ZSFG JOINT CONFERENCE COMMITTEE MEETING

December 12, 2023

MEDICAL STAFF Report

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ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on December 12, 2023
October – November 2023 MEC Meetings

I. CLINICAL SERVICE REPORT: OB GYN Division– Jody Steinauer, MD, Interim Service Chief

The Service's mission is to promote justice, equality, and equity in women's health care. The Service does not only provide clinical care but also has a large research unit, Bixby Center, to improve policy and practice through research and scholarship.

A. Scope of the Clinical Service – Clinical services are provided in various clinics at ZSFG, HPP, Mission Neighborhood Health Center, and Mt. Zion.

   a. Obstetrics – low and high-risk; prenatal genetic diagnosis; HIV care (HIVE); Team Lily, wraparound prenatal care for people with SUD and MH; psychiatry; antenatal testing; syphilis experts for DPH system; and vaginal birth after cesarean, 24/7 midwifery, Centering Pregnancy, breech deliveries
   The following services were highlighted:
   - HIVE – It has achieved much success, including zero mother to child transmissions of HIV.
   - Team Lily – This is a thriving program that provides care to pregnant people with significant barriers to access through homelessness, SUD, mental illness, incarceration, and IPV.

   b. Gynecology – inpatient, outpatient, emergency, OR; specialty services such as Gyn-Onc, Urogyn, etc. ; tertiary care center for abortion services; low-cost IVF in partnership with UCSF; low-cost IVF in partnership with Laurel Fertility; 24/7 reproductive infectious disease and family planning consult services; and consultants for DPH network clinics.

   The Women's Option Center (WOC) also provides care for people from other states and countries. WOC recently received more than $1M grant from the state that will basically make abortion care free for anyone from anywhere whose income is up to 400% of the poverty line. The WOC is a tertiary center for abortion and receives referrals mostly for people who are passed the first trimester. Its expertise is early abortion care which is widely available in the Bay Area. Another expertise is caring for people with complex medical conditions. In addition, two ZSFG providers travel to Kansas to provide abortion care.

   c. Volume by Year
   - Family Birth Center – There was a much higher delivery volume this year. The volume significantly decreased in 2020, but the numbers have continued to increase since then.
   - Women's Options Center – The volume is slightly increasing after a significant decline.
   - OMG! (Obstetrics, Midwifery and Gynecology), formerly known as 5M- The total office and telehealth visits slightly declined last year to about 12K.

B. Faculty and Training Programs

   a. Faculty - There are 17 core MD clinical faculty members, along with many consulting MD faculty. There are also 7 Family Medicine (FCM) attendings in labor and delivery. They have been critical in teaching Family Medicine and OB residents in the Family Birth Center Service, along with providing high quality care for patients in triage/labor and postpartum. There are also 16 midwife faculty.
   The Service works with colleagues in Pediatrics, Anesthesia, Addiction Care, Nursing, Social Work, Pharmacy, Lactation Support, Doula, Emergency Medicine, and consulting services. Also, Dr. Diane Greene Foster was named a 2023 MacArthur Fellow. She created *The Turnaway Study* and published a book with the same title filled with stories of people who received or denied of abortion.

   b. Training Programs
   - Kenneth J. Ryan Residency Training Program – This program supports abortion training in OB GYN departments throughout the US. It has supported > 50 OB GYN residents to travel for training and has matched 12 programs with host institutions (1.1K residents and 56 programs in states with bans).
   - Innovating Education in Reproductive Health- This program provides online curricula that will be required for all OB GYN residents.
   - Residency - There is a 4-year residency with 10 residents per year. Majority of residents are UIM (Underrepresented in Medicine). A Song-Brown grant aims to encourage post-residency work in medically underserved settings like community health network clinics and jail clinic. The residents spend ⅓ rotation time at ZSFG. There are also FCM residents in L&D and OMG. Oftentimes, there are Internal Medicine residents in the clinics.
   - Fellowship – The Complex Family Planning (CFP) Fellowship was founded at ZSFG in 1991. There are 36 ob-gyn graduates, 3 family medicine graduates, and 2 current fellows. It was approved by ACGME in 2020 and a certified subspecialty in ob-gyn in many states. In 2015, an FCM-based Fellowship was founded with 4 graduates to date.

C. Focus on Equity
   a. Anti-Racism, Equity, Inclusion, & Structural Change (AEISC) Work
      - Supervisor 360 Review Reflection Pilot – This is a significant project that focused on supervisors managing people across racial, ethnic, and other identity differences. Each supervisor received a lot of feedback from their respective team. There was supportive reflection with both Dr. Rebecca Jackson, Division Chief and Ms. Jasmin Powell. AEISC Lead. Though long-term outcomes are still unknown, people felt very supported with this impactful project.
      - Division-wide DEI Trainings & Clinical/PPET (Perinatal and Pediatric Equity Team) Tools- A PPET tool is a multidisciplinary CPS huddle to support postpartum patients who possibly will be unable to parent with consideration of CPS. There are other tools in the Family Birth Center focused on equity.
   b. Family & Pregnancy Pop-Up Village – This is a monthly event which is a partnership between UCSF, ZSFG, city organizations, and community-based organizations. It is designed to be celebratory for people to obtain much support and to learn about different organizations in the community.

D. Performance Improvement and Patient Safety Initiatives
   a. PIPS Projects
      - C-Section Rates - Low C-section rates are monitored with a statewide target of less than 23.6% for the marker Nullip Term Singleton Vertex (NTSV). ZSFG had a rate slightly higher than 23.6% in 2021, but overall, ZSFG performed well. Data by race and ethnicity indicated that the Black rate at ZSFG was slightly above the statewide target in 2017-2018 and 2020-2021. However, from 2022 to current year, the Black rate is under the statewide target.
      - Exclusive Breastfeeding Rates – The target of >77% has been met with an average rate of 82%. ZSFG is the first hospital in the Bay Area to be designated as a Baby-Friendly Hospital due primarily to support on breastfeeding.

    The ZSFG Birth Center was the 2022 winner of the most consistently lowest scores of obstetrics racism in SF County per study done by Karen A Scott, a researcher at University of Washington. Moreover, the areas that need to be worked on include inadequate VTE prophylaxis after C-section and high postpartum hemorrhage rates (at 5.1% which is over the 5% threshold).
   b. Hospital and Medical Staff Committees – A list of membership in various ZSFG Committees by faculty was presented.

E. Research- There is clinical research at ZSFG, and the Service is part of the NIH-funded Contraceptive Clinical Trials Network. The research programs at the Bixby Center include Advancing New Standards in Reproductive Health (ANSIRH), UCSF-University of Zimbabwe Clinical Trials Unit, and more.
   The ANSIRH program was highlighted. It is a program that has been instrumental in conducting research to influence policy and to study the impacts of post-*Dobbs* restrictions. There is a big study following patient experiences and another one on provider experiences. ANSIRH is also critical in Free the Pill Coalition; it was approved based largely on research done at ANSIRH.

F. Financial Report – The Service's (including Bixby Center) estimated annual income is $41.8M that includes the following: $3.8M of profees, $7.3M from affiliation agreement, $13M from private grants, $14M in government grants and contracts, $1.7M in gifts and endowments.

G. Summary
   a. Strengths – These include the mission-driven faculty, staff, and residents; national and international impacts of research and advocacy/education; broad research funding; and equity focus, growing engagement with community.
   b. Challenges- These include more patients, too few faculty, inadequate diversity among faculty, inadequate funding for CFP Fellowship, only 1 NIH funding for abortion research (recently granted), large division across the Bay, and extreme assaults on reproductive health with medication abortion still at risk.
   c. Goals – These include continued work on volume, diversity and equity (developing Community Accountability Board and improving clinical care for trans and non-binary patients), abortion care and pregnancy care (raise money for CHP Fellowship).

Dr. Ortiz, along with other MEC members, praised the wonderful presentation, leadership, interdisciplinary teamwork, and various works of the Service in light of the political changes in the country.

II. CLINICAL SERVICE REPORT: Dental OMFS – Brian Bast, MD, Service Chief

A. Scope of Service
   a. Clinical Services/Programs - The Service runs a hospital-based oral and maxillofacial surgery practice, along with an ambulatory service in its outpatient clinic. Also, the Service runs the Dental Department at LHH. For the last 3 years, the Service has taken over the clinical services and residency program at Highland Hospital.
   b. Hospital Service
      - Call Schedule - At ZSFG, the Service provides 24/7 on-call dental services and shares a facial trauma call with OHNS and Plastic Surgery. In 2022, there were almost 400 consults.

- Operating Room – The Service is in the OR 1 day/week. In 2022, there were 123 cases with ≈20K minutes used and 70% utilization rate. This utilization rate has significantly increased over past years, and the Service continues to focus on improving the utilization rate.
- Admissions – In 2022, there were 74 hospital admissions.

c. Ambulatory Service – The 1N Clinic is open on all weekdays except Tuesdays. It is a fairly busy outpatient clinic with about 5K – 6K patients a year. A number of procedures happen in the clinic, and the clinic daily offers procedures under moderate sedation. Over 2 years ago, a *simulation human* was purchased to prepare for simulated emergencies (for procedures under moderate sedation) in the outpatient setting, leading to improved outpatient services. The incredible nursing staff is effectively led by Ms. Alena Maunder, the Nurse Manager.

B. Faculty and Residents

a. Leadership and Faculty – The Dean of the UCSF School of Dentistry is Dr. Michael Reddy. Dr. Brian Bast is concurrently the Chair at the Department at UCSF and Service Chief at ZSFG. Moreover, Dr. Sohail Saghezchi is the Residency Program Director. Three other faculty members were noted. Four new full-time faculty members were hired to support services and training at Highland Hospital.

b. Trainees and Training Program Elements
- The 6-year Oral and Maxillofacial Surgery Residency has 4 residents per year. The residents spend time in the Medical School, Anesthesia, and General Surgery; residency is completed at UCSF. About 40% of the graduates pursue fellowship and take full-time academic positions. There are also 1st year residents from OHNS and Plastic Surgery who spend a month at ZSFG. A list of current residents was presented.
- The integrated program consists of 4 years of completing medical school and a 6-year surgical residency. A number of residents complete rotation at ZSFG with the following programs: (1) Dental Student Clinical Rotations for seniors – 90 students/year and (2) Dentistry for Medical Students – 75 students/year.

C. Performance Improvement and Patient Safety Initiatives

The 4 completed projects during the year relate to the following: (1) TNAA, (2) clinic no-show rate, (3) clinic patient volume, and (4) clinic cycle times. The details for the first 2 projects are as follows:

a. TNAA – It has been fairly consistent at below 21 days, marked by some elevated instances due to faculty availability. Thus, a new faculty member was hired to help coverage for the coming academic year.

b. Clinic No-Show Rate – These rates have been inconsistent with instances of fairly high no-show rates in some months. The nursing staff has put effort on this metric with small changes that have led to some success. This metric will continue to be monitored.

D. Research

a. Research Lab - A basic science NIH-funded research lab is led by Dr. Jon Levine. The research focuses on the cellular aspect of pain and analgesia.

b. Research-Focused Retreat – Although the Service is largely a clinical department, most or all faculty participate in research. The first retreat held last year included faculty from all sites: VA, ZSFG, Parnassus, and Mission Bay. The goal was to identify research done by each faculty member. The focus was enabling students and resident to access all faculty members doing research and to identify projects they wish to participate in. Consequently, a research page on the Service's website was created.

E. Financial Report – Though margins are small, the Service is committed to allowing margins to support the Service's mission in areas of clinical care, research, and education. Moreover, the scale of the School of Dentistry is significantly different from that of the School of Medicine.

a. The total revenue amounted to about $12M with most arising from clinical revenue that is used to support missionaries in education and research.

b. FY2020 ZSFG OMFS Clinical Revenue – The total charges amounted to about $1.2M with total collections of about $700K. The collections are primarily dental billing at ZSFG.

F. Summary

a. Strengths – The colleagues in other departments, staff, faculty, and residents are all committed to providing excellent patient care.

b. Challenges – There is maximized use of limited resources and thus not compromising quality of patient care. The limited resources pertain to the clinical space and number of people available to do the work.

c. Goals – For the coming year, the focus is on patient access with hiring new faculty to support care at ZSFG. Another goal is to have another leader to step in one of the leadership roles currently held by Dr. Bast.

Dr. Ortiz and other MEC members commended Dr. Bast for the comprehensive report, his leadership, and the Service's collaboration with other departments. Dr. Ortiz praised the Service's partnership with the nursing team which has led to great patient care at 1N Clinic, along with its PIPS project on increasing the utilization rate. Dr. Bast noted that the Service's success in its operations and projects lies in the dedication of team members who are focused on solving problems.

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG December 12, 2023
OCTOBER - NOVEMBER 2023 MEC Meetings

Clinical Service Rules and Regulations

- Summary of OBGYN Rules & Regulations (attached)
- Obstetrics & Gynecology 2023 (copies sent to Commissioners)
- Dental- Oral Maxillofacial Surgery 2023 – no changes (copies sent to Commissioners)

Credentials Committee –

- Standardized Procedures – (Summary of Changes for each SP Attached; Copies of SPs sent to Commissioners)
  - 2023 CIDP SP Preamble
  - Summary of Changes for Influenza Vaccination RN SP & OBGYN SP
  - Influenza Vaccination RN SP approved at CIDP 10-4-23
  - OB GYN SP approved by CIDP 10-4-23 and sent to CC 10-6-23

- Privileges List – None

City and County of San Francisco

Department of Public Health

London Breed
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Gabriel Ortiz, MD, PhD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	*ZSFG Clinical Service Rules and Regulations*
Clinical Service :	*Obstetrics and Gynecology*
Date of last approval:	*2021*
Summary of R&R updates:	We renamed our outpatient clinic, removed a procedure that is no longer available in the US from our reappointments and privileges sections, modified the description of indicator reviews and proctoring, and updated our leadership and committee membership.
Update #1:	Section 1A now read: There is 24-hour, in-hospital coverage by active or courtesy members of the medical staff. (It used to say "members of the department.")
Update #2:	Section 1C: The name of our clinic has been changed from "Women's Health" to "Obstetrics, Midwifery and Gynecology". We also made this change in Appendix XV
Update #3:	We have removed hysteroscopic sterilization from sections 2B, 4B, and from our privileges form – because this is no longer a procedure available in the US.
Update #4:	We changed 6D to reflect our current protcols for reviews of indicators. For example, 4a now reads "All kick-outs that occur are reviewed, and at least one case is reviewed in our Ob and Gyn M&M conferences. During the M&M conference one clinician is assigned to record the findings and completes review of the case." Our gynecology M&M now occurs monthly and our Obsetrics M&M continues to meet weekly, so we changed removed those details. We made similar changes in 6F section 3b (M&M)
Update #5:	We revised the review of OMG charts to reflect that we no longer review Advanced Practice Physicians charts on a routine basis.
Update #6:	We removed Induction of Labor under section 11C. We have not done written informed consent for many years.

OBGYN CLINICAL SERVICE ORGANIZATION CHART

Interim Chief of Service	**Jody Steinauer, MD, PhD**
Chief of Service tentatively beginning 11/1/23	Rebecca Jackson, MD.
Medical Director Obstetric Service	**Ben Li, M.D.**
Medical Director Gynecology Service	Abner Korn, M.D.
Medical Director, OMG Clinic	**Margy Hutchison, CNM, MSN**
Ob-gyn Liaison, OMG Clinic	**Dilys Walker, M.D.**

Medical Director, Women's Options Center	Eleanor Drey, MD, EdM
Site Director, Resident Education & Training	Biftu Mengesha, M.D., M.A.S.
Director of Medical Student Education	**Naomi Stotland, M.D.**
Medical Director, New Generation Health Center	**Rebecca Jackson, M.D., M.A.S.**
Medical Director, Reproductive Infections	**Nika Seidman, M.D., M.A.S.**
Chair of Midwifery Council	**Margy Hutchison, CNM, MSN**
Director Nurse Midwifery Education	Kim Dau CNM,
Director of Quality Improvement	Ana Delgado, CNM

MEDICAL STAFF COMMITTEE ASSIGNMENTS

Ambulatory Care Committee	**Margy Hutchison, CNM, MSN**
Cancer Committee	Abner Korn, M.D
Credentials Committee	Jennifer Kerns, M.D., MPH, Kara Myers, CNM
Interdisciplinary Practice	Kara Myers, C.N.M..
Medical Executive Committee	Rebecca Jackson, M.D.
Operating Room Committee	**JiaJia Zhang, M.D.**
Performance Improvement & Patient Safety (PIPS)	Ana Delgado, CNM.
Perinatal Linkage Committee	Ana Delgado, CNM
Clinical Practice Group	Rebecca Jackson M.D., M.A.S.
Risk Management Committee	Rebecca Jackson, M.D., M.A.S.

OB/GYN CLINICAL SERVICE RULES AND REGULATIONS

~~2021~~

2023

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

OB/GYN CLINICAL SERVICE
RULES AND REGULATIONS
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I. OB/GYN CLINICAL SERVICE ORGANIZATION

The Rules and Regulations of the Clinical Service of Obstetrics, Gynecology and Reproductive Sciences define certain standards of practice and other rules for members of the clinical service.

Standards of clinical practice will be consistent with those standards established by the American College of Obstetricians and Gynecologists, as set forth in the document, Standards for Obstetric Gynecologic Services. If any apparent conflict exists, the standard defined in this document will prevail.

These Rules and Regulations will supplement those set forth in the ZSFG Bylaws, Rules and Regulations of the Medical Staff of Zuckerberg San Francisco General Hospital & Trauma Center. Should a conflict exist between these Rules and Regulations and those of the Medical Staff, the Medical Staff standards will prevail, except in circumstances where the clinical service adopts a more stringent standard.

A. SCOPE OF SERVICE

The Department of Obstetrics, Gynecology and Reproductive Sciences provides full-scope obstetric and gynecologic services, including inpatient and outpatient obstetrics, inpatient and outpatient gynecologic care and gynecologic surgery and abortion care. Sub-specialty care is also provided in maternal-fetal medicine, gynecologic-oncology, gynecologic-urology, and reproductive infectious diseases. There is 24-hour, in-hospital ~~attending physician coverage by members of the department~~coverage by active or courtesy members of the medical staff.

The scope of service includes but is not limited to:

1. Obstetrics
    a. Normal antenatal, intrapartum and postpartum care;
    b. Complicated antenatal, intrapartum and postpartum care;
    c. Antenatal testing;
    d. Basic obstetric ultrasound; and
    e. Perinatal genetics services.

2. Inpatient Gynecology
    a. Gynecologic surgery, admission of patients with gynecologic diagnoses and consultation on inpatients admitted to other services, encompassing the usual scope of Board-Certified Obstetrician-Gynecologist.
    b. Specialty services:
        1) Laser therapy of vulva, vagina and cervix;
        2) Surgery for incontinence and pelvic organ prolapse (gynecologic-urology); and
        3) Surgery for treatment of gynecologic cancer.
3. Outpatient Gynecology
    a. Broad range of outpatient services, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist.
    b. Specialty clinics include:
        1) Dysplasia including colposcopy, cryotherapy, and loop excision;
        2) Gynecologic urology;
        3) Gynecologic oncology; and
        4) Reproductive endocrine and infertility services.
4. Family Planning
    a. Broad range of family planning services, encompassing the usual scope of a Board-Certified Obstetrician-Gynecologist;
    b. Tubal sterilization; and
    c. Abortion, up to 24 weeks, 0 days by ultrasound
        1) Exclusions: Terminations beyond 24 weeks 0 days by BPD of 58mm (or its equivalent in femur length, if that is the more appropriate measurement) may be performed in special circumstances where maternal health is compromised by the pregnancy after discussion and approval by the Medical Director of the Women's Option's Center, a representative of the Ethics Committee, and, when appropriate, consultation with relevant medical specialist(s). The

indications for terminations beyond 24 weeks 0 days for fetal indications will be assessed by an attending neonatologist to determine the degree of fetal compromise and thus the appropriateness of offering the termination.

B. MEMBERSHIP REQUIREMENTS

Membership in the Medical Staff of Zuckerberg San Francisco General Hospital & 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 AND STAFFING OF THE OB/GYN CLINICAL SERVICE

An organizational chart and duties of the OB/GYN Clinical Service appears in Appendix C.

The Officers of the OB/GYN Clinical Service are:

1. Chief of Service;
2. Medical Director of Obstetric Service;
3. Medical Director of Gynecologic Service;
4. Medical Director, ~~Women's Health~~Obstetrics, Midwifery and Gynecology (OMG) Clinic;
5. Medical Director, Family Planning Service;
6. Director of Resident Education;
7. Director of Medical Student Education;
8. Chair Nurse Midwifery Service Leadership Council; and
9. Director of Interdepartmental Nurse Midwife Education Program.
10. Director of QI

II. CREDENTIALING

A. NEW APPOINTMENTS

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

1. Current licensure to practice in the State of California is required. No member shall engage in patient care responsibilities unless his/her license is current and clear.
2. CPR or neonatal resuscitation certification is encouraged but not required.
3. In accordance with ZSFG Bylaws, all practitioners providing medication or supervising others who prescribe or furnish medications must have a valid federal DEA certificate.
4. Active and Courtesy Members are required to be Board-Certified by or Active Candidates of the American Board of Obstetrics and Gynecology as per the Hospital bylaws

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the OB/GYN Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, Credentialing Procedure Manual, 1.3 – Reappointment Process as well as these Clinical Service Rules and Regulations.

1. Re-appointment will occur every 2 years. At this time, the following will be reviewed:
   a. Review of QI file: reports of peer review cases, complaints by staff or patients, sentinel events, or problems with the performance of certain procedures; and
   b. Review of levels of clinical activity in each category of obstetrical and gynecological care.

2. Active medical staff members must perform a minimum number of procedures or activities in the prior two years as specified in the table below.

a. If activity thresholds have not been met in a category of privileges requested by the member, then a program of educational activities and proctoring will be designed by the members of the department. Once completed, the privilege in the core category may be approved by the service chief. Exceptions to proctoring may be granted in certain circumstances with approval of a majority of active staff members. For courtesy staff members who perform the predominance of their clinical activities at other hospitals, a letter of good standing from the medical staff office at the primary hospital is sufficient proof of adequate clinical activity.

b. If there has been no activity in any category in the prior 2 years, the staff member will be contacted and asked whether he or she intends to remain a member of the ZSFG medical staff. If there is no response within 60 days or if the individual states that they intend to resign from the medical staff, the ZSFG Medical Staff Office should be notified of the member's resignation. This holds for active staff members. For courtesy staff members, see above under 2a.

c. If the individual states that he or she does intend to remain on the SGFH Medical Staff and to maintain their privileges, the department will devise a time-limited proposal for additional professional activity, with specification of proctoring thresholds, if necessary. Upon satisfactory completion of requisite activity, privileging will continue in those areas.

Reappointment Requirements:	
OBSTETRICS	
Outpatient clinic: obstetrics	50 clinic visits
Basic obgyn ultrasound (IUP, dating, adnexa etc)	10 interpretations
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, lac repair)	15 cases
GYNECOLOGY	
Outpatient clinic: gynecology	50 clinic visits
Inpatient gynecology and gynecologic surgery	15 operative procedures
Emergency gynecology and gynecologic surgery	15 procedures including at least 4 laparoscopies or laparotomies
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	10 procedures
Laser therapy	2 cases
~~Hysteroscopic sterilization~~	~~2 operative procedures~~
Urogynecology	10 operative procedures
Moderate sedation/analgesia	5 case reviews and documented completion of module
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	10 operative procedures
Maternal-Fetal Medicine	Care of 20 patients

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of Affiliated Professionals to ZSFG through the OB/GYN Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations, Credentialing Manual, 3.1 – Affiliated

Professional Staff, and accompanying manuals as well as these Clinical Service Rules and Regulations. Affiliated professionals within the ZSFG Department of Ob/Gyn include certified nurse midwives (CNM) who work in the Family Birth Center (H22), Women's Options Center (6G), and Obstetrics, Midwifery, and Gynecology Clinic (5M)~~6C and 5M and Nurse Practitioners who work in New Generation Health Center, 6G and 5M, Physician Assistants who work in 5M~~, and Licensed Clinical Psychologists who work in 5M and New Generations Health Center.

D. DEFINITIONS OF MEDICAL STAFF CATEGORIES

All members of the medical staff in the ZSFG Department concurrently shall be a member of the academic or clinical faculty of the University of California, San Francisco, School of Medicine, Department of Obstetrics, Gynecology, and Reproductive Sciences.

1. Active staff members are defined as any of the following:
    - a. Academic faculty member;
    - b. Clinical faculty members who regularly attend at ZSFG, but who do not have active staff membership at other hospitals; and
    - c. UCSF fellows who are assigned the predominance of their clinical responsibilities at the ZSFG.
2. Courtesy staff members are defined as any of the following:
    - a. Academic and Clinical faculty members who have active staff membership at other hospitals and who perform the predominance of their clinical practice at hospitals other than ZSFG; and
    - b. Clinical faculty members who do not regularly attend at ZSFG and who do not have active staff membership at other hospitals.
    - c. Many courtesy staff are board-certified sub-specialists (gyn-oncology, reproductive endocrinology, maternal-fetal medicine) who offer specialty services that our generalist Ob/Gyn staff members are not able to provide.
3. The term "regularly attend" is defined as an attending who is assigned to a clinical service activity for 30 or more days per year.
4. Temporary Privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws.

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

The OB/GYN Clinical Services privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article IV: Clinical Privileges, Rules and Regulations and accompanying manuals as well as these Clinical Service Rules and Regulations, privileges to practice in the Clinical Service of Obstetrics and Gynecology will be commensurate with documentation of clinical training of an acceptable standard of clinical practice.

Privileges are delineated by consensus of the Active Members of the Clinical Service, subject to the approval of the Credentials Committee of the Medical Staff. Delineation of privileges will be reviewed yearly and at other times as necessary.

B. CATEGORIES OF PRIVILEGES

1. Privileges shall be defined in two categories: core and special
    - a. Core privileges are defined as the cognitive and procedural clinical activities customarily performed by fully trained obstetricians or gynecologists.
    - b. Special privileges are defined as procedural clinical activities that are not customarily performed by fully trained obstetricians or gynecologists and which require additional training, experience, and expertise to perform.
2. Core privileges will be granted in the following areas;
    - a. Outpatient gynecology and family planning;
    - b. Outpatient obstetrics;
    - c. Inpatient gynecology; and
    - d. Inpatient obstetrics.

3. Special privileges will be those sub-specialty areas and specialized procedures designated by the department as requiring skills (see table below and Privilege Form).
4. All new appointees to the Active Staff of the department must undergo a provisional period of no less than 3 months. During the provisional period, the clinician will be expected to satisfactorily complete proctoring.

C. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The OB/GYN Clinical Services Privilege Request Form shall be reviewed annually.

D. CLINICAL PRIVILEGES & MODIFICATION/CHANGE TO PRIVILEGES

The OB/GYN Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article IV: Clinical Privileges, Rules and Regulations and accompanying manuals. All requests for clinical privileges will be evaluated and approved by the Chief of OB/GYN Clinical Service.

The process for modification/change to the privileges for members of the OB/GYN Clinical Service is in accordance with the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals.

IV. PROCTORING AND MONITORING

Proctoring is defined as an evaluation of a member's clinical training, skills, and judgment by a peer clinician who is fully privileged in the area being evaluated. It is intended to evaluate the clinical skills of the member in performing clinical services, but not to evaluate their abilities as a teaching or supervising clinician, which will be done in other ways.

A. CIRCUMSTANCES REQUIRING PROCTORING

All medical staff members initially granted privileges shall complete a period of proctoring, in accordance with the following monitoring requirements below. Proctoring may be accomplished in any the following settings:

1. After initial appointment to the Medical Staff and performed within the first 6 months after joining the ZSFG medical staff.
    a. For physicians who completed residency at UCSF and will join the department soon after completion of the residency, proctored procedures during the Chief Residency year will be considered applicable toward proctoring requirements. There are therefore fewer cases required to be proctored upon joining Medical Staff for former UCSF residents as shown in the Table below.
2. When a member requests privileges for a procedure in which there has been insufficient clinical activity in the prior 2 years.
3. When a member requests special privileges in a category or procedure for which they recently have completed training.
4. At the time of reappointment to the Medical Staff, if it is found that proctoring at the time of initial appointment was incomplete or insufficient.

B. PROCTORING AFTER INITIAL APPOINTMENT

Individuals' privileges are subject to review and revision at initial appointment, throughout the period of proctoring, at the time of reappointment, at any time as judged necessary by the Chief of Service or at any time recommended by a two-thirds vote of a quorum of the clinical service's Active Staff.

