments, and review of systems.
   b. Ongoing/Continuity: review of symptoms and history relevant to the disease process or presenting complaint.
   c. Pain history to include onset, location, and intensity.
2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Age-appropriate screening tests, and /or diagnostic tests for purposes of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

c. Immunization update.
d. Referral to specialty clinics and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or change of medication other than those in the formulary/ies.
   f. Problem requiring hospital admission or potential hospital admission.
3. Education
   a. Patient education appropriate to diagnosis including treatment modalities and lifestyle counseling (e.g. diet, exercise).
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.
4. Follow-up
   As indicated and appropriate to patient health status and diagnosis.

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record.

Protocol #2: Health Care Management – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions at health sites within the Community Primary Care Clinical Service including health centers, health center satellite locations, and the Ambulatory Care Call Center.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
2. Objective Data
   a. Physical exam appropriate to presenting symptoms.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes and a statement of the current status of the disease.

D. PLAN

1. Therapeutic Treatment Plan
   a. Diagnostic tests for purposes of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   c. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation

b. Problem that is not resolved after reasonable trial of therapies
c. Unexplained historical, physical or laboratory findings
d. Uncommon, unfamiliar, unstable, and complex patient conditions
e. Upon request of patient, NP, PA, or physician
f. Initiation or change of medication other than those in the formularies.
g. Any Problem requiring hospital admission or potential hospital admission.

3. Education

Patient education should include treatment modalities. Discharge information and instructions.

4. Follow-up

As appropriate regarding patient health status and diagnosis.

E. RECORD KEEPING

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

Protocol # 3: Health Care Management – Prenatal Care

A. DEFINITION

This protocol covers the procedure for the routine prenatal care of essentially healthy women. This includes the provision of comprehensive education and primary care during the prenatal and postpartum period and the promotion of a healthy pregnancy and optimal outcome in all appropriate sites within the Community Primary Care clinical service.

B. DATA BASE

1. Subjective Data
   a. Complete appropriate history.
   b. Symptoms relevant to the prenatal health process.
2. Objective Data
   a. Initial prenatal visit includes a complete physical examination with sizing of uterus and fetal heart tones if at least 10 weeks.
   b. Routine follow-up visits, the physical exam to include:
      1. Blood pressure
      2. Weight and weight gained or lost since last visit.
      3. Urinalysis at initial visit and then at every visit >/= 26 weeks gestation or prn based on risk factors.
      4. Fetal heart tones
      5. Abdominal exam for fundal height (starting at 20 wks gestation) and presentation (starting at 36 weeks).
      6. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
      7. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.
   c. Pelvic examination when indicated by history.

C. DIAGNOSIS

Assessment and diagnosis of pregnancy status, risk factors, or disease process consistent with the subjective and objective findings.

D. PLAN

1. Therapeutic Treatment Plan
    a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
        1. Routine prenatal labs, including but not limited to: blood type and screen, Rubella titer, CBC, hemoglobinopathy evaluation, HBsAG, RPR, HIV antibody, pap smear (if indicated), clean catch urine culture, chlamydia, gonorrhea, GBS culture, and genetic carrier screen.
        2. First trimester genetic screen or NIPT and Second Trimester integrated genetics screening, and NT ultrasound if desired by patient.
        3. Glucose Load Test (GLT) at 24 to 28 weeks Gestational Age (GA). Do 1 hr. GLT at 1st visit (if 13-24 weeks GA) or hgb a1c (If <13 weeks GA) if at high-risk for Diabetes (as per SFGH GDM Screening Protocol). Do a 3 hr GTT if 1 hr GLT elevated.
        4. If patient is RH Negative repeat antibody screen and order Rhogam at 28 weeks.
        5. Order and review all imaging studies as appropriate.
    b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.
        1. Furnishing of prenatal vitamins.
    c. Immunization update.
    d. Referral to specialty clinics and supportive services as needed (e.g. nutritionist, social work, health education WIC).

2. Patient conditions requiring consultation as per Preamble section III b 2.
    a. Acute decompensation of patient situation.
    b. Problem that is not resolved after reasonable trial of therapies.
    c. Unexplained historical, physical, or laboratory findings.
    d. Upon request of patient, affiliated staff or physician.
    e. Initiation or change of medication other than those in the formulary (ies).
    f. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.

