ZSFG JOINT CONFERENCE COMMITTEE MEETING

March 28, 2023

MEDICAL STAFF Report

Contents:

1. Chief of Staff Report
2. Chief of Staff Action List

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on March 28, 2023
March 2023 MEC Meeting

CLINICAL SERVICE REPORT: Ophthalmology Service - Jay Stewart, MD, Service Chief
The highlights of the report are as follows:

A. Scope of Clinical Services
   1. Clinical Services and Service Areas– The Ophthalmology Service areas include :
      - ZSFG Outpatient Services, Inpatient Services, Surgery, and Emergency Department
      - LHH
      - Tele-retinopathy screening (cameras) at the Health Centers
      - Future plans include expansion at Chinese Community Hospital and Southeast HC
   2. Technical Services – All manner of technical services is provided with most involving testing, scanning, and they are all done within the 4M Clinic.
   3. Clinical Productivity – There are about 15K outpatient visits per year at ZSFG Ophthalmology and almost 10K outpatient visits at ZSFG Optometry. Challenges with space and capacity limitations during COVID pandemic were successfully addressed by staff. Other details are as follows:
      - Optometry Service with 4 full-time optometrists and 1 part-time optometrist
      - Volume of Ophthalmology OR cases relatively stable over the past few years; cataract services (most common performed surgical procedure) with considerable backlog; other OR cases relate to retina, oculoplastics, glaucoma, and others
      - Minor procedures (mostly lasers and injections) performed at the clinic to use minor procedures' space and avoid patients escalating to OR.
      - Significant volume of diagnostic testing accredited to dedicated staff at DPH and UCSF technicians; many patients visiting providers also get multiple diagnostic tests; continuous work to improve efficiency for optimized cycle time of patient visits.
   4. Leadership – Dr. Jacque Duncan is the new Department Chair of USCF Ophthalmology.

B. House Staff - The Department has a 3-year residency program with 15 residents, along with internship, 1 float resident, and 1 oculoplastics resident. At any given time, there are 4-5 residents on-site. The residency program, with a highly diverse set of residents, is one of the top programs in the country. ZSFG is considered to be one of the biggest assets to the program.
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C. True North for Eye Care
   1. Patient Safety – There were root cause analyses and corresponding corrective actions on three cases involving medication administration, wrong patient laser, and wrong intraocular lens implanted.
   2. In-Clinic Cycle Times - With EPIC providing much more accurate cycle times, the cycle time was identified as relatively stable over the course of a year. Continuous effort is underway to reduce in-clinic cycle time.
   3. Referral Queue – Patient access continues to be a challenge with many patients (almost 2K patients currently waiting to be scheduled for Ophthalmology and Optometry). Queue was caused by either the pandemic or busy patient pattern. There is ongoing collaborative work with Patient Access Team.
   4. Cataract Surgery Backlog – Generally, there are 300-500 patients in queue. The goal is to reduce the number of patients in queue by performing surgery soonest after diagnosis.
      - Fast Track - Extensive efforts over the years focused on developing the fast track workflow in the OR for straightforward cases (about 40% of cases).
      - Slow Track- This is for complex cases with longer time due to various complexities and steps needed.
      - Collaboration with the Chinese Community Hospital – There is ongoing collaboration with use of available OR space at CCH. Patients receive all pre and post-op care at ZSFG, and only surgery is done at CCH by the Department's surgeons. Almost 40 highly successful cases have been completed. The plan is for about 15 doctors to have a quarterly duty wherein doctors spend a day at CCH every quarter to perform 10-12 quick cases/day. Also, there will be several surgeons who will continue to have regular block time every week or 2 weeks. The straightforward cases performed at CCH will free up ZSFG OR schedule for more complex cases.

5. Minor Room Pterygium Surgery Initiative – Pterygium is a benign growth that occurs on the surface of the eye. It can be visually disabling and be very uncomfortable for people. To reduce wait list, a workflow was developed to perform surgery for many cases at the minor procedures room. Some doctors have piloted to develop a semi-fast track process in the minor room for procedures.
6. Telemedicine and Test-Only Visits – PDSA and then full deployment in clinic workflows to reduce patient in-clinic wait time.
7. Equity
   - Equity and Care Experience - PIPS projects include No Show Rate data stratification by patient demographics and PDSA targeted strategies to improve show-rate/diabetic screening appointments.
   - Equity and Department Initiatives – These include staff engagement, along with patient services on translation of postoperative instructions in various languages.
   - Clinical Trial Center in Ophthalmology – The Department participates in NIH-sponsored studies in eye disease (Retina Network). A goal is to increase diverse population representation in clinical trials.
   - Advancing Ocular Health Equity at ZSFG – A new large database study looks at diabetic patient population over the last 10 years and identifies opportunities for intervention to improve equity of treatment, outcomes, and deliveries.
8. Developing People
   - Various developmental opportunities (training, continuing education, meetings, etc.) for staff
   - DEI-related considerations by staff, including a mission statement on Diversity, Equity, Inclusion and Justice.
   - Education – 60% women and 15% URM for residents; 40% female fellows (above ACGME benchmarks)
   - Grand Round Speakers – 50% female speakers and 12% URM for past several years

D. Research –There are basic research programs and various clinical research efforts with outside sponsorships.

E. Financial Stewardship- Total income for FY21/22 was $5.42M with most coming from affiliation agreements and the rest from pro-fees. Total expenditures for FY 21/22 was $4.73M.

F. Challenges and Opportunities – These include:
   - Cataract Backlog – optimize use of OR time that is made available to the Service and develop Chinese Hospital workflow
   - Clinic Referral Queue – working together with Patient Access team
   - Collaboration with other departments to improve the Department's performance as a consulting service.

Dr. Winston and other MEC members acknowledged the patient-centered work, commitment to safety, and excellent report by Dr. Stewart and the Ophthalmology Service.

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG on March 28, 2023
March 2023 MEC Meetings

Clinical Service Rules and Regulations

- Ophthalmology Rules and Regulations with Tracked Changes
- Ophthalmology Rules and Regulations Summary of Changes

Credentials Committee –

- Standardized Procedures
  - Revised Neurology SP
  - Revised Ambulatory Care Clinical Pharmacist SP
  - Summary of Changes for Neurology SP and Ambulatory Care Clinical Pharmacist SP

Ophthalmology Rules and Regulations

Changes from prior versions

- Updated date to 2023
- Correct Table of Contents formating
- Replaced previous OPPE criteria with current OPPE criteria
- Un-highlight 26.30 CTSI
- Change “chairman” to “chair”
- Change “his” to “their”

OPHTHALMOLOGY CLINICAL SERVICE
RULES AND REGULATIONS
~~2021~~2023

Approved by MEC TBD

OPHTHALMOLOGY CLINICAL SERVICES
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I. OPHTHALMOLOGY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

It is the intention of the Ophthalmology Clinical Service, Zuckerberg San Francisco General Hospital and Trauma Center, to provide the highest quality and prompt eye care to our children and adult patients.

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF OPHTHALMOLOGY CLINICAL SERVICE

- Chief of Service
- Associate Chief of Service
- Director of Retina Service
- Director of Glaucoma Service
- Director of Comprehensive Ophthalmology Service
- Director of Pediatric Ophthalmology Service

1. Chief of Service

a. The Chief of Service is appointed in accordance with ZSFG Bylaws, Article IX, *Clinical Services.*

b. The Chief of Service will be evaluated at regular intervals by the Executive Committee of the Medical Staff in accordance with the Bylaws of the Medical Staff.

c. The Chief of Service shall perform the duties outlined in the Bylaws, Rules and Regulations for the Medical Staff, as minimum. Refer to Appendix D.

d. The Chief of Service shall work with the Associate Dean's Office, ZSFG, to be certain that requirements of the Affiliation Agreement between CCSF and UCSF are fulfilled.