The number of cases that must be proctored are contained in the tables below.

Individual Proctoring Plan for Former UCSF Resident or Fellow:

OBSTETRICS	
Outpatient clinic: obstetrics	Review of 3 medical records
Basic ob/gyn ultrasound (IUP, dating, adnexa, etc)	Interpretation of 3 ultrasound exams
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, lac repair)	Observed care of 2 patients, including 1 Cesarean
GYNECOLOGY	
Outpatient clinic: gynecology	Review of 3 medical records
Inpatient gynecology and gynecologic surgery	3 observed operative procedures including at least one laparotomy and one laparoscopy
Emergency gynecology and gynecologic surgery	2 observed procedures including at least one laparoscopy
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	2 observed operative procedures
Laser therapy	2 observed procedures
~~Hysteroscopic sterilization~~	~~2 observed procedures~~
Urogynecology	2 observed procedures
Moderate sedation/analgesia	Review of 5 cases
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	2 observed procedures
Maternal-Fetal Medicine	Observed care of 2 patients

Individual Proctoring Plan for Non-UCSF Resident or Fellow:

OBSTETRICS	
Outpatient clinic: obstetrics	Review of 5 medical records
Basic ob.gyn ultrasound (IUP, dating, etc)	Interpretation of 5 ultrasound exams
Inpatient obstetrical care (e.g. NSVD, Cesarean, operative vaginal delivery, labor management, lac repair)	Observed care of 5 patients, including 2 Cesarean deliveries
GYNECOLOGY	
Outpatient clinic: gynecology	Review of 5 medical records
Inpatient gynecology and gynecologic surgery	5 observed operative procedures including one laparotomy and one laparoscopy
Emergency gynecology and gynecologic surgery	3 observed operative procedures including at least one laparoscopy
SPECIAL PRIVILEGES	
2nd trimester Abortion Procedures	3 observed operative procedures
Laser therapy	2 observed procedures
~~Hysteroscopic sterilization~~	~~2 observed procedures~~
Urogynecology	3 observed procedures
Moderate sedation/analgesia	Review of 5 cases
SUBSPECIALTY PRIVILEGES	
Gynecologic Oncology	3 observed procedures
Maternal-Fetal Medicine	Observed care of 3 patients

C. QUALIFICATIONS OF PROCTORS

1. Proctoring will be carried out by Active members of the staff who enjoy unrestricted privileges in the category subject to proctoring.
    a. In certain cases, the proctoring of privileges, which are not held by another member of the Active Staff, may be performed by a Board-Certified Member of the Active Staff at the direction of the Chief of Service. At the discretion of the Chief of Service, such proctoring may be supplemented by consultation with a physician who holds unrestricted privileges in that category at another affiliated hospital (UCSF affiliated), or who holds unrestricted privileges in a similar field at Zuckerberg San Francisco General Hospital & Trauma Center
2. One or two primary proctors will be assigned for each individual, but this does not preclude other members from service as proctors in individual cases.

V. EDUCATION OF MEDICAL STAFF

The CME requirements set forth in the current ZSFG Bylaws, Rules and Regulations of the Medical Staff of Zuckerberg San Francisco General Hospital & Trauma Center shall apply as the minimum required by the Department. The Obstetrics & Gynecology Clinical Service members are encouraged to attend UCSF department courses for CME credits.

VI. OB/GYN CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

Attending faculty shall supervise house staff in such a way that house staff assumes progressively increasing responsibility for patient care according to their level of training ability and experience. House Staff providing clinical services shall do so only under the supervision of active or courtesy medical staff that have ultimate responsibility for patient care, are members of the University of California, San Francisco Faculty, and have appropriate clinical privileges. Details are in Appendix B. A summary is below.

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSESTAFF

House staff care for patients under supervision of attending physicians in all clinical settings described in I.A. Scope of Service. Attending physicians are immediately available for consultation in all clinical settings.

Attending physicians are present 24 hours per day to supervise all deliveries and surgical procedures. Guidelines for calling the Attending in other situations are disseminated to the residents yearly and are available on the residents' website.

B. RESIDENT EVALUATION PROCESS

The Ob/GYN residency program has a robust system for monitoring and evaluating competencies of residents. It includes electronic global evaluations by multiple faculty members every 6 weeks, assessment of surgical competency for benchmark cases (e.g. R1=Cesarean: R2=Laparoscopy; R3=Abdominal Hysterectomy; R4=Vaginal Hysterectomy), assessment at weekly case conferences, and assessment in surgical skills labs and obstetric simulations. The Ob/Gyn Residency program's evaluation system for accessing competency of its residents has been approved by the ACGME. Residents' evaluations are reviewed twice yearly with the resident by the Residency Program Director or Associate Director. Their contracts are renewed annually assuming clinical, educational and professional competencies have been met. Remediation or discipline occurs as necessary according to the UCSF GME Guidelines.

C. ABILITY TO WRITE PATIENT CARE ORDERS

1. House staff may write patient care orders with the following exceptions:
   a. DNR;
   and
   b. AMA.

VII. OB/GYN CLINICAL SERVICE CONSULTATION CRITERIA

The Obstetric or Gynecology On-Call resident physician is paged to notify of inpatient consultation requests. Attending physicians supervise all inpatient consultations. For outpatient consultations, the electronic medical record system is used.

VIII. DISCIPLINARY ACTION

The Zuckerberg San Francisco General Hospital & Trauma Center Medical Staff Bylaws, Rules and Regulations, which include provision for due process where applicable, will govern all disciplinary action involving members of the ZSFG OB/GYN Clinical Service.

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY (PIPS)

The Department of Obstetrics, Gynecology and Reproductive Sciences at Zuckerberg San Francisco General Hospital & Trauma Center is committed to a systematic and comprehensive program of Quality Improvement, through the PIPS program, in an effort to promote the highest possible standard of care for patients.

A. GOALS & OBJECTIVES

1. Demonstrate a commitment to continuous improvement in obstetrical and gynecological services;
2. Objectively examine aspects of care in order to improve the overall services of the department;
3. Monitor morbidity and mortality and to reduce them to the lowest possible rate;

4. Facilitate a multi-disciplinary approach to the assessment and development of health care services;
5. Ensure that the delivery of sexual and reproductive health care by personnel in training is competently and fully supervised;
6. Pursue opportunities to continually improve the patient care experience, including patient satisfaction with services delivered;
7. Implement and document actions to improve care with follow-up, periodic review, and evaluation; and
8. Provide ongoing education on approach and methods of continuous quality improvement and utilization management.

B. RESPONSIBILITY

Overall responsibility for monitoring and evaluation of this program is assigned to the Chief of Service. The departmental Quality Improvement committee and the data assistant facilitate implementation of this program. All members of the department are expected to actively participate in the Quality Improvement (QI) activities outlined in this program.

1. Chief of Service
   a. Assures that care delivered by Medical Staff meets acceptable standards;
   b. Assures that the monitoring and evaluation encompasses the full scope of care delivered;
   c. Investigates any specific cases where the quality of care has been questioned: evaluates, takes corrective action as needed, and implements follow-up plans;
   d. Facilitates formation of strategies for resolution of identified problems and monitors progress;
   e. Works collaboratively with other departments and services for resolution of issues that require interdepartmental cooperation;
   f. Assures reporting of potential litigation events to the UC Risk Manager;
   g. Assures that the systematic review of patterns of practice and clinical trends are an integral part of the staff evaluation and provider credentialing process;
   h. Disseminates the results of QI activities to clinic chiefs and individual providers, as appropriate; and
   i. Appoints a departmental Director of Quality Improvement.

2. Departmental Quality Improvement Committee
   a. Identifies potential QI activities
   b. Reviews on-going contribution of activities to continuous improvement of patient care.
   c. Is chaired by the departmental Director of Quality Improvement.
3. The QI Data Assistant
   a. Provides administrative support to departmental members for selected QI activities.
   b. Performs and monitors documentation of QI activities to assure completeness and consistency.
   c. Work under the direction of the Chief and MSO to perform data retrieval.
4. Medical Providers (Physicians, Residents, CNMs, and Nurse Practitioners)
   a. Participate in assigned Medical Staff Committees (according to hospital by-laws).
   b. Participate in peer evaluation of performance as requested.
   c. Maintain departmental standards by incorporating quality improvement into clinical practice.
   d. Report unusual occurrences (events/trends) outside the expected outcome to UC Risk Management.
5. Nursing Personnel
   a. Work with the Medical Staff to deliver quality patient care.
   b. Identify problem areas in patient management and collaborate with the Chief and/ or designee for resolution.
   c. Identify and resolve patient care problems within their scope of nursing practice.

6. Non-Medical Departmental Clinic Staff
   a. Work with the Medical Staff to deliver quality patient care.
   b. Work as members of multi-disciplinary groups to address problems identified as a result of QI activities.
   c. Perform QI activities to identify areas for potential improvement in patient satisfaction and

experience.

d. Serve as patient advocates regarding the care experience.

7. ZSFG Quality Management Staff

a. Organize and support the departmental QI activities by obtaining requested data and assuring that there is support staff to document the proceedings; and

b. Perform assessment on institution-wide indicators.

C. REPORTING

1. Results of Quality Improvement activities are disseminated in the following manner:

a. Results of department-specific activities reviewed by the QI Committee are shared with department faculty at least quarterly;

b. Summary information is presented to the ZSFG Medical Staff Quality and Utilization Management Committee on a semi-annual basis;

c. Minutes of all meetings in which quality improvement activities are discussed are distributed to appropriate staff and faculty. Copies of all minutes are maintained in the Quality Improvement binder in the departmental office; and

d. Feed-back information will be provided to all parties involved in QI or peer-review actions.

2. Access to documents produced by the QI Program outside the department is limited to: Chief of Staff; Chair, Medical Staff Quality and Utilization Management Committee; and Risk Managers. Additional access may be granted at the discretion of the Chief of Service.

3. The Chief of Service is responsible for addressing patient care problems which involve other clinical services. This responsibility may be delegated to the appropriate section directors.

4. Patient care will be referred to the Hospital PIPS Committee when:

a. They consistently cross clinical service/departmental lines;

b. Further assistance is needed in their resolution;

c. Operational link with risk management when deemed necessary by the Chief of the Service or the PIPS Chief.

D. CLINICAL INDICATORS

1. Indicators are used to monitor the outcome or process of the provision of care. Thresholds (TH) are targets for clinical performance, using current literature or aggregate hospital experience, and are established for each indicator developed. They represent the level or point at which stimulus is strong enough to signal the need for departmental response to indicator data and the beginning of the process of investigating opportunities for improvement.

2. Indicators for obstetrics, gynecology, and abortion services will be recommended by the Quality Improvement Committee to the department as a whole. Review of indicators will occur at least once a year, or more often as needed.

3. On a periodic basis (not to exceed once a month), the QI Data Assistant (or designee) will review all medical records of patients admitted to the obstetrical, gynecologic, and abortion services once discharged. Each record will be evaluated to determine whether an indicator definition is met, in which case it is considered to be a “kick out” case.

4. When an indicator is present, the medical record of the “kick-out” case will be reviewed as follows.

a. All kick-outs that occur ~~each week are listed~~are reviewed, and at least one case is reviewed in our ~~for weekly~~ Ob and ~~monthly~~ Gyn M&M conferences. During the M&M conference one clinician is assigned to record the findings and completes review of the case. Those that are not reviewed in M&M are referred to a clinician reviewer to review.

b. The clinician reviewers complete the "Kick-Out Evaluation From" and designates whether there is no deficiency, suggestion to clinician, room for improvement, or deficiency. The reviewer also determines whether the case should be referred to the Peer Review Committee. If the attending of the case is not present at the M&M conference, a copy of the Kick-Out form is given to them for review.

c. The QI Data Assistant will track the status of all medical records being reviewed by clinician reviewers.

5. The QI Data Assistant will keep statistical records regarding patient cases reviewed, the percentage of cases that met the definition of an indicator, a comparison of observed indicator rates to established thresholds, and the percentage distribution of the dispositions of cases reviewed by clinician reviewers. These statistical summaries will be presented to the Quality Improvement Committee and will be evaluated by the Chief of Service (or designate) prior to reappointment to medical staff.

E. QUALITY OF CARE INDICATORS

1. Inpatient Obstetrics
    1. Apgar score < 5 at 5 minutes (TH 2%)
    2. Cord UA pH less than 7.00 or base excess greater than -12 (TH 2%)
    3. Delivery of infant weighing < 1,200 grams (NA)
    4. C-Section for fetal indication (TH 5%)
    5. 4th degree laceration
    6. Transfusion or greater than 1,500 cc of blood loss (TH 5%)
    7. Eclampsia
    8. ICU Admission (TH 2%)
    9. Unplanned Return to OR
    10. Unplanned removal, injury, or repair of an organ during surgery (TH 5%)
    11. Perinatal death (TH 0%)
    12. Maternal death (TH 0%)
    13. Readmission for PP complications (TH 2%)
    14. Surgical procedure on undelivered patient
    15. Other [no threshold].

2. Inpatient Gynecology
    1. Unplanned readmission within 14 days
    2. Admission/procedure after >1 vst to ER
    3. Cardiopulmonary arrest (TH 1%)
    4. Antibiotics >24 hrs after surg or adm
    5. Unplanned admission of Come and Go patient (no 6G pt) (TH 10%)
    6. Unplanned admission to ICU (TH 2%)
    7. Unplanned return to the operating room (TH 2%)
    8. Unplanned removal, injury or repair of an organ during surgery (TH 5%)
    9. Death during admission
    10. Hospital admission > 5 days (non-oncology pt) (TH 10%)
    11. Procedure time > 4 hours (non-oncology pts) (TH 10%)
    12. Transfusion for intraoperative blood loss (TH 10%)
    13. Post operative transfusion (no 6G patients)
    14. Development of infection not present on adm
    15. Other

3. Women's Options Center
    1. Bleeding complications
        a. Transfusion
        b. UAE (IR)
    2. Damage to organs
        a. Cervical laceration requiring suture

b. Perforation

3. Hospital admission
    a. Subsequent surgery
    b. Observation of bleeding
4. Reaspiration
    a. After 24 hours of original procedure

F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE

The focus of Quality Improvement activities is on high-volume (HV), high-risk (HR), or problem-prone (PP) services. Other aspects of care may be selected because of their direct relationship to patient satisfaction, which is also a focus of QI activities. The following aspects of care are selected for review and monitoring:

a. Inpatient Obstetrics: delivery Outcomes (HV)
b. Inpatient Gynecology: surgical and non-surgical outcomes (HV, HR)
c. Women's Options Center Services
    1. Conscious Sedation Monitoring Compliance (HR)
    2. Abortion Outcomes (HV)

1. Quality Improvement Committee
    a. The Committee will meet at least quarterly, in sessions separate from regularly scheduled Department meetings. b.
    Membership
        1. Departmental Director of Quality Improvement (chair)
        2. Medical Director of the Women's Health Center
        3. Representative member of the Obstetrics Division
        4. Representative member of the Gynecology Division
        5. Nurse midwife representative (s)
        6. Representative to the ZSFG QI Committee
        7. Representative to the ZSFG Risk Management Committee
        8. Departmental MSO
        9. QI Data assistant
        10. At large member(s), appointed by the department Chief of Service
        11. Chief of Service is an ex-officio, voting member c.
    Activities
        1. Present and discuss reports of hospital QI and Risk Management Committees
        2. Review indicator statistics, including follow up of "kick-out' cases
        3. Review report from departmental Peer Review Committee
        4. Review report of M&M Conferences
        5. Designate, execute, and review focus studies c.
    d. Because the Department of Obstetrics, Gynecology and Reproductive Sciences at ZSFG is a part of a larger educational institution (UCSF), on-going education is an important component of its activities. Where additional educational needs are identified, interventions are scheduled as appropriate.
    e. Issues that cross departmental lines are referred by the Chief to the appropriate clinical or non- clinical department for evaluation and resolution. Further departmental involvement in efforts to improve these processes is assigned by the Chief or designee.
    f. Most issues require a multi-disciplinary approach, and with the assistance of the hospital Quality Management staff, groups are organized to assess the deficiencies and recommend steps for resolution, initiate responses, and evaluate results.
    g. The Quality Improvement Program is reviewed periodically for effectiveness and evidence of improvement in patient care. Plans are made, at that time, to identify indicators for monitoring care in the upcoming period.
    h. Problem Resolution
        1. Assessment: patient care problems are assessed with an appropriate tool which may include:
            a. Medical records audit using pre-determined, clinically valid criteria
            b. Observation of clinical practice (see also Proctoring Plan)
            c. Fact-finding and discussion with clinical staff d.

Clinical Research

2. Recommendations may include:
    a. Review of charts by attending physician or Section Directors.
    b. Education and training with unit staff.
    c. Procedure changes
    d. Staff meetings
    e. Equipment changes
    f. Development of standards of care.
    g. Individual staff remediation and appropriate disciplinary action
3. Remedial action for identified problems may include:
    a. Changing or creating new policies and treatment protocols
    b. Education of faculty, nursing staff, etc
    c. Proctoring and counseling
    d. Recommendations for equipment purchase and use
    e. Adherence to blood & fluid safety precautions, and infection control guidelines.

2. Peer Review Committee
    a. The Peer Review Committee is expected to review clinical performance or professional behavioral issues regarding individual provider staff members.
    b. Cases reviewed may arise from the following sources:
        1. "Kick out" cases referred to the Committee by a clinician reviewer;
        2. Cases from the M&M Conference identified as requiring peer review evaluation;
        3. Unusual Occurrence Reports (UORs) submitted to the Chief of Service; and
        4. Complaints from patients or staff submitted to the Chief of Service.
    c. The Peer Review Committee will be composed of the physician and CNM members of the departmental Quality Improvement Committee.
    d. The Peer Review Committee will meet "as needed" (if there are cases for review) after the completion of a Quality Improvement Committee meeting, or in extraordinary session if necessary.
    e. A "Peer Review Committee Record" will be completed and stored in a secure location.
    f. Peer Review Committee meetings will be closed to non-members and its proceedings will be considered to be confidential and protected by Section 1157 regulations.

3. Morbidity and Mortality (M&M) conferences
    a. Separate Obstetrical Morbidity and Mortality (Ob M&M) and Gynecology Morbidity and Mortality (Gyn M&M) Conferences are held regularly and attended by all available active attending faculty and residents on service at Zuckerberg San Francisco General Hospital & Trauma Center.
    b. During Ob and Gyn M&M we review cases of patients who delivered recently and who meet quality indicators requiring review. In addition, all cases that have met specific quality indicators are peer-reviewed.
    c. Cases discussed will come from three sources.
        1. Patients recently discharged from ZSFG where one of the Obstetrical or Gynecologic indicators appears to be present
        2. Cases not previously presented to the M&M Conference that are referred through the indicator review process (Ob, Gyn, and Women's Option Center)
        3. Cases that arise from the Obstetrics, Midwifery and Gynecology clinic (5M)
    d. For all cases discussed, the M&M Review Forms (see Appendix D) will be completed. An assessment is made as to whether there was a deficiency, an opportunity for improvement, or no deficiency in care provided. Recommendations for further QI follow-up or activities will be made and tracked for completion.
    e. An aggregate report of cases presented to the M&M Conference will be produced by the departmental director of Quality Improvement and presented to the Quality Improvement Committee at each of its meetings.

f. Additional Morbidity and Mortality Conferences are held monthly in conjunction with the Pediatric Department. This M&M Conference reviews all deaths and major morbidity, with special attention to readmissions, untoward drug effects, complications (by clinical indicator) and maternal or fetal deaths.

4. Ongoing Professional Performance Evaluation (OPPE)
   a. Practitioner-specific information identified as a result of Peer Review and other QI activities are reviewed by the Chief as part of the reappointment process and every 6 months.
   b. Bi-annual activity reports for Obstetrics, Gynecology and Family Planning are created for all provider staff and are maintained in the departmental credentialing file. These reports include volume of cases, number of those with indicators, and result of review of the cases with indicators (no deficiency, room for improvement, deficiency).
   c. An OPPE form is completed by the Chief or his/her designee each 6 months to ensure adequate volume and quality of care for each clinician. (Appendix E)

5. Other Patient Care Conferences
   a. Weekly GYN Pre-Operative Conferences: Review by multiple faculty of surgical plan for the following week's operative cases.
   b. Gynecologic Tumor Board meets once monthly for prospective planning and retrospective review of treatment of gynecologic cancers at ZSFG.
   c. Ultrasound Conference occurs once monthly for review of Obstetric and Gynecologic Ultrasound.
   d. Dysplasia case conference occurs weekly.
   e. Ob/Gyn Medical Staff Meetings: The ob/gyn attending staff meets at least monthly. Patient care problems are discussed, solutions are recommended, and the resolution of problems tracked.

6. Ongoing Review of All OMG Charts
   ~~a.~~
   a. All charts of medical students and unlicensed resident physicians are reviewed by the attending MD.
   b. Outpatient-only physicians who are Courtesy staff are paired with an Active staff member during clinical sessions so are subject to observation during the clinical session. Any quality issues that are noted by the Active staff physician are brought to the QI committee. In addition, 5 charts are reviewed at the time of re-appointment.

   ~~All charts of medical students, unlicensed resident physicians, selected charts of nurse practitioners, PA's, proctored attendings, CNM's and RN's are reviewed by the Medical Director, attending MD and/or Chief Resident daily.~~

7. Unusual Occurrence
   a. All reports will be reviewed by the Chief of Service and Medical Director of the appropriate service (5M, 6G, H22 etc) who assigns review and response to responsible attending. A plan will be developed if quality of care has been compromised to ensure that the problem has been resolved.

8. Oral or Written Patient Complaints
   a. Oral or written patient complaints will be reviewed by the Chief of Service and Head Nurse and forwarded to the Outpatient Grievance Committee and assigned for review and response to the responsible attending.

9. Drug Adverse Reactions
   a. All are identified through daily chart review and appropriate follow-up, and completion of adverse drug reaction form.

10. Nosocomial Infections
    a. Staph skin infection reported at M&M Conference.
    b. Surgical wound infection reported at M&M Conference.

11. Missed Appointments

a. All missed appointments are reviewed by the clinic nurse or clinician. When appropriate, another appointment is made by mail or phone. If follow-up fails, a public health nurse can be called upon for assistance.

X. MEETING REQUIREMENTS A.

COMMITTEE MEETINGS

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

The OB/GYN Clinical Services shall meet as frequently as necessary, but at least monthly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

Refer to Appendix C for Committee Assignment for members of the OB/GYN Clinical Service.

B. FACULTY MEETINGS

All faculty must attend at least 75% of all regularly scheduled faculty meetings. Anticipated absenteeism should be communicated to the Chief of Service in a prompt manner.

Minutes of all faculty meetings will be maintained in the service, distributed to all faculty members, and forwarded to the Medical Staff Office in a timely manner.

1. M&M Conferences
   a. Faculty are expected to attend any M&M conference wherein a patient they cared for is being discussed. If unable to attend, they are expected to learn about the proceedings of the M&M from an attendee. In addition, faculty are expected to attend at least 50% of either Ob or Gyn M&M Conferences according to their clinical duties. Outpatient only physicians do not have this requirement.

XI. ADDITIONAL OB/GYN SERVICE SPECIFIC INFORMATION

A. ATTENDING PHYSICIAN RESPONSIBILITIES

1. Obstetrics Service Attending
   a. The role of attending physician on the Obstetric Service will generally rotate on a weekly basis.
   b. On all weekdays (excluding holidays) the OB Attending is expected to be in-house and readily available from the time of morning rounds through the time of evening rounds. Responsibilities include:
      1. Conducting teaching rounds with house staff and students each weekday (excluding holidays)
      2. Attendance at all deliveries and other major procedures
      3. Supervision of house staff for all admissions, discharges and significant changes in the plan of care
      4. Review and co-sign all antenatal-testing procedures
      5. Review and co-sign all obstetrics ultrasounds performed by house staff
      6. Review of e-consults submitted to the Obstetrics and Gynecology services
      7. Collaboration with nursing staff to ensure effective, efficient, quality care.
      8. It is the responsibility of the attending to arrange for alternate coverage in situations of anticipated absence.
2. Gynecology Service Attending
   a. The role of attending physician on the Gynecology Service will generally rotate on a weekly basis.
   b. The GYN Attending will be responsible for the following:
      1. Attendance at all operative procedures scheduled by the team
      2. Daytime coverage of emergency procedures
      3. Conducting teaching rounds with house staff and students each weekday

(excluding holidays)

4. Supervision of house staff for all ED and inpatient consult admissions, discharges and significant changes in plans of care
5. Review of e-consults submitted to the Gynecology service
6. Review and approval of all scheduled surgical cases

3. It is the responsibility of the GYN Attending to arrange for alternate coverage in situations of anticipated absence.

4. Family Planning Service Attending

a. The role of attending physician on the Family Planning Service will generally rotate on a daily basis.

b. The family Planning Attending will be responsible for the following:

1. Attendance at all abortion surgical procedures, whether performed in an outpatient or inpatient setting;
2. Supervision of Family Planning Resident and medical students assigned to Women's Options Center;
3. Supervision of pre-operative examinations;
4. Review and co-sign all ultrasounds performed by house staff; and
5. Collaboration with nursing staff to ensure effective, efficient, quality care.

5. 5M Outpatient Attending

a. Attending physicians are generally assigned to 5M for the same ½ day clinic session each week.

b. The 5M Attending will be responsible for the following:

1. Attendance at the outpatient clinic from start to finish with only brief periods of absence;
2. Supervision of all house staff and medical students in 5M;
3. Review and co-sign all ultrasounds performed by house staff in 5M;
4. Collaboration with nursing staff to ensure effective, efficient, quality care.

6. Night and Weekend Attending

a. The attending physician on nights and weekends is expected to be in-house and readily available at all times.

b. The Night and Weekend Attending will be responsible for the following:

1. Attendance at all deliveries (except those uncomplicated deliveries attended by a Certified Nurse Midwife or Attending Family Medicine Physician), unless concurrent clinical situations prevent such attendance; and
2. Attendance at all surgical cases in the operating room.
3. Supervision of house staff for all ED and inpatient consults, admissions, discharges and significant changes in plans of care;
4. Review and co-sign all ultrasounds performed by house staff; and
5. The Night and Weekend Attending is expected to call in the back-up attending when the level of clinical activity jeopardizes adequate coverage of attending responsibilities.

7. Night and Weekend Back-up Attending

a. A back-up attending physician will be assigned every weeknight and weekend and is expected to be available to be called in from home should the necessity arise.

b. The Back-up attending will be called in at the discretion of the Night and Weekend Attending or at the request of the Ob/Gyn Chief Resident. The Back-up Attending will also be expected to fill in for the Night and Weekend Attending in the event of illness or other urgent absence.

B. MEDICAL RECORDS

The members of the OB/GYN Clinical Service are committed to the maintenance of complete, accurate and timely medical records. The requirements are set forth in the Zuckerberg San Francisco General Hospital & Trauma Center Bylaws, and Rules and Regulations of the Medical Staff, which define the minimum standard for records in the clinical service. All operative procedures must include a pre-operative and post-operative note by the attending surgeon of record.

C. INFORMED CONSENT

All decisions for treatment should involve the active participation of the patient, and informed consent should be made after appropriate discussion of risks, benefits and alternatives.

Documentation of "Informed Consent" on Medical Staff-approved forms is required for all the following:

1. All surgical procedures performed in the operating room;
2. All procedures in which tissue is removed;
3. All procedures involving laser therapy;
4. Vaginal breech delivery; operative vaginal delivery (forceps, vacuum)
5. Cesarean delivery;
6. Tubal sterilization;
7. Amniocentesis;
8. External cephalic version; and
9. IUD insertion, contraceptive implant insertion.
10. ~~induction of labor~~

XII. ADOPTION AND AMENDMENT

The OB/GYN Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the OB/GYN Service annually at an OB/GYN Clinical Service Meeting.

These Rules and Regulations may be adopted and revised on a voice vote of a majority of Active Staff members, providing that at least 72 hours' notice has been given.

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.