3. Education
    a. Normal process and progression of pregnancy.
    b. Psychosocial issues pertinent to pregnancy, age of client and home situation.
    c. Signs and symptoms of complications
    d. Fetal kick counts.
    e. Stages of labor.
    f. Pain management during labor and delivery.
    g. Infant nutrition: breast or formula feeding.
    h. Postpartum family planning.
4. Follow-up (Intervals determined by risk factors)
    a. Every 4-8 weeks until 28 weeks gestational age.
    b. Every 2 to 4 weeks from 28 to 35 weeks gestational age.
    c. Every week after 35 weeks gestational age.

E. RECORD KEEPING

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

Protocol #4: Furnishing Medications/Drug Orders

A. DEFINITION

““Furnishing “of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A “drug order” is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license. . Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistants Practice Agreement document. Nurse practitioners may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol. The practice site, Surgical Services, scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies to be used are: Zuckerberg San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2), the writing of Drug Orders. (Policy no. 13.5) & California AB1196 (Chapter 748) .

B. DATA BASE

1. Subjective Data
   a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
   b. Pain history to include onset, location, and intensity.
2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Describe physical findings that support use for CSII-III medications.

c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
d. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. When ordering respiratory treatments, a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device and frequency of treatments. Patient response will be monitored and documented.
   c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of electronic health record The protocol will include the following:
      i. location of practice
      ii. diagnosis, illness, or condition for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      i. name of medication
      ii. strength
      iii. directions for use
      iv. name of patient
      v. name of prescriber and title
      vi. date of issue

vii. quantity to be dispensed
viii. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring consultation
   a. Problem which is not resolved after reasonable trial of therapies.
   b. Initiation or change of medication other than those in the formulary.
   c. Unexplained historical, physical or laboratory findings.
   d. Upon request of patient, NP, PA, or physician.
   e. Failure to improve pain and symptom management.
   f. Acute, severe respiratory distress
   g. An adverse response to respiratory treatment or lack of therapeutic response.
3. Education
   a. Instruction on directions regarding the taking of the medications in patient's own language.
   b. Education on why medication was chosen, expected outcomes, side effects, and precautions.
4. Follow-up
   a. As indicated by patient health status, diagnosis, and periodic review of treatment course.

E. RECORD KEEPING

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

Protocol #5: Arthrocentesis and Intraarticular Injections

A. DEFINITION

This protocol covers joint arthrocentesis and the injection of corticosteroids and/or anesthetic preparations for pain relief or diagnostic purposes. The procedure includes inserting a needle into the joint space to aspirate fluid for analysis and/or to introduce medications.

1. This procedure can be completed at any health site within the Community Primary Care Clinical Service.

2. Performance of procedure:
   a. Indications
      - **Acute and chronic inflammatory musculoskeletal conditions such as osteoarthritis, rheumatoid arthritis, and other joint arthropathies**
      - Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of the joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of this will distinguish among hemarthrosis, effusion, fracture and septic arthritis.
   b. Precautions
      - Patients with a coagulopathy
   c. Contraindications
      - Severe dermatitis or soft tissue infection overlying the joint.
      - Acute trauma with open wound
      - Medication allergy

B. DATA BASE

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

performed.

c. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained, consistent with hospital policy, before procedure is performed.

b. Time out performed per hospital policy.

b. The procedure is performed following standard medical technique.

c. Diagnostic tests for purposes of disease identification.

d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

e. Referral to orthopedic clinic and supportive services, as needed.

2. Patient conditions requiring Consultation

a. Acute decompensation of patient situation

b. Unexplained historical, physical or laboratory findings

c. Upon request of patient, NP, PA, or physician

d. Any problem requiring hospital admission or potential hospital admission.