2. Associate Chief of Service

a. The Associate Chief of Service is appointed by the Chief of Service.

b. The Associate Chief of Service's performance is evaluated at least annually by the Chief of Service in accordance with the program outlined below. Less than satisfactory performance will be referred to the Medical Staff Office for action.

c. The Associate Chief of Service shall perform clinical service administrative duties as requested by the Chief of Service. The Associate Chief of Service shall represent the Chief of Service in ~~his~~ their absence.

3. Director of Retina Service

a. The Director of Retina Service is appointed by the Chief of Service.

b. The Director of Retina Service's performance is evaluated at least annually by the Chief of Service in accordance with the program outlined below. Less than satisfactory performance will be referred to the Medical Staff Office for action.

c. The Director of Retina Service shall oversee all aspects of clinical care of patients on the retina service.

4. Director of Glaucoma Service

a. The Director of Glaucoma Service is appointed by the Chief of Service.

b. The Director of Glaucoma Service's performance is evaluated at least annually by the Chief of Service in accordance with the program outlined below. Less than satisfactory performance will be referred to the Medical Staff Office for action.

c. The Director of Glaucoma Service shall oversee all aspects of clinical care of patients on the glaucoma service.

5. Director of Comprehensive Ophthalmology Service

a. The Director of Comprehensive Ophthalmology Service is appointed by the Chief of Service.

b. The Director of Comprehensive Ophthalmology Service's performance is evaluated at least annually by the Chief of Service in accordance with the program outlined below. Less than satisfactory performance will be referred to the Medical Staff Office for action.

c. The Director of Comprehensive Ophthalmology Service shall oversee all aspects of clinical care of patients on the comprehensive ophthalmology service.

6. Director of Pediatric Ophthalmology Service

a. The Director of Pediatric Ophthalmology Service is appointed by the Chief of Service.

b. The Director of Pediatric Ophthalmology Service's performance is evaluated at least annually by the Chief of Service in accordance with the program outlined below. Less than satisfactory performance will be referred to the Medical Staff Office for action.

c. The Director of Pediatric Ophthalmology Service shall oversee all aspects of clinical care of patients on the pediatric ophthalmology service.

7. Attending Physician Responsibility

a. An attending physician (board certified or qualified) with current hospital staff privileges will be available during all clinic sessions for resident consultation.

b. Attending physician (board certified or qualified) coverage is required on all surgical cases performed by the Ophthalmology Service. This regulation is to be waived only in emergencies where the delay in proceeding to surgery required to obtain attending coverage would be vision or life threatening. Such cases will be documented in writing by the resident in charge and signed by the Chief of Service. Such records will be maintained in the Ophthalmology Clinical Service Performance Improvement and Patient Safety (PIPS) files.

8. Committees

a. Ophthalmology Clinical Service Credentials Review Committee

The Ophthalmology Clinical Service shall maintain a Credentials Review Committee. It shall be the responsibility of this committee to review the credentials of staff members. The committee shall be composed of all Ophthalmology salaried medical staff members with non-proctored privileges. The Chief of Service (or ~~his~~ their representative) shall serve as ~~Chairman~~ Chair of the Committee and it shall be the ~~Chairman's~~ Chair's responsibility to forward the recommendations of this committee to the ZSFG Credentials Committee.

b. Ophthalmology Clinical Service Performance Improvement & Patient Safety (PIPS) Committee

The Ophthalmology Clinical Service shall maintain a Performance Improvement & Patient Safety Committee. It shall be the responsibility of this committee to oversee the quality of procedures outlined in this document. The committee shall be composed of all Ophthalmology salaried staff members with non-proctored privileges. The Chief of Service (or ~~his~~ their representative) shall serve as Chair~~man~~ of the Committee and it shall be the ~~Chairman's~~ Chair's responsibility to execute the recommendations of the committee.

c. A quorum of any Ophthalmology Clinical Service committee shall consist of one half of its members.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Ophthalmology Clinical Service is in accordance with ZSFG Bylaws Article II, *Medical Staff Membership* and *Appointments*/*Reappointments* as well as these Clinical Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Ophthalmology 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 Performance Profiles are maintained by the Chief of the Ophthalmology Service.

2) **Staff Status Change**
The process for Staff Status Change for members of the Ophthalmology Services is in accordance with ZSFG Bylaws, Rules and Regulations.

3) **Modification/Changes to Privileges**
The process for Modification/Change to Privileges for members of the Ophthalmology Service is in accordance with ZSFG Bylaws, Rules and Regulations.

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Ophthalmology Clinical Services privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V, *Clinical Privileges*, Rules and Regulations. (Refer to Appendix A)

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Ophthalmology Clinical Services Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Ophthalmology Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V, *Clinical Privileges*, Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Ophthalmology Clinical Service. The Credentials Committee shall oversee and recommend clinical privilege actions.

1. Requirements for Ophthalmology Clinical Service Privileges

a. Compliance with Section IX.G Monitoring & Evaluation of Professional Performance of Ophthalmology resulting in an approved description of clinical privileges (see Appendix A – *Ophthalmology Clinical Service Privileges*) and annual letter recommending continuation of privileges. New staff physicians working under Section IX.H.1 (New Staff Physicians and Technicians) will be proctored.

b. Current medical or technical license, or equivalent.

c. Board certification or eligibility, where appropriate.

d. Evidence of Continuing Medical (or Technical) Education as required for licensure and by the Medical Staff Office, ZSFG.

e. Current completed ZSFG/Departmental application for staff privileges.

f. Staff members shall conform to hospital requirements regarding Body Substance Precautions.

g. It is recommended that all Ophthalmology Staff members have current CPR certification.

h. DEA is not required, but is optional for the Ophthalmology staff members.

D. TEMPORARY PRIVLEGES

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

IV. PROCTORING AND MONITORING

Refer to Section IX.G. Monitoring and Evaluation of Professional Performance of Ophthalmology

A. MONITORING (PROCTORING) REQUIREMENTS

Refer to Section IX.B Performance Improvement & Patient Safety (PIPS) Program

B. ADDITIONAL PRIVILEGES

Additional Privileges are requested in accordance with ZSFG Bylaws, Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Removal of Privileges is requested in accordance with ZSFG Bylaws, Rules and Regulations.

V. EDUCATION

Refer to Section IX.A. Performance Improvement and Patient Safety (PIPS) Program, 6) through 9)

VI. OPHTHALMOLOGY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

(Refer to CHN Website for Housestaff Competencies link.)
Attending faculty shall supervise house staff in such a way that house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience.

Refer to Section IX.B. Performance Improvement and Patient Safety (PIPS) Program and IX.G Monitoring and Evaluation of Professional Performance of Ophthalmology.

VII. OPHTHALMOLOGY CLINICAL SERVICE CONSULTATION CRITERIA

Refer to Section IX.B Performance Improvement and Patient Safety.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY AND UTILIZATION MANAGEMENT

A. RESPONSIBILITY

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

B. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PROGRAM

1) The Ophthalmology Clinical Service Performance Improvement & Patient Safety (PIPS) Committee shall oversee QI and patient safety activities and make recommendations to the Chief of Service for action.