OBGYN **OBSTETRICS and GYNECOLOGY (2015) (1010, 0711 MEC)**

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	
______	______	**24.00 CORE PRIVILEGES**
______	______	**24.01 OUTPATIENT CLINIC: OBSTETRICS** PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. PROCTORING: review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents. REAPPOINTMENT: 50 clinic visits in the previous 2 years
______	______	A. Prenatal care visits, both low and high risk patients
______	______	B. Interpretation of fetal monitoring
______	______	C. Treatment of medical complications of pregnancy including, but not limited to: pregnancy induced hypertension, chronic hypertension, diabetes mellitus, renal disease, coagulopathies, cardiac disease, anemias and hemoglobinopathies, thyroid disease, sexually transmitted disease, pulmonary disease, thromboembolic disorders, infectious disease, ectopic pregnancy and other accidents of pregnancy, such as incomplete, complete, or missed abortion
______	______	**24.02 BASIC OB/GYN ULTRASOUND** PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. PROCTORING: Interpretation of 5 ultrasound exams. Interpretation of 3 ultrasound exams for UCSF-trained Fellows/Residents. REAPPOINTMENT: Interpretation of 10 ultrasound exams in the previous two years
______	______	A. Localization of intrauterine pregnancy (ie. diagnose IUP)
______	______	B. Evaluation of fetal viability and heart rate
______	______	C. Estimation of gestational age, fetal weight
______	______	D. Fetal presentation
______	______	E. Evaluation of vaginal bleeding, placental location
______	______	F. Measurement of cervical length
______	______	G. Amniotic fluid estimation (AFI)

Requested Approved

______ ______ **24.03 INPATIENT OBSTETRICAL CARE**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Note: Procedures marked with an asterisk may only be performed by obstetrician gynecologists, unless the physician has received additional obstetrical training and experience and has been approved by the Chief of OB/GYN & RS to perform these procedures.

PROCTORING: Observed care of 3 patients, each of whom has received at least one of the procedures below. For UCSF-trained residents and fellows: observed care of 2 patients, each of whom has received at least one procedure below.

REAPPOINTMENT: 15 procedures in the previous two years

______ ______ A. Routine inpatient antepartum, intrapartum, and postpartum care

______ ______ B. Management of spontaneous and induced labor

______ ______ C. Pudendal block* and local anesthesia

______ ______ D. Fetal assessment, antepartum and intrapartum

______ ______ E. Internal fetal monitoring

______ ______ F. Normal cephalic vaginal delivery

______ ______ G. Episiotomy and repair, including 1st and 2nd degree lacerations

______ ______ H. Exploration and repair of the vagina and cervix

______ ______ I. Deliver placenta

______ ______ J. Evaluate, diagnose, treat, and provide consultation for medical conditions complicating pregnancy (beyond that contained in routine inpatient antepartum, intrapartum, and postpartum care)*

______ ______ K. Fetal scalp sampling*

______ ______ L. Tubal ligation, post-partum*

______ ______ M. Non-genetic amniocentesis*

______ ______ N. Forceps delivery*

______ ______ O. Delivery by vacuum extraction*

______ ______ P. Manual or instrumental extraction of the placenta and fragments*

______ ______ Q. Cesarean section (primary surgeon)*

______ ______ R. Repair of incompetent cervix (cervical cerclage)*

______ ______ S. External version of breech presentation*

______ ______ T. Vaginal breech delivery*

______ ______ U. Vaginal multiple fetus delivery*

______ ______ V. Repair of rectal injury (3rd and 4th degree laceration)*

______ ______ W. Cesarean hysterectomy*

______ ______ X. Vaginal birth after caesarean section*

______ ______ Y Pregnancy termination via labor induction *

Requested Approved

______ ______ **24.04 OUTPATIENT CLINIC: GYNECOLOGY**

Evaluate, diagnose, treat, and provide consultation, pre-and post-operative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgical disorders and injuries of the mammary glands. When inpatient gynecologic care privileges have been approved, procedures in this privilege group also can be performed in the hospital operating room.

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.

PROCTORING: Review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 50 clinic visits in the previous 2 years

______ ______ A. Preventive health visits: well women, family planning visits

______ ______ B. Problem-oriented gynecologic visits

______ ______ C. Microscopic diagnosis of urine and vaginal smears

______ ______ D. Colposcopy

______ ______ E. Vulvar, vaginal and cervical biopsy

______ ______ F. Endometrial biopsy

______ ______ G. Cervical or endometrial polypectomy

______ ______ H. Insertion and removal of intrauterine contraceptive (IUC)

______ ______ I. Insertion and removal of contraceptive implant

______ ______ J. Pessary fitting

______ ______ K. Trigger point injection

______ ______ L. Cryosurgery (cervix, vulva, vagina)

______ ______ M. Loop electrosurgical excision procedure (LEEP), cervix

______ ______ N. Bartholin duct procedures (incision and drainage, marsupialization)

______ ______ O. Dilation and curettage, suction curettage and manual uterine aspiration

______ ______ P. Simple cystometry

______ ______ Q. Paracervical and intracervical block

______ ______ R. Insertion of cervical dilators

______ ______ S. Anoscopy

Requested Approved

______ ______ **24.05 INPATIENT GYNECOLOGY AND GYNECOLOGIC SURGERY**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 5 observed operative procedures, including at least one laparotomy and one laparoscopy.
REAPPOINTMENT: 15 operative procedures in the previous two years

______ ______ A. Admission of patients with gynecologic issues
______ ______ B. Care of admitted post-op and non-operative gyn patients
______ ______ C. Repair of vaginal, vulvar or cervical lacerations
______ ______ D. Drainage or removal of pelvic abscess (vaginal, laparoscopic or open)
______ ______ E. Placement of intra-uterine balloon catheter to manage bleeding
______ ______ F. Excision, I&D or surgical management of vulvar or vaginal lesions and abscesses
______ ______ G. Dilatation and curettage, suction curettage, manual uterine aspiration; diagnostic or therapeutic
______ ______ H. Cervical cone biopsy, LEEP procedure
______ ______ I. Hysterectomy, abdominal
______ ______ J. Hysterectomy, vaginal
______ ______ K. Hysterectomy, laparoscopic-assisted or total laparoscopic
_____ ______ L. Exploratory laparotomy
______ ______ M. Adnexal procedures (open or laparoscopic) including: salpingectomy, salpingostomy, oophorectomy, ovarian cystectomy, ovarian drilling, ovarian biopsy, ovarian detorsion, oophoropexy
______ ______ N. Myomectomy, abdominal or vaginal
______ ______ O. Incidental appendectomy
______ ______ P. Fistula repairs (vesicovaginal or rectovaginal)
______ ______ Q. Repair simple rent/ tear of bowel or bladder
______ ______ R. Perineoplasty, labiaplasty
______ ______ S. Repair of cystocoele, rectocele, enterocele
______ ______ T. Tuboplasty
______ ______ U. Hernia repair (incisional or umbilical)
______ ______ V. Paracentesis
______ ______ W. Wound management: I&D, skin debridement wound dehiscence, wound closure
______ ______ X. Cystoscopy
______ ______ Y. Hysteroscopy: diagnostic or operative including polypectomy, myomectomy, adhesiolysis, septum removal, endometrial ablation
______ ______ Z. Laparoscopy, diagnostic or operative including adnexal procedures, management of ectopic, chromopertubation, adhesiolysis, biopsy, fulgaration or excision of endometriosis, myomectomy
______ ______ AA. Tubal sterilization with cautery, rings, or clips

______ ______ BB. Non-hysteroscopic endometrial ablation techniques: HTA, thermal balloon, Nova-Sure

______ ______CC. First assist in obstetric procedures that require expertise in gynecology surgery, when requested by the attending obstetrician. See gynecologic surgery privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be their expertise in gynecologic surgery.

Requested Approved

______ ______ 24.06 EMERGENCY GYNECOLOGY AND GYNECOLOGIC SURGERY

Evaluate, diagnose, treat, and provide consultation, inpatient care and pre-and post-operative care necessary to correct or treat female patients of all ages presenting urgently or already hospitalized with injuries and disorders of the female reproductive system and the genitourinary system such as ectopic pregnancy, adnexal torsion, ruptured ovarian cyst, miscarriage, reproductive infections, uterine bleeding and trauma.

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00

PROCTORING: 3 observed operative procedures including at least one laparoscopy.

REAPPOINTMENT: 15 procedures in the previous two years including at least 4 laparoscopies or laparotomies

______ ______ A. Admission of patients with gynecologic issues

______ ______ B. Care of admitted post-op and non-operative gyn patients

______ ______ C. Surgical and non-surgical treatment of ectopic pregnancy and suspected ectopic pregnancy

______ ______ D. Surgical and non-surgical treatment of miscarriage

______ ______ E. Placement of intra-uterine balloon catheter to manage bleeding

______ ______ F. Exam under anesthesia

______ ______ G. Excision, I&D or surgical management of vulvar and vaginal lesions and abscesses

______ ______ H. Dilatation and curettage, suction curettage, manual uterine aspiration; diagnostic or therapeutic

______ ______ I. Exploratory laparotomy

______ ______ J. Diagnostic laparoscopy, lysis of adhesions

______ ______ K. Adnexal procedures (open or laparoscopic) such as: salpingectomy, salpingostomy, oophorectomy, ovarian detorsion, ovarian cystectomy, ovarian biopsy,salpingo-oophorectomy

______ ______ L. Drainage or removal of pelvic abscess (vaginal, laparoscopic or open)

______ ______ M. Repair of vaginal, vulvar or cervical lacerations and trauma

______ ______ N. Myomectomy, abdominal or vaginal

______ ______ O. Repair simple rent/tear of bowel or bladder

______ ______ P. Paracentesis

______ ______ Q. Wound management: skin debridement, wound dehiscence, wound closure

______ ______ R. Cystoscopy

______ ______ S.Emergent hysteroscopy

______ ______ **24.10 WAIVED TESTING PRIVILEGES**

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and

maintaining waived testing privileges providers satisfy competency expectations for waived testing by The Joint Commission. PREREQUISITES: Currently Board Admissible, Board Certified, or Re- Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology or General Surgery.
PROCTORING:By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.
REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

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

______ ______ **24.20 SPECIAL PRIVILEGES**

______ ______ **24.21 SECOND TRIMESTER ABORTION PROCEDURES** (also request 24.25 to practice in Women's Options Center)
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 3 observed operative procedures. 2 observed operative procedures for UCSF-trained Fellows/Residents.
REAPPOINTMENT: 10 procedures in the previous two years

______ ______ A. Second trimester abortion by dilation and evacuation
______ ______ B. Intra-fetal or intra-amniotic injection

______ ______ **24.22 LASER THERAPY**
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Appropriate training, complete the laser safety module prepared by the ZSFG Laser Safety Committee at http://insidechnsf.chnsf.org/det/HealthStream.htm and baseline eye examination within the previous 1 year.
PROCTORING: 2 observed procedures by a member of the medical staff with laser surgery privileges at ZSFG. 2 observed procedures for UCSF-trained Fellows/Residents.
REAPPOINTMENT: 2 cases in the previous two years reviewed by a member of the medical staff with laser surgery privileges at ZSFG.

______ ______ A. Laser therapy of the cervix
______ ______ B. Laser therapy of the vagina, vulva, and perineum
______ ______ C. Laser conization of the cervix

Requested Approved

______ ______ **24.23 ~~HYSTEROSCOPIC STERILIZATION~~**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.

TRAINING AND PROCTORING:

1. Providers must be trained in hysteroscopy and have current gynecologic endoscopy privileges in the ZSFG Department of Obstetrics and Gynecology
2. As required by the FDA, the physician must attend a training course sponsored by the manufacturer of the Essure System (Conceptus)
3. After training, the provider must be proctored for two Essure procedures. Proctoring may be performed at ZSFG by a provider privileged for this procedure at ZSFG or may be proctored at an outside institution by a qualified provider
4. Once proctoring has been completed, certification in the Essure procedure will be issued by Conceptus. This certification is a required prerequisite for approval of this privilege at ZSFG.
5. Providers who have been certified by Conceptus at another institution may apply for this privilege at ZSFG after being proctored for one procedure by an ZSFG physician who currently holds the privilege.

REAPPOINTMENT: 2 operative procedures in the previous two years

______ ______ A. ESSURE tubal occlusion procedure

______ ______ **24.24 UROGYNECOLOGY**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.

PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained Fellows/Residents.

REAPPOINTMENT: 15 operative procedures in the previous two years

______ ______ A. Urodynamics

______ ______ B. Intravesical and intraurethral injections

______ ______ C. Abdominal bladder neck suspension procedures

______ ______ D. Vaginal bladder neck suspension procedures

______ ______ E. Vaginal vault suspension procedures

______ ______ F. Urethral procedures: dilation of urethral stricture

______ ______ G. Colpocleisis

Requested Approved

______ ______ **24.25 PROCEDURAL SEDATION**

Procedural sedation privilege is required for those who will work in Women's Options Center.
PREREQUISITES: The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the procedural sedation test as evidenced by a satisfactory score on the examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Obstetrics and Gynecology or the American Board of Family Medicine or a member of the Clinical Service prior to 10/17/00, and has completed at least one of the following:

1) Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
2) Management of 10 airways via BVM or ETT per year in the preceding 2 years or,
3) Current Basic Life Support (BLS) certification by the American Heart Association

PROCTORING: Review of 5 cases. Review of 5 cases for UCSF-trained Fellows/Residents.
REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:

1) Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Emergency Medicine or Anesthesia or,
2) Management of 10 airways via BVM or ETT per year for the preceding 2 years or,
3) Current Basic Life Support (BLS) certification by the American Heart Association

______ ______ **24.41 GYNECOLOGIC ONCOLOGY**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Current certification or active participation in the examination process leading to subspecialty certification in gynecologic oncology by the American Board of Obstetrics and Gynecology
PROCTORING: 3 observed procedures. 2 observed procedures for UCSF-trained
Fellows/Residents.
REAPPOINTMENT: 15 operative procedures in the previous two years, at least 5 of which are performed at ZSFG

______ ______ A. Evaluate, diagnose, treat, and provide consultation and treatment to female patients with gynecologic cancer and complications resulting there from, including carcinomas of the cervix, ovary, fallopian tubes, uterus, vulva, and vagina and the performance of procedures on the bowel, ureter, and bladder as indicated.

______ ______ B. Radical hysterectomy for treatment of invasive carcinoma of the cervix

______ ______ C. Radical surgery for treatment of gynecologic malignancy to include procedures on bowel, ureter, or bladder, as indicated

______ ______ D. Treatment of invasive carcinoma of vulva by radical vulvectomy

______ ______ E. Treatment of invasive carcinoma of the vagina by radical vaginectomy

Requested Approved

______ ______ **24.42 MATERNAL-FETAL MEDICINE**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Successful completion of postgraduate training program in Maternal and Fetal Medicine and current certification or active participation in the examination process leading to subspecialty certification in maternal and fetal medicine by the American Board of Obstetrics and Gynecology or having been given his privilege at ZSFG prior to 10/17/00
PROCTORING: Observed care of 3 patients. Observed care of 2 patients for UCSF-trained Fellows/Residents.
REAPPOINTMENT: Care of 20 patients in the previous 2 years

______ _______ A. Evaluate, diagnose, treat, and provide consultation to female patients with medical and surgical complications of pregnancy such as maternal cardiac, pulmonary, metabolic, connective tissue disorders, and fetal malformations, conditions, or disease

______ _______ B. Genetic amniocentesis

______ _______ C. Level 2 obstetrical ultrasound, including Doppler

______ _______ D. Invasive fetal procedures, including cordocentesis, intrauterine fetal transfusion, cardiocentesis, thoracentesis

______ ______ **24.50 DUAL DEPARTMENT APPOINTMENT**

FOR PHYSICIANS WHO DO NOT HAVE A PRIMARY APPOINTMENT IN OB/GYN. Physicians trained in specialties other than obstetrics and gynecology may apply for dual appointment in the Department of Obstetrics and Gynecology for specified privileges, assuming that training and experience in a residency, fellowship, or clinical practice can be documented.

______ ______ 24.51 **WOMEN'S OPTION CENTER PROCEDURES (Dual Department Appointment only)**

PREREQUISITES:
1. Successful completion of an ACGME accredited postgraduate training program in family medicine, internal medicine, or pediatrics
2. Current medical staff appointment to a ZSFG clinical department (other than the Department of Obstetrics and Gynecology)
3. Completion of a fellowship program in family planning or documentation of training and experience in performing the requested procedures in residency, fellowship, or clinical practice.

If a family planning fellowship has not been completed, clinical experience in the past 5 years of practice must include, at a minimum:
Insertion of contraceptive implants (5 procedures)
Insertion of intrauterine contraceptives (5 procedures)
First trimester abortion (through 14 weeks) (50 procedures)
Second trimester abortion (15 weeks and later) (50 procedures)
Basic obstetrical ultrasound as an adjunct to abortion (15 procedures)

PROCTORING:
Insertion of contraceptive implants (2 procedures)
Insertion of intrauterine contraceptives (2 procedures)
First trimester abortion (through 14 weeks) (5 procedures)
Second trimester abortion (15 weeks and later) (5 procedures)
Basic obstetrical ultrasound as an adjunct to abortion (5 procedures)

REAPPOINTMENT (procedures in the past 2 years):
Insertion of contraceptive implants (2 procedures)
Insertion of intrauterine contraceptives (2 procedures)
First trimester abortion (through 14 weeks) (10 procedures)
Second trimester abortion (15 weeks and later) (10 procedures)
Basic obstetrical ultrasound as an adjunct to abortion (10 procedures)

______ ______ 24.511 Insertion of contraceptive implants
______ ______ 24.512 Insertion of intrauterine contraceptives
______ ______ 24.513 First trimester abortion (through 14 weeks)
______ ______ 24.514 Second trimester abortion (through 15 weeks and later)
______ ______ 24.515: Basic obstetrical ultrasound as an adjunct to abortion

______ ______ **24.61 LICENSED CLINICAL PSYCHOLOGIST**

Provide individual counseling and psychotherapy at the New Generations Health Center
PREREQUISITES: Must hold a doctoral degree in Psychology from an approved APA accredited program and must be licensed by the State of California, Board of Psychology.
PROCTORING: Review of 5 cases by a clinical psychologist on the ZSFG Medical Staff.
REAPPOINTMENT: Review of 3 cases by a clinical psychologist on the ZSFG Medical Staff.

______ ______ **24.65 CTSI (Clinical and Translational Science Institute) - Clinical Research**

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

Prerequisites: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants.
Proctoring: All OPPE metrics acceptable
Reappointment: All OPPE metrics acceptable

Applicant signature:____ Date:

Department Chief signature:____ Date:

XIV. APENDIX B.- HOUSE STAFF

COMPETENCIES APPENDIX B.

HOUSESTAFF COMPETENCIES

HOUSESTAFF SUPERVISON

House Staff providing clinical services shall do so only under the supervision of active or courtesy medical staff who have ultimate responsibility for patient care, are members of the University of California, San Francisco Faculty, and have appropriate clinical privileges.

A. ATTENDING RESPONSIBILITY

Zuckerberg San Francisco General Hospital & Trauma Center Medical Staff Bylaws, JCAHO Standards and California law require that the attending physician oversee and assume ultimate responsibility for the care of each patient. Accordingly, house staff shall be always supervised by and accountable to a member of the ZSFG Medical Staff with a University of California faculty appointment. In order to discharge that responsibility, close supervision and active participation in decision-making is required.

1. Inpatient Attending Rounding/Supervision

a. The attending physician will discuss the management of the patient with House Staff at least once a day and as necessary in light of material changes or developments in the patient's clinical status.
b. The attending physician will be available and participate in major decision-making (.e.g., DNR, admission, or discharge orders) at all times.

2. Outpatient Attending Supervision

a. Attending physicians will oversee the care provided to all outpatients. Attending physicians are assigned to specific outpatient sessions, which may vary from week to week. Attending physicians will be physically present in the outpatient clinics to supervise the care provided by house staff. It is the attending physician's responsibility to arrange coverage for absences.

3. Attending Supervision of Major Procedures/Complex Medical Treatments

a. The attending physician will provide direct supervision for the main portion of all major operative procedures, including all surgery performed in the main operating room, the Birth Center, and 6G, and all advanced outpatient procedures (e.g. hysteroscopy, cystoscopy, and electro-excisional procedures of the cervix). The attending physician will determine each house staff officer's scope of practice and level of supervision required according to the year of post-graduate training and demonstrated clinical skills.

4. Attending Supervision of Informed Consent Process

a. All patients with medical decision-making capacity must be given adequate information about the risks, benefits, and alternatives for any treatment, operation, or special diagnostic or therapeutic procedure, which involves significant risk of bodily harm.
b. The attending physician is responsible for ensuring adequate disclosure is made prior to procedures requiring informed consent, for supervising the informed consent process and ensuring appropriate documentation in the medical record. The attending physician may delegate the task to a licensed physician, but the attending physician should document his or her confirmation that informed consent was obtained in the medical record prior to the procedure.
c. The patient has a right to know the names and professional relationships of the physicians involved in her medical care. Accordingly, the patient shall be informed which attending physician will be supervising the procedure and, prior to the procedure, when a different attending physician is substituted
due to scheduling changes, etc.
d. In the event of a medical emergency, when immediate services are required to alleviate severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required, if delay of such treatment would lead to serious disability or death, the treating physician, preferably the attending, should document the existence and nature of the emergency and the

necessity of the proposed or rendered treatment. There is no requirement that the physician seek consultation ("the two attending" rule).

B. HOUSE STAFF RESPONSIBILITES

1. House Staff Compliance
   a. House Staff shall comply with the ZSFG Medical Staff Bylaws, Rules and Regulations, Departmental Rules and Regulations, Hospital Policies and Procedures and the Principles of Medical Ethics of the American Medical Association and participate in the ZSFG PIPS and Risk Management Programs.

2. Responsibilities
   a. House Staff will be able to always identify an available supervising attending physician during patient care. House staff must consult the attending physician, directly or through the chain of command, as appropriate, prior to material changes in the plan of care of a major surgical or obstetrical procedure.
   House staff should not proceed with the care or procedure unless and until there is meaningful consultative interaction with the Attending physician, directly or through the chain of command, as appropriate.
   b. House Staff must consult the attending physician, directly or through the chain of command, as appropriate, with questions or concerns regarding patient care and when the plan of care requires that
   house staff undertake at treatment outside the House Staff member's level of commensurate with his or
   her level of advancement and responsibility.

C. MEDICAL RECORDS DOCUMENTATION BY ATTENDINGS/HOUSE STAFF

These are delineated in Section XI.B of the OB/GYN Clinical Service Rules and Regulations. Operative reports, discharge summaries, and consultation notes may be written or dictated by House Staff as appropriate but must ultimately be reviewed and signed by the attending physician.

D. HOUSE STAFF EVALUATION AND DISCIPLINARY ACTION

1. Evaluation
   a. House staff are evaluated informally by more senior house staff and by attending physicians as clinical rotations are underway. A formal electronic evaluation is compiled at the end of each rotation, kept on file in the Residency Program Office, and distributed to the resident and his or her faculty advisor. Residents are not advanced to the next postgraduate training year without successful completion of clinical rotations, the annual in-service examination, any delinquent medical records, and their personal house staff experience statistics.

2. Disciplinary Action: Refer to Section VIII. Other disciplinary actions may occur at the direction of the Residency Program.

XV. APPENDIX C- OB/GYN CLINCAL SERVICE ORGANIZATION CHART

Interim Chief of Service Jody Steinauer, MD, PhD
Chief of Service, tentatively beginning 11/1/23 Rebecca Jackson, MD, MAS.
Medical Director Obstetric Service ~~Eleanor Drey, M.D.~~Ben Li, M.D.
Medical Director Gynecology Service Abner Korn, M.D.
Medical Director, ~~Women's Health Center~~OMG Clinic ~~Misa Perron-Burdick, M.D.~~Margy Hutchison

Ob-gyn Liaison, OMG Clinic	Dilys Walker, M.D.
Medical Director, Women's Options Center	Eleanor Drey, MD, EdM
Site Director, Resident Education & Training	Biftu Mengesha, M.D., M.A.S.M.D.
Director of Medical Student Education	Sara Newmann, M.D.Naomi Stotland, M.D.
Medical Director, New Generation Health Center	Sara Newmann, MDRebecca Jackson, M.D., M.A.S.
Medical Director, Reproductive Infections	Deborah Cohan, M.D.Nika Seidman, M.D., M.A.S.
Chair of Midwifery Council	Margy Hutchison, CNM, MSN
Director Nurse Midwifery Education	Kim Dau CNM,
Director of Quality Improvement	Ana Delgado, CNM

MEDICAL STAFF COMMITTEE ASSIGNMENTS

Ambulatory Care Committee	Misa Perron-Burdick, MMargy Hutchison.D.
Cancer Committee	Abner Korn, M.D
Credentials Committee	Jennifer Kerns, M.D., MPH, Kara Myers, CNM
Interdisciplinary Practice	Kara Myers, C.N.M..
Medical Executive Committee	Rebecca Jackson, M.D.
Operating Room Committee	Eleanor Drey, MD, EdM JiaJia Zhang, M.D.
Performance Improvement & Patient Safety (PIPS)	Ana Delgado, CNM. Perinatal Linkage
Committee	Ana Delgado, CNM
Clinical Practice Group	Rebecca Jackson MD, MAS-
Risk Management Committee	Rebecca Jackson, MD, MAS

sf

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

XVL APPENDIX D OB/GYN M&M REVIEW FORMS

A.

San Francisco General Hospital
Department of Obstetrics and Gynecology

Quality Assurance Committe Confidential Peer Review--Obstetrics

B Number:
Delivery Date:
Indicator Date:

Clinical Indicators(s):

Clinical Summary:

Reviewer's Comments:

Reviewed by:__________________ Date:____________

Conclusions:	Faculty	CNM	Housestaff	Other
No Deficiency	☐	☐	☐	☐
Suggestion to clinician	☐	☐	☐	☐
Opportunity for Improvement	☐	☐	☐	☐
Deficiency	☐	☐	☐	☐

If Deficiency or Opp for Improvement, Describe:

Attd/CNM Present ☐ OR Date Attd/CNM Notified:____________

Injury: *only if opp for improvement or deficiency
☐ None ☐ Short-term Morbidity
☐ Long Term Morbidity ☐ Death

Action:
☐ No Further Action
☐ Refer to QI committee

QI Committee Actions:

Date:____________

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

B.

San Francisco General Hospital
Department of Obstetrics and Gynecology

Quality Assurance Committe Confidential Peer Review--Gynecology

B Number:
Discharge Date:

Clinical Indicators(s):

Clinical Summary:

Reviewer's Comments:

Reviewed by:_________________ Date:___________

Conclusions:	Faculty	Housestaff	Other
No Deficiency	☐	☐	☐
Suggestion to clinician	☐	☐	☐
Opportunity for Improvement	☐	☐	☐
Deficiency	☐	☐	☐

If Deficiency or Opp for Improvement, Describe:

Attd/CNM Present ☐ OR Date Attd/CNM Notified:___________

Injury: * Only If opp for improvement or deficiency

☐ None ☐ Short-term Morbidity
☐ Long Term Morbidity ☐ Death

Action:

☐ No Further Action
☐ Refer to QI committee

QI Committee Actions:

Date:___________

Form revision -- 1/11/11

XVII. APPENDIX E- OPPE FORM

CONFIDENTIAL: Protected by Attorney-Client Privilege and California Evidence Code 1157
Zuckerberg San Francisco General Hospital and Trauma Center - Ongoing Professional Performance Evaluation (OPPE)

*** 6 Month Range:** **July-Dec 2018** ☐ **No patient care and/or clinical teaching for this time period**
(if checked, metrics need not be completed, but Y/N questions at bottom, signature & date are required)

Last, First & Degree: ____________ **Status:** ____________ **CHN #** ____________

Service: **OB / GYN**

Metric	Acceptable	Marginal*	Unacceptable*	Metric Not Relevant During This Period	Comments
MEDICAL & AFFILIATED STAFF:					
Deaths: Preventable or Possibly Preventable	☐ 0	☐ 1	☐ > 1	☐	
Cases of Concern, Patients Complaints, U/Os, Sentinel Events	☐ < 2	☐ 2	☐ > 2	☐	
Completed & Passed Microscopy Test without Reminders	☐ Both	☐ Needed 1 Reminder	☐ >1 Reminder or Failed	☐	
GYN Surgical Procedures					
Total Number of Procedures	☐ > 2	☐ 2	☐ 0 - 1	☐	
Number Showing Complication with Atttribution	☐ 0	☐ 1	☐ > 1	☐	
Number Showing Need for Improvement	☐ 0 - 1	☐ 2	☐ > 2	☐	
>1 ED visit same problem with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	
Transfused with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	
Cases > 4 Hours in OR with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	
OB Procedures					
Total Number of Procedures	☐ > 3	☐ 3	☐ 0 - 2	☐	
Total Number Showing Complication with Atttribution	☐ 0	☐ 1	☐ > 1	☐	
Total Number Showing Need for Improvement	☐ 0 - 1	☐ 2	☐ > 2	☐	
Transfused with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	

CONFIDENTIAL: Protected by Attorney-Client Privilege and California Evidence Code 1157
Zuckerberg San Francisco General Hospital and Trauma Center - Ongoing Professional Performance Evaluation (OPPE)

*** 6 Month Range:** **July-Dec 2018** ☐ **No patient care and/or clinical teaching for this time period**
(if checked, metrics need not be completed, but Y/N questions at bottom, signature & date are required)

Last, First & Degree: ____________ **Status:** ____________ **CHN #** ____________

Service: **OB / GYN**

Metric	Acceptable	Marginal*	Unacceptable*	Metric Not Relevant During This Period	Comments
OB Procedures, cont.					
Low Cord pH with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	
Abortion Procedures					
Total Number of Procedures	☐ > 8	☐ 6 - 8	☐ < 6	☐	
Number of 2nd Tri Procedures	☐ > 7	☐ 5 - 7	☐ < 5	☐	
Transfusion with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	
Laceration & Suture with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	
Admission with Complication with Atttribution or Oppor for Improvement	☐ 0	☐ 1	☐ > 1	☐	
AFFILIATED STAFF-Outpatient 5M NP/PA only					
% of IUD + Implanon in FPACT Patients Initiating Contraception	☐ > 10 %	☐ 7 % - 10 %	☐ < 7 %	☐	

*** Explanation of rating system: This OPPE is used in conjunction with quarterly Departmental QI data for each provider. QI data shows the numbers of procedures and whether the procedure had any QI indicators present. There are 14 indicators for Ob, 14 for Gyn and 8 for Abortions. Procedures with indicators present are reviewed in M&M and providers are assigned: no Complication with Atttribution, suggestion to clinician, opportunity for improvement or Complication with Atttribution.