3. Education

Patients will be informed that pain relief may occur immediately due to the early onset of certain drug preparations, but the longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

4. Follow-up

As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisite, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation proctoring and provision of direct patient care: Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience, defined as active privileges for this procedure at another institution within the past six months. If the NP/PA has experience, direct observation is still required (see proctoring). Prerequisite 1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times. 2. Training will include NP/PA being able to demonstrate knowledge of the following: a. Indications for procedure and treatment. b. Risks and benefits of procedure and medication. c. Related anatomy and physiology. d. Consent process consistent with hospital policy. e. Time out policy and procedure. f. Wound infection and wound healing mechanisms. g. Use of required equipment. h. Steps in performing procedures. i. Ability to interpret results and formulate follow-up plans j. Ability to recognize complications k. Documentation and CPT and ICD-10 coding
Proctoring Period 1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator 2. New provider to procedure, a minimum of 2 successful observed

demonstrations. 3. Experienced provider to procedure, a minimum of 1 successful observed demonstration. 4. Explanation needed for any exceptions to minimum requirements. 5. Chart review will be done on all observed procedures. 6. Documentation of completion of training must be sent to the Medical Staff office.
Reappointment Competency Documentation 1. The evaluator will be an Attending Physician 2. Perform a minimum of 1 procedure every two years. 3. One chart review every two years.

Protocol #6: Musculoskeletal Soft Tissue Injections/Aspirations

A. DEFINITION

This protocol covers the aspiration of and/or injection of medications into soft tissue structures such as bursa, tendon sheaths, cysts, trigger points and carpal tunnel, for therapeutic or diagnostic purposes.

1. Location to be performed: This procedure may be completed at all healthcare sites within the Community Primary Care Clinical Service.
2. Performance of procedure:
   a. Indications
      i. Acute or chronic inflammatory conditions that impair function or cause discomfort, loss of motion or paresthesias.
   b. Precautions for injection:
      i. Chronic overlying dermatitis
      ii Diabetes
      iii Coagulopathy
      i. Close proximity to neurovascular (arterial) structures
   c. Contraindications
      i. Allergy to medication
      ii. Severe dermatitis or soft tissue infection overlying the joint or injection site.
      iii. Acute trauma

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, and allergies.
2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease

processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.

b. Time out performed per hospital policy.

c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

d. Diagnostic tests for purposes of disease identification.

e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient conditions requiring Attending Consultation

a. Acute decompensation of patient situation

b. Unexplained historical, physical or laboratory findings

c. Upon request of patient, NP, PA, or physician

d. Any problem requiring hospital admission or potential hospital admission.)

3. Education

Patients will be informed that pain relief may occur immediately due to the early onset on xylocaine preparations, but the longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

4. Follow-up

Patient follow-up determined based on whether procedure performed was diagnostic versus a therapeutic injection.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation proctoring and provision of direct patient care: Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience, defined as active privileges for this procedure at another

institution within the past six months. If the NP/PA has experience, direct observation is still required. Prerequisite 1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times. 2. Training will include NP/PA being able to demonstrate knowledge of the following: a. Indications for procedure and treatment. b. Risks and benefits of procedure and medication. c. Related anatomy and physiology. d. Consent process consistent with hospital policy. e. Time out policy and procedure. f. Wound infection and wound healing mechanisms. g. Use of required equipment. h. Steps in performing procedures. i. Ability to interpret results and formulate follow-up plans k. Ability to recognize complications h. Documentation and CPT and ICD-10 coding
Proctoring Period 1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator 2. New provider to procedure will have a minimum of 3 successful observed demonstrations. 3. Experienced provider to procedure will have a minimum of 1 successful observed demonstration. 4. Explanation needed for any exceptions to minimum requirements. 5. Chart review of all observed cases. 6. Documentation of completion of training must be sent to the Medical Staff office.
Reappointment Competency Documentation 1. The evaluator will be an Attending Physician 2. Perform a minimum of 2 procedures every two years. 3. One chart review every two years.

Protocol # 7: Endometrial Biopsy

A. DEFINITION

Evaluation of the endometrium by obtaining tissue for pathological diagnosis.

1. Indications:
   Women considered at increased risk for endometrial cancer (including but not limited to: abnormal uterine bleeding, endometrial cells on Pap, unopposed estrogen therapy, tamoxifen therapy) will be evaluated by endometrial biopsy as well as others requiring evaluation of endometrial tissue (infertility, infection) will be evaluated by endometrial biopsy.
2. Precautions:
   Consult an MD before performing biopsies on women with extreme retroversion or anteversion of the uterus. Also, consult when the procedure requires manual dilatation of the cervix.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed,
b. Diagnostic tests for purposes of disease identification.
c. Screening tests performed as part of age-appropriate health maintenance.
d. Biopsy tissue is sent to pathology.
Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
a. Acute decompensation of patient situation.
b. Unexplained historical, physical or laboratory findings
c. Uncommon, unfamiliar, unstable, and complex patient conditions
d. Upon request of patient, NP, PA, or physician
e. Initiation or adjustment of medication other than those in the formularies.
f. Problem requiring hospital admission or potential hospital admission.