2) Clinical results, which constitute a “complication” of ophthalmic care, are difficult to define. However, as a minimum, unexpected loss of life or vision, unexpected returns to the operating room, adverse reactions to medical therapy, and post operative infections would fall into this category. Such cases will be detected by methods described in Section IX.B 5 below. They will be reviewed as outlined in accordance with Section IX.B. 6) through 11) below and remedial action advised. Repeat complications of a given nature may constitute care which deviates from acceptable standards. This should be reviewed as described above, and action taken as outlined in Section IX.G. 2) and 3) below, IX.B.. 14) and Section VIII. Actions by staff members which are deemed unethical or illegal may also constitute a deviation from standards of acceptable medical care. Such cases will be referred by the Chief (or Associate Chief) of Service to the Medical Staff Office for action.

3) Physicians and technical staff shall be in compliance with Section III.C and IX.G.

4) Regular chart review of clinic and inpatient records by the Chief, Associate Chief, and other attending physicians will help insure that all care rendered is consistent with appropriate standards. Outpatient records are reviewed for appropriateness of care and diagnosis, untoward therapeutic results, and completeness of records. No show outpatient records are reviewed by a clinic nurse, and if appropriate, a reminder is provided to the patient regarding the missed appointment and the need for follow-up. Inpatient records are reviewed for appropriateness of treatment and diagnosis, outcome at discharge, completeness of documentation and identification of utilization problems. The "Chief's Signature" indicates that such review has been performed. Deviation from appropriate standards of care will be managed as described in Section IX.B. 6) through 12) and Section IX.G.

5) Computerized records of patient visits, diagnoses, surgical procedures, and complications will be maintained. The Ophthalmology Clinical Service Administrative Assistant and Chief of Service review cases coded as complications (see Section IX.B. 2) quarterly for care consistent with acceptable standards. Deviations from appropriate standards of care will be managed as described in Section IX.B. 6) through 12) and Section IX.H. 1) through 3.

6) Quarterly meetings shall be held which will include staff physicians, technicians (including Optometry), nurses, administrators, and clerks. The agenda will include specific patient care problems, appointment scheduling, records, and staff interrelationships. Plans for correction of difficulties will be developed.

7) Regular meetings are held between the Chief of Service (or ~~his~~ their representative) and the resident staff to discuss management of difficult cases and to review clinical problems. Quality and morbidity issues (including infection data) are recorded on the appropriate departmental forms and maintained in the department QI files.

8) A weekly morbidity and mortality conference is held for the Department of Ophthalmology, UCSF and its affiliated hospital services. Difficult patient management problems and complications are reviewed. Suggestions for future management and avoidance are proposed. Quality improvement and morbidity issues relevant to ZSFG are recorded on the appropriate departmental form and maintained in the department QI files.

9) UCSF Ophthalmology Grand Rounds offers an opportunity to discuss interesting and difficult patient management cases.

10) Tissue and infection control data are maintained and included as part of staff members' reappointment review.

11) Unusual Laser Incident reports are reviewed by the Ophthalmology Clinical Service Laser Safety Officer. Where appropriate, these are referred to the Ophthalmology Clinical Service Performance Improvement and Patient Safety Committee for action.

12) Clerical and nursing staff shall comply with and be hired according to regulations set forth by the City and County of San Francisco. Difficulties in these areas related to patient care shall be referred by the Chief of Service or ~~his~~ their representative to the appropriate supervisor for investigation.

13) All clinical research programs involving ZSFG Department of Ophthalmology patients shall have Committee on Human Research, UCSF, approval and shall be conducted as approved. Specific permission to include ZSFG patients must be included in the approved protocol and a copy of this must be on file in the Department office. Specific application must also be made to the Associate Dean's office, ZSFG, and approved.

14) Ophthalmology Clinical Service quality of care indicators shall be monitored via Section IX.B. 1) through 13). The Indicators are described in Appendix C – Ophthalmology Clinical Service Department Quality of Care Indicators.

C. MEDICAL RECORDS

1) Medical records shall be maintained in accordance with requirements of the Bylaws and Rules and Regulations of the Medical Staff.

2) Attending physicians are ultimately responsible for the completion of medical records.

D. INFORMED CONSENT

Informed consent shall be obtained in accordance with the Bylaws and Rules and Regulations of the Medical Staff.

E. CLINICAL INDICATORS

Refer to Appendix C – *Ophthalmology Clinical Service Department Quality of Care Indicators*

F. CLINICAL SERVICE PRACTITIONER SERVICE PERFORMANCE PROFILES

Refer to Section IX.B – Performance Improvement and Patient Safety (PIPS) Program

G. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

Refer to Section IX.D.

H. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE OPHTHALMOLOGY

1. New Staff Physicians & Technicians
New staff physicians and technicians shall be assigned a proctor for one year to be certain that the care provided is consistent with appropriate standards. This determination shall be made through review as described by Section IX.B. 3) through 11) as well actual clinical observation where appropriate. Full privileges as requested will be granted or modified at the end of that time. A description of these privileges shall be maintained in the Department file.

2. Housestaff
Resident physicians and fellows shall be provided by contract between the City and County of San Francisco and UCSF. Ophthalmology residents shall meet, as a minimum, requirements for continuation as residents set forth by the Department of Ophthalmology, UCSF. Resident and fellow performance is reviewed monthly at

UCSF Departmental meetings. Less than satisfactory evaluation of any resident or fellow requires specific efforts to more closely supervise and improve that resident's performance. Continued unsatisfactory performance will lead to a separation of that resident from the University and secondarily, removal of that resident from duties at ZSFG.

3. Physicians, Affiliated Professionals & ZSFG Employees

Attending physician and technician performance will be evaluated annually by the Chief of Service through review methods described in Section IX.B. 4) through 11). If such review reflects clinical and ethical performance consistent with acceptable standards of care, the Chief of Service will recommend to the Credentials Committee that reappointment occur. Such documentation will be placed in the individual's Department file. Deviation from appropriate standards may result in assignment of a proctor for a period of one year with the goal of raising the quality of care to acceptable levels. Such action must be recommended by the Credentials Committee with advice from the Medical Staff Office, ZSFG. Continued deviation from acceptable standards may result in loss of clinical privileges after appropriate review by the Chief of the Medical Staff and the Medical Staff Office, ZSFG. The Chief of Service shall be reviewed annually by the Associate Chief of Service, as well as by the Executive Committee of the Medical Staff at designated intervals. The Chief shall be subject to the same requirements described above without exception.

X. MEETING REQUIREMENTS

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

The Ophthalmology Clinical Service shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of quality and appropriateness of the care and treatment provided to patients. Refer to Section I.C.5. Committees for Ophthalmology Clinical Service Committees.

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 Rules and Regulations of the Ophthalmology Clinical Service, Zuckerberg San Francisco General Hospital and Trauma Center, may be adopted or amended by a majority vote of a quorum meeting of the Performance Improvement and Patient Safety Committee of Ophthalmology Clinical Service. Recommendations for such changes shall be made at the quarterly meeting of the Ophthalmology Clinical Service Medical Staff. This document replaces any prior Rules and Regulations or Quality Assurance Program of the Ophthalmology Clinical Service, Zuckerberg San Francisco General Hospital and Trauma Center.