*** IN ANY ONE CATEGORY:**
Two consecutive **marginal** ratings require Chief of Service's commentary
Three consecutive **marginal** ratings require FPPE and notification to the Credentials Committee Chair
Two consecutive **unacceptable** ratings require FPPE and notification to the Credentials Committee Chair

REQUIRED FOR EVERY PRACTITIONER ON ROSTER:

☐ Yes ☐ No Recommend continued current privileges
☐ Yes ☐ No Recommend a Focused Professional Practice Evaluation (FPPE). If YES, attach a detailed FPPE plan
☐ Yes ☐ No Recommend changes to current privileges: ____________

☐ Yes ☐ No To my knowledge, this practitioner does not have a medical/mental health condition that could affect clinical care or judgment. (If such a condition exists, please reference the plan for monitoring this condition)

Chief of Service (or designee) ____________ Date: ____________
(Electronic signature acceptable)

Practitioner Signature* : ____________ Date: ____________
(Electronic signature acceptable) * Required only if "marginal" or "unacceptable" notes above

DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
CLINICAL SERVICE
RULES AND REGULATIONS
~~2021~~2023

Reviewed/Approved – ~~Jan 21~~Nov 13, ~~2021~~2023 Business MEC

The Pricilla Chan and Mark Zuckerberg
San Francisco General Hospital and Trauma Center
1001 Potrero Ave
San Francisco, CA 94110

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DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
CLINICAL SERVICE
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I. DENTISTRY/ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

1. The full scope of practice of the Dentistry/Oral and Maxillofacial Surgery Clinical Service covers:

   - Patient Assessment
   - Anesthesia in Outpatient Clinic
   - Dentoalveolar Surgery
   - Oral and Craniomaxillofacial Implant Surgery
   - Surgical Correction of Maxillofacial Skeletal Deformities
   - Cleft and Craniofacial Surgery
   - Trauma Surgery
   - Temporomandibular Joint Surgery
   - Diagnosis and Management of Pathologic Conditions
   - Reconstructive Surgery
   - Cosmetic Maxillofacial Surgery

Except for the clinical areas of cleft and craniofacial surgery and cosmetic (soft tissue) maxillofacial surgery, the full scope is practiced extensively by this Dentistry/Oral and Maxillofacial Surgery Clinical Service.

2. General Dentistry scope of service is indicated by the accepted definition of dentistry:

   "*Dentistry is defined as the evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of disease disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body, provided by a dentist, within the scope of his/her education, training, and experience, in accordance with the ethics of the profession and applicable law.*"

Currently, the Dentistry/Oral and Maxillofacial Surgery Service provides limited general dental care. However, there is adequate facility and equipment leaving open the potential for resumption of this type of care. Additionally, general dentists have been appointed to the Courtesy Staff.

3. Chief of Dentistry / Oral & Maxillofacial Surgery Clinical Service Job Description (See APPENDIX E)

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of San Francisco General Hospital is a privilege which shall be extended only to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in ZSFG

Medical Staff Bylaws, Article II, *Medical Staff Membership* as well as these Clinical Service Rules and Regulations.

C. ORGANIZATION OF ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE

Refer to Appendix D – Clinic Matrix Organization Chart in Oral and Maxillofacial Surgery Service

II. CREDENTIALING

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

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

1) **Practitioners Performance Profiles**
Refer to Appendix C - OMS Performance Improvement and Patient Safety Plan – Section IV

2) **Staff Status Change**
The process for Staff Status Change for members of the Dentistry/Oral & Maxillofacial Surgery Clinical 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 Dentistry/Oral & Maxillofacial Surgery Clinical Services is in accordance with ZSFG Bylaws, Rules and Regulations.

C. AFFLIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals to ZSFG through the Dentistry/Oral & Maxillofacial Surgery Clinical Service is in accordance with ZSFG Bylaws, Rules and Regulations.

D. STAFF CATEGORIES

The Dentistry/Oral & Maxillofacial Surgery Clinical Service staff fall into the same categories which 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

The Dentistry/Oral & Maxillofacial Surgery Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations as well as these Clinical Service Rules and Regulations. Applicants must indicate on the privilege form the procedures for which they have demonstrated competence and wish to have.

GROUP A: GENERAL DENTISTRY
Applicants for general dentistry privileges must satisfy all of the following criteria except the requirements for training in oral maxillofacial surgery, board eligibility or certification, ACLS and current DEA certificate

GROUP B: ORAL & MAXILLOFACIAL SURGERY
The criteria for oral and maxillofacial surgery are:

1. Graduation from a school of dentistry which is accredited by the American Dental Association Commission on Dental Accreditation or listed in the World Directory of Dental Schools as published by the World Organization of Health.
2. Completion of residency in oral and maxillofacial surgery from a program accredited by the American Dental Association Commission on Dental Accreditation.
3. Possession of a valid, current dental or medical license in the state of California.
4. Possession of a valid, current DEA.
5. Current professional liability insurance, if not insured either through the University of California as a faculty member or through the City & County of San Francisco in an amount considered appropriate for the type and scope of practice by this hospital’s medical staff and governing body on an individual basis.
6. Completion of a BLS and ACLS course within the last two years.
7. Must provide proof of Admissibility or Certification by the American Board of Oral & Maxillofacial Surgery.
8. If the applicant received his/her training in a country other than the United States of America, and has an academic or clinical appointment in the Department of Oral and Maxillofacial Surgery at the University of California San Francisco, then requirements #1 and #2 are satisfied.
9. If the applicant wishes privileges in Outpatient General Anesthesia, the applicant must have a valid General Anesthesia permit in the State of California after the probationary year, and the request is approved by the Chief of Anesthesia.
10. Absence of a history or involvement in malpractice suits, or arbitrations, or settlements, OR, in the case of an applicant with this history, evidence that the history of malpractice claims does not demonstrate probably ongoing substandard professional performance.
11. Absence of physical or mental impairments which may interfere with the ability to practice dentistry and/or medicine.

12. Absence of a history of professional disciplinary action, OR, in the case of an applicant with this history, evidence that this history does not demonstrate probably ongoing substandard professional performance.

13. Absence of history of criminal conviction or indictment; OR, in the case of an applicant with this history, evidence that this history does not demonstrate probable substandard professional or ethical performance. A conviction within the meaning of these criteria includes a plea or verdict of guilty or a conviction following a plea of non-contender.
14. Completion of an application form and absence of intentional falsification or omission by the applicant.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Dentistry/Oral & Maxillofacial Surgery Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES

Dentistry/Oral & Maxillofacial Surgery Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V: *Clinical Privileges*, Rules and Regulations as well as the Clinical Service Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of the Oral & Maxillofacial Surgery Clinical Service. The initial determination of privileges shall be guided by the applicant's education, training and experience.

All new privileges are normally proctored for up to one year or until competency has been verified. During the proctoring period, all cases must have the approval of a member of the active staff of the Dentistry/Oral & Maxillofacial Surgery Service. Supervision of procedures done in the operating room will be at the discretion of the Chief of Service. If the applicant completed the oral & maxillofacial surgery training program of the University of California San Francisco within five years of application, the applicant will be exempt from case approval and supervision of procedures during the proctoring period.

D. TEMPORARY PRIVLEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

All medical staff members initially granted privileges shall complete a period of proctoring. Proctoring (monitoring) requirements for the Dentistry/Oral & Maxillofacial Surgery Clinical Service shall be the responsibility of the Chief of the Service or his designee.

The initial determination of privileges shall be guided by the applicant's education, training and experience. All new privileges are probationary for one year. During the probationary period, all cases must have the approval of a member of the active staff of the Dentistry/Oral & Maxillofacial Surgery Service. Supervision of procedures done in the operating room will be at the discretion of the Chief of Service. If the applicant completed the oral & maxillofacial surgery training program of the University of California San Francisco within five years of application, the applicant will be exempt from case approval and supervision of procedures during the probationary period.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Dentistry/Oral & Maxillofacial Surgery Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations and accompanying manuals.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Dentistry/Oral & Maxillofacial Surgery Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations and accompanying manuals.

V. EDUCATION

The Dentistry/Oral and Maxillofacial Surgery Clinical Service offers ongoing high quality educational and training programs for their members through ward rounds, M&M Conferences, Clinicopathologic Conferences, Journal Club, Human Anatomy Dissections in the laboratory, ZSFG Maxillofacial Trauma Grand Rounds, and UCSF Grand Rounds.

Members of the Dentistry/Oral and Maxillofacial Surgery Clinical Service are required to obtain a minimum of 50 CME units every two years.

VI. ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

SUPERVISION OF RESIDENTS (See Appendix D - OMS Housestaff Manual)

1. Dentoalveolar surgery
   - Limited supervision by attending surgeons
2. Maxillofacial Trauma Surgery
   - Direct attending surgeons' supervision, except for closed reduction of fractures and repair of non-complex facial lacerations.

The following items require direct attending supervision

3. Intravenous Moderate Sedation and OPD General Anesthesia
4. Oral and Craniofacial Implant Surgery
5. Surgical Correction of Maxillofacial Skeletal Deformities
6. Temporomandibular Joint Surgery
7. Management of Pathological Conditions
8. Reconstructive Surgery

Limited supervision means independent decision-making and provision of care by Residents with appropriate attending consultation.

Direct supervision indicates attending surgeon responsibility for the preoperative, intraoperative and postoperative care of each patient. Also, the attending must be consulted by Resident(s) prior to any invasive procedure or material change in the treatment plan. The medical record must show that the attending surgeon was directly involved in the care of each patient.

VII. ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

A. Consultation for patient care is provided 24 hours per day by:
   1. Consultation request form delivered to the Clinic (lN1)
   2. Telephone request by calling the Clinic at Ext. 8104 or 6539
   3. Direct referral to oral and maxillofacial surgery residents
   4. Paging the on-call resident – page number may be obtained from the hospital telephone operator.

B. Non-emergency consultation shall be answered within 24 hours.

C. A written consultation report shall be placed in the patient’s chart at the time of patient evaluation. This report shall be dated and signed. In urgent situations the consulting resident or attending shall contact the requesting physician by telephone.

D There is attending surgeon coverage 24 hours per day. After clinic hours, the on-call attending may be contacted through the hospital telephone operator or the telephone/pager number on the monthly “on-call” schedule, available at key locations within the hospital.

VIII. DISCIPLINARY ACTION

The San Francisco General Hospital Medical Staff Bylaws, Rules and Regulations will govern all disciplinary action involving members of the ZSFG Dentistry/Oral & Maxillofacial Surgery Clinical Service.

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

A. GENERIC CLINICAL INDICATORS FOR ORAL AND MAXILLOFACIAL SURGERY IN INPATIENT OR OUTPATIENT FACILITIES

Each indicator will be used as a marker, which will be further evaluated by assigned Q.A. Officers in the context of the clinical circumstances. These indicators are not random unknown events or occurrences but rather indices of risks and complications known to be associated with management of the various clinical conditions, covered by the Scope of Practice.

The presence of clinical indicators does not necessarily reflect on the quality of care. Rather, the presence of such indicators may indicate that a treatment modality is of concern after a critical threshold has been reached. What that threshold is will depend on several factors, including the nature of the indicator, the clinical status of the patient receiving care and the patient population for the condition being treated.

These indicators are divided into three groups. These indicators are considered generic to the performance of oral and maxillofacial surgery. When a clinical indicator is selected for review, known risks and complications associated with therapy will be included.

1. Admission after hospital ambulatory surgery
   Comments and Exceptions:
   - Patient informed that additional inpatient management may be required.

2. Performance of additional procedures not specified in consent form.
   Comments and Exceptions:
   - Disparity between preoperative consent form and operative report.

3. Unplanned and/or avoidable removal, injury, or repair of an organ or structure during surgery or invasive procedure; loss of instruments and/or supplies (i.e., sponges and needles)

4. Unplanned return to the Operating Room.

5. Medical and/or surgical complications occurring during the operative and post-operative period
   a. Development of neurological deficit which was not present on admission, other than those accepted as a normal course of the patient's surgical management (e.g. excision of mandibular and maxillary third molars, mandibular resection, sagittal split osteotomy)

6. Surgical and other invasive procedures which do not meet criteria for necessity and appropriateness.
   a. Pathology or imaging reports does not match preoperative diagnosis
   b. Nondiagnosis or normal tissue removed and criteria for necessity or appropriateness not met
   c. No tissue removed, and criteria for necessity and appropriateness not met
   d. Procedure and details of operative report do not match the preoperative diagnosis.
   Comments and Exceptions:
   - Surgical case review committee has developed and approved specific criteria for non-tissue producing cases following individual service consultation, and for the intentional removal of excessive redundant normal tissue.

7. Acquired drug sensitization

8. Transfer from general care to intensive care unit (inpatient only)
   a. Complication
   b. Utilization problem
   Comments and Exceptions:
   - Scheduled prior to surgery or other special procedure.

9. Hospital, Surgery Center, or office-incurred patient incident
   a. Falls, slips and/or patient accidents
   b. Intravenous infusion problems (e.g., calculation error or overloads)

c. Medication error or problem (e.g., drug type or dosage, contrast material reaction)
d. Skin problem (e.g., rash, infiltrations, threatened or new decubitus ulcer)
e. Equipment failure
f. Other incidents (e.g., procedural errors, electric shock or burn, actual or attempted suicide, lost or damaged property)

10. Abnormal laboratory, radiographic or other test results not addressed by surgeon
    Comments and Exceptions:
    – As monitored by the medical staff

11. Discharge to home with
    a. Blood pressure on day of discharge:
       Systolic: Less than 80 or greater than 180
       Diastolic: Less than 50 or greater than 110
    b. Core temperature on day of discharge greater than 101 degrees
    c. Pulse: Less than 50 or greater than 120 within 24 hours of discharge
    d Intravenous (IV) fluids or drugs on the day of discharge (excludes keeping the IV in place, antibiotics, chemotherapy or TPN)
    e. Significant purulent or bloody drainage of postoperative wounds within 24 hours prior to discharge.

12. Patient and/or family dissatisfaction.
    Comments and Exceptions:
    – As monitored by post surgery random sampling

13. Subsequent visit to emergency room for complications or adverse results related to previous hospitalization or outpatient surgery.
    Comments and Exceptions:
    – Planned return for wound checks or suture removal
    – Patient not previously hospitalized at this hospital

B. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

See Appendix C – OMS Performance Improvement and Patient Safety Plan

C. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

Annual Performance Improvement & Patient Safety (PIPS) Reports are presented to the PIPS Committee.

1. Policy for Attending Staff Review
   The activities of the attending staff are:
   a. Teaching –predoctoral and postdoctoral (residents) students
   b. Private Practice – intramural or extramural
   c. Research - clinical and laboratory
   d. Continuing education courses – faculty or attending
   e. Committee work

2. Basis for reviews are:
   a. Monitoring progress notes by Chief of Service
   b. Operating room visits by Chief of Service, when that attending is managing a case
   c. Participation on rounds
   d. Participation in and case discussion during monthly department meetings
   e. Biannual review of reappointment
   f. Since most of the attending surgeons are members of the UCSF faculty, they are also subject to the scrutiny of the University's Academic Senate for merit increases and promotions.

3. Policy for Housestaff Review:
   a. Review of medical records on discharge
   b. Presence of attending surgeon for all invasive procedures
   c. Ward rounds, directed by attendings surgeon
   d. UCSF Grand Rounds, Clinicopathologic Conference, Morbidity and Mortality conference – presentations and active participation by residents – Tuesday A.M.
   e. ZSFG Maxillofacial Trauma Grand Rounds – residents' presentations – first and fourth Friday of each month - A.M
   f. Formal Resident's evaluation by attendings surgeons at end of rotations.

D. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to IX C. Above

X. MEETING REQUIREMENTS

In accordance with ZSFG Medical Staff Bylaws *Committees of the Medical Staff*, 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 Dentistry/Oral & Maxillofacial Surgery Clinical Services shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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 ADMENDMENT

The revised Dentistry/Oral & Maxillofacial Surgery Clinical Service Rules and Regulations ~~will~~ shall be adopted and revised by a majority vote of all Active members of the Dentistry/Oral & Maxillofacial Surgery Clinical Service annually at one of its monthly meetings.

The Pricilla Chan and Mark Zuckerberg
San Francisco General Hospital and Trauma Center
1001 Potrero Ave
San Francisco, CA 94110

APPENDIX A – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PRIVILEGE FORM

Privileges for San Francisco General Hospital

Requested Approved

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

OMFS ORAL & MAXILLOFACIAL SURGERY 2009

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.

______ ______ **8.0 CORE PRIVILEGES**

______ ______ 8.10 GENERAL DENTISTRY

Evaluation, diagnosis, prevention and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and conditions of the oral cavity, and maxillofacial area, to include dental surgery on the teeth as a treatment for dental caries and traumatic injuries, prosthetic therapy, routine endodontic therapy, routine orthodontic therapy, routine periodontal therapy, intraoral biopsy, simple and surgical exodontias.
PREREQUISITES: A current dental license, oral surgery permit, or special permit from the Dental Board of California.
PROCTORING: Five (5) operative cases and 10 retrospective reviews of operative cases.
REAPPOINTMENT: Twenty (20) operative procedures in the previous two years.

______ ______ 8.20 ORAL & MAXILLOFACIAL SURGERY

Diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region, excluding surgical management of malignant lesions and the parotid gland. This includes local anesthesia blocks of head and neck sensory nerves, history and physical examinations, dentoalveolar surgery, implantology, major infections of the oral and maxillofacial region, orthognathic surgery, pathologic surgery, preprosthetic surgery, soft and hard tissue trauma surgery, reconstructive surgery, splint and surgical treatment of sleep apnea, and temporomandibular joint surgery.
PREREQUISITES: A current dental license, oral surgery permit or special permit from the Dental Board of California or medical license from the Medical Board of California, and Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00
PROCTORING: Five (5) observed operative procedures and 10 retrospective reviews of operative procedures.
REAPPOINTMENT: Twenty (20) operative procedures in the previous two years.

______ ______ **8.30 SPECIAL PRIVILEGES**

______ ______ 8.31 BENIGN & MALIGNANT PAROTID GLAND TUMORS & MALIGNANT TUMORS OF THE JAWS & ASSOCIATED SOFT TISSUES

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00. In addition to that for core privileges, additional training in oncological surgery and/or retrospective review of ten (10) cases.
PROCTORING: Two (2) operative procedures.
REAPPOINTMENT: Five (5) operative procedures in the previous two years.

______ ______ 8.32 MODERATE SEDATION

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

Services Department.
PROCTORING: Review of 5 cases.
REAPPOINTMENT: Review of 5 case done in the previous two years or completion of the educational module and post test as evidenced by a satisfactory score on the examination, and a signed Physician Attestation Form submitted to the Medical Staff Services Department.

______ ______ 8.33 DEEP SEDATION/GENERAL ANESTHESIA
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00. Completion of a dental anesthesia or medical anesthesia or oral and maxillofacial surgery residency training program and Board Admissible or Certified or Re-certified by the respective professional association. Additionally, a current general anesthesia permit from the Dental Board of California is required for providers, who practice exclusively under a dental license, oral surgery permit or special permit.
PROCTORING: Observation of 5 cases.
REAPPOINTMENT: Review of 10 cases in the previous two years.

______ ______ 8.34 LASER SURGERY
Incisional biopsy, excisional biopsy and ablation of congenital and acquired lesions of the oral and maxillofacial region and associated soft tissues.
PREREQUISITES: Appropriate training. Viewing of the laser safety video prepared by the ZSFG Laser Safety Committee, and baseline eye examination. Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Oral and Maxillofacial Surgery or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Two (2) observed procedures.
REAPPOINTMENT: Two (2) cases in the previous two years, and viewing of the laser safety video prepared by the ZSFG Laser Safety Committee and documentation of eye examination within the previous 6 months.

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

The Pricilla Chan and Mark Zuckerberg
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DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
SAN FRANCISCO GENERAL HOSPTIAL
REQUEST FOR PRIVILEGES COVER SHEET

NAME________________________

I am requesting the specific attached marked privileges. I understand that I may request additional or reduced privileges in the future. In making application to the Dentistry/Oral & Maxillofacial Surgery Clinical Service for these privileges, I acknowledge having read and agree to abide by the following procedures:

1. I have indicated the requested privileges on the attached form. I understand that the granting of privileges will require written evidence of competence by my training program director and the Department of the Dentistry/Oral & Maxillofacial Surgery Service at an institution in which I currently hold such privileges. It is my responsibility to provide the name or names of appropriate individuals to contact at the end of the privilege form. As a general dentist without residency training, I will provide written evidence of competence by the Dean of my dental school and Chair of the Department of Restorative Dentistry, in lieu of a training program director.

2. I understand that my application will be reviewed by a departmental review committee only after receipt of all requested materials. Additional materials or information may be requested from me after preliminary review. I may be requested to meet with the committee in person. Upon the recommendation of the service committee, my application will be forwarded to the Chief of Service. The process of approval beyond that point is delineated in the Bylaws and Rules and Regulations of the Medical Staff. Approval by the Chief of Service, the Credentials Committee, the Chief of Staff and Executive Director of the Hospital and the Governing Body is sufficient for me to begin the exercise of requested privileges.

3. I understand that all privileges granted are proctored. The nominal period of proctoring is one year. During the period of proctoring one or two members of the active staff of the service will be assigned as my proctor(s). The function of the proctor is to evaluate the care given to patients by me. The level of involvement of proctors may vary at the discretion of the proctor. It is my obligation to promptly notify my proctor(s), or the attending oral and maxillofacial surgeon on-call, upon admission of my patients.

4. I understand that it is my responsibility to maintain a current list of all hospital patients on the form provided, and to insure that the proctor indicates successful completion of the review process by his/her signature on that form within one week of patient discharge. It is my responsibility to provide the original copies of the proctoring form to the service at 3, 6, 9 and 12 months after initiation of proctoring. I understand that no prompting for this requirement will be given and that failure to do so may result in a report of no proctoring activity being sent to the Credentials Committee. This may results in a delay in granting permanent privileges.

5. I may petition my proctor(s) for completion of the proctoring period with regard to certain procedures or classes of procedures which have been repeatedly observed with satisfactory evaluations. The decision to conclude the proctoring period rests with the service review committee and with the Chief of Service.

6. I understand that if certain requested privileges have not been sufficiently proctored during the initial year, these may be continued into a second year upon a special request by the Service Chief, and approval of the Credentials Committee. If not completed after 18 months, and there is still insufficient evidence to grant full privileges in certain areas, these privileges will be withdrawn. I understand, therefore, that it is in my best interest to request only those privileges which I can reasonably expect to perform on a regular basis.

DENTISTRY/ORAL & MAXILLOFACIAL SURGERY
SAN FRANCISCO GENERAL HOSPTIAL
PRIVILEGE CRITERIA

GROUP I: GENERAL DENTISTRY

Dentistry is the evaluation, diagnosis, prevention, and/or treatment (nonsurgical, surgical or related procedures) of diseases, disorders and/or conditions of the oral cavity, maxillofacial area and/or the adjacent and associated structures and their impact on the human body: provided by a dentist, within the scope of his/her education, training and experience, in accordance with the ethics of the profession and the law.

Applicants for general dentistry privileges must satisfy all of the following criteria except the requirements for training in oral maxillofacial surgery, board eligibility or certification, ACLS and current DEA certificate

GROUP II: ORAL & MAXILLOFACIAL SURGERY

Oral and Maxillofacial Surgery (OMS) is the specialty of dentistry which include the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the bone and soft tissues of the oral and maxillofacial region. The term “maxillofacial” refers to the area that encompasses the maxilla and the face.

The criteria for oral and maxillofacial surgery are:

1. Graduation from a school of dentistry which is accredited by the American Dental Association Commission on Dental Accreditation or listed in the World Directory of Dental Schools as published by the World Organization of Health.
2. Completion of residency in oral and maxillofacial surgery from a program accredited by the American Dental Association Commission on Dental Accreditation.
3. Possession of a valid, current dental or medical license in the state of California.
4. Possession of a valid, current DEA.
6. Current professional liability insurance, if not insured either through the University of California as a faculty member or through the City & County of San Francisco in an amount considered appropriate for the type and scope of practice by this hospital’s medical staff and governing body on an individual basis.
6. Completion of a BLS and ACLS course within the last two years.
7. Must provide proof of Admissibility for examination or Certification by the American Board of Oral & Maxillofacial Surgery.
8. If the applicant received his/her training in a country other than the United States of America, and has an academic or clinical appointment in the Department of Oral and Maxillofacial Surgery at the University of California San Francisco, then requirements #1 and #2 are satisfied.
9. If the applicant wishes privileges in Outpatient General Anesthesia, the applicant must have a valid General Anesthesia permit in the State of California after the probationary year and approval by the Chief of Anesthesia.
10. Absence of a history or involvement in malpractice suites, or arbitration’s, or settlements, OR, in the case of an applicant with this history, evidence that the history of malpractice claims does not demonstrate probably ongoing substandard professional performance.
11. Absence of physical or mental impairments which may interfere with the ability to practice dentistry and/or medicine.
12. Absence of a history of professional disciplinary action, OR, in the case of an applicant with this history, evidence that this history does not demonstrate probably ongoing substandard professional performance.

13. Absence of history of criminal conviction or indictment; OR, in the case of an applicant with this history, evidence that this history does not demonstrate probable substandard professional or ethical performance. A conviction within the meaning of these criteria includes a plea or verdict of guilty or a conviction following a plea of non-contender.
14. Completion of an application form and absence of intentional falsification or omission by the applicant.

Appendix B - HOUSE STAFF COMPETENCIES

REFER TO CHN INTRANET SITE, HOUSE STAFF COMPETENCIES LINK

APPENDIX C - DENTISTRY/ORAL & MAXILLOFACIAL SURGERY PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN

Currently Held at Dentistry/OMS Service

APPENDIX D – DENTISTRY/ORAL & MAXILLOFACIAL SURGERY HOUSESTAFF MANUAL

Currently Held at Dentistry/OMS Service

APPENDIX E - CHIEF OF DENTISTRY / ORAL & MAXILLOFACIAL SURGERY CLINICAL SERVICE JOB DESCRIPTION

CLINICAL SERVICE CHIEF OF DENTAL/ORAL/MAXILLOFACIAL SURGERY SERVICE
JOB DESCRIPTION
September 11, 2007

Chief of Dental/Oral/Maxillofacial Surgery Clinical Service

Position Summary:

The Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of San Francisco General Hospital (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 Dentistry/Oral/Maxillofacial Surgery Clinical Service reports directly to the Associate Dean at ZSFG and the Chairperson, UCSF Department of Oral and Maxillofacial Surgery. 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 Dentistry/Oral/Maxillofacial Surgery Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

The major responsibilities of the Chief of Dentistry/Oral/Maxillofacial Surgery Clinical Service include the following:

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

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

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

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

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

Dentistry/Oral & Maxillofacial Surgery Clinical Rules and Regulations
Revised: ~~January 10~~November 13, ~~2021~~2023

N.B. 1 The changes in privileges are editorial only and reflect established changes over the past four years.
2. Table of Contents – to be renumbered to correlate with changes in document.