3. Education
Discharge information and instructions

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING

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

F. SUMMARY OF PREREQUISTES, PROCTORING AND REAPPOINTMENT COMPETENCY

Prerequisites: 1. At least 6 months experience in women's health care. 2. Provider will observe a qualified provider do procedure 2 time.
Proctoring Period: 1. New provider to procedure, a minimum of 2 successful observed demonstrations 2. Experienced provider to procedure, a minimum of 1 successful observed demonstrations 3. Explanation needed for any exceptions to minimum requirements 4. Two chart reviews.

Reappointment Competency Documentation:

1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator
2. Perform a minimum of 1 procedure every 2 years.
3. 1 chart review every 2 years.

Protocol #8: Incision and drainage of skin abscesses

A. DEFINITION

Incision and Drainage (I&D) of abscesses involves making an incision in the skin to draw pus from the abscess. This protocol excludes abscesses on the face, neck, perirectal and genitalia.

1. Location to be performed: For the purposes of this protocol, the procedure may be completed at all of the health care sites within the Community Primary Care Clinical Service.

2. Performance of procedure:
   - i. Indications:
     -Abscess amenable by size and location to I&D with local anesthesia
     -Known allergies/adverse reactions to material used for incision and drainage, immunocompromised
   - ii. Precautions:
     Large abscesses that require extensive incising or debridement
   - iii. Contraindications:
     -Deep abscesses that may require more extensive anesthesia
     -Abscesses that invade the palmar or plantar spaces
     -Suspected pseudo aneurysm must be ruled out by further diagnostic evaluation
   - iv. Exclusions:
     Abscesses on the face, neck, perirectal area, and genitalia

B. DATA BASE

1. Subjective Data
   - a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
   - b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
   - a. Physical exam appropriate to the procedure to be performed.
   - b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   - c. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Explain procedure to the patient
   c. Time out performed per hospital policy.
   d. Diagnostic tests for purposes of disease identification.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical, or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.
3. Education - Discharge information and instructions.
4. Follow-up - As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Documentation

Prerequisite
1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.
2. Procedure performed following standard medical technique according to departmental standards.
3. One year experience in wound care.
4. Training will include:
a. Indications for procedure and treatment
b. Risks and benefits of procedure and medications
c. Related anatomy and physiology
d. Consent process consistent with hospital policy
e. Wound infection and healing mechanisms

f. Use of required equipment g. Steps in performing procedure h. Ability to interpret results and formulate follow up plans i. Ability to recognize complications
Proctoring Period 1. New provider to procedure will have a minimum of 2 successful observed demonstrations. 2. Experienced provider to procedure will have a minimum of 1 successful observed demonstration. 3. Explanation will be needed for exceptions to the minimum requirements. 4. Documentation of training or experience will be sent to the Medical Staff Office.
Reappointment Competency Documentation 1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator 2. Perform a minimum of 1 procedure every 2 years. 3. 1 chart review every 2 years.

Protocol #9: Procedure: Insertion of Contraceptive Implant

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm via a preloaded inserter.

1. Location to be performed: This procedure can be completed at all Community Primary Care clinical sites.
2. Indications:
   a. A woman desires long acting, reversible contraception.
   b. Precautions:
      i. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.
      ii. May have drug interactions with anti-HIV medications and some herbal products.
      iii. See drug precautions/interactions in implant prescribing information.
   c. Contraindications:
      i. Known or suspected pregnancy
      ii. Current or past history of thrombotic disease
      iii. Hepatic tumors, active liver disease
      iv. Known, suspected or history of breast cancer
      v. Undiagnosed abnormal genital bleeding
      vi. Hypersensitivity to any components of implant

B. DATA BASE

1. Subjective data
   a. History and review of symptoms relevant to implant insertion, including sexual history to rule out preexisting pregnancy.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam, including a negative pregnancy test.
   d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify if patient is eligible for implant insertion/removal.