APPENDIX A – OPHTHALMOLOGY SERVICE PRIVILEGE REQUEST FORM

Privileges for San Francisco General Hospital

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

Ophthal OPHTHALMOLOGY 2017
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
______ ______

Requested Approved
______ ______ **26.00 NON-SURGICAL PRIVILEGES/GENERAL OPHTHALMOLOGY**
PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified by the American Board of Ophthalmology, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 2 reviews of patient encounters for each subsection.
REAPPOINTMENT: 2 reviews of patient care encounters for each subsection in the previous two years

______ ______ Basic Privileges: Diagnosis, measurement, and medical management of disorders and abnormalities affecting the eye, ocular adnexa, visual system and related systems. Includes H&Ps, diagnostic and therapeutic treatments, administration of topical anesthesia, and procedures, interventions, and similar activities involving the following areas:

______ ______ a. General Ophthalmology
______ ______ b. Cornea
______ ______ c. Glaucoma
______ ______ d. Oncology
______ ______ e. Pediatric Ophthalmology
______ ______ f. Oculo-Plastics
______ ______ g. Retina

______ ______

26.10 SURGICAL PRIVILEGES/GENERAL OPHTHALMOLOGY
PREREQUISITES: 1. Currently Board Eligible, Board Certified, or Re-Certified by the American Board of Ophthalmology or a member of the Clinical Service prior to 10/17/00 and 2. Completion of the ZSFG laser safety module developed by the ZSFG Laser Safety Committee and provide documentation of baseline eye examination within the previous 1 year.
PROCTORING: Five (5) reviews of operative procedures
REAPPOINTMENT: Three (3) reviews of operative procedures in the previous two years

______ ______ a. Primary Cataract Surgery With or Without Intraocular Lens Implantation
______ ______ b. Intraocular Lens Exchange
______ ______ c. Secondary Placement of Intraocular Lens
______ ______ d. Anterior Vitrectomy
______ ______ e. Repair of Anterior Segment Lacerations
______ ______ f. Pterygium Excision
______ ______ g. Minor Eyelid Surgery
______ ______ h. Secondary Scleral and Iris Fixated Intraocular Lens Placement
______ ______ i. Urgent repair of traumatic injury to the globe or eyelids
______ ______ j. Nd: YAG Laser (Posterior and Anterior Capsulotomies)

_______ ________ k. Argon Laser (Retinal Lasering and Laser Suture Lysis Procedure)

______ ______ **26.10 SPECIAL PRIVILEGES**

______ ______ 26.11 COMPLEX CORNEAL SURGERY

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified in Ophthalmology, with fellowship training in Cornea and external disease.
PROCTORING: 2 observed operative procedures and 3 retrospective review of operative procedures
REAPPOINTMENT: 3 operative procedures in the previous two years
Patient management, diagnosis, and medical and surgical treatment of complex corneal disorders:

______ ______ a Corneal Transplantation (Full Thickness and Lamellar)
______ ______ b Excision of Ocular Surface Neoplasms
______ ______ c Corneal Epithelial Debridement
______ ______ e Amniotic Membrane Grafting
______ ______ f Iris Repair
______ ______ g Scleral Patch Grafts

______ ______ 26.12 COMPLEX GLAUCOMA SURGERY

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified in Ophthalmology with fellowship training in Glaucoma; or significant experience in glaucoma surgery, as approved by the department chief.
PROCTORING: 2 observed operative procedures and 3 retrospective review of operative procedures
REAPPOINTMENT: 3 operative procedures in the previous two years

Patient management, diagnosis, and medical and surgical treatment of complex glaucoma disorders:

Requested Approved

______ ______ a Trabeculectomy Surgery
______ ______ b Tube Shunt Implantation
______ ______ c Goniotomies
______ ______ d Cyclodestructive Procedures

______ ______ 26.13 COMPLEX VITREORETINAL SURGERY

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified in Ophthalmology and with fellowship training in diseases and surgery of the vitreous and retina; or significant experience in retinal diseases, as approved by the department chief.
PROCTORING: 2 observed operative procedures and 3 retrospective review of operative procedures
REAPPOINTMENT: 3 operative procedures in the previous two years

Patient management, diagnosis, and medical and surgical treatment of complex vitreoretinal disorders

______ ______ a Pars Plana Vitrectomies
______ ______ b Pars Plana Lensectomies
______ ______ c Scleral Buckling Procedures
______ ______ d Removal of Intraocular Foreign Bodies
______ ______ e Use of Silicone Oil and Expansile Gases in the Eye
______ ______ f Use of Diathermy
______ ______ g Pneumatic Retinopexies
______ ______ h Retinectomies
______ ______ i Retinal Repair Surgeries

______ ______ 26.14 COMPLEX OCULOPLASTICS SURGERY

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified in Ophthalmology with fellowship training in Oculoplastics surgery; or with significant experience in oculoplastics surgery, as approved by the department chief.
PROCTORING: 2 observed operative procedures and 3 retrospective review of operative procedures
REAPPOINTMENT: 3 operative procedures in the previous two years

Patient management, diagnosis, and medical and surgical treatment of complex eyelid disorders:

______ ______ a Eyelid Lifting Procedures
______ ______ b Eyelift Lowering Procedures
______ ______ c Gold Weight Placements
______ ______ d Repair of Lacrimal System
______ ______ e Dacryocystorhinostomies
______ ______ f Entropion/Ectropion Repairs
______ ______ g Enucleations
______ ______ h Eviscerations
______ ______ I Exenterations
______ ______ j Orbital Bone Fracture Repair
______ ______ k Orbital Decompression Surgery
______ ______ l Optic Nerve Sheath Decompression
______ ______ m Socket Reconstruction
______ ______ n Buccal Mucosal Grafts
______ ______ o Eyelid Reconstruction Surgery with Tissue Transfer

______ ______ 26.15 PEDIATRIC OPHTHALMOLOGY SURGERY

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified in Ophthalmology and with fellowship training in Pediatric ophthalmology; or significant experience in pediatric ophthalmology, as approved by the department chief.
PROCTORING: 2 observed operative procedures and 3 retrospective review of operative procedures
REAPPOINTMENT: 3 operative procedures in the previous two years

Patient management, diagnosis, and medical and surgical treatment of complex pediatric ophthalmologic disorders:

Requested Approved

______ ______ a Pediatric Cataract Surgery With and Without Intraocular Lens Insertion (Primary of Secondary)
______ ______ b Strabismus Surgery (in Children and Adults).

______ ______

______ ______ 26.30 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) – CLINICAL RESEARCH

PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified by one of the boards of the American Board of Medical Specialities. Approval of the Director of the CTSI (below) is required for all applicants.
PROCTORING: All OPPE metrics acceptable
REAPPOINTMENT: All OPPE metrics acceptable

I hereby request clinical privileges as indicated above.

____ _______________
Applicant date

FOR DEPARTMENTAL USE:

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

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

______ CPR certification is required.
______ CPR certification is not required.

APPROVED BY:

____ _______________
Division Chief date

____ _______________
Service Chief date

APPENDIX B – CRITERIA FOR LASER CREDENTIALS & SAFETY TRAINING

The Ophthalmology Clinical Service criteria for Laser user credentialing shall include one of the following:

1. Satisfaction of hospital criteria that would be required of a Department Laser Safety Officer,

Or

2. Completion of the department sponsored laser science and safety course

And

3. Completion of the vision screening.

Unsatisfactory performance will be handled as outlined in the Ophthalmology Clinical Service policy manual, and may result in loss of laser privileges.

All non-user personnel who may be exposed to laser light shall undergo an annual safety review and vision screening.

Tests, reviews, and vision screening shall be kept in individual personnel file.