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

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: ___

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). Membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, 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 _____ 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, ambulatory and specialty clinic care setting, or inpatient care in a unit-based hospital setting. The NP/PA conducts physical exams, diagnoses, and treats illness, orders and interpret tests, counsels on preventative health care, assists in surgery, performs invasive procedures, and furnish medications/issue drug orders as established by state law.

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. NPs 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 NP 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). While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (documents supervising agreement between supervising physician and PA).

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is the outpatient _____Clinic and Inpatient units at ___
   2. Role in the outpatient and inpatient setting may include performing physical exams, diagnosing, and treating illnesses, ordering, and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications.

B. Supervision
   1. Overall Accountability: The NP/PA is responsible and accountable to the ______
   2. A consulting physician, which may include attendings and fellows, will be available to the NP/PA by phone, in person, or by other electronic means always.
   3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
      a. Acute decompensation of patient situation.
      b. Problem that is not resolved after reasonable trial of therapies.
      c. Unexplained historical, physical, or laboratory findings.
      d. Upon request of patient, NP, PA, or physician.
      e. Initiation or change of medication other than those in the formulary(ies).
      f. Problem requiring hospital admission or potential hospital admission.

IV. Scope of Practice

Protocol #1

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 Practice Agreement. Copies of Practice Agreement must be kept at each practice site for each PA.

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

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

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

   1. Length of proctoring period will be three (3) months. The term may be shortened or lengthened at the discretion of the supervising clinical provider; however, the proctoring period shall not exceed the six (6) months CCSF probationary period. At the end of the proctoring term, the NP/PA will be generally supervised by Chief of ____, _____ Service Attending, or designated clinical provider.
   2. The evaluator will be the Chief of ____ or designated clinical provider.
   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. Medical Record review is conducted for out-patient discharge medication
      c. Medical Record review may be conducted retrospectively by the clinical supervisor.
      d. Proctoring will include a minimum evaluation of five (5) chart reviews and direct observations, with at least one case representing each core protocol, discharge

of inpatients, and furnishing medications/drug orders, if applicable.

e. Procedural skills are incorporated into the competency assessment orientation

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

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

VI. Development and Approval of Standardized Procedure

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

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

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

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

DIRECTIONS: Include protocols after this section of the document. Use page breaks between each protocol.

City and County of San Francisco

Department of Public Health

London Breed
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Gabriel Ortiz, MD, PhD
Chief of Staff

Committee on Interdisciplinary Practice
Standardized Procedures Summary of Changes for **October 2023**

Standardized Procedure Name:	Influenza Vaccination Screening and Administration RN
Department:	ZSFG Nursing
Date of last approval:	Sept 2022
Summary of SP updates:	Updates to Prerequisites, Proctoring, and Competency requirements (page 7)
Update #1:	1. Deleted prerequisites o E-Learning education module is assigned to RN staff annually o Administration of IM injections is within the RN scope of practice, is part of RN prelicensure programs, and documentation of IM administration competency is captured during orientation to their care area at ZSFG 2. Deleted proctoring period o EHR order entry is part of the RN orientation to hospital o Unnecessary as Nurse Manager is responsible for ensuring all RN orientations are completed prior to working independently in their care area 3. Updated competency requirements o Changed to “Completes annual flu education module” inclusive of: screening workflow, attestation of SP review, and attestation of order entry policy review ▪ This is assigned to RNs annually ▪ SF Learning is the source of documentation (removed “annual performance appraisal” as this is a duplicative process and “Nurse Manager or their designee will be the evaluator” as this also duplicative re: already included in the Annual Performance Appraisal process)

Standardized Procedure	OB/GYN SP

Name:	
Department:	OB/GYN
Date of last approval:	Jan 2019 with additional protocols approved in Apr 2020 and June 2020
Summary of SP updates:	Grammatical and formatting changes. Updates to be inclusive of SB 697. Protocol updates.
Update #1:	Changes that apply to entire SP 1. Changed "woman/women" to "people/person" re: gender inclusive language 2. Changed "LCR" to electronic medical record (EMR)" re: LCR no longer used in DPH, nonspecific term 3. Changes related to PA practice related to SB 697 4. Changed "physician and other supervisor" to "supervising clinical provider" as APPs can serve in this role 5. Changed "needed" to "must be"
Update #2:	Changes by section • Section II (page 1): o Moved "The NP/CNM/PA conducts physical exams, diagnoses and treats illnesses, orders and interprets tests, counsels on preventative health care, performs invasive procedures and furnishes medications/issue drug orders as established by state law" from further in document to first paragraph re: provides general information about professional scope and is related to the previous sentence o Moved Certified Nurse Midwife to first in list of APPs • Section II (page 2): Removed granular information about PA academic training and continuing education requirements re: redundant as the professional is licensed is required AND these are not listed for any other APP • Section III • B.1 Updated clinic names to Obstetric, Midwifery, and Gynecology Clinic and 6G • VI.3 Deleted OPPE • VII.D.1 Deleted "accompanies by the dated and signed approval sheet" re: no longer our process
Update #3:	Changes by Protocol • Protocol 3 o B.1.c patient-centered assessment per MD author's request (page 11) o D.1.a.2 added trichomonas and deleted VZV titer (page 12)

- o D.3.c added patient education (page 12)
- o F added information about the management of HIV-infected pregnant people (page 13)

- Protocol 4
  - A added Healthy Workers and Healthy San Francisco
  - D.1.c.ii added "and refills, if applicable" (page 15)
- Protocol 8 deleted prerequisite (page 27)
- Protocol 9 deleted prerequisite (page 30)
- Protocol 11 removed brand name Nexplanon (page 34)
- Protocol 13 deleted prerequisite (page 41)
- Protocol 19
  - Changed "amniotic fluid" to "deepest vertical pocket (DVP) of amniotic fluid" (page 58 and 59)
  - Removed from proctoring "If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Obstetrics Medical Director or his/her physician designee(s) within 24 hours." (page 59)
  - Changed reappointment to "1 peer chart review every 2 years" and deleted "Limited third trimester obstetric ultrasound…signed by a physician attending within 24 hours" (page 60)
- Protocol 21
  - A. and A.2.i Added "13 weeks 6 days" (page 64)
  - B.2.b added trichomonas and replaced "RPR" with "syphilis test" (page 65)
  - D.1.a added "if desired" (page 65)
  - D.1.j added "when clinically indicated"
  - Prerequisite: removed information about Health Workforce Pilot Project curriculum and added Abortion training curriculum (page 67)
  - Proctoring: Changed "performances" to "abortions" (page 67)
  - Deleted appendix 1
- Protocol 22
  - D.2.a changed "status 3" to "class III" (page 73)
  - D.4.B deleted reference to retired Unusual Occurrence platform and hospital policy, added reference to SAFE (page 74)
  - Prerequisite: changed passing score to 80% re: hospital standard (page 75)

	○ Reappointment: changed passing score to 80% re: hospital standard (page 75)

Medical Staff Services Department
San Francisco General Hospital Medical Center
1001 Potrero Avenue ◦ Suite 2A5 ◦ San Francisco, CA 94110
Telephone (415) 206-3517 ◦ Fax (415) 206-3434

Approved
~~9/2022~~

COMMITTEE ON INTEDISCIPLINARY PRACTICE

STANDARDIZED PROCEDURE - REGISTERED NURSE

TITLE: Influenza Vaccination Screening and Administration

1. Policy Statement

   A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG) that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Registered Nurses, Pharmacists, Physician Assistants, Physicians and administrators and other affiliated staff and must conform to the Nurse Practice Act, Business and Professions Code Section 2725.

   B. A copy of the signed procedures will be kept in an operational manual located in the Nurse Manager Office of each unit covered by this protocol and on file in the Medical Staff Office.

2. Functions to be performed

   The Registered Nurse based upon the nursing process determines the need for a standardized procedure. The RN provides 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 RN to seek physician consultation.

3. Circumstances under Which RN May Perform Function

   A. Setting
      The Registered Nurse may perform the following standardized procedure functions in the ZSFG 4A Skilled Nursing Facility, Units H22/25, H24/26, H32/38, H34/36, H42/44, H48, H52, H54/56, H58, H62/64, H66/68, H76/78, PACU, 7B, 7C, 7L and Psychiatric Emergency Service consistent with their experience and training.

   B. Scope of Supervision Required:
      1. The RN is responsible and accountable to the Nurse Manager of the unit and to the Medical Provider for the patient’s primary team.
      2. Overlapping functions are to be performed in areas which allow for a consulting physician to be available, at all times, to the RN, by phone or in person, including but not limited to the clinical area.

3. Physician consultation is to be specified in the protocols and under the following circumstances:
    - Questions regarding interpretation of a contraindication
    - Patient questions unable to be addressed by nursing expertise

4. List of Protocols that will be used in the practice area
    - Protocol #1 Influenza Vaccination Screening and Administration

5. Requirements for the Registered Nurse

   A. Experience and Education
      1. Active California Registered Nurse license.
      2. Current Basic Life Support certification from an approved American Heart Association provider.

   B. Special Training
      1. None

   C. Evaluation of the Registered Nurse competence in performance of standardized procedures.
      1. Initial:
         At the conclusion of the standardized procedure training the Nurse Manager or designee will assess the RN's ability to perform the procedure:
         a. Clinical Practice
            - Length of proctoring period will be consistent with the RNs orientation period in their specific unit
            - A minimum of 1 observation will be conducted
            - Evaluator will be the RN preceptor, Charge RN or Nurse Manager

      2. Annual:
         Nurse Manager or designee will evaluate the RN's competence through an annual performance appraisal and skills competency review along with feedback from colleagues, physicians, direct observation or chart review may be used. The standardized procedures will be a required Unit Based Competency for annual review.

      3. Follow-up:
         Areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Nurse Manager, or designee at appropriate intervals until acceptable skill level is achieved. This may include chart reviews.

6. Development and Approval of Standardized Procedures

A. Method of Development
Standardized procedures are developed collaboratively by the registered nurses, nurse managers, 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
All standardized procedures must be approved by the Committee on Interdisciplinary Practice, Credentials Committee, Medical Executive Committee and the Joint Conference Committee prior to use.

C. Review Schedule
The standardized procedure will be reviewed every three years or as practice changes, by the registered nurses, nurse managers and medical directors.

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

Protocol #1
TITLE: Influenza Vaccination Screening and Administration

A. DEFINITION

During the annual flu season, the RN completes influenza screening, provides education and administers the vaccine.

1. Location to be performed: ZSFG 4A Skilled Nursing Facility, Units H22/25, H24/26, H32/38, H34/36, H42/44, H48, H52, H54/56, H58, H62/64, H66/68, H76/78, PACU, 7B, 7C, 7L and Psychiatric Emergency Service

2. Performance of procedure:

   a. Adult Indications: Annually during Flu season any patient older than 6 months of age seen at ZSFG will be offered the inactivated influenza vaccine unless there are documented contraindication(s) and/or a documented immunization for that year.
   b. Pediatric patient Indications (≥ 6 months old and < 9 years old) initial vaccination requires two doses at least four weeks apart.

   c. Adult Contraindications (≥ 18 years old)
      - Previous administration of Influenza vaccine during existing Flu season
      - Previous adverse reaction to vaccination or component
      - Fever >/= 38 degrees Celsius in the last 48 hours
      - History of Guillain Barre Syndrome

   c. Pediatric Contraindications (≥ 9 years old and < 18 years old)
      - Previous administration of Influenza vaccine during current Flu season
      - Previous adverse reaction to vaccination or component
      - History of Guillain Barre Syndrome

   d. Pediatric Contraindications (≥ 6 months old and < 9 years old)
      - Previous adverse reaction to vaccination or component
      - History of Guillain Barre Syndrome
      - Previous administration of Influenza vaccine during current Flu season for patients that have already been vaccinated with 2 doses during a prior season

- Less than 4 weeks since first influenza vaccination in patients who have not been vaccinated with a series of 2 doses during a prior season

B. DATA BASE

1. Subjective Data (Adult ≥ 18 years)
   a. Patient/decision maker declaration of previous administration of Influenza vaccine during existing Flu season.
   b. Patient/decision maker declaration of prior reaction to vaccination or component.
   c. Patient/decision maker declaration of history of Guillain Barre Syndrome

   Subjective Data (Pediatric patients ≥ 9 years old and < 18 years old)
   a. Patient/decision maker declaration of previous administration of Influenza vaccine during existing Flu season
   b. Patient/decision maker declaration of prior reaction to vaccination or component
   c. Patient/decision maker declaration of history of Guillain Barre Syndrome

   Subjective Data (Pediatric patients ≥ 6 months old and < 9 years old)
   a. Patient/decision maker declaration of prior reaction to vaccination or component
   b. Patient/decision maker declaration of history of Guillain Barre Syndrome
   c. Patient/decision maker declaration of prior administration during existing Flu season for a patient that was already vaccinated with a series of 2 doses 4 weeks apart during a prior season
   d. Patient/decision maker declaration of less than 4 weeks since first influenza vaccination in a patient who has not been vaccinated with a series of 2 doses during a prior season

2. Objective Data (Adult ≥ 18 years)
   a. Fever ≥ 38 degrees Celsius in the last 48 hours
   b. Documentation in the medical record of a prior administration of the Influenza vaccine during existing Flu season, prior reaction the vaccination or component, or history of Guillain Barre Syndrome

   Objective Data (Pediatrics ≥ 9 years old and < 18 years old)

a. Documentation in the medical record of a prior administration of the Influenza vaccine during existing Flu season, prior reaction the vaccination or component, or history of Guillain Barre Syndrome

Objective Data (≥ 6 months old and < 9 years old)

a. Documentation in the medical record of a prior reaction to the vaccination or component or history of Guillain Barre Syndrome
b. Documentation of prior administration during existing Flu season for a patient that was already vaccinated with a series of 2 doses 4 weeks apart during a prior season
c. Documentation of less than 4 weeks since first influenza vaccination in a patient who has not been vaccinated with a series of 2 doses during a prior season

C. Determination of Administration

Screening of patient considering subjective and objective data to determine administration qualifications

D. PLAN

1. Screen Patient for Influenza Vaccination on admission to hospital during declared Flu season
   a. Review chart for documented objective contraindications
   b. If no temperature taken within 48 hours, take the patient's temperature
   c. Talk to patient/decision maker for subjective contraindications
   d. For patients that qualify, offer vaccination and document accepts or declines vaccination in the screen.
   e. For patients that are not responsive, unable to engage, the screen may occur later during admission
   f. When a patient qualifies for a vaccination with pending or active transfusion orders (Blood, Platelets, of FFP), delay administration of vaccine to avoid confusion with a possible transfusion reaction.

2. Patient conditions requiring Physician Consultation
   a. Questions regarding interpretation of a contraindication
   b. Patient questions unable to be addressed by nursing expertise

3. Education

Prior to vaccination, patients/decision maker will be provided education via Vaccine Information Sheets (VIS).

4. Administration of Vaccination
   a. RN to enter age appropriate order for Influenza Vaccination using the mode “per protocol no co-sign required” for patients that qualify and accept vaccination and do not require further physician consultation.
      i. Inactivated Influenza vaccine (IIV) is given IM for infants starting at 6 months of age (minimum age) through adulthood. There is no upper age limit. IIV is the preferred inpatient formulation for influenza vaccination.
   b. Timing of administration will occur prior to discharge.
   c. RNs are not authorized to place orders for Live Attenuated Influenza Vaccine.

5. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Vaccination lot number, expiration date, and location of injection will be documented in the medical record

F. Summary of Prerequisites, Proctoring and Competency Documentation

~~Prerequisite:~~ ~~a. Completion of a training module on flu vaccination~~ ~~b. For RN staff in orientation: completion of 1 IM injection~~ ~~c. Review of Protocol~~ ~~d. Review of Administrative Policy: Order Entry~~
~~Proctoring Period:~~ ~~a. For RNs in orientation: observe placement of order in EHR for “ordered per protocol, no signature required”~~ ~~b. Nurse Manager or RN designee will provide supervision~~
~~Annual~~ Competency Requirements ~~Documentation~~: a. Completes annual Flu education module inclusive of: • screening workflow • Attestation of Standardized Procedure Review ~~a.~~ • Attestation of Order Entry Policy Review. ~~b. Annual performance appraisal~~ ~~c. Nurse Manager or their designee will be the evaluator~~
~~Any additional comments:~~

Medical Director or Division Chief Approval or Service Chief Approval

Lisa Winston, MD
Infection Control

Author: Dana Freiser RN
Nursing Director: ~~Leslie Holpit RN~~ Christina Bloom

CIDP Approval Date: 8/16/2022
Credentials Approval Date: 9/06/2022
MEC Approval Date: 9/15/2022
Gov. Body Approval Date: 9/27/2022

Zuckerberg San Francisco General Hospital
Committee on Interdisciplinary Practice

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

PREAMBLE

Title: OBSTETRICS AND GYNECOLOGY

I. Policy Statement

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

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in all appropriate sites within the OB/GYN service.

II. Functions To Be Performed

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

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

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

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

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

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

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

A. Setting

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

B. Supervision

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

IV. Scope of Practice

1. Health Care Management: Acute/Urgent Care
2. Health Care Management: Well Woman Care
3. Health Care Management: Prenatal Care
4. Furnishing Medications/Drug Orders
5. Discharge of Inpatients
6. eConsult Review
7. Colposcopy and Cryotherapy
8. Endocervical Polyp Removal
9. Endometrial Biopsy
10. Episiotomy and Perineal Laceration Repair
11. Contraceptive Implant Insertion
12. Contraceptive Implant Removal
13. Intrauterine Device Insertion
14. Intrauterine Devise Removal: Non-visualized Strings
15. Pre-op Evaluation for Second Trimester Abortion

16. Trigger Point Injections for Pelvic Pain
17. Limited Obstetric Ultrasound: <14 Weeks Gestational Age
18. Limited Obstetric Ultrasound: ≥14 Weeks Gestational Age Assessment
19. Limited Obstetric Ultrasound: Third Trimester Assessment of Cardiac Activity, Presentation, and Amniotic Fluid
20. Waived Testing
21. First-Trimester Aspiration Abortion
22. Procedural Sedation
23. Vulvar Skin Biopsy
24. CNM First-Assist for Cesarean-Section

V. Requirements for the Nurse Practitioner / Certified Nurse-Midwife/Physician Assistant

A. Basic Training and Education

1. Active California Registered Nurse, Nurse Practitioner, Certified Nurse-Midwife/or Physician Assistant license.
2. Successful completion of an education program, which conforms to the Board of Registered Nurses (BRN) requirements for licensure or to the Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP/CNM) or National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
5. Possession of a National Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number.
8. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center ~~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 FNP, ANP, WHNP, OB/GYN NP, CNM or Physician Assistant.

VI. Evaluation

A. Evaluation of NP/CNM/PA Competence in performance of standardized procedures.

1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated ~~physician and other supervisors~~supervising clinical provider~~, as applicable~~ will assess the NP/CNM/PA's ability to practice.
   a. Clinical Practice
      - Length of proctoring period will be 3 months.
      - The evaluator will be the Medical Director***,*** Chief of Service, designated supervising ~~physician~~clinical provider~~, and/or designated peer~~***.***
      - The method of evaluation in clinical practice will be 3 observations and associated chart reviews representing each core procedure (HCM acute/urgent care, HCM well woman care, HCM prenatal care, furnishing, and discharge of inpatients), with no less than 10 observations/chart reviews in total. Additional, procedurally specific requirements are listed in individual protocols.

2. Follow-up: areas requiring increased proficiency as determined by the initial or reappointment evaluation will be re-evaluated by the Medical Director or~~,~~ designated supervising clinical provider. ~~physician, and/or designated peer at appropriate intervals.~~ If staff have not achieved competency within two years of initial appointment, provider may no longer operate under these standardized procedures.

3. ~~Ongoing Professional Performance Evaluation (OPPE)~~

~~Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.~~

4. Biennial Reappointment: Medical Director, designated physician, and/or designated peer must evaluate the NP/CNM/PA's clinical competence as described in each procedure and perform at least 1 chart review which may represent multiple core procedures.

~~5. Physician Assistants:~~
   ~~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 that by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

VII. Development and Approval of Standardized Procedure

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

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

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

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

Protocol #1: Health Care Management – 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 in all appropriate sites within the OB/GYN Service.

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 consultation as per Preamble, section IIIb3
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. Uncommon, unfamiliar, unstable, and complex patient conditions
   e. Upon request of patient, affiliated staff or physician

f. With the exception of labor-related diagnoses, 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 (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases that by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.~~

Protocol #2: Health Care Management – Well ~~Woman~~ Person Care

A. DEFINITION

This protocol covers health care maintenance and promotion, management of common acute illness and chronic stable illnesses related to well person~~woman~~, gynecologic, reproductive, and breast care in all sites within the OB/GYN service.

B. DATA BASE

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

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

C. DIAGNOSIS

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

D. PLAN

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

2. Patient conditions requiring consultation as per Preamble, section IIIb3,
   a. Acute decompensation of patient situation

b. Problem that is not resolved after reasonable trial of therapies
c. Unexplained historical, physical or laboratory findings
d. Uncommon, unfamiliar, unstable, and complex patient conditions
e. Upon request of patient, affiliated staff, or physician
f. Problem requiring hospital admission or potential hospital admission.

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

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

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

Protocol #3: Health Care Management – Prenatal Care

A. DEFINITION

This protocol covers the procedure for the routine prenatal care of essentially healthy ~~women~~people. This includes the provision of comprehensive education and primary care during the prenatal and postpartum period and the promotion of a healthy pregnancy and optimal outcome in all appropriate sites within the OB/GYN service.

B. DATA BASE

1. Subjective Data
    a. Complete appropriate history.
    b. Symptoms relevant to the prenatal health process.
    c. Patient-centered assessment of patient's preference re: mode of prenatal care and desire for racially/ethnically/linguistically-concordant prenatal provider.

2. Objective Data
    a. Initial prenatal visit includes a complete physical examination with sizing of uterus and fetal heart tones if at least 10 weeks.
    b. Routine follow-up visits, the physical exam to include:
        1. Blood pressure
        2. Weight and weight gained or lost since last visit.
        3. Urinalysis as indicated
        4. Fetal heart tones
        5. Abdominal exam for fundal height (starting at 20 wks gestation) and presentation (starting at 36 weeks).
        6. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
        7. All Point of Care Testing (POCT) will be performed according to the ZSFG POCT policy and procedure 16.20.
    c. Pelvic examination when indicated by history.

C. DIAGNOSIS

Assessment and diagnosis of pregnancy status, risk factors, or disease process consistent with the subjective and objective findings.

D. PLAN

1. Therapeutic Treatment Plan
    a. Appropriate screening tests, and /or diagnostic tests for purposes of disease identification.
        1. Routine prenatal labs, including but not limited to: blood type and screen, Rubella titer, VZV titer, CBC, ferritin,

hemoglobinopathy evaluation, HBsAG, RPR, HIV, Hep C antibody, pap smear (if indicated), clean catch urine culture, chlamydia, gonorrhea, trichomonas, GDM screening, and *GBS* culture. If indicated, ~~, VZV titer and~~ TB Screening

2. First and Second Trimester ~~integrated~~ genetics screening, if desired by patient
3. If patient is RH Negative repeat antibody screen and order Rhogam at 28 weeks or earlier if vaginal bleeding.
4. Order and review all imaging studies as appropriate.

b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.
c. Immunization update.
d. Referral to specialty clinics and supportive services as needed (e.g. nutritionist, social work, health education WIC).

2. Patient conditions requiring consultation as per Preamble, IIIb3:
   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 (as per established departmental guidelines, including diagnosis-specific criteria)
   e. Upon request of patient, affiliated staff, or physician.
   f. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.

3. Education
   a. Normal process and progression of pregnancy.
   b. Psychosocial issues pertinent to pregnancy, age of client and home situation.
   c. Signs and symptoms of complications
   d. Fetal kick counts.
   e. Preparation for labor, postpartum, and infant care.
   f~~e~~. Stages of labor.
   g~~f~~. Pain management during labor and delivery.
   hg. Infant nutrition: breast or formula feeding.
   i~~h~~. Postpartum family planning.

4. Follow-up (Intervals determined by risk factors)
   a. Every 4-*8* weeks until 28 weeks gestational age.
   b. Every 2 to 4 weeks from 28 to 38 weeks gestational age.
   c. Every week after 38 weeks gestational age.

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 of five (5%) sample of medical records of patients treated by the physician assistant within 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.~~

F. Management of HIV-infected Pregnant People (HIVE) and pregnant people for whom traditional clinic-based care does not suffice (Team LILY)~~MANAGEMENT OF HIV-INFECTED PREGNANT WOMEN PEOPLE AT THE BAY AREA PERINATAL AIDS CENTER (BAPAC)/HIVE~~

NPs, PAs and CNMs in 5M may participate in care for patients in these clinical service areas with co-management by an attending OBGyn physician.~~Obstetric and HIV care of BAPAC/HIVE patients by the BAPAC nurse practitioner will be co-managed by the BAPAC attending, Reproductive Infectious Disease fellow and/or other OB attending designee.~~

G. RECORD KEEPING

a. Patient visit, consent forms, and other procedure specific documents will be recorded in ~~LCR/~~EMR as appropriate.

Protocol #4: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners and nurse-midwives is defined to mean the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure. A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license. ~~All PA 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 and midwives may order Schedule II - V controlled substances when in possession of a BRN furnishing certificate and an appropriate DEA license. Schedule II - III medications need a patient specific protocol. The practice site (clinic or inpatient), scope of practice of the NP/CNM/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formularies used will be: San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Jail Health Services, ~~San Francisco Health Plan,~~ Medi-Cal, Healthy Workers, Healthy San Francisco, 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. 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. Nurse Practitioners and Nurse Midwives may order Schedule II - III controlled substances for patients with patient specific protocols. The protocol will include the following:
      i. location of practice
      ii. diagnoses, illnesses, or conditions for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   c. 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 and refills, if applicable
      viii. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation as per Preamble, section IIIb2.
    a. Problem which is not resolved after reasonable trial of therapies.
    b. Unexplained historical, physical or laboratory findings.
    c. Uncommon, unfamiliar, unstable, and complex patient conditions
    d. Upon request of patient, affiliated staff, or physician.

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/CNMs and all drug orders written by PAs will be recorded in the electronic medical record (\EMR)MAR, as appropriate. The medical record of any patient cared for by a PA 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 #5: Discharge of Inpatients

A. DEFINITION
This protocol covers the discharge of inpatients from the Birth Center at Zuckerberg San Francisco General Hospital and Trauma Center.

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 ensure 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 EMR.

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. Ensure that appropriate follow-up arrangements (appointments/studies) have been made.

2. Patient conditions requiring Consultation as per preamble, section IIIb2.

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

3. Education
    a. Review inpatient course and need for outpatient 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. ~~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 that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

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 specialty service, admitted to the specialty service nor seen in the specialty clinic within the previous two years.

1. Prerequisites:
   a. Providers reviewing eConsults will have six months experience with patients in the specific specialty area provided at ZSFG or elsewhere before being allowed to review eConsults independently.
   b. Providers reviewing eConsults will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
   c. Providers reviewing eConsults will consistently provide care to patients in the specialty clinic for which they are reviewing.
   d. Providers reviewing eConsults will have expertise in the specialty practice for which they are reviewing.

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral guidelines developed and approved by the Medical/Surgical Director, which will be used to facilitate screening, triaging and prioritizing of patients in the eConsult system.

3. Proctoring: A review of the eConsult consultation decisions will be performed by the designated physician or peer proctor concurrently for the first 20 eConsults (minimum). More eConsult reviews may be required depending on performance.

4. Reappointment Competency:
   A review of five eConsult consultations every 2 years by the consulting physician or other supervisor.