D. PLAN

1. Therapeutic treatment plan
   a. Patient consent obtained before procedure is performed.
   b. Timing of insertion: see prescribing information.
   c. Implant inserted/removed as described in prescribing information.
   d. Initiation or adjustment of medication per furnishing/drug orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring attending consultation
   a. Difficult insertions/removals.
   b. Acute decompensation of patient situation.
   c. Upon request of patient, NP, CNM, PA, or physician
3. Education

   Discharge information and instructions for care of site, expectant side effects, precautions and urgent/emergent symptoms.
4. Follow-up

   As appropriate for implant insertion/removal.

E. RECORD KEEPING

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

F. Summary of prerequisites, proctoring, and reappointment competency

Prerequisites: Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience in contraceptive procedures (requires documentation) AND completion of required Nexplanon training course. Established Experience: Documentation of greater than five (5) cases in the past two (2) years. Limited Experience: Documentation of less than five (5) cases in the past two (2) years

Proctoring period: 1. For a new provider to procedure, a minimum of 2 successful observed demonstrations of insertions by a qualified provider. 2. For an experienced provider to pro a minimum of 1 successful observed demonstration of an implant insertion.
Reappointment competency documentation: 1. Review of 1 case of insertion every two years.

Protocol #10: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm and remains effective for 3 years. Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within CPC.

2. Performance of procedure:
   a. Indications
      Patient desires removal of implant or implant is expired.
   b. Precautions: See prescribing information.
   c. Contraindications: See prescribing information.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Diagnostic tests for purposes of disease identification.
   c. Timing of removal: See prescribing information
   d. Removal: as described in prescribing information
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.
2. Patient conditions requiring consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Difficult Implant removal.
   c. Upon request of patient, affiliated staff or physician
   d. If patient desires removal and rod is not readily palpable.
3. Education

   Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.
4. Follow-up

   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:
Must be a licensed healthcare provider (MD, DO, NP, PA, CNM) with prior experience. Established Experience: Documentation of greater than five (5) cases in the past two (2) years. Limited Experience: Documentation of less than five (5) cases in the past two (2) years

Proctoring period: a. Performance of a minimum of 2 removals for a new provider and 1 removals for a provider who has prior experience with independent removal. b. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator c. Chart review of all observed cases
Reappointment Competency Documentation: Review of 2 cases every 2 years.

Protocol #11: Procedure: Insertion of Intrauterine Device

A. DEFINITION
Intrauterine devices offer a highly effective, safe, long-term contraception.

1. Indications: Patient desires intrauterine device.

2. Precautions:
   a. Abnormalities of the uterus resulting in distortion of the uterine cavity
   b. Postpartum endometritis or postabortal endometritis in the past 3 months

3. Contraindications:
   a. Pregnancy of suspicion of pregnancy
   b. Acute pelvic inflammatory disease or current behavior suggestion of a high risk for pelvic inflammatory disease
   c. Know or suspected uterine or cervical malignancy
   d. Genital bleeding of unknown etiology
   e. Mucopurulent cervicitis
   f. Wilson's disease (for Paraguard IUD (TM))
   g. Allergy to any component of Paraguard IUD ™
   h. A previously placed IUD that has not been removed

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed,
   b. Timeout performed per hospital policy
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP/CNM/PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.

3. Education
   a. Discharge information and instructions.

4. Follow-up
   a. As appropriate for procedure performed.

E. RECORD KEEPING

All information relevant to patient care will be recorded in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: 1. Prior experience or training required for this procedure. 2. 6 months experience in women's health care. 3. Review of departmental policies and procedures.
Proctoring: 1. Direct observation of 2 successful insertions by a qualified provider. who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator 2. Documentation of training course completion.
Reappointment Competency Documentation: 1. Performance of one procedure every 2 years. 2. One chart review every 2 years.

Protocol # 12: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the Community Primary Care Clinical Service that are beyond simple cuts and abrasions. These wounds may require local anesthesia and suturing.

1. Location to be performed: this procedure can be completed all health sites within the Community Primary Care Clinical Service.