APPENDIX C - OPHTHALMOLOGY CLINICAL SERVICE QUALITY OF CARE INDICATORS (OPPE)

Metric 1 ACGME Core Competency: Patient Care Occurrence of Complications Attributable to Physician (number) Data Source: Collected by Dept. from Epic Operative Reports	Metric 2 ACGME Core Competency: Patient Care Sentinel Event Review Discussion OutComes Data Source: Collected by Dept. from Epic Operative Reports	Metric 3 ACGME Core Competency: Medical/Clinical Knowledge Maintaining Board Certification in Ophthalmology Data Source: Collected by Medical Staff Office	Metric 4 ACGME Core Competency: Medical/Clinical Knowledge California Medical License Data Source: Medical Staff Office	Metric 5 ACGME Core Competency: Medical/Clinical Knowledge Obtaining 50 CME Credits Every Two Years Data Source: Collected by Department
Threshold Ranges	Threshold Ranges	Threshold Ranges	Threshold Ranges	Threshold Ranges
Acceptable: 0-4	1 = Acceptable: Implemented	1 = Acceptable: Active/Current	1 = Acceptable: Licensed	1 = Acceptable: 50 CMEs Obtained
Marginal: 5-8	Marginal: n/a	2 = Marginal: Received letter that boards are due at next reappointment	Marginal: n/a	Marginal: n/a
Unacceptable: > 8	2 = Unacceptable: Not Implemented	2 = Unacceptable: Administrative suspension from Medical Staff during the 6 month reporting period for lack of board certification	2 = Unacceptable: Not Licensed	2 = Unacceptable: 50 CMEs Not Obtained
Metric 6 ACGME Core Competency: Practice-Based Learning & Improvement Consistent Participation in Time-Outs To Verify Procedure Details Data Source: Collected by Dept.	Metric 7 ACGME Core Competency: Practice-Based Learning & Improvement Completion of Required Annual Hospital Training Modules Data Source: Collected by Medical Staff Office	Metric 8 ACGME Core Competency: Interpersonal and Communication Skills Absence of Credible, Substantive Negative Faculty Evaluations by Trainees Data Source: Collected by Dept.	Metric 9 ACGME Core Competency: Interpersonal and Communication Skills Absence of Unusual Occurence Reports in This Area Attributable to the Physician Data Source: Collected by Dept.	Metric 10 ACGME Core Competency: Professionalism Regular Participation in Dept. Surgical Quality Improvement Conferences (percent) Data Source: Collected by Dept.
Threshold Ranges	Threshold Ranges	Threshold Ranges	Threshold Ranges	Threshold Ranges
1 = Acceptable: Consistent	1 = Acceptable: Current	1 = Acceptable: Absent	1 = Acceptable: Absent	Acceptable: > 50% of sessions, not counting excused absences

Marginal: n/a	Marginal: n/a	Marginal: n/a	Marginal: n/a	Marginal: 25-49% of sessions, not counting excused absences
2 = Unacceptable: Not Consistent	2 = Unacceptable: Not Current	2 = Unacceptable: Present	2 = Unacceptable: Present	Unacceptable: < 25% of sessions, not counting excused absences

Metric 11 ACGME Core Competency: Professionalism Absence of Unusual Occurrence Reports in This Area Attributable to the Physician (number) Data Source: ZSFG/UCSF Quality Management, Risk Management, Collected by Dept.	Metric 12 ACGME Core Competency: Systems-Based Practice Notes Signed Within 72 hrs Data Source: Epic	Metric 13 ACGME Core Competency: Systems-Based Practice On-Time Operating Room Starts Attributable to the Physician Data Source: Epic
Threshold Ranges	Threshold Ranges	Threshold Ranges
Acceptable: 0	Acceptable: > 90%	Acceptable: > 80%
Marginal: 1	Marginal: 80-90%	Marginal: 50-80%
Unacceptable: > 2	Unacceptable: < 80%	Unacceptable: < 50%

~~**APPENDIX C - OPHTHALMOLOGY CLINICAL SERVICE QUALITY OF CARE INDICATORS**~~

~~Aspect of Care~~	~~Indicator~~	~~Threshold~~	~~HR/HV~~	~~I/O~~	~~Monitoring~~
~~**Effectiveness of Therapy**~~					
	~~1. Operative complications~~	~~0%~~	~~HR~~	~~I/O~~	~~Computer Database~~

	Indicator	Threshold	Risk	Type	Data Source
	and return to OR				Medical Record Review
	2. Poor vision outcome	0%	HR	I/O	Prospective Analysis Medical Record Review
	3. Perioperative death	0%	LR		Prospective Analysis Medical Record Review
Infection Control					
	1. Post operative infection	0%	LR	I/O	Computer Database Infection Control Committee
	2. EKC rates	0%	LR	O	Computer Database
	3. Compliance with BSP	100%			Attendance at training and review
Response to Patient Needs					
	1. Time to surgical treatment of ruptured globes (<12HRS)	100%	HR	I	Hospital CQI Report Computer Database Medical Chart Review
	2. Unusual occurrence reports/patient grievances	0%	HR	I/O	Special review of all reports

APPENDIX D - CLINICAL SERVICE CHIEF OF OPHTHALMOLOGY SERVICE JOB DESCRIPTION

APPENDIX D – CLINICAL SERVICE CHIEF OF OPHTHALMOLOGY SERVICE JOB DESCRIPTION

Chief of Ophthalmology Clinical Service

Position Summary:

The Chief of Ophthalmology Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) and the Department of Public Health (DPH). The Chief also insures 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 Ophthalmology 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 Ophthalmology 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 Ophthalmology 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.

SUMMARY OF CHANGES

- Ambulatory Care Pharmacist SP
  - Now includes Cardiology Clinic
  - IV.B.2 Changed from 10 to 5 chart reviews or 5 direct observations every 2 years

- Neurology SP
  - Removed recordkeeping references to PAs throughout the SP
  - II. Changed PA recert from 6 to 10 years and replaced "Delegation of Services" to "Practice"
  - V.A.7 Included "for NPs
  - V.A.8 Replaced "Delegation of Services" to "Practice"
  - V.C.3 Changed "six months" to "year"
  - V.C.5 deleted
  - BLS deleted

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

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Neurology Nurse Practitioner/Physician Assistant

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, Nurse –Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, Pharmacists, Psychologists and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in Title16, CCR Section 1474.

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Neurology Department Office 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 a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

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

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

The NP/PA conducts 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/PA May Perform Function

A. Setting
   1. Location of practice is the outpatient Neurology Clinic and Inpatient units at Zuckerberg San Francisco General Hospital and Trauma Center.
   2. Role in the outpatient and inpatient setting may include performing physical exams, diagnosing and treating illnesses, ordering and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications or issuing drug orders for the Neurology patient. Will only be seeing adult patients.

B. Supervision
   1. Overall Accountability:
      The NP/PA is responsible and accountable to the Chief of Neurology.
   2. A consulting physician which may include attending's and fellows, will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:

a. Acute decompensation of patient situation
b. Problem that is not resolved after reasonable trial of therapies.
c. Unexplained historical, physical, or laboratory findings.
d. Upon request of patient, 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.

IV. Scope of Practice

Protocol #1	Core – Neurology Clinic
Protocol #2	Core – Acute/Urgent Care
Protocol #3	Core - Furnishing Medications/Drug Orders
Protocol #4	Lumbar Puncture
Protocol #5	Ordering Transfusions
Protocol #6	eConsult Review
Protocol #7	Core - Discharge Inpatients
Protocol #8	Botox injections

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) by an approved 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 within 12 months of hire for NPs.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center ~~Delegation of Service~~Practice Agreement ~~(DSA)~~. Copies of ~~DSA~~ Practice Agreement must be kept at each practice site for each PA.