5. Location to be performed: all sites with the OB/GYN service.

B. DATA BASE

1. Subjective Data
   a. History: appropriate history that includes but is not limited to past medical history, surgical history, hospitalizations/injuries, habits, family history, psychosocial history, allergies, current medications, treatments and review of systems relevant to the presenting disease process as

provided by the referring provider on the electronic referral. eConsult review will be confined to data found in the submitted eConsult form. Data contained in the paper or electronic medical record, but not in the eConsult, is specifically excluded from the eConsult review. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

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

C. DIAGNOSIS

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

D. PLAN

1. Review of eConsult
   a. Algorithms or referral guidelines developed and approved by the Medical/Surgical Director 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 consultation as per Preamble, section IIIb2.
   a. Unexplained historical, physical or laboratory findings
   b. Uncommon, unfamiliar, unstable, and complex patient conditions
   c. Upon request of the referring affiliated staff, or physician

d. Problem requiring hospital admission or potential hospital admission
e. When recommending complex imaging studies or procedures for the referring provider to order
f. Problem requiring emergent/urgent surgical intervention
g. As indicated per the algorithms developed by the Medical Director

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

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

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

E. RECORD KEEPING

All information contained within the electronic referral including the initial referral and any electronic dialogue between providers will be recorded in the EMR upon scheduling and after consultation visit and follow up visits.

Protocol # 7: Procedure: Colposcopy and Cryotherapy

A. DEFINITION

People~~Women~~ with abnormal Pap smears or suspicious lesions in the lower genital tract will be evaluated by colposcopy with biopsy of suspicious lesions and treatment or referral as indicated. Cryotherapy is a treatment for cervical dysplasia or large condylomatous lesions.

1. Location to be performed: All appropriate sites with the OB/GYN service.

2. Performance of procedure:
   - i. Indications

     Patients with certain abnormal cervical cancer screening results, cervical, vaginal or vulvar lesions visible by gross examination, may be referred for colposcopy. Cryotherapy can be used in people~~women~~ < 40 years old to treat high grade dysplasia (CIN 2 or 3) in people~~women~~ with satisfactory colposcopy, no dysplasia on endocervical curettage (ECC) and when the lesion can be completely covered by cryo probe during treatment. Cryotherapy can also effectively treat large condylomatous lesions found in the vulvar or perianal area
   - ii. Precautions/Contraindications

     Consult an MD before performing biopsies on patients used anticoagulants or with a clotting disorder. ~~Women~~ People who are pregnant who require biopsy due to lesion suspicious for malignancy should be referred to an MD. ECC should not be perfomed during pregnancy. Cryotherapy of the cervix should not be performed in pregnant ~~women~~people, ~~women~~ people with unsatisfactory colposcopy, dysplasia found on ECC or in ~~women~~ people with large cervical lesions that cannot be completely covered by the cryo probe.

B. DATA BASE

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

b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
c. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

2. Patient conditions requiring consultation as per section, IIIb2.
   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, affiliated staff or physician
   e. Problem requiring hospital admission or potential hospital admission.

3. Education

   Discharge information and instructions.

4. Follow-up

   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR~~LCR~~ 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 Prerequisite, Proctoring and Reappointment Competency

Prerequisite a. One week course (14 hours) in theory and practice of cervical colposcopy. Certificate of course completion required.
Proctoring Period a. New practitioner to procedure, a minimum of 25 colposcopies at least 10 of which include biopsy and a minimum of 3 cryotherapy. b. Experienced practitioner to procedure must show documentation of 25 proctored studies at previous institution and be proctored for a minimum of 5 colposcopies and 1 cryotherapy. c. Proctor must be a qualified colposcopist.
Reappointment Competency: a. Evaluation will be done by a qualified colposcopist b Minimum number of 4 procedures must be completed every two years. c. Minimum number of 2 chart reviews needed every two years.

Protocol #8: Procedure: Endocervical Polyp Removal

DEFINITION: Evaluation of a cervical polyp seen on pelvic speculum exam by removing the polyp for pathological diagnosis.

1) Location to be performed: all appropriate sites with the OB/GYN service,

2) Performance of procedure:
   1. Indications
      Endocervical polyp seen on pelvic speculum examination
   2. Precautions
      Consult a GYN attending or senior resident if polyp is especially large, abnormal-appearing or site of origin is unclear; or if the patient is anticoagulated or has a history of a bleeding disorder.
   3. Contraindications
      None

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

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

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

D. PLAN
   1. Therapeutic Treatment Plan
      a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
      b. Time out performed per hospital policy.
      c. The procedure is performed following standard medical technique.

d. Diagnostic tests for purposes of disease identification.
e. Biopsy tissue is sent to pathology
f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
g. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Consultation, as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, CNM, PA, or physician
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and ~~LCR~~ EMR 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:~~ ~~6 months prior experience in women's health care experience, training or expertise is required.~~
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider or at another site with documentation of competency
Proctoring Period: a. Observation of a minimum of 1 (one) procedure for both new and experienced providers. b. Charts of all observed cases during initial proctoring will be reviewed.
Reappointment Competency: a. Minimum number of 2 procedures must be completed every two years. b. Minimum number of 2 chart reviews needed every two years.

Protocol #9: Procedure: Endometrial Biopsy

A. DEFINITION
Evaluation of the endometrium by obtaining tissue for pathological diagnosis.
1. Location to be performed: all appropriate sites with the OB/GYN service.

2. Performance of procedure:
   a. Indications
   ~~Women~~ People considered at risk for endometrial cancer including but not limited to: abnormal uterine bleeding, endometrial cells on Pap Smear, postmenopausal bleeding, obesity, family history of hereditary nonpolyposis colon cancer, unopposed estrogen therapy, Tamoxifen therapy and others needing evaluation of endometrial tissue (infertility, infection) will be evaluated by endometrial biopsy.
   b. Precautions
   Consult a physician before performing biopsies on ~~women~~ people with extreme retroversion or anteversion of the uterus. Also consult with physician when the procedure requires manual dilation of the cervix.
   c. Contraindications
   None

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

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

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

D. PLAN

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

2. Patient conditions requiring Consultation, as per Preamble, IIIb2.
    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, affiliated staff, or physician
    e. Problem requiring hospital admission or potential hospital admission.

3. Education
    Discharge information and instructions.

4. Follow-up
    As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and ~~LCR~~EMR 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:~~ ~~6 months prior experience, in women's health care~~
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider or training at another site with documentation of competency
Proctoring Period: a. Observation of a minimum of 3 procedures for a new provider and 1 procedure for a provider who has prior experience with independent endometrial biopsy. b. Chart review of all observed cases.
Reappointment Competency: a. Perform 6 procedures every 2 years. b. 2 chart reviews needed every two years.

:

Protocol #10: Procedure: Episiotomy & Perineal Laceration Repair

A. DEFINITION
1. Episiotomy-A surgical incision of the perineal body done in order to facilitate delivery of the fetus by enlarging the outlet.
2. Laceration-Spontaneous tear in the perineal body, peri-urethral area or walls of the vagina.
   a. Peri-urethral laceration of the area surrounding the urethra.
   b. Peri-clitoral laceration of the area surrounding the clitoris.
   c. Labial- laceration of the labia majora or minora.
   d. 1st degree laceration involving the vaginal mucosa, posterior fourchette, perineal skin.
   e. 2nd degree laceration includes above and the perineal muscles.
   f. Sulcus tears- 2nd degree lacerations involving the vaginal walls.

3) Location to be performed: Birth Center, H22.

4) Performance of procedure:
   Indications
   a. Episiotomy is performed in circumstances when the condition of the fetus (as indicated by decelerations of the fetal heart rate or shoulder dystocia) requires shortening the time to delivery.
   b. Repair of episiotomy is indicated after performance of episiotomy.
   c. Repair of lacerations by the nurse-midwife is indicated when there is active bleeding from minor lacerations or for all second degree lacerations.

B. DATA BASE
1. Subjective Data
   Pt. history reviewed prior to admission in labor including medication allergies. Focused review of symptoms relevant to episiotomy or repair as needed.

2. Objective Data
   a. Prior to NSVD: position and station of fetus, force and control of maternal expulsion efforts, estimated time to delivery, fetal heart tracing, clinical assessment of perineum (elasticity of tissue, length of perineal body)

b. Following NSVD: status of vagina, vulva, perineum, and rectum; quantified blood loss, maternal vital signs. The uterine cervix is to be assessed if indicated by bleeding and/or if clinical situation suggests risk for cervical laceration.

C. DIAGNOSIS
Assessment of subjective and objective data to identify need for episiotomy (based on indicators identified above) and need for repair of laceration, as indicated by type of laceration and extent of bleeding.

D. PLAN
1. Therapeutic Treatment Plan
   a. Performance of episiotomy and their repair or repair of lacerations is conducted using sterile technique.
   b. Local anesthesia of area using up to 25 cubic centimeters of 1% lidocaine is provided before episiotomy and/or repair, whenever indicated. The maximum total dose should not exceed 4.5 mg/kg and the maximum total dose of 300 mg should not be exceeded (prior doses e.g. with epidural need to be considered).
   c. During recovery period, Tylenol 650mg every six hours, Ibuprofen 600mg every 6 hours, oxycodone 5 mg-10 mg every 3 hours for pain unrelieved by ibuprofen or acetaminophen, and stool softeners as appropriate (See Furnishing/Drug Order SP).

2. Patient conditions requiring consultation, as per Preamble, IIIb2.
   a. Extensions of episiotomy or lacerations into rectal mucosa or rectal sphincter.
   b. Cervical lacerations
   c. Inability to assess origin of vaginal bleeding and/or control hemorrhage
   d. Evidence of perineal or vaginal hematoma (pain, bruising, swelling)
   e. Breakdown of repair
   f. Evidence of infection at site of repair-malodorous discharge, fever, pain, edema
   g. Unexplained historical, physical or laboratory findings
   h. Uncommon, unfamiliar, unstable, and complex patient conditions

3. Education

a. Wound care of episiotomy/laceration reviewed with client
b. Signs and symptoms of normal healing, infection and wound breakdown reviewed at discharge
c. Bowel habits

4. Pain management–reference therapeutic treatment plan above

5. Follow-up
   a. Assessment of perineum postpartum day 1 & 2
   b. Assessment of healing of perineum at 4-week post partum outpatient visits if indicated. Earlier assessment may be needed~~indicated~~ for complex repairs.

E. RECORD KEEPING
CNM completes delivery note, including indication for and performance of procedures. Postpartum notes include evaluation of repair site as needed.

F. Summary of Prerequisite, Proctoring and Reappointment Evaluation of Competency

Prerequisite No special training is required for performance of this procedure. Education and training in conduct of episiotomy and laceration repair is basic to all nurse-midwifery programs accredited by the BRN and American College of Nurse-Midwives (ACNM). This standardized procedure does not cover a new skill or practice but is developed in compliance with SB 1738.
Proctoring Period Initial: Within 3 months of hire the Medical Director, designated physician, and/or designated peer will assess the CNM's ability to practice. This assessment is based upon concurrent observation of a minimum of 3 cases of vaginal delivery, including episiotomy and/or repair of laceration, with chart review.
Reappointment Competency a. Evaluator: Medical Director, designated physician, and/or designated peer b. Ongoing competency evaluation. 1. 5 procedures needed every 2 years. 2. 1 chart review every 2 years.

Protocol #11: Procedure: Contraceptive Implant Insertion

A. DEFINITION
The contraceptive implant is placed under the skin of the upper arm via a preloaded inserter. Insertion is performed under local anesthetic using aseptic technique.

1. Location to be performed: all appropriate sites with the OB/GYN service

2. Performance of procedure:
   a. Indications
      Pt desires contraceptive implant
   b. Precautions
      See contraceptive implant ~~(Nexplanon)~~ drug precautions/interactions in prescribing information.
   c. Contraindications:
      1. Known or suspected pregnancy
      2. Hepatic tumors, active liver disease
      3. Known, suspected or history of breast cancer
      4. Hypersensitivity to any components of implant

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

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

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

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Timing of insertion: See prescribing information
   e. Insertion as described in prescribing information
   f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   g. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation, as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Difficult insertions
   c. Upon request of patient, affiliated staff or physician

3. Education
   Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and ~~LCR~~EMR 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. Completion of a company sponsored training class
Proctoring Period: a. Performance of a minimum of 3 insertions for a new provider and 2 insertions for a provider who has prior experience with independent insertion. b. Proctor must be a qualified provider. c. Chart review of all observed cases.
Reappointment Competency Documentation: a. Performance of 6 insertions every 2 years. b. 1 chart review needed every two years.

Protocol #12: Procedure: Contraceptive Implant Removal

A. DEFINITION

The contraceptive implant is placed under the skin of the upper arm Removal is performed under local anesthetic using aseptic technique.

1. Location to be performed: All appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Woman desires removal of implant or implant is expired.
   b. Precautions: See prescribing information.
   c. Contraindications: See prescribing information.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c.. Diagnostic tests for purposes of disease identification.
   d.. Timing of removal: See prescribing information
   e. Removal: as described in prescribing information

f.. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
g.. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Unable to palpate implant or difficult implant removal.
   c. Upon request of patient, affiliated staff or physician

3. Education
   Discharge information and instructions for care of site, expected side effects, precautions and emergent/urgent symptoms.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR~~LCR~~ 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. Completion of a company sponsored training class
Proctoring Period: a. Performance of a minimum of 3 removals for a new provider and 2 removals for a provider who has prior experience with independent removal. b. Proctor must be a qualified provider. c. Chart review of all observed cases
Reappointment Competency Documentation: a. Performance of 6 removals every 2 years. b. 1 chart review needed every two years.

Protocol # 13. Procedure: Intrauterine Device Insertion

A. DEFINITION
Intrauterine devices offer a highly effective, safe and long lasting contraception. Both insertion and Removal can be performed by the NP/CNM/PA with insertion subject to the criteria described below.

1. Location to be performed: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Patient desires intrauterine device.
   b. Precautions
      See IUD (Mirena/Skyla/Paragard/Liletta) prescribing information
   c. Contraindications
      1. Pregnancy or suspicion of pregnancy
      2. Acute pelvic inflammatory disease or current behavior suggestive of a high risk for pelvic inflammatory disease.
      3. Post-partum endometritis or post abortal endometritis.
      4. Known or suspected uterine or cervical malignancy
      5. Genital bleeding of unknown etiology.
      6. Wilson's disease (for ParaGard IUD (TM).
      7 Allergy to any component of ParaGard IUD, Mirena, Skyla, or Liletta IUD.
      8 An IUD in the uterus that has not been removed.
      9. Uterine anomaly

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.

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

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. The procedure is performed following standard medical technique. A cervical or intrauterine block may be placed.
   d. Diagnostic tests for purposes of disease identification.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble section IIIb2.
   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, affiliated staff, or physician
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR~~LCR~~ 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:~~ ~~6 months experience in women's health care.~~
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider or at another site with documentation of competency
Proctoring Period: a. Observed performance of a minimum of 3 procedures for a new provider and 2 procedures for a provider who has prior experience with independent IUD insertion. b. Observed performance of a minimum of 3 cervical and 3 intrauterine blocks for a new provider and 2 cervical and 2 intrauterine blocks for a provider who has prior experience with independent cervical blocks. b. Chart reviews of all observed cases.
Reappointment Competency: a. Perform 6 procedures every two years. b. 1 chart review needed every two years.

Protocol # 14. Procedure: IUD Removal: Non-visualized Strings
criteria described below.

A. DEFINITION

IUD strings are not visible at the external cervical os at IUD when desiring removal. Removal can be performed by the NP/CNM/PA with MD assistance for removal subject to the criteria below.

1. Location to be performed: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Patient desires intrauterine device removal, IUD strings not visualized at cervical os.
   b. Precautions
      Test for pregnancy if suspicion of pregnancy
   c. Contraindications
      1. Allergy to any component
      2. Acute pelvic inflammatory disease
      3. Known or suspected uterine or cervical malignancy

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
b. Time out performed per hospital policy.
c. Procedure:
If IUD strings are not visualized at exernal os, strings may be identified by intracervical instrumentation with cytobrush or thin (alligator) forceps. If strings still not identified, a physician-assisted pelvic ultrasound is used to visualize IUD. If the IUD is confirmed within the uterus and there is no concern for pregnancy, a paracervical or intrauterine block is placed, tenaculum is placed on external cervix, and thin (alligator) forceps used to remove the IUD under ultrasound guidance.
d. Diagnostic tests for the purpose of disease identification.
e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring consultation as per Preamble section IIIb2.
a. Acute decompensation of patient situation.
b. Unexplained historical, physical or laboratory findings
c. Uncommon, unfamiliar, unstable, and complex patient conditions
d. If moderate traction does not remove the embedded IUD, refer for hysteroscopic removal
e. Upon request of patient, affiliated staff, or physician
f. Problem requiring hospital admission or potential hospital admission.

3. Education
Discharge information and instructions.

4. Follow-up
As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR~~LCR~~ 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: 1 year experience with IUD insertions.
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: training on site by a qualified provider
Proctoring Period: a. Observed performance of a minimum of 6 IUD removals of non-visualized strings. b. Chart reviews of all observed cases.
Reappointment Competency: a. Perform 6 procedures every two years. b. 1 chart review needed every two years.

Protocol #15: Procedure: Pre-operative Evaluation for Second Trimester Abortion

A. DEFINITION

1. Pre-operative evaluation:
   The evaluation of patients before abortion procedures, including patient history, physical examination and evaluation of surgical risks. Informed consent is obtained following hospital policy.

2. Dilator placement:
   The placement of intracervical osmotic dilators using sterile technique and local anesthesia.

3. Mechanical dilation:
   The use of graduated dilators to open the cervix.

4. Location to be performed: ~~Women's Options Center~~ (6G).

B. DATA BASE

1. Subjective Data
   a. Patient history including: gynecological history (including history of sexually transmitted infections and abnormal Pap smears)
   b. Obstetric history (including number of vaginal deliveries, number of cesarean deliveries, previous abortions, miscarriages, ectopic pregnancies and any associated complications)
   c. Past medical history
   d. Past surgical and anesthesia history, including any associated complications.
   e. Social history (including substance use, homelessness and intimate partner violence)
   f. Allergies
   g. Medications

2. Objective Data
   a. Physical examination including:
      1. Review of vital signs
      2. Airway assessment
      3. Auscultation of heart and lungs
      4. Examination of abdomen
      5. Palpation of uterine fundus as measure of gestational duration
      6. Inspection of perineum
      7. Speculum examination of vagina and cervix.
      8. Cervical specimen collection for gonorrhea and chlamydia testing.

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

Nearly all patients who present to ~~the Women's Option Center~~6G are requesting pregnancy termination services. A primary goal of the initial pre-operative evaluation is to determine the gestational duration of the pregnancy accurately. Additionally, an accurate medical history and focused physical examination is performed to identify any significant medical problems that might complicate the ~~pregnancy termination~~abortion procedure. Psychosocial assessment includes determination that the termination is voluntary and that the patient does not have any risk factors that could affect their safety.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed ~~and obtained~~ according to hospital policy.
   b. Time out performed per hospital policy.
   c. Treatment Procedure
      Depending on gestational duration, almost all patients having a second-trimester abortion will have dilators inserted one or two days before her procedure. After testing for gonorrhea and chlamydia, sterile technique will be used, including cleansing of the cervix, administering a paracervical block~~ will be administered~~, placing a tenaculum ~~placed~~ on the anterior lip of the cervix and inserting ~~then~~ dilators ~~inserted~~ into the cervical os. ~~Generally, the number of medium laminarias to be inserted = gestational duration in weeks – 10; however t~~The number of osmotic dilators may be adjusted based on Dilapan or laminaria sizes used and other factors, including patient comfort. After all dilators are inserted the tenaculum is removed, the cervix inspected for hemostasis and a 4X4 gauze sponge placed in the vagina to hold the dilators in place. In some cases, should the cervix not admit sufficient dilators, pre-dilator mechanical dilation may be needed and/or pharmacologic adjuvants may be used.
   d. Diagnostic tests for purposes of disease identification.

2. Patient conditions requiring consultation, as per Preamble section III b2.

1. Inability to obtain accurate measurements for gestational duration estimation
2. History of cardiovascular disease, including uncontrolled hypertension
3. Current pulmonary compromise or a history of severe pulmonary disease
4. Active or recent hepatic or renal disease
5. Insulin-dependent diabetes
6. Coagulation disorders or anti-coagulation therapy
7. Inability to give informed consent
8. Previous cesarean deliveries with ultrasound findings suspicious for accreta~~e~~ or other abnormal placentation
9. Termination requested for fetal or maternal indications beyond 24 weeks 0 days
10. Patients with complicated or active/recent chronic medical and/or psychiatric problems in case additional diagnostic procedures or consultations need to be ordered
11. Inability to identify cervix or difficulty inserting dilators adequate for the gestational duration
12. Morbid obesity
13. Upon request of affiliated staff or physician
14. Problem requiring hospital admission or potential hospital admission
15. Rupture of membranes during dilator insertion.

3. Education (primarily reviewed with the counselor and RNs)
   a. Explain to the patient that the dilator insertion is the first part of the abortion. Explain to the patient that ~~she~~ they should not undergo osmotic dilator insertion if they are~~she is~~ unsure about their~~her~~ decision to terminate the pregnancy.
   b. Explain the dilator insertion procedure, expected discomforts and possible complications (including bleeding, infection and ruptured membranes).
   c. Explain what the patient can expect overnight before their abortion procedure.
   d. Give patient precautions and telephone numbers to call in case of emergency overnight.

5. Follow-up
   a. All patients return to the clinic the day of their scheduled D&E. Post-abortion follow up may be scheduled at the clinic of the patient's choice.
   b. All ~~women~~ patients ~~must~~should have at least one telephone number at which they can be reached. ~~Women~~ Patients without access to a telephone ~~must~~should leave some

method by which they can be reached in case of emergency. ~~Women~~ Patients can request complete confidentiality, in which case if the clinic needs to call them a code word is used (usually a code name) and no mention is made of the clinic. If a patient with dilators in place does not show up for their scheduled abortion procedure, at least three attempts are made to reach them ~~he~~ by telephone. If they are ~~she is~~ unreachable by telephone, all appropriate parties will be contacted to reach them~~her~~.

E. RECORD KEEPING

All patients complete a self-administered medical history form. This form is reviewed and signed by the NP/CNM/PA evaluating the patient for an abortion. As described above, additional medical history and the physical examination are recorded on the standardized abortion Pregnancy Consultation and Evaluation form. For ~~women~~ patients with any complex medical problems that may influence surgical risk (as described above), physician consultation is obtained and this is documented in the patient's medical record. The number of dilators and gauze sponges placed in the cervix and vagina respectively are recorded on the Epic History and Physical ~~Pre-Operative~~ Note for Abortion and clinic communication form. ~~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 that by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.~~

F. Summary of Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Training in paracervical blocks, mechanical dilation and osmotic dilator placement. b. One-on-one, directly supervised on-the-job training in mechanical dilation and dilator insertion.
Proctoring Period: a. A minimum of 5 observed procedures with 3 chart reviews. b. If proficiency is demonstrated after 5 procedures, the NP/CNM/PA can independently perform the procedure. If proficiency is not demonstrated after 5 procedures, the NP/CNM/PA will continue to be proctored until competence is achieved. The proctoring should be completed within the first 6 months of

initial granting of new privileges and must be completed within the first year (12 months) of initial granting of new privileges.
Reappointment Competency: a. 5 procedures must be completed every two years. b. 2 chart reviews ~~needed~~ must be completed every 2 years.

Protocol #16: Procedure: Trigger Point Injections for Pelvic Pain

A. DEFINITION

Relief of chronic myofascial pain by injecting local anesthesia or saline into areas of tenderness called "trigger points". Injection of trigger points has been found to be 60 to 90% successful in relieving myofascial pain.

1. Location to be performed: all appropriate sites within the OB/GYN service.

2. Performance of procedure:
   a. Indications
      Identification of a trigger point on examination in a chronic pelvic pain patient presenting with myofascial pain. Trigger points will be identified in the abdomen, groin and perineum and injections are limited to subcutaneous and soft tissues. No internal (vaginal) injections will be given.
   b. Precautions
      Avoid injection into blood vessel by aspirating after insertion of needle.
   c. Contraindications
      Allergy to local anesthetic.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Explain procedure to patient
   b. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   c. The procedure is performed following standard medical technique.
   d. Diagnostic tests for purposes of disease identification.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

2. Patient conditions requiring consultation as per Preamble, section IIIb2.
   a. Acute decompensation of patient situation.
   b. Upon request of patient, affiliated staff, or physician
   c. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR~~LCR~~ 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 Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Training will provided by an experienced provider.
Proctoring Period: a. Proctoring by a qualified provider.

b. New practitioner to procedure: observation of a minimum of 2 injections for each site. c. Practitioner who has prior experience with independent performance of this procedure: observation of a minimum of 1 injection for each site. d. Chart review of all observed cases.
Reappointment Competency : a. Minimum of 2 procedures every 2 years. b. Minimum number of 1 chart review every two years.

Protocol # 17: Procedure: LIMITED OBSTETRIC ULTRASOUND <14 Weeks Gestational Age

A. DEFINITION

A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service

2. Performance of procedure:
   a. Indications for limited obstetric ultrasound include a need to identify:
      - Intrauterine pregnancy
      - Fetal number
      - Fetal cardiac activity
      - Gestational duration
   b. Precautions: None
   c. Contraindications: Previously diagnosed multiple gestation

B. DATA BASE
1. Subjective Data
   a. Review history of last menstrual period
2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS

Diagnosis must be supported by diagnostic images obtained

D. PLAN
1. Review patient identification, procedure to be conducted, adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation**:**
   - Multiple gestation
   - No evidence of cardiac activity
   - Gestational age assessment not correlated to other subjective and objective data

- Vaginal bleeding
- Abdominal pain
- Inability to confirm intrauterine location of pregnancy
- Inability to obtain adequate image for diagnostic interpretation
- Unclear or abnormal findings

4. Education
   Discuss findings with patient; establish need for follow-up consultation; examination or referral; give discharge information and instructions
5. Follow up
   As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR b. Recent (within 5 years) experience in limited obstetric ultrasound at gestational age <14 weeks (including ≥ 30 ultrasound exams), and/or privileges to perform limited obstetric ultrasound at gestational age <14 weeks granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising ZSFG physician who has been designated as an evaluator by the Director of Obstetrics.
Proctoring: Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently performing limited obstetric ultrasonography. These exams must be of gestational sacs, embryos, or fetuses at <14 weeks' gestation and must include assessment of the location and dating of pregnancy, cardiac motion and fetal number. Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review and sign the clinical report before the patient is discharged. If the evaluator is an NP/CNM/PA, all reports will additionally be reviewed by the Director

of Obstetrics or his/her physician designee(s) within 24 hours.
Reappointment Competency: Clinicians will be evaluated for continued competency through consultant (as per Preamble section III2b) chart review. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.
Any additional comments: If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed. All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.

Protocol #18: Procedure: LIMITED OBSTETRIC ULTRASOUND: ≥14 Week Gestational Age Assessment

A. DEFINITION

A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service

2. Performance of procedure:
   a. Indications for limited obstetric ultrasound include a need to identify:
      - Gestational age (≥14 weeks gestation)
      - Placental location
   b. Precautions: None
   c. Contraindications: Previously diagnosed multiple gestation

C. DATA BASE
1. Subjective Data
   a. Review of history of last menstrual period
2. Objective Data
   a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS
1. Diagnosis must be supported by diagnostic images obtained

D. PLAN
1. Review patient identification, procedure to be conducted, and adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation**:**
   - Multiple gestation
   - No evidence of cardiac activity
   - Gestational age assessment not correlated to other subjective and objective data
   - Inability to confirm intrauterine location of pregnancy
   - Vaginal bleeding

- Abdominal pain
- Increased risk for accreta (previa and previous cesarean delivery at >16 weeks' gestation)
- Inability to obtain adequate image for diagnostic interpretation
- Unclear or abnormal findings
- BPD close to 58 mm or when inconsistent measurements between the BPD and FL might allow or disallow a pregnancy termination (6G only)

4. Education
   Discuss findings with patient, establish need for follow-up consultation, examination or referral, and give discharge information and instructions
5. Follow-up
   As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR
b. Recent (within 5 years) experience in limited obstetric ultrasound for ≥14 weeks' gestational age assessment (including ≥ 30 ultrasound exams), and/or privileges to perform limited obstetric ultrasound for ≥14week gestational age assessment granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising ZSFG physician who has been designated as an evaluator by the Director of Obstetrics.

Proctoring:

Clinicians must perform a minimum of 5 ultrasounds to demonstrate competency before independently using limited obstetric ultrasonography to date a ≥14week pregnancy.

Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review and sign

the clinical report prior to the patient’s discharge. If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Director of Obstetrics or his/her physician designee(s) within 24 hours.
Reappointment Competency Documentation: Clinicians will be evaluated for continued competency through consultant chart review. Limited obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.
Any additional comments: If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed. All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.