2. Performance of procedure/minor surgery:
   a. Indications: This protocol covers patients presenting to the Community Primary Care Service for assessment and treatment of lacerations, avulsions, bites and stings, burns and abscesses.

b. Precautions Immunocompromised patients.
c. Contraindications:
    - Wound infection
    - Noninfected wound caused by clean object that has remained open for longer than eighteen (18) hours (or twenty-four [24] hours for head wounds).
    - Vascular compromise or cases when direct pressure does not stop bleeding.
    - Wounds requiring large areas of debridement or excision prior to closure.
    - Wounds with bone fragments involved.
    - Wounds with tendon, ligament, vessel or nerve involvement.
    - Head lacerations where galea disruption is greater than 2 cm.
    - Facial lacerations with cosmetic considerations (i.e., eyelids and vermillion borders).
    - Lacerations penetrating into joints.
    - Patients requiring conscious sedation.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Unexplained historical, physical, or laboratory findings
   c. Upon request of patient, nurse practitioner, physician assistant, or physician
   d. Initiation or change of medication other than those in the formulary(ies)
   e. Problem requiring hospital admission or potential hospital admission

3. Education

   Discharge information and instructions.

4. Follow-up

   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. SUMMARY OF PREREQUISITES, PROCTORING AND REAPPOINTMENT COMPETENCY

Prerequisite 1. New provider will attend a wound care/suturing course or lab at AN outside facility or through SFGH. 2. Training will Include: a. Indications for procedure and treatment b. Risks and benefits of procedure c. Related anatomy and physiology d. Consent process consistent with hospital policy e. Time out process consistent with hospital policy f. Wound infection and wound healing mechanisms g. Use of required equipment h. Steps in performing procedure i. Ability to recognize complications.
Proctoring Period 1. New provider to procedure, a minimum of 2 successful observed demonstrations with chart review of all observed cases. 2. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstration. Chart review of all observed cases 3. Explanation needed for any exceptions to minimum requirements. 4. Documentation of completion of training must be sent to the medical staff office
Reappointment Competency 1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator 2. Must perform wound care/suturing a minimum of 1 time every two years. 3. One chart review every two years.

Protocol #13: Splinting

A. DEFINITION

Splinting involves the immobilization of joints and/or limbs or appendages to stabilize and protect fractures, and/or to provide comfort for patients with fractures, sprains, or other musculoskeletal injuries.

1. Location to be performed: This procedure may be completed at all health care sites within the Community Primary Care Clinical Service.

2. Performance of procedure:
   a. Indications: fractures, sprains, tendon injuries, other musculoskeletal injuries and conditions for which splinting may be part of the standard of care for treatment
   b. Precautions: known allergies/adverse reactions to materials used for splinting
   c. Contraindications: open fractures, otherwise complicated fractures or other musculoskeletal conditions, coagulation disorder

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
    a. Patient consent obtained consistent with hospital policy before procedure is performed.
    b. Time out performed per hospital policy.
    c. Explain procedure to the patient.
    d. Diagnostic tests for purposes of disease identification.
    e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
    a. Acute decompensation of patient situation
    b. Problem that is not resolved after reasonable trial of therapies
    c. Unexplained historical, physical, or laboratory findings
    d. Upon request of patient, nurse practitioner, physician assistant, or physician
    e. Initiation or change of medication other than those in the formulary (ies)
    f. Problem requiring hospital admission or potential hospital admission

3. Education
    Discharge information and instructions.

4. Follow-up
    As appropriate for procedure performed.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites
1. Procedure performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
2. Training will include:

a. Indications for procedure and treatment b. Risk and benefits of procedure c. Related anatomy and physiology d. Obtain Consent consistent with hospital policy e. Perform a time Out consistent with hospital policy. f. Use of required equipment g. Steps in performing procedure h. Ability to interpret results and formulate follow up plans. i. Ability to recognize complications.
Proctoring Period 1. New provider to procedure, a minimum of 2 successful observed demonstrations. 2. Experienced providers to procedure, a minimum of 1 successful observed demonstration. 3. Explanation needed for any exceptions to minimum requirements. 4. Documentation of completion of training must be sent to the Medical Staff Office.
Reappointment Competency Documentation 1. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator 2. Perform 1 procedure every two years. 3. 1 Chart review every two years.