B. Specialty Training
   1. Specialty requirements
      a. NP specialty certification as a ANP, FNP, ACNP
      b. Certification as a Certified Neuroscience Registered Nurse (CNRN) within 3 years of hire
   2. Amount of previous experience in specialty area expected for this position.
      a. Two years experience as a Registered Nurse or Nurse Practitioner in an acute care hospital or clinic within six months of hire
      b. Two years experience as a PA in an acute care hospital or clinic within six months of hire.

C. Evaluation of NP/PA Competence in performance of standardized procedures.
   1. Initial: at the conclusion of the standardized procedure training, the Medical Director, supervising 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. The term may be shortened or lengthened (not to exceed six months CCSF probationary period) at the discretion of the supervising physician. At the end of the proctoring term, the NP/PA will be generally supervised by Chief of Neurology, Neurology Service Attending, Neurology Fellow and Senior Neurology Residents.
         2. The evaluator will be the Chief of Neurology or designated Neurology Physician or designated clinician.
         3. The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
            a. All cases are presented to the evaluator
            b. Evaluator reviews co-signs orders and progress notes
            c. Co-signatures by a licensed physician must be concurrent to patient care
            d. Medical record review is conducted for out-patient discharge medication
            e. Medical Record review may be conducted retrospectively by the Clinical Supervising Physician
            f. Proctoring will include a minimum evaluation of five (5) chart reviews and direct observations,

with at least one case representing each core protocol (core - neurology clinic, core – acute/urgent care), discharge of inpatients, and furnishing medications/drug orders if applicable).

g. Procedural skills are incorporated into the competency assessment orientation

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

3. Ongoing Professional Performance Evaluation (OPPE) Every ~~six months~~year, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.

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

5. ~~Ongoing:~~

~~a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are 1) Examination of the patient by Supervising Physician the same day as care is given by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

VI. Development and Approval of Standardized Procedure

A. Method of Development
   1. Standardized procedures are developed collaboratively by the Nurse Practitioners/Physician Assistants, 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 Core – Neurology Clinic

A. DEFINITION

This protocol covers the procedure for health care management in the Neurology outpatient clinic. 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 history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history allergies, current medications, treatments and review of symptoms.
   b. Ongoing/Continuity: review of symptoms and history relevant to the presenting complaint and/or disease process.
   c. Pain history to include onset, location and intensity.

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

C. DIAGNOSIS

Assessment of data from the subjective and objective findings, identification of risk factors and knowledge of disease processes will be used to derive a list of differential diagnoses. Status of disease may be stable, unstable, or uncontrolled.

D. PLAN

1. Therapeutic Treatment Plan
   a. Diagnostic tests for purposes of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   c. 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 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. Problem requiring hospital admission or potential hospital admission.

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

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

E. RECORD KEEPING

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

Protocol #2: Core – 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. Patients will be seen in the Outpatient Neurology Clinic and Inpatient Units

B. DATA BASE

1. Subjective Data
    a. History and review of symptoms relevant to the presenting complaint and/or disease process.
    b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

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

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes. May include statement of current status of disease.

D. PLAN

1. Therapeutic Treatment Plan
    a. Diagnostic tests for purposes of disease identification.
    b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    c. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation

    a. Acute decompensation of patient situation
    b. Problem that is not resolved after reasonable trial of therapies
    c. Unexplained historical, physical or laboratory findings
    d. Uncommon, unfamiliar, unstable, and complex patient conditions
    e. Upon request of patient, NP, PA, or physician

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

Protocol #3: Core - Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of a DEA number. ~~All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively, PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistants Delegation of Service document.~~

Nurse practitioners may order Schedule II - V controlled substances when in possession of a DEA number. Schedule II - III controlled substances may be ordered for, but not limited to, the following conditions: patients presenting with acute and chronic pain and patients presenting with ADHD or other mental health-related disorders requiring the use of controlled substance Schedule II medications.

The practice site scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies that will be used are: San Francisco General Hospital and Trauma Center, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows CHN policy on Furnishing Medications (policy no. 13.2) and the writing of Drug Orders. (Policy no. 13.5).

B. DATA BASE

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

2. Objective Data

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
   c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, and 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. Upon request of patient, NP, PA, or physician.
d. Failure to improve pain and symptom management.

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

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

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record as appropriate. ~~The medical Record of any patient cared for by a P.A. for whom the supervising physician and Surgeon's schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.~~

Protocol #4: Procedure: Lumbar Puncture

A. DEFINITION

A diagnostic procedure used to identify infectious, inflammatory, and neoplastic processes of the central nervous system. Lumbar puncture is also used to administer diagnostic as well as therapeutic agents. Lumbar puncture can also be done to determine the intracranial pressure.

1. Location to be performed: Neurology Service Lumbar Puncture

2. Performance of Lumbar Puncture

a. Indications
   1. To obtain Cerebral Spinal Fluid (CSF) for diagnosis of infectious, inflammatory or neoplastic diseases
   2. To determine the presence of subarachnoid hemorrhage
   3. To diagnose and treat hydrocephalus increased intracranial pressure for selective patients

b. Precautions
   1. Obtain brain imaging study to rule out mass effect, subarachnoid hemorrhage or obstructive hydrocephalus
   2. Aseptic technique / avoid chemical meningitis, abscess
   3. Platelets should be greater than or equal to 100,000
   4. Patients on anticoagulants or who have bleeding tendencies (F.F., Von Willebrand's, Hemophilia, Liver disease)
   5. ASA/NSAIDS/Cox II Inhibitors
   6. Withdraw CSF slowly and only the amount that is needed

c. Contraindications
   1. Increased intracranial pressure secondary to mass or mass effect
   2. INR greater than 1.4
   3. Therapeutic anticoagulation or blood dyscrasias
   4. Soft tissue infection at the entry site / spinal osteomyelitis
   5. Known spinal cord arteriovenous malformations
   6. Posterior fossa lesion
   7. 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 or meningitis symptoms, motor/sensory deficits, and new/persistent CSF leak.

b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications including aspirin, aspirin-containing-products, anticoagulants, anti-platelet agents, and non-steroidal anti-inflammatory agents, and allergies including anesthetic agents.

2. Objective Data

a. Physical exam appropriate to the procedure to be performed including detailed neurologic examination, assessment of papilledema, and integrity of the lumbar skin site.

b. The procedure is performed following standard medical technique according to The Handbook of Neurosurgery by Mark Greenberg, Section 23.7.3. Lumbar Puncture.

c. Laboratory evaluation to include CBC with platelets, PT, PTT, and INR. Brain imaging evaluation to rule out a mass lesion, a posterior fossa lesion, or subarachnoid hemorrhage, as indicated by history and physical exam.

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes. Differential diagnoses would include but not limited to meningitis, encephalitis, sarcoidosis, subarachnoid hemorrhage, meningeal carcinomatosis, increased intracranial pressure, and decreased intracranial pressure.

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 on the CSF for purposes of disease identification may include protein level, glucose level, gram stain, culture and sensitivity, blood cell count and differential, and measurement of CSF pressure. Additional diagnostic tests may include: cytologic testing, staining for AFB, cryptococcal antigen, serologic testing for syphilis, Lyme disease, viral titers, immunoglobulin profiles, and oligoclonal banding.