Protocol #19: Procedure: LIMITED OBSTETRIC ULTRASOUND: Third Trimester Assessment of Cardiac Activity, Presentation, and Amniotic Fluid

A. DEFINITION

A limited obstetric ultrasound exam is not intended to replace a basic obstetric ultrasound, which is a well-defined and complex examination that is performed by a physician with specialty training. A limited obstetric ultrasound is a review of certain discrete elements that can be safely performed by a clinician with specific training and experience who has been trained and privileged to perform the exam.

1. Location to be performed: all appropriate sites within the OB/GYN service
2. Performance of procedure:
    i. Indications for limited third trimester obstetric ultrasound include a need to identify:
        - Fetal cardiac activity
        - Fetal presentation
        - ~~Amniotic fluid volume~~ Deepest vertical pocket (~~/~~DVP) of amniotic fluid
    ii. Precautions: None

B. DATA BASE
1. Subjective Data
    a. Review history of last menstrual period
2. Objective Data
    a. Review pertinent objective data (prior ultrasounds and/or physical exam)

C. DIAGNOSIS
2. Diagnosis must be supported by diagnostic images obtained

D. PLAN
1. Review patient identification, procedure to be conducted, adequacy of privacy for exam, readiness and cleanliness of equipment
2. Perform limited obstetric ultrasound
3. Patient conditions requiring Attending or Senior Resident consultation**:**
    - No evidence of cardiac activity
    - Fetal position other than cephalic (if ≥35 weeks gestation)
    - ~~Amniotic fluid index outside of normal range (≤5 or ≥24) or~~ D~~d~~eepest vertical pocket <2 or ≥8
    - Fetal heart rate of <110 beats per minute

- Inability to obtain adequate image for diagnostic interpretation
- Unclear or abnormal findings

4. Education
   Discuss findings with patient, establish need for follow-up consultation, examination or referral, give discharge information and instructions
5. Follow-up
   As indicated by ultrasound findings and clinical condition.

E. RECORD KEEPING
Ultrasound report will be completed using departmentally-accepted format within 24 hours of exam.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

a. Completion of a limited obstetric ultrasound training course, which includes both didactic and hands-on experience, either on-site or outside of the institution; OR
b. Recent (within 5 years) experience in limited obstetric ultrasound in the third trimester (including ≥ 30 ultrasound exams), and/or privileges to perform limited obstetric ultrasound in the third trimester granted at another institution. Experience and/or privileges must be verified by a letter from prior institution or from a supervising ZSFG physician who has been designated as an evaluator by the Director of Obstetrics.

Proctoring:

Clinicians must perform a minimum of 5 ultrasounds (including fetal presentation and ~~amniotic fluid volume~~DVP) to demonstrate competency prior to independently performing limited third trimester obstetric ultrasonography.

Proctoring will be performed by an attending Obstetrician/Gynecologist or an NP/CNM/PA who has been designated as an evaluator by the Director of Obstetrics (i.e., who has demonstrated competence in performance of the clinical skill). This evaluator will review ~~and sign~~ the clinical report prior to the patient's discharge. ~~If the evaluator is an NP/CNM/PA, all reports will later also be reviewed by the Obstetrics Medical Director or his/her physician designee(s) within 24 hours.~~

Reappointment Competency Documentation:

Clinicians will be evaluated for continued competency through 1

~~consultant~~ peer chart review every 2 years. ~~Limited third trimester obstetric ultrasound images and documentation will be reviewed for accuracy and thoroughness on an ongoing basis given that every ultrasound must be reviewed and co-signed by a physician attending within 24 hours.~~
Any additional comments: If proficiency is not achieved in the 5 exams articulated above, individualized plans for achievement of competency may be established as needed. ~~All ultrasound reports will be reviewed and signed off by the Director of Obstetrics or his/her physician designee(s) within 24 hours of the exam.~~

Protocol #20**:** Procedure: Waived Testing

A. DEFINITION

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

1. Location where waived testing is to be performed: any in- or outpatient location providing emergency or primary care

2. The following non-instrument based waived tests are currently performed at ZSFG:
   a. Fecal Occult Blood Testing (Hemocult ®)
      Indication: Assist with detection or verification of occult blood in stool.
   b. Vaginal pH Testing (pH Paper)
      Indication: Assist with assessment for ruptured membranes in pregnancy, bacterial vaginosis, yeast and trichomonas.
   c. SP® Brand Urine Pregnancy
      Indication: Assist with the diagnosis of pregnancy.
   d. Chemstrip® Urine Dipstick
      Indication: Assist with screening for and monitoring of kidney, urinary tract and metabolic diseases.

B. DATA BASE

1. Subjective Data
   Rationale for testing based on reason for current visit, presenting complaint or procedure/surgery to be performed

2) Objective Data
   Each waived test is performed in accordance with approved ZSFG policies and procedures specific for each test as well as site-specific protocols and instructions for:
   a. Indications for testing
   b. Documentation of test results in the medical record.
   c. Actions to be taken (follow-up or confirmatory testing, physician consultation, referrals) based on defined test results.
   d. Documentation or logging of tests performed

C. DIAGNOSIS
   Waived tests may serve as an aid in patient diagnosis but should not be the only basis for diagnosis.

D. PLAN

1. Testing
   a. Verify patient ID using at least two unique identifiers: full name and date of birth (DOB) or Medical Record Number (MRN)
   b. Use gloves and other personal protective equipment, as appropriate.
   c. Assess/verify suitability of sample, i.e., sample should be fresh or appropriately preserved, appropriately timed, if applicable (for example first morning urine), and must be free of contaminating or interfering substances.

Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name <u>and</u> DOB or MRN.

   d. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?

2. Test Results requiring consultation
   a. Follow established site-specific protocols or instructions. When in doubt, consult as per Preamble, section IIIb2.

3. Education
   a. Inform patient of test results and need of additional tests, as necessary

4. Follow-up
   a. Arrange for repeat or additional testing, as appropriate.

E. RECORD KEEPING

Test and control results will be recorded in the medical record as per site-specific protocols (may be in paper charts or entered in electronic data bases).

A record of the test performed will be documented in a log, unless the result entry in the medical record permits ready retrieval of required test documentation.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: Certification as NP/CNM/PA within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics
Proctoring: Successful completion of quizzes for each of the waived tests the practitioner is performing at ZSFG, i.e., achievement of passing scores of at least 80% on each module.
Reappointment Competency Documentation: Renewal required every two years with documentation of successful completion of the required quizzes. Provider must have passed each required module with a score of 80%.

PROTOCOL #21: First-Trimester Aspiration Abortion:

A. DEFINITION

First-trimester aspiration abortion includes manual and electric vacuum procedures for ~~women~~ people with an intrauterine pregnancy confirmed by ultrasound for gestational ages 5.0 weeks through 13 weeks ~~2~~.6 ~~weeks~~days.

1) Location to be performed: San Francisco General Hospital: 6G, 5M, ED.

2) Performance of procedure:
   i. Indications: ~~Women~~ People desiring aspiration abortion in the first trimester for a normal or abnormal intrauterine pregnancy confirmed by ultrasound between 5.0 and ~~12.6~~13 weeks 6 days~~'~~ gestation.
   ii. Contraindications
      a. ASA classes 3 and 4
      b. Hemodynamic instability or other evidence suggesting a problem that might require hospital admission.

3) Supervision
   i. Overall Accountability:
      The NP/CNM/PA is responsible and accountable to the Medical Director of 6G~~the Women's Options Center~~.
   ii. An in-house attending gynecologist will be available to the NP/CNM/PA in person, by phone or by other electronic means at all times.

B. DATA BASE

1. Subjective Data
   a. Obtain patient's/caregiver's description of:
      Last menstrual period history
      Medical history
      Obstetrical history
      Gynecologic history, including history of STIs
      Surgical history
      Current medications; allergies; tobacco, alcohol and illicit drug use
      Contraception history and counseling
      Contraception plans after abortion
      Psychosocial factors as indicated after counseling assessment

2. Objective Data
    a. Perform physical assessment to include:
        - Limited pelvic ultrasound to assess gestational duration and confirm intrauterine pregnancy (if not already completed)
        - Review of vital signs
        - Vaginal and cervical exam
        - Uterine position and size
        - Airway assessment
    b. Obtain/review the following laboratory tests as indicated:
       GC/CT/trichomonas screening
       ~~RPR~~Syphilis test
       Hemoglobin, CBC or hemoglobin/hematocrit
       Type and hold (or Type and Screen if clinically indicated)
       Qualitative or quantitative beta HCG if clinically indicated
       HIV according to patient's preference
       Cervical cancer screening
        - Review pelvic ultrasound results for gestational dating and confirmation of intrauterine pregnancy
    c. All Point of Care Testing (POCT) will be performed according to ZSFG POCT Policy and Procedure 16.20.

C. DIAGNOSIS

Assessment and diagnosis of pregnancy status, risk factors or disease process consistent with the subjective and objective findings.

D. PLAN

1. Therapeutic Treatment Plan
    a. Obtain separate patient consents for abortion and procedural sedation (and any long-acting reversible contraceptive method if desired) before procedure according to hospital policy.
    b. Time out performed per hospital policy.
    c. Diagnostic tests for purposes of disease identification.
    d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
    e. Referral to physician, specialty clinics, and supportive services, as needed.
    f. Provide local anesthesia via paracervical block, with additional pain control via oral medications, intravenous medications and/or procedural sedation to be administered according to patient preference, hospital- and department-specific protocols
    g. Perform first-trimester manual or electric vacuum aspiration

procedure

h. Visual inspection of products of conception, with specimens sent to Pathology as per protocol
i. Provide Rh immunoglobulin (RhoGAM) to Rh-negative patients when clinically indicated
j. Provide contraception as appropriate

3. Patient Conditions Requiring Pre-Operative Attending Consultation
    1. Difficulty determining gestational duration
    2. Unexplained historical, physical or laboratory findings
    3. Known or suspected cervical or uterine abnormalities
    4. Evidence or suspicion of ectopic pregnancy
    5. Suspected molar pregnancy
    6. Suspected uterine or pelvic infection
    7. Client requests care by an anesthesiologist for uterine evacuation
    8. Client hemoglobin less than 8 gm/dL
    9. Upon request of patient, NP, CNM or physician

4. Patient Conditions Requiring Intra- or Post-Operative Attending Consultation
    a. Evidence or suspicion of uterine perforation during procedure
    b. Difficulty obtaining adequate cervical dilation
    c. Excessive pain during procedure
    d. Intra- or post-operative hemorrhage
    e. Cervical laceration requiring repair
    f. Evidence of hemodynamic instability or other evidence suggesting the need for potential hospital admission
    g. Respiratory distress.

5. Procedures for Provision of Emergency Care
    a. For any acute deterioration in patient condition, the in-house Gynecology attending will be paged to assume care of the patient.
    b. If emergency services are required in the interim, the protocols of ~~the Women's Options Center~~6G will be implemented, which include paging the Airway STAT pager or the MERT, or calling a Code Blue.

6. Education
    a. Instruct patient/family/caregiver to:
       Limit physical activity for 24 hours
       Implement pelvic rest for ~~2~~ 1 week~~s~~
       Resume or initiate contraception prescribed

Call or go to ED with fever or chills, heavy bleeding (soaking 2 or more pads per hour for more than 2 hours), abdominal pain unrelieved by medications

7. Follow up
   Follow-up appointment to be scheduled, if indicated.

E. RECORD KEEPING
   Patient visit, consent forms, and other procedure-specific documents will be recorded in the medical record and EMR~~LCR~~ 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 that 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:
Consistent with Section 2725.4 of CA Business and Professions Code, completion of the ~~Health Workforce Pilot Project curriculum and clinical competencies (see Appendix)~~Early Abortion Training curriculum, which includes guidelines, core competencies, and training plan. (https://aptoolkit.org/)
Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of training on site related to unit workflow, documentation and protocols b. Observation of~~e~~ 5 procedures performed by a qualified provider
Proctoring Period: a. Actual number of ~~performances~~ abortions needed to be directly observed: 30 b. Any qualified provider can do the proctoring c. Until proctoring has been completed and procedural sedation protocol has also been successfully proctored, all procedures must be supervised by an attending physician who holds privileges for both abortion and procedural sedation.
Appointment/Reappointment Competency Documentation: a. Minimum number of procedures that must be completed in two years: 10

b. Is direct observation of procedure needed? No
c. Chart Review: 3/year
d. Successful renewal of procedural sedation protocol at time of reappointment or ongoing supervision of all procedures by attending physician

~~Appendix 1 – Health Workforce Pilot Project #171 Curriculum~~

~~Curricular Overview can be found here:~~

~~http://www.ansirh.org/research/pci/hwpp/hwpp-curriculum-and-competency-resources.php~~

~~First-trimester abortion competencies can be found here:~~

~~http://www.ansirh.org/wp-content/uploads/2014/05/ANSIRH_CoreCompetencies.pdf~~

~~Table of Contents for Curriculum can be found here:~~
~~http://www.ansirh.org/training/workbook.php~~

~~Includes the following subjects:~~

~~Early Abortion Training Workbook~~

~~ANSIRH's *Early Abortion Training Workbook* was developed for use in a clinical setting where an experienced trainer or provider is available to lead a discussion of its didactic context and exercises. It is intended to help clinicians learn to identify key elements of informed consent counseling, recognize major psychosocial issues of importance for women who seek abortions, understand the basic steps involved with first-trimester vacuum aspiration abortions and early medical abortion service provision, and identify common complications related to first-trimester abortion care.~~

~~Now in its fourth edition, the workbook is currently in use at top medical schools around the world. It is designed for use with *Management of Unintended and Abnormal Pregnancy*.~~

~~Supplementary training tools and resources~~

~~Additional downloadable chapters:~~

- ~~Chapter 11: Evaluation~~
- ~~Chapter 12: Becoming a Trainer~~
- ~~Chapter 13: Office Practice Integration~~

~~Chapter 11: Evaluation—Instruments~~

- ~~Skills Inventory~~
- ~~Trainee Agreement and Consent~~
- ~~Procedure Log~~
- ~~Training Program Evaluation~~
- ~~Daily Evaluation Card~~
- ~~Observed Performance Assessment~~
- ~~Clinician Feedback Form for Clinic Staff~~
- ~~Clinic Services Satisfaction Survey~~
- ~~Basic Ultrasound Evaluation~~
- ~~New Trainer Skills Evaluation~~

~~Chapter 13: Office Practice—Tools~~

- ~~Abortion Medication Fact Sheet~~
- ~~Abortion Reimbursement Rates~~
- ~~Abortion Scheduling Template~~
- ~~Additional Security Drills~~
- ~~Bomb Threat Report Form~~
- ~~Chart Review Form for Medication Abortion~~
- ~~Comparison of Medication and Aspiration Abortion~~
- ~~Contraceptive Options Fact Sheet~~
- ~~Danco (Mifeprex) Patient Agreement~~
- ~~Disruption/Violence Report for Patients or Visitors~~
- ~~Disruption/Violence Report for Staff~~
- ~~Early Medication Abortion Using Methotrexate and Misoprostol~~
- ~~Ectopic Pregnancy Fact Sheet~~
- ~~Emergency Contraception Fact Sheet~~
- ~~FP Insurance Letter~~
- ~~Insurance Proposal~~
- ~~Interpreter Agreement~~
- ~~IV Sedation Client Information and Consent~~
- ~~Medication Abortion Chart Review~~
- ~~Medication Abortion Consent Form (English)~~
- ~~Medication Abortion Consent Form (Spanish)~~
- ~~Medication Abortion Log~~
- ~~Medication Abortion Follow-Up Log~~
- ~~Medication Abortion Visit~~
- ~~Mifeprex Alternative Treatment Patient Information and Consent~~
- ~~MVA Chart Review~~
- ~~MVA Consent Form~~
- ~~MVA Procedure Notes~~
- ~~MVA Pre-Procedure Notes~~
- ~~Phone Script~~
- ~~Pre-Abortion Patient Instructions~~

- ~~Post-Abortion Patient Instructions~~
- ~~Rho(o) Immune Globulin Client Information Form~~
- ~~Sample Complication Log~~
- ~~Spreadsheet Tool~~
- ~~Talking About your Work with Others~~
- ~~Transfer Agreement~~
- ~~Unwrapping Sterile Packs (Poster)~~
- ~~Values Clarification Workshop~~
- ~~What to Expect After Taking Mifeprex~~
- ~~When a Small Amount of Pregnancy Tissue was Obtained~~
- ~~Working with an Interpreter Training Tool~~
- ~~Wrapping Instruments (Poster)~~
- ~~Reprocessing Vaginal Ultrasound Probe (Poster)~~

Protocol # 22: Procedure: Procedural Sedation/Moderate Sedation

A. DEFINITION

Procedural Moderate Sedation/Analgesia is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation (ZSFG policy number 19.08 titled, "Procedural Sedation: Moderate and Deep") by the Nurse Practitioner/Certified Nurse Midwife/Physician Assistant during procedures within 6G~~the Women's Options Center~~. The nurse practitioner (NP)/certified nurse-midwife (CNM)/physician assistant (PA) practices under the supervision of the Medical Director or designee. Practitioners inducing a level of moderate sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedures may only be performed in the designated areas for procedural sedation within 6G~~the Women's Options Center~~, which are adequately equipped and staffed, according to departmental and hospital policy.

Materials necessary for procedural sedation and rescue include:

a. Appropriate monitoring equipment.
b. Emergency medications and equipment for care and resuscitation, including a cardiac defibrillator, must be immediately available. Medications include, but are not limited to, reversal agents (naloxone and flumazenil) and vasoactive medications (phenylephrine).
c. Supplemental oxygen and positive pressure ventilation equipment.
d. Suction equipment/supplies.
e. Intravenous access.

Indications:

Procedural sedation may be indicated for first-trimester abortion and other minor gynecologic procedures, such as difficult intrauterine device placement or endometrial biopsy.

Contraindications:

a. Regarding the patient's American Society of Anesthesiologists (ASA) class, the Anesthesia Service must be consulted for patients who have an ASA score of 3 or greater. A procedure requiring sedation would not be performed on a patient with an ASA score above a three (3) without anesthesia assistance.

b. Anticipated difficult intubation.

Precautions:

a. Inability to obtain informed patient consent.

B. DATA BASE

1. Subjective Data
    a. Obtain a history within 24 hours of the procedure and sedation, or if earlier, an interim history must be completed.
    b. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
    c. Pertinent past medical history, surgical history, hospitalizations, habits, anesthetic, allergy and drug history.

2. Objective Data
    a. Physical exam within 24 hours of procedure and sedation, or if earlier, an interim physical must be completed. The exam is to include an airway evaluation (mouth opening and neck flexibility and extension, loose teeth, and weight)
    b. Diagnostic data, as appropriate.
    c. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.
    d. Laboratory and imaging results, as indicated, relevant to the history and physical exam.

C. DIAGNOSIS/ASSESSMENT

1. A judgment as to the appropriateness of the procedure and safety of sedation for the particular patient which~~that~~ includes consideration of the patient’s age, medical condition, and the procedure and sedation side effects and risks.
2. Assignment of an ASA physical status. Patients with a Physical ASA class of IV or V will not undergo moderate sedation by the NP/CNM/PA in 6G~~the Women’s Options Center (WOC~~.~~).~~
3. Assignment of the pre-procedure Modified Aldrete Score.
4. Evidence of verification of compliance with the NPO status (adult: minimum 8 hours (solids) and 2 hours (clear liquids) before procedure to decrease risk of aspiration).
5. Assess and document the benefits of sedation against the risk of possible aspiration.
6. A responsible adult is available to take the patient home after the procedure.

D. PLAN

1. Therapeutic Treatment Plan shall follow ZSFG policy number 19.08 titled “Procedural Sedation: Moderate and Deep”
    a. Informed consent for the procedure and sedation must be

obtained and documented by the NP/CNM/PA prior to the delivery of sedation. Consent forms must be completed for the procedure to be performed as well as for the planned sedation.

b. Pre-procedure patient education shall be given and documented, to include, but not be limited to:
   1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
   2. Risks, benefits, and alternatives.
   3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
   4. Date/time of procedure.
   5. Necessity of an adult escort for discharge to home in an appropriate mode of transportation.

c. Re-assessment prior to the procedure to include:
   1. Indication for procedure.
   2. Two patient identifiers.
   3. A “time out” documented.
   4. Immediate pre-procedure vital signs (blood pressure, cardiac rhythm, heart rate, oxygen saturation and end-tidal carbon dioxide).
   5. An assessment of level of movement and consciousness, and responsiveness.

d. The Procedure:
   1. Verify pre-procedure assessment and monitoring guidelines.
   2. Administer appropriate medications as indicated.
   3. Continuously assess the patient’s response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, ETCO2, rhythm, and pain level). Vital signs will be documented no less frequently than every 5 minutes beginning with the first administration of sedation.
   5. Reversal agents, if indicated.

e. Post-procedure
   1. Monitor level of consciousness, respiratory (RR, SaO2) and cardiovascular parameters, and pain level.

f. Termination of Treatment
   1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.

2. Patient conditions requiring Attending consultation:
   a. ~~ASA~~ ASA class III ~~status 3~~ or greater.
   b. Aspiration.
   c. Acute decompensation of patient.
   d. Unexplained historical, physical or laboratory findings.
   e. Upon request of patient, NP, CNM, PA, or physician.
   f. Problem requiring hospital admission or potential hospital

admission.

3. Education

   Patient will be instructed on signs and symptoms of complications. A 24-hour emergency advice number will be given to the patient for any post-procedural problems.

4. Follow-up
   A. If the patient is transferred to the recovery unit:
      1. The patient must be accompanied by trained and/or licensed personnel.
      2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:
         a. Pertinent medical history.
         b. The procedure performed.
         c. The condition of the patient; including pain score.
         d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
         e. Any significant clinical events occurring during and post-procedure.
         f. Any additional orders relating to the post-procedural/moderate sedation care.
   B. Any patient receiving a reversal agent (naloxone or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re- sedation. In addition, ~~an Unusual Occurrence Report must be completed. See Hospital Policy 19.08 for other criteria requiring the submission of an unusual occurrence report~~a SAFE report must be submitted.
   C. The outpatient is discharged "to home":
      1. By a specific discharge order from a physician or NP/CNM/PA; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.
      2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
      3. Outpatients who are discharged to home must be accompanied by a responsible adult.

E. RECORD KEEPING

   Patient visit, consent forms, and other procedure-specific documents will be recorded in the medical record~~ and LCR ~~and EMR as appropriate. The patient status and compliance with discharge criteria must be documented in the patient's medical record by the physician, NP/CNM/PA or registered nurse discharging the patient. Document all

findings in the computerized procedure database, usually the PACS system.

F. Summary of prerequisites, proctoring & reappointment of competency

Prerequisites

A. Training Program
   1. Completion of the ZSFG Procedural Sedation module and Test with a passing score of 8~~9~~0%.
   2. Completion of Basic Life Support (BLS) training.
   3. Furnishing License and DEA number.

Proctoring

The NP/CNM/PA will be able to demonstrate knowledge of the following:

1. Indications for procedures.
2. Risks and benefits of procedures.
3. Related anatomy and physiology.
5. Informed consent process.
6. Use of required equipment.
7. Steps in performing procedures.
8. Ability to interpret results and formulate follow-up plans.
9. Documentation.
10. Ability to recognize a complication.
11. The ability to take a medical history, perform a physical examination, order appropriate laboratory and imaging studies and initiate an appropriate treatment program based on the data obtained utilizing applicable protocols.

A. Direct observation by WOC attending staff credentialed in moderate sedation for a minimum of 30 procedures under moderate sedation. An experienced practitioner who previously had moderate sedation privileges at another institution requires a minimum of 10 successful observed demonstrations.
B. Review by WOC attendings of 30 procedure notes.

Reappointment

A. Ongoing competency will be demonstrated by observation by the Medical Director or designee of three procedures every 2 years.
B. Maintenance of BLS Certification.
C. Passing of Procedural Sedation test with a passing score of 8~~9~~0%.

Protocol #23: Procedure: Vulvar Skin Biopsy (Excision, Punch)

A. DEFINITION

Removal of a small portion of abnormal vulvar skin to be evaluated in the pathology laboratory. Punch biopsy or small excisional biopsy *not requiring suturing* can be performed in the outpatient clinic; ~~women~~ people whose skin requires suturing should have the excisional biopsy performed by a physician.

1. Location to be performed: is in the outpatient OB-GYN Clinic.

2. Performance of procedure:
   i. Indications
      - Papular or exophtic lesions, except genital warts
      - Thickened lesions to differentiate VIN vs. lichen simplex chronicus (LSC)
      - Hyperpigmented lesions, unless obvious nevus or lentigo
      - Ulcerative lesions, unless obvious herpes, syphilis or chancroid
      - Lesions that worsen or don't respond with treatment
   ii. Precautions
      a. Previous treatment of inflammatory skin disease and scar tissue from a previous biopsy can make diagnosis more difficult.
      b. Immunosuppression, bleeding disorders or circulatory problems such as diabetes, which can lead to healing problems.
      c. Heart valve conditions, which increase the risk for inflammation of the heart's inner lining after surgery.
   iii. Contraindications: None

B. DATA BASE

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

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

according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. The procedure is performed following standard medical technique.
   d. Diagnostic tests for purposes of disease identification.
   e. Biopsy tissue is sent to pathology as appropriate.
   f. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   g. Referral to physician, and supportive services, as needed.

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

3. Education

   Preprocedure and post procedure education as appropriate and relevant in verbal or written format.

4. Follow-up

   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and EMR~~LCR~~ 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 Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: Practitioner will have on-site training at ZSFG or at another site with documentation of competency.
Proctoring: a. Proctoring period will be 6 months in length. b. Practitioner must have a minimum of 5 successful observed demonstrations, including either type of biopsy, but at least 2 of each type. c. Will require a minimum of 3 chart reviews.
Reappointment Competency: a. Evaluator will be the Medical Director or other qualified physician. b. Competency evaluation. 2 chart reviews needed to monitor competency every 2 years.

Protocol # 24: Procedure: CNM First-Assist for Cesarean-Section

A. DEFINITION

As the first-assistant in a cesarean-section, the CNM provides primary assistance to the main surgeon. This role involves providing retraction, exposure, and hemostasis as well as other functions determined by the main surgeon.

1. Location to be performed: ZSFG
2. Performance of procedure:
    i. Indications
       This protocol addresses the surgical care of patients whom a physician has consented for cesarean-section (emergent or non-emergent).
    ii. Precautions/Contraindications
       Unless emergent staffing needs require it, CNMs will not serve as first-assist for patients with a history of two or more cesarean-sections. In these cases, they may serve as second-assist if needed.

B. DATA BASE

1. Subjective Data
    a. Antepartum and labor history
    b. Pertinent past medical history, surgical history, family history, hospitalizations, current medications, allergies
2. Objective Data
    a. Physical exam
    b. Laboratory and imaging evaluation, as indicated
    c. Fetal status
    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 related to fetal and maternal status as well as any pertinent medical problems.

D. PLAN

1. Therapeutic Treatment Plan
    a. Patient consent obtained by physician before procedure is performed.
    b. Time out performed per hospital policy.
    c. The procedure is performed following standard surgical technique under direct supervision of the attending physician**.**
    d. The first-assistant’s role may include but is not limited to:
        - Positioning, preparing, and draping the patient

- Using surgical instruments and devices
- Providing exposure
- Handling and dissection of tissues
- Closing and suturing wounds
- Providing hemostasis
- Initiating emergency actions as indicated

2. Patient conditions requiring consultation as per section, IIIb2.
   All operative care under this protocol is rendered in direct consultation with and under direct supervision by the attending physician.

3. Education
   Post-operative care and instructions.

4. Follow-up
   Post-operatively, the patient's care, including any complications, is managed by the Provider team.

E. RECORD KEEPING
Consent forms and other procedure specific documents will be recorded in the medical record as appropriate.

F. Summary of Prerequisite, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: <u>One</u> of the following: 1. Completion of the UCSF Nurse-Midwifery Education Program First-Assist for Cesarean-Section training module 2. Surgical first-assist certification [certified registered nurse first assistant (CRNFA), certified surgical assistant (CSA), or certified surgical first assistant (CSFA)] 3. Documentation of surgical first-assist privileges (or approved standardized procedures) held at another institution within the past two years
Proctoring Period: a. New practitioner to procedure: 3 cases in which there are two surgeons present, including the OB attending who is available to directly assist the CNM. More than 3 cases of this nature may be required if determined by the OB attending. These cases will be followed by 3 cases in which the CNM acts independently as

the first-assist. b. Experienced practitioner to procedure (must show documentation of first-assist privilege/standardized procedure held at another institution within the past two years): 3 cases in which the CNM acts independently as the first-assist. c. Proctor must be an OB attending physician.
Reappointment Competency: a. Perform 4 procedures every two years. b. Ongoing feedback will be provided by the OB attending physician as well as through the departmental quality review process.