Proctocol #14: Waived Testing

A. DEFINITION

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

1) Location where waived testing is to be performed: any in- or outpatient location providing emergency or primary care

2) The following non-instrument based waived tests are currently performed at SFGH:
   a. Fecal Occult Blood Testing (Hemocult ®)
      Indication: Assist with detection or verification of occult blood in stool.
   b. Vaginal pH Testing (pH Paper)
      Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis and trichomonas.
   c. SP® Brand Urine Pregnancy
      Indication: Assist with the diagnosis of pregnancy.
   d. Chemstrip® Urine Dipstick
      Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

1) Subjective Data
   Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed

2) Objective Data
   Each waived test is performed in accordance with approved SFGH policies and procedures specific for each test as well as site-specific protocols and instructions for:
   a. Indications for testing
   b. Documentation of test results in the medical record or LCR
   c. Actions to be taken (follow-up or confirmatory testing, Attending consultation, referrals) based on defined test results.

d. Documentation or logging of tests performed

C. DIAGNOSIS

Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.

D. PLAN

1. Testing
   a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
   b. Use gloves and other personal protective equipment, as appropriate.
   c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.

   Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.
   a. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?

2. Test Results requiring Attending Consultation

   Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

3. Education
   a. Inform patient of test results and need of additional tests, as necessary

4. Follow-up
   a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

Tests and control results will be recorded in the medical record.

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,
Proctoring: Successful completion of Halogen quizzes for each of the waived tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module.
Reappointment Competency Documentation: Renewal required every two years with documentation of successful completion of the required Halogen quizzes. Provider must have passed each required module with a score of 80%.
Any additional comments: N/A

Protocol #15: Tattoo Removal

A. DEFINITION

The removal of a tattoo (or multiple tattoos) from a patient's skin using the medlite CB laser. The treatment is always conducted in conjunction and consultation with a laser technician from Monarch Laser Services (or company that is contracted to provide laser services to SFDPH), the company which rents the laser to the City and County of San Francisco. Treatment is scheduled every six to eight weeks, until such time as the desired cosmetic outcome is achieved or complications arise requiring the cessation, suspension, or modification of therapy.

1. Location to be performed: San Francisco General Hospital and Trauma Center and affiliated SFDPH ambulatory settings.

2. Performance of procedure:
   a. Indications:
      1. The presence of one or more tattoos on the patient's skin, with a primary focus on gang-related tattoos or "bad choice" tattoos, especially in areas not usually covered by clothing (face, neck, hands, forearm's etc.)
   b. Precautions:
      1. A health screening questionnaire is completed by all program participants prior to acceptance into the program.
      2. Providers check in with patients prior to each treatment session.
      3. Extensive post-treatment counseling regarding after-care is conducted following each treatment session, along with any supplies needed to properly care for the treatment site.
   c. Contraindications:
      1. Immunodeficiency
      2. Pregnancy/breastfeeding
      3. Acute intoxication
      4. Open wounds at or near treatment site
      5. Acute infection at or near treatment site
      6 Severe reaction to laser treatment

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to tattoo removal.
   b. The tattoo removal is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

C. DIAGNOSIS

Assessment of subjective and objective data to identify eligibility for tattoo removal.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed. If patient is minor, parent/guardian consent must be obtained
   b. Time out performed.
   c. Diagnostic tests for purposes of disease identification.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education

Discharge information and instructions.

4. Follow-up

Six to eight weeks following treatment or as needed to address any concerns or complications.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Observation of twenty five tattoo removal clinic sessions. Completion of the laser safety module prepared by the SFGH Laser Safety Committee and baseline eye examination within the previous 1 year.
Proctoring Period: a. 10 cases by a provider with active privilege for tattoo removal or who has met proctoring and reappointment competency requirements as outlined in the SP.
Reappointment Competency Documentation: a. Completion of 5 procedures every 2 years. b. Completion of 5 chart reviews every 2 years.

Protocol # 16: Procedure: Nail Debridement

A. DEFINITION

Nail debridement is the removal of elongated overgrown nail material.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
   a. Indications: Elongated nail material, overgrowth, thick nail, painful fungal nails.
   b. Precautions: Vascular status, caution to amount of nail removed.
   c. Contraindications: none.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to ZSFG Admin POCT policy and procedure #16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Trim nails with use of sterile instrumentation.
   b. Diagnostic tests for purposes of disease identification.
   c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

d. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions. Instructions will include signs and symptoms of infection and follow-up if infection occurs.