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 Attending Consultation

3. Education
   a. Discharge information and instructions pertaining to lumbar puncture. Krames-on-Demand educational print outs titled "Lumbar Puncture" and "Having a Lumbar Puncture" can be provided to patients to assist with pre- and post-procedural education.

4. Follow-up
   As appropriate for procedure performed.
   a. Assess for signs and symptoms of insertion site infection
   b. Assess for signs of CSF leak
   c. Assess for complaints of headache in the upright position

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency 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 #5: Ordering Blood Transfusions

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

1. Location to be performed: Neurology Clinic.

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.

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

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

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

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

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

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

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

4. Follow-up
   As appropriate for patients 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, as appropriate. ~~For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite: a. Successful completion of the 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 year. c. Review of any report from the Transfusion Committee. d. Evaluator will be the medical director or other designated physician.

PROTOCOL #6: eConsult Review

A. DEFINITION

eConsult review is defined as the review of new outpatient consultation requests via the online eConsult system. A new outpatient is defined as a patient that has neither been consulted upon by the Neurology service, admitted to the Neurology service nor seen in the Neurology 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 review eConsult independently.
   b. Providers reviewing eConsults will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
   c. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
   d. Providers reviewing eConsults will have expertise in the specialty practice for which they are reviewing.

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.
3. Proctoring: A review of 5% of the eConsult consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.
4. Reappointment: 5 chart reviews will be needed for reappointment every 2 years.

B. DATA BASE

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

adequate assessment of urgency and appropriateness of the referral.
   b. Pain history to include onset, location, and intensity, aggravating and alleviating factors, current and previous treatments.

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

C. DIAGNOSIS

A diagnosis will not be determined at the time of eReferral 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 eReferral
   a. Algorithms or referral guidelines developed and approved by the Chief of Service will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.
   b. All data provided via the eConsult consultation request will be reviewed and assessed for thoroughness of history, adequacy of work up, and urgency of condition.
   c. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

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

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

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

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

E. RECORD KEEPING

All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the electronic medical record (EMR) 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 print out. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into the EMR and forwarded to the scheduler.

Protocol #7: Core - Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from Zuckerberg San Francisco General Hospital.

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

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

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

3. Education

a. Review inpatient course and what will need follow-up.
b. Provide instructions on:
- follow-up clinic appointments
-outpatient laboratory/diagnostic tests
-discharge medications
-signs and symptoms of possible complications

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

E. RECORD KEEPING

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

Protocol #8: Botox injections

A. DEFINITION
Administration of Botox (Onabotulinum toxin A) for the treatment of chronic migraine.

1. Location to be performed: Neurology Service 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 Neurology Consultation with attending input confirming the need for the procedure.

3. Education
   a. Discharge instructions and patient education material will be provided.

4. Follow-up
   As appropriate for procedure performed.
   d. 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.
   e. 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 or his/her designee who maintains the Botox privilege. b. Ongoing competency evaluation. 1. Completion of three procedures every 2 years. 2. Three chart reviews needed every 2 years.

References

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San Francisco Health Network of San Francisco
Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE FOR AMBULATORY CARE CLINICAL PHARMACIST

Medication Therapy Management Clinics at:

Anticoagulation Clinic
Cardiology Clinic
Castro Mission Health Center
Chinatown Health Center
Ocean Park Health Center
Maxine Hall Health Center
Curry Senior Center
Potrero Hill Health Center
Silver Avenue Family Health Center
Southeast Health Center
Tom Waddell Urban Health Center
Family Health Center
Richard Fine People's Clinic
Positive Health Program
Children's Health Center
Community Health Programs for Youth
Special Programs for Youth

I. Policy statement

A. It is the policy of the San Francisco Health Network and Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively by health professionals, including physicians, pharmacists, and registered nurses.

B. A copy of the signed procedures will be kept in the Medical Staff Office and the respective clinics.

II. Functions to be performed

The clinical pharmacist, in accordance to the California Business and Profession Code 4050 to 4052, who has standardized procedures conforming to Title 16, California Code of Regulations, Section 1474, Standardized Procedure Guidelines, may perform the following procedures or functions to provide health care services in a clinic as part of a multidisciplinary group that includes physicians and registered nurses.

A. Performing patient assessment

B. Ordering and interpreting drug therapy-related tests

C. Referring patients to other health care providers

D. Participating in the evaluation and management of diseases and health conditions in collaboration with other health care providers

E. Initiating, adjusting, or discontinuing drug therapy; the patient's treating prescriber may prohibit, by written instruction, any adjustment or change in the patient's drug regimen by the clinical pharmacist.

F. Administering drugs and biologicals by injection pursuant to a prescriber's order (the administration of immunizations under the supervision of a prescriber may also be performed outside of a licensed health care facility).

G. Initiating and administering vaccine listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC)

H. Providing consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

III. Circumstances under which a clinical pharmacist may function

A. Setting

The clinical pharmacist may perform the following standardized procedure functions in the listed clinics consistent with their experience and training.

B. Scope of supervision required

1. Clinical pharmacists are responsible and accountable to the Chief Pharmacy Officer, and the medical directors of clinics where they provide clinical pharmacist services.

2. University of California-San Francisco pharmacists practicing in SFHN clinics are under the direct supervision of the clinic medical director. They are responsible and accountable to the DPH Chief Pharmacy Officer to provide clinical services consistent with the needs and expectations of the DPH and SFHN. Performance appraisals and other professional oversight are the responsibility of the clinic medical director.

3. Overlapping functions are to be performed in areas which allow for a consulting provider to be available to the clinical pharmacist, available by phone, in person or other electronic means at all times

4. Provider consultation is to be obtained under the following circumstances:

   a) Medical conditions requiring prompt medical intervention
   b) Acute decompensation of a patient
   c) Medical problems not resolving as anticipated
   d) Unexpected historical, physical or laboratory findings
   e) Before ordering invasive laboratory procedures other than venipuncture needed to assess pharmacologic therapy

f) Early requests for controlled substance refills based upon pain agreement between a provider and the patient
g) Upon request of patient, provider or clinical pharmacist
h) Violent or verbally abusive patient behavior

IV. Requirements for the clinical pharmacist

A. Experience and education

1. Active California pharmacist license

2. Possession of a Doctor of Pharmacy degree, and completion of an American Society of Health-System Pharmacists or American College of Clinical Pharmacy accredited one-year pharmacy residency program; OR

   Possession of a Baccalaureate of Pharmacy degree, completion of a one year pharmacy residency program, and one year of verifiable post-graduate work experience performing clinical functions in medication management

   (Two years of verifiable post-graduate work experience performing clinical functions in medication management may be substituted for the one year residency or fellowship experience requirement)

3. Completion of immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education if initiating or administering vaccines under section II, G

4. Completion of an annual geriatric competency relevant to the pharmacist's professional practice

B. Evaluation of the clinical pharmacist competence in performance of standardized procedures

1. Initial: At the conclusion of the standardized procedure training, the Chief Pharmacy Officer or designee will assess the clinical pharmacist's ability to practice utilizing feedback from consulting providers, and review ten charts or 10 direct observations that include medication changes made by the clinical pharmacist. Documentation will be reviewed and signed off by the clinic medical director or designee.

2. Annual: Chief Pharmacy Officer or designee will evaluate the clinical pharmacist's competence by ~~reviewing~~ performing 5 chart reviews or 5 direct observations every 2 years to align with the ~~2- year~~ reappointment window for Medical Staff Office credentialing. Documentation will be reviewed and signed off by the clinic medical director or designee.

3. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Chief Pharmacy Officer or designee at appropriate intervals until acceptable skill level is achieved.

V. Development and approval of standardized procedure

A. Method of development

Standardized procedures are developed collaboratively by health professionals, including physicians, pharmacists, and registered nurses, and should conform to the Standardized Procedure Guidelines promulgated by the Medical Board of California and the Board of Registered Nursing in Title 16, California Code of Regulations, Section 1474

B. Approval

All standardized procedures must be approved by the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee, and Joint Conference Committee prior to use.

C. Review schedule

The standardized procedures will be reviewed every three years by the clinical pharmacist and medical director, and as practice changes.

D. Revisions

All changes or additions to the standardized procedures are to be approved prior to use.

VI. Standardized procedures in Medication Therapy Management Clinic

A. Definition: This protocol describes the pharmacist management of patients referred to medication therapy management clinic at one of the following clinics: Anticoagulation Clinic, Cardiology Clinic, Castro Mission Health Center, Chinatown Public Health Center, Ocean Park Health Center, Maxine Hall Health Center, Curry Senior Center, Potrero Hill Health Center, Silver Avenue Family Health Center, Southeast Health Center, Tom Waddell Urban Health Center, Family Health Center, Richard Fine People's Clinic, and Positive Health Program, Children's Health Center, Community Health Programs for Youth, Special Programs for Youth (see page 1).

The patient must meet the following criteria:

a. is a registered patient at the clinic
b. has previously been evaluated by a DPH/UCSF licensed provider or contracted provider

B. Assessment

1. Subjective
   a. Chief complaints
   b. History of present illness including relevant medication history
   c. Signs and symptoms related to the patient's medication therapy or underlying illnesses
   d. Medication reconciliation, adherence and concordance
   e. History of allergy and medication intolerance

2. Objective
   a. Physical assessment
   b. Drug-therapy related test results

c. Medication coverage based on insurance or other coverage plan.

C. Evaluation

1. Evaluate medication response in relation to pertinent diagnosed chronic diseases

2. Evaluate patient's understanding of chronic diseases and therapy

3. Evaluate the appropriateness of patient's drug therapy, drug interactions, allergies and adherence

4. Evaluate the need for provider consultation as outlined under section III, B, 3.

5. Evaluation to ensure that, whenever possible, prescribed or recommended medications are consistent with the patient's insurance or medication plan coverage.

D. Management

1. Educate patient on the pathophysiology of chronic diseases, and medication therapy including indications, efficacy and side effects.

2. Initiate, adjust or discontinue medication(s) for documented diagnosed chronic conditions to enhance medication adherence and efficacy, decrease risks for adverse effects and drug interactions, and to meet formulary requirements with respect to the patient's pharmacy benefits, with consideration of the most recent edition of SFDPH-based and/or nationally recognized guidelines.

3. Recommend over-the-counter medications based on signs and symptoms.

4. Educate on self-management techniques to improve chronic disease management.

5. Order tests for monitoring and managing drug therapy, in coordination with the patient's primary care provider or specialty providers.

6. Refer patients to other members of the multidisciplinary team for additional services or consultation as needed, such as nutritional consults and behavioral health services.

7. Schedule follow-up appointments with patient's primary care provider or specialty providers

8. Schedule follow-up appointments to medication therapy management clinics based upon patient's treatment plan.

9. Consult with provider as outlined under section III, B, 4.

E. Record keeping

1. Progress notes are completed within 72 hours of patient visits.

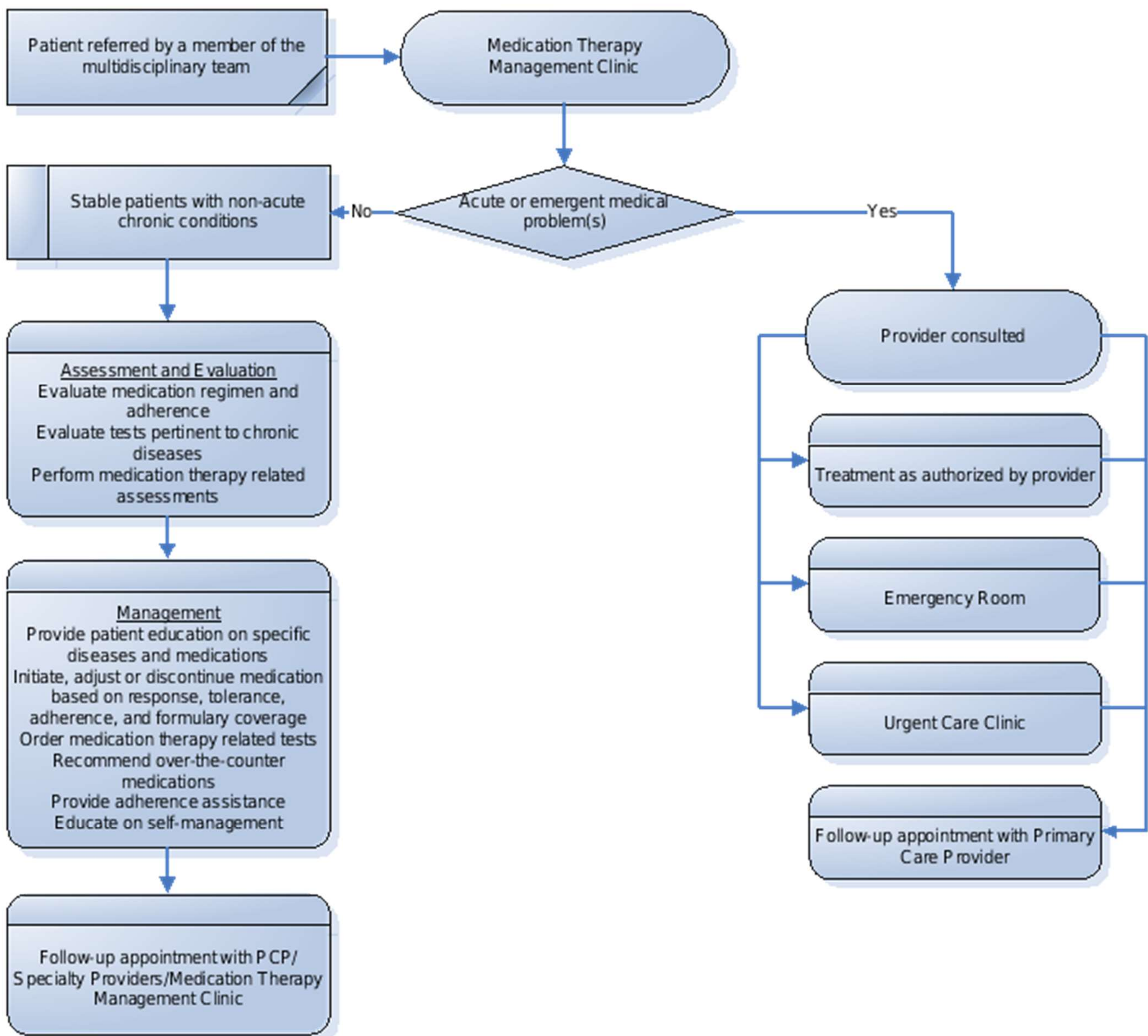
2. All drug therapy initiations, adjustments and discontinuations are entered in the electronic health record within 24 hours.

3. Vaccinations are entered in the electronic health record within 24 hours.

4. All prescriptions, including those requiring a paper prescription, are entered in the electronic medical record.

Figure 1

Medication Therapy Management Clinic



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