Triennial Review 2019
CIDP: 12/05/2018
CC: 1/07/2019
MEC: 1/17/2019
JCC: 1/22/2019

Additional location added 4/2020
CIDP email approval: 4/02/2020
CC: 4/06/2020
MEC: 4/13/2020
JCC: 4/21/2020

Additional new protocol #24 CNM Surgical First Assist SP added
CIDP: 5/06/2020
CC: 6/01/2020
MEC: 6/08/2020
JCC: 6/23/2020

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To: San Francisco Health Commission

From: Erin Amerson, MD

Date: November 28, 2023

Re: Appointment of Dr. Shonul Jain to Chief of Pediatrics, ZSFG

Dear Health Commissioners,

I write on behalf of the Search Committee for a new Chief of Pediatrics at Zuckerberg San Francisco General Hospital. The committee, comprised of leaders from both the DPH and UCSF, conducted a competitive national search, and we were thrilled to nominate Dr. Shonul Jain for the position.

Dr. Jain has served with distinction in the interim Chief role for the past year. She is a strong advocate for babies and children from vulnerable communities, a respected clinician, an award-winning educator, and a public health advisor.

Drs. Elena Fuentes-Afflick (Vice Dean, UCSF at ZSFG), Susan Ehrlich (CEO, ZSFG), and Raphael Hirsch (UCSF Chair of Pediatrics) have enthusiastically accepted the committee's recommendation and offered the position to Dr. Jain, and the Medical Executive Committee unanimously voted to approve on November 14, 2023. We are pleased that Dr. Jain has agreed to accept the position and eager to welcome her to our leadership team at ZSFG.

Sincerely,

Erin H. Amerson, MD, Search Committee Chair
Clinical Professor & Vice Chair of Dermatology, UCSF
Chief of Dermatology, Zuckerberg San Francisco General Hospital & Trauma Center

Prepared: March 16, 2023

University of California, San Francisco
CURRICULUM VITAE

Name: Shonul Agarwal Jain, MD

Position: HS Clinical Professor, Step 1
Pediatrics
School of Medicine

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1001 POTRERO AVE., MS6E
University of California, San Francisco
San Francisco, CA 94110
Voice: 206-4324
Fax: 206-3686
Email: shonul.jain@ucsf.edu

EDUCATION

1995 - 1999	Rice University, Houston, TX	B.A.	Cum Laude, Biochemistry
2000 - 2004	Stanford University School of Medicine	M.D.	
2004 - 2005	University of California, San Francisco	Intern	Pediatrics
2005 - 2007	University of California, San Francisco	Resident	Pediatrics
2007 - 2008	University of California, San Francisco	Chief Resident	Pediatrics

LICENSES, CERTIFICATION

2005	Medical Licensure, California (License #A94229, NPI #1689701450)
2007	Board Certified Pediatrics, current (Diplomate #671580)
2022	Neonatal Advanced Life Support, recertification
2022	Pediatric Advanced Life Support, recertification

PRINCIPAL POSITIONS HELD

2007 - 2008	University of California, San Francisco	Chief Resident & Clinical Instructor	Pediatrics
2008 - 2010	University of California, San Francisco	HS Clinical Instructor	Pediatrics

2010 - 2015	University of California, San Francisco	HS Assistant Clinical Professor	Pediatrics
2015 - 2020	University of California, San Francisco	HS Associate Clinical Professor	Pediatrics
2020 - present	University of California, San Francisco	HS Clinical Professor	Pediatrics
2022 - present	Zuckerberg San Francisco General Hospital	Interim Chief	Pediatrics
2022 - present	University of California, San Fancisco	Interim Vice-Chair, ZSFG	Pediatrics

OTHER POSITIONS HELD CONCURRENTLY

2008 - present	Zuckerberg San Francisco General Hospital	Attending Physician	Pediatrics
2008 - 2014	Valley Care Medical Center	Hospitalist	Pediatrics
2011 - 2022	Zuckerberg San Francisco General Hospital, Children's Health Center	Medical Director	Pediatrics
2011 - 2022	ZSFG Department of Pediatrics, Leadership Team	Member	Pediatrics
2015 - 2022	Zuckerberg San Francisco General Hospital, Pediatrics Department	Vice-Chief	Pediatrics
2022 - present	ZSFG, Children's Health Center	Advising Medical Director	Pediatrics
2022 - present	Zuckerberg San Francisco General Hospital	Interim Chief of Service	Pediatrics

HONORS AND AWARDS

1999	Mickey Leland Hunger Fellowship	Congressional Hunger Center, Washington DC
2001	Medical Scholars Research Grant	Stanford University
2005	UCSF Medical Student Teaching Award	UCSF Pediatrics Residency
2007	UCSF Resident Teaching Scholars Fellowship	UCSF School of Medicine
2007	UCSF Medical Student Teaching Award	UCSF Pediatrics Residency
2010	UCSF Academy of Medical Educators Excellence in Teaching Award	UCSF Academy of Medical Educators

2014	Interprofessional Education at SFGH: Bridging NP and Medical Learners in a Clinical Setting	UCSF Academy of Medical Educators Innovation Grant
2015	Steven M. Thompson Physician Corps Loan Repayment Program Award	Health Professions Education Foundation, CA Office of Statewide Health Planning and Development (OSHPD)
2015	UCSF Essential Core Teaching Award Nomination	UCSF School of Medicine
2017	Holly Smith Award for Exceptional Service to the School of Medicine	UCSF School of Medicine
2020	UCSF Pediatrics Excellence in Mentoring Recognition	UCSF Department of Pediatrics
2021	Dean□s Commendation for Exceptional Volunteerism and Community Service; CARES (Collaborative to Advise on Reopening in Education Safely)	UCSF School of Medicine
2021	UCSF Pediatrics Commendation for Exceptional Service to UCSF, colleagues, and community	UCSF Department of Pediatrics

KEYWORDS/AREAS OF INTEREST

social determinants of health, pediatric ambulatory care, medical education, health care delivery to underserved communities, pediatric hospital medicine, quality improvement, public health, teenage smoking cessation

CLINICAL ACTIVITIES

CLINICAL ACTIVITIES SUMMARY

At Zuckerberg San Francisco General Hospital, I am currently serving as the interim Chief of Service for Pediatrics, working closely with our medical directors to oversee all clinical operations across our inpatient hospitalist service, inpatient NICU and well baby services, and outpatient ambulatory care operations. A large part of this role is also advocating for pediatric services through all other ZSFG clinical departments (such as radiology, lab, anesthesia); a critical role at a largely adult-based hospital. In my prior vice-chief position, I had an enormous role in overseeing all clinical and operational adjustments to the COVID-19 pandemic for all pediatric ambulatory care at ZSFG and serving as a pediatric advisor for all inpatient operations; a role I continue to hold. In addition, given the rapid transition to my interim role, I am currently still serving as the Advising Medical Director of the Children□s Health Center, where I oversee all clinical and operational activities involved in caring for more than 12,000 of San Francisco□s most vulnerable children in a clinic with over 34,000 patient visits per year. I am in the process of transitioning some of these responsibilities while i serve in the interim chief of service role, though I continue to maintain oversight and mentorship to those taking on these tasks.

For direct clinical care, I continue to serve as an attending urgent care physician, seeing patients and supervising residents and medical students in the high acuity urgent care setting. I also continue to attend on the inpatient pediatric hospitalist service at ZSFG.

CLINICAL SERVICES

2008 - 2014	Pediatric Hospitalist, Valley Care Medical Center	4 24-hour shifts per month
2016 - 2019	Attending Physician, Pediatric Nocturnist Service, Zuckerberg San Francisco General Hospital - overnight in-house attending serving NICU, ward, and pediatric ED	1 shift per month
2007 - present	Attending Physician, General Pediatric Inpatient Service, Zuckerberg San Francisco General Hospital	6 weeks per year
2007 - present	Attending Physician, Pediatric Urgent Care Clinic, Children's Health Center, Zuckerberg San Francisco General Hospital	2 shifts per week
2022 - present	Interim Chief of Service, Pediatrics, Zuckerberg San Francisco General Hospital	

PROFESSIONAL ACTIVITIES

MEMBERSHIPS

2000 - 2004	Member, American Medical Association
2004 - present	Fellow, American Academy of Pediatrics
2010 - present	Member, Academic Pediatric Association
2014 - present	Member, Institute for Healthcare Improvement
2017 - present	Member, Society for Pediatric Urgent Care (SPUC)
2020 - present	Member, California Medical Association
2020 - present	Member, San Francisco-Marin Medical Society

INVITED PRESENTATIONS - NATIONAL

2015	Routine biochemical screening to assess smoking and secondhand smoke exposure among adolescents in an urban public hospital clinic. Poster presented at the 14th Annual Flight Attendants Medical Research Symposium, Miami, F.L., U.S.A.	Poster Presentation
2016	Second hand smoke exposure among a vulnerable population of adolescents. Poster presented at the 15th Annual Flight Attendants Medical Research Symposium, Miami, F.L., U.S.A.	Poster Presentation

2021	Implementation of routine immunization services through a pediatric urgent care clinic during the COVID-19 pandemic. Oral presentation, 2021 APHA Conference, Denver, CO, USA	Oral Presentation
2022	Implementation of routine immunization services through a pediatric urgent care clinic during the COVID-19 pandemic. Oral Postar Symposia, 2022 Pediatric Academic Societies Conference, Denver, CO, USA	Oral Presentation

INVITED PRESENTATIONS - REGIONAL AND OTHER INVITED PRESENTATIONS

2009	Implementing a Resident Teaching Observation Program: Feedback and Mentoring to Improve Medical Education Skills Among Housestaff; UCSF Medical Education Day	Poster Presentation
2014	Quality Improvement in the Children's Health Center: The Coleman DPI Experience; Pediatric Grand Rounds, San Francisco General Hospital, San Francisco, CA	Presenter
2016	Resilience in urban, low-income adolescents with depression through photography Academic Pediatrics Association Regional Meeting,Monterrey, CA	Mentor/PI for trainee presentation
2015	Quality Improvement in the Children's Health Center: Annual Update; Pediatric Grand Rounds, San Francisco General Hospital, San Francisco, CA	Presenter
2016	An introductory curriculum in continuous process improvement, UCSF Education Showcase, San Francisco, CA	Presenter
2016	Building a Culture of Quality; Pediatric Grand Rounds, San Francisco General Hospital, San Francisco, CA	Presenter
2017	Primary Care Transformation at the Children's Health Center; Pediatric Grand Rounds, Zuckerberg San Francisco General Hospital, San Francisco, CA	Presenter
2018	Public Health Care Delivery: Advancements and Challenges; Pediatric Grand Rounds, Zuckerberg San Francisco General Hospital, San Francisco, CA	Presenter

CONTINUING EDUCATION AND PROFESSIONAL DEVELOPMENT ACTIVITIES

2012	AAMC Women's Early Career Professional Development Seminar
2014	SFHP and UCSF Center for Health Professions Quality Culture Series
2016	AAMC Te4Q (Teaching for Quality) Faculty Development Workshop
2017	UCSF Advances and Controversies in Clinical Pediatrics
2017	American Academy of Pediatrics Annual Meeting

2018	UCSF Advances and Controversies in Clinical Pediatrics
2019	UCSF Advances and Controversies in Clinical Pediatrics
2017	ZSFG Quality Improvement A3 Workshop and Seminar
2017	ZSFG Relationship Centered Communication
2018	SF Department of Public Health Racial Humility Training
2019	LEAN Daily Management Systems Training
2019	UCSF Diversity, Equity, and Inclusion Champion Training
2022	UCSF Coro Leadership Collaborative
2022	AMSPDC Division Director Leadership Academy

GOVERNMENT AND OTHER PROFESSIONAL SERVICE

2011 - 2020	Division of Maternal Child and Adolescent Health, SF Department of Public Health	Steering Committee Member, Pediatric Advisory Committee
2015 - 2020	Project 500 and HOPE SF: San Francisco Mayor and San Francisco Department of Public Health joint initatives to provide services for vulnerable families in SF	Advisory Group Member
2016 - 2021	Clinical Performance Improvement Programs, San Francisco Health Plan	Advisory Group Member
2020 - 2021	Influenza vaccination Task Force, San Francisco Department of Public Health	Pediatrics representative
2020 - 2022	COVID Central Command Center (CCC), San Francisco Department of Public Health	Pediatrics Advisor
2021 - 2023	COVID Vaccine Task Force, San Francisco Health Network & San Francisco Department of Public Health	Pediatrics Representative
2021 - present	Pediatric Clinical Working Group, San Francisco Health Network	Member
2022 - present	CalAIM Enhanced Care Management Task Force, San Francisco Department of Public Health, Pediatrics Subgroup	Member

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UNIVERSITY AND PUBLIC SERVICE

SERVICE ACTIVITIES SUMMARY

Many of my service activities tie into my focus on health care delivery for vulnerable populations. I have taken on a variety of leadership roles, most recently as the interim Chief of Pediatrics at ZSFG, and as a result I also serve on a large variety of hospital and department committees spanning clinical, educational, and administrative areas. Since my last

advancement, I have been facilitating and advising the SFDPH and San Francisco Health Network on pediatric issues around COVID-19 response, including development of city-wide pediatric testing protocols which were implemented at various DPH mass testing sites throughout the city, and the adaptation of pediatric ambulatory visit schedules and approaches with the goal of maintaining in person health care access for vulnerable populations with limited ability to access telehealth services. In addition, I joined the COVID vaccination task force and was particularly involved in vaccination strategies for children and adolescents, including development of at-home vaccination services for vulnerable patients and, with colleagues, development of culturally-concordant patient education materials and webinars. I was awarded a Commendation for Exceptional Service from the Pediatrics Department for my efforts around COVID-19 programs with SFDPH. Additionally, I have continued an active role in quality improvement both locally at SFGH and as a pediatric voice for ambulatory care quality in the San Francisco Health Network and through advisory boards with local health care plans. Outside of COVID-19, I continue to work closely with colleagues in the SF Department of Public Health on numerous initiatives around children and families to serve the greater San Francisco community of children, most recently with the CalAIM Enhanced Care Management Task Force, seeking to create a broad strategy around the city-wide implementation of expanded care coordination services for children and adolescents. This is connected to new CA statewide programs linked to major Medi-Cal payment enhancements and reform.

UCSF CAMPUSWIDE

2009 - 2010	SFGH Pain Management Committee	Member
2010 - 2014	SFGH Pharmacy & therapeutics Committee	Member
2012 - 2016	UCSF Chancellor's Advisory Committee on Family Services	Member
2013 - 2016	Task Force, ZSFG Rebuild Pediatric Emergency Care	Member
2013 - 2018	SFGH Pediatric Emergency Medicine Committee	Member
2014 - 2019	Maternal Infant Leadership Collaborative	Member
2015 - 2018	SFGH Performance Improvement and Patient Safety (PIPS) Committee	Member
2017 - 2019	UCSF Clinical Practice Group at SFGH	at large Voting Member
2020 - 2022	UCSF CARES: Collaborative to Advise on Reopening in Education Safely	Member
2021 - 2022	UCSF CPG at SFGH Outpatient Standardization Workgroup	Member
2014 - present	SFGH Ambulatory Care Committee	Member
2017 - present	UCSF CPG at SFGH Clinical Operations, Metrics, and Performance Committee	Member
2018 - present	Ready! Resilient! Rising! & Early Success Clinic Collaborative	Member
2020 - present	SFGH Medical Executive Committee	Member

2022 - present	UCSF Clinical Practice Group at SFGH	Board Member
2022 - present	ZSFG Risk Management Committee	Member
2022 - present	UCSF CPG at SFGH Finance Committee	Member

SCHOOL OF MEDICINE

2008 - 2011	UCSF Medical Student Pediatrics Clerkship	Co-coordinator, Valley Care site
2014 - 2015	Dermatology Module for Medical Student Core Clerkship in Pediatrics ? developed powerpoint presentation and accompanying handout as part of core curriculum for all UCSF 3rd year medical students on pediatric rotation	Creator
2014 - 2015	Search Committee, SFGH Emergency Medicine Department Chair	Member
2019 - 2019	UCSF SOM Childbearing/Childrearing Leave Task Force	Member
2019 - 2020	Search Committee, SFGH Dermatology Department Chair	Member
2016 - present	Mental and Behavioral Health Integration into ZSFG Pediatric Clinical Sites, in collaboration with UCSF/ZSFG Department of Psychiatry	Co-coordinator
2023 - present	Search Committee, SFGH Otolaryngology Chair	Member
2023 - present	Search Committee, UCSF Vice Dean for Population Health and Health Equity	Member

SCHOOL OF NURSING

2018 - 2019	Search Committee, SON ACPNP Faculty Member (3 positions)	Member

DEPARTMENTAL SERVICE

2004 - 2008	UCSF Pediatrics Curriculum Committee	Resident Representative
2006 - 2020	Member, UCSF Pediatrics Resident Selection Committee	Member
2009 - 2009	UCSF Residency Jeopardy Restructuring Committee	Faculty Representative
2010 - 2010	Ad Hoc Committee on the Structure of General Pediatrics	Member
2010 - 2010	Working Group on Redesigning SFGH Chief Resident Positions	Chair
2011 - 2011	Department of Pediatrics Chief Resident Clinical Duties Task Force	Member

2012 - 2014	SFGH Children's Health Center CareLink SF (EMR) Implementation Committee	Member, Leadership Group
2012 - 2014	Search Committee, UCSF/SFGH General Pediatrics Faculty (4 positions)	Chair
2013 - 2019	Pediatric Mental Health / Neuro Developmental Delay Task Force	Member
2014 - 2015	Search Committee, UCSF Division of General Pediatrics Faculty	Member
2015 - 2016	Search Committee, UCSF Division of Hospital Medicine Faculty	Member
2016 - 2016	Search Committee, ZSFG General Pediatrics Faculty (2 positions)	Chair
2016 - 2016	Search Committee, UCSF Division of General Pediatrics Faculty (3 positions)	Member
2016 - 2017	Working Group to asses Neonatology Work Expectations	Co-Chair
2017 - 2019	Search Committee, UCSF Division of Hospital medicine Faculty (3 positions)	Member
2018 - 2019	Search Committee, UCSF Division of General Pediatrics Faculty	Member
2019 - 2020	Search Committee, UCSF/SFGH General Pediatrics Faculty	Member
2019 - 2020	Search Committee, UCSF Division of Hospital Medicine Faculty	Member
2019 - 2020	Epic EMR Implementation Pediatric Implementation Committee	Member, Leadership Group
2007 - present	UCSF Pediatrics Resident Selection	Faculty Interviewer
2011 - present	SFGH Pediatrics Quality Improvement Workgroup	Member
2011 - present	SFGH Pediatrics Leadership Council	Chair
2014 - present	SFGH Pediatric Executive Committee	Chair
2016 - present	UCSF Center for Child and Community Health (CCCH)	Advisory Board Member
2018 - present	Department of Pediatrics HS Clinical Promotions Committee	Member
2019 - present	UCSF Division of General Pediatrics Leadership Group	Member, Leadership Team
2021 - present	UCSF Pediatrics Compensation Committee	Member

COMMUNITY AND PUBLIC SERVICE

2013 - 2019	San Francisco Health Plan Performance Improvement Program	Advisory Board Member
2013 - 2019	San Francisco Health Network Primary Care Coordinating Committee	Member
2013 - present	Pediatric and Adolescent Ambulatory Quality Improvement Committee, San Francisco Health Network	Leadership Member
2014 - present	San Francisco Ambulatory Safety Center for Innovation; Agency for Healthcare Research and Quality	Advisory Board Member
2015 - present	Solid Start Mental Health Collaborative	Steering Committee Member
2015 - present	Clinical Practice Guideline Development - guidelines for Pediatric LTBI, Pertussis screening and treatment, and pediatric COVID-19 screening and testing, among others. Protocols are disseminated and utilized throughout DPH SFHN clinics county-wide as well as other public health consortium clinics that see children. Continue to develop and update these as requested by SFDPH leadership.	Senior Clinician
2018 - present	Girl Scouts of Northern California	NorCal Regional "First Aider," Local Troop Leader
2020 - present	San Francisco Health Network Equity Task Force	Member
2020 - present	Burlingame School District COVID advisory group	Member
2020 - present	Crystal Springs Uplands School Medical Advisory Committee (CMAT)	Member

CONTRIBUTIONS TO DIVERSITY

CONTRIBUTIONS TO DIVERSITY Contributions to Diversity, Equity & Inclusion Guidance

My clinical work has always been centered at Zuckerberg San Francisco General Hospital, serving pediatric patients and families in a highly diverse, economically underserved environment. As clinic director I have spearheaded significant clinical innovations in addressing health care disparities and issues unique to underserved, diverse populations such as implementation of social determinants of health screening and intervention, implementation of new immigrant clinic with community ties to legal support, and focus on mental health and trauma integration and support.

Since my last advancement, I joined the Equity Task Force within the San Francisco Health Network to integrate an equity framework in public health practices and hiring as well as stratification of all public health metrics by race/ethnicity to better address disparities. I have also been working with the SFDPH Covid-19 Command Center particularly around issues of

pediatric equity related to the pandemic. Specifically, we developed approaches and protocols to maximize in person well child care for vulnerable communities in acknowledgement of limited access to technology and telehealth - and as a result were largely able to maintain childhood vaccination rates during the pandemic. In addition I was part of the SFHN COVID vaccination task force with a particular focus on vaccine equity for vulnerable communities - including partnering with community organizations to develop pop-up and mobile vaccination clinics in community locations as well as development of culturally concordant patient education materials and webinars. Locally at ZSFG, I, along with colleagues, obtained funding and implemented a "patient pantry" in our ambulatory care center to provide food, diapers, and basic necessities for families who were left vulnerable during the pandemic and were coming in to seek health care. We were able to expand this to include backpacks with basic schools supplies to facilitate remote schooling for our patients.

I am now working more broadly with SFDPH Clinical Leadership on the the CalAIM Enhanced Care Management Task Force, seeking to create a broad, equity-focused strategy around the city-wide implementation of expanded services for publicly insured children and adolescents. This is connected to new CA statewide programs linked to major Medi-Cal payment enhancements and reform.

TEACHING AND MENTORING

TEACHING SUMMARY

As a faculty member in Pediatrics, I have participated in numerous teaching opportunities with a variety of different departments, ranging from Pediatrics, Family and Community medicine, and Emergency medicine, and many different types of learners including medical students, residents, nursing students and advance practice nurses. I am also a regular participant in many didactic conferences and lectures which are attended by both pediatric housestaff and medical students in their pediatric clerkship.

In addition, I perform a great deal of informal clinical teaching. In the inpatient setting I teach at the bedside during daily inpatient rounds as well as small group teaching after rounds. The teaching includes modeling family centered rounds, giving real time feedback on presentations including clinical assessments, and disease processes and clinical management. In the outpatient setting, I work with learners one-on-one in the urgent care clinic. The learners include medical students, nurse practitioner students, and residents from Pediatrics, Emergency Medicine, and Family and Community medicine.

In addition to medical education I have been involved in mentorship around QI and career planning for numerous individuals across the spectrum of pre-medical, medical, resident, and faculty learners. I also serve as a PLUS POD mentor for the Pediatric Leadership for the Underserved program. Since my last advancement I have taken on additional mentees and was recognized for Excellence in Mentoring by the Pediatrics Department.

FORMAL TEACHING

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2006 - 2006	UCSF IDS 115: Coda Course	Section Leader	Medicine	20

	Academic Yr	Course No. & Title	Teaching Contribution	School	Class Size
	2008 - 2017	UCSF IDS 107: Life Cycles Class	Small Group Leader	Medicine	12-15
	2008 - 2017	UCSF IDS 114: Transitional Clerkship	Clinical Preceptor	Medicine	6-8
	2010 - 2012	UCSF IDS 131:Foundations of Patient Care	Small Group Leader	Medicine	8
	2018 - 2020	UCSF IDS 122A: Life Stages	Small Group Leader	Medicine	12-15

INFORMAL TEACHING

2007 - 2012 Resident Teaching Observation Program (monthly lecture feedback)

2007 - 2014 Valley Care Hospital Medical Student Precepting (8 days/month)

2007 - 2020 Pediatric Medical Student Core Clerkship Lecture Series at SFGH (one lecture per med student block) - scheduled lecture every 8 weeks as part of core pediatrics clerkship curriculum on Dermatology or ID topics.

2004 - present Pediatric Resident Teaching Conferences (3-5 one hour conferences/year) - morning and noon conferences for trainees (medical students and pediatrics and family medicine housestaff) at SFGH on topics in General Pediatrics

2007 - present SFGH Pediatrics Ward Attending Rounds (4 weeks/year)

2007 - present SFGH Urgent Care Attending and Precepting (10 hrs/week) - working with medical students, NP students, and residents from Pediatrics, Family and Community Medicine, and Emergency Medicine

PREDOCTORAL STUDENTS SUPERVISED OR MENTORED

Dates	Name	Program or School	Mentor Type	Role	Current Position
2010 - 2010	Joshua Berezin	UCSF Medical School	Career Mentor	Career Advisor	Pediatric Attending
2011 - 2011	Margaret Emmott	University of Colorado MS2	Project Mentor	Summer QI Research Intern	UCSF Pediatric Faculty
2011 - 2014	William Goodson	UCSF Medical School	Career Mentor	Career Advisor	Community Physician

Dates	Name	Program or School	Mentor Type	Role	Current Position
2012 - 2012	Alicia Callejo-Black	Lewis and Clark College, Undergraduate Sophomore	Project Mentor	Summer QI Research Intern	ACLU Attorney
2013 - 2013	Hillary Vansell	UCSF Berkeley, Undergraduate Senior	Project Mentor	QI research intern	Program Coordinator, Vanderbilt TB Center
2014 - 2014	Yoseph Kram	UCSF Medical School	Project Mentor	Model SFGH Project Advisor	Physician
2014 - 2014	Lizzy Tarr	Bowdoin College	Project Mentor,Career Mentor	Career Advisor, Project Mentor	Medical Student, NYU
2014 - 2014	Rachael Pann	University of Texas - Austin Undergraduate	Project Mentor	Briger Summer QI Fellow	University of Texas - Austin Undergraduate
2014 - 2014	Jessica Ellison	SF State Nursing Student	Project Mentor	Briger Summer QI Fellow	SF State Nursing Student
2014 - 2014	Nina Nguyen May	UCLA Undergraduate	Project Mentor	Briger Summer QI Fellow	IT Consultant
2015 - 2016	Harold Navea	SF State Undergraduate	Project Mentor,Career Mentor	Briger Summer QI Fellow	SF State Undergraduate, applying for medical schools
2016 - 2016	Noemi Cocone	SF State Undergraduate	Project Mentor,Career Mentor	Briger Summer QI Fellow	applying for medical school
2016 - 2016	Miriam Valenzuela	SF State Undergraduate	Project Mentor,Career Mentor	Briger Summer QI Fellow	applying for medical school

Dates	Name	Program or School	Mentor Type	Role	Current Position
2017 - 2017	Amber Kuo	UC Berkeley Undergraduate	Project Mentor,Career Mentor	Briger Summer QI Fellow	nursing school at NYU
2017 - 2021	Antonio Hernandez	UC Davis Medical Student	Project Mentor,Career Mentor	Quality Improvement Analyst	current med student
2018 - 2020	Ahmed Elattma	Wayne State Medical Student	Project Mentor,Career Mentor	Quality Improvement Analyst	current med student
2019 - 2021	Erica Thompson	UCLA Undergraduate	Career Mentor	Summer Volunteer	interested in health care career
2020 - 2021	Aarohi Bhargava-Shah	Stanford Medical Student	Project Mentor,Career Mentor	Quality Improvement Analyst	current med student
2022 - present	Geraldine Abilo	SF State Undergraduate	Project Mentor,Career Mentor	Quality Improvement Analyst	interested in health care career

POSTDOCTORAL FELLOWS AND RESIDENTS MENTORED

Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2012 - 2015	Kaitlin Thein, MD	Pediatrics R1	Career Mentor	Faculty Advisor	graduate
2012 - 2013	Katey Hoffman, MD	Pediatrics Chief Resident	Career Mentor	Clinial Supervisor and Administrative/Career Advisor	Director, Marin General Pediatric Hospitalist Program
2013 - 2014	Sabrina