4. Follow-up
   Will be determined based on individual needs for interval palliative survey.

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

F. Summary of Prerequisites, Training, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
1. Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience. If has experience will still require direct observation.
2. Training will include;
   a. Indications for procedure and treatment.
   b. Risks and benefits of procedure and medication.
   c. Related anatomy and physiology.
   d. Consent process

e. Wound infection and wound healing mechanisms assessment f. Use of required equipment. g. Steps in performing procedures. h. Ability to interpret results and formulate follow-up plans. i. Documentation and CPT and ICD-10 coding j. Ability to recognize complication.
Proctoring: 1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations. 2. Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration. 3. Chart review of all observed cases.
Reappointment Competency: 1. Performance of 1 procedure and 1 chart review every 2 years. 2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

Protocol # 17: Procedure: Nail Removal/Matrisectomy

A. DEFINITION

Nail removal or Matrisectomy is the complete or partial removal of the nail bed and nail plate.

1. Location to be performed will be all appropriate sites within the FCM department.
2. Performance of procedure:
   a. Indications: Chronic or acute nail infection (including fungal) or ingrown nails.
   b. Precautions: Severe infections that would indicate major surgical intervention and vascular status.
   c. Contraindications: Poor blood flow and other diagnoses not ruled out.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.

c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation:
a. Acute decompensation of patient situation
b. Unexplained historical, physical, or laboratory findings
c. Upon request of patient, nurse practitioner, physician assistant, or physician
d. Problem requiring hospital admission or potential hospital admission

3. Education
Patient will be informed of post matrisectomy care. Will be instructed in signs and symptoms of infection and follow up if infection occurs.

4. Follow-up
High risk patients will be followed at intervals for nail care. Post matrisectomy patients will be followed as needed to evaluate healing.

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

F. Summary of Prerequisites, Training, Proctoring and Reappointment Competency

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

1. Training in above procedures will occur on site during orientation period. If NP/PA does not have previous experience. If has experience will still require direct observation.

2. Training will include NP/PA being able to demonstrate knowledge of the following:
a. Indications for procedure and treatment.
b. Risks and benefits of procedure and medication.
c. Related anatomy and physiology.
d. Consent process
e. Wound infection and wound healing mechanisms assessment
f. Use of required equipment.

g. Steps in performing procedures. h. Ability to interpret results and formulate follow-up plans. i. Documentation and CPT and ICD-10 coding j. Ability to recognize complication.
Proctoring: 1. New practitioner to procedure will have a minimum of 2 successful observed demonstrations. 2. Experienced provider (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years) will have a minimum of 1 successful observed demonstration. 3. Chart review of all observed cases.
Reappointment Competency: 1. Performance of 1 procedure and 1 chart review every 2 years. 2. Medical Director, Physician-in-Charge, attending physician or designated clinician shall be the evaluator.

Protocol # 18: Procedure: Skin Biopsy

A. DEFINITION

Removal of a small portion of abnormal skin to be treated in a laboratory. There are three types of skin biopsy:

- Shave biopsy: the outer part of the suspect area is removed.
- Punch biopsy: a small cylinder of skin is removed using a punch tool.
- Excision biopsy: the entire area of abnormal growth is removed.

1. Location to be performed: all sites within the FCM department.

2. Performance of procedure:
   a. Indications
      i. Lesions for which dermal or subcutaneous tissue is necessary for diagnosis.
   b. Precautions
      i. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
      ii. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
      iii. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.
   c. Contraindications: None

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure /surgery to be performed.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   d. Diagnostic tests for purposes of disease identification.
   e. Biopsy tissue is sent to pathology *as appropriate.*
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those listed in or approved by the formularies.
   f. Problem requiring hospital admission or potential hospital admission.
3. Education

   Pre-procedure and post procedure education as appropriate and relevant in verbal or written format.
4. Follow-up

   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. 2 direct observations of a qualified provider doing each procedure b. Review of aseptic technique c. Review of departmental policy and procedure
Proctoring Period a. New practitioner to procedure, a minimum of 2 successful observed demonstrations of each procedure b. Experienced practitioner to procedure (as defined by proctoring at another institution with ongoing performance assessment documented within the past 2 years), a minimum of 1 successful observed demonstrations of each procedure c. Chart review of all observed cases.
Reappointment Competency a. A qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator b. Competency 1. Perform 1 of each procedure every 2 years. 2.1 chart review of each procedure every 2 years.

Approval Dates:

Committee on Interdisciplinary Practice (CIDP)	
Credentials Committee	
Medical Executive Committee	
ZSFG Joint Conference Committee (JCC)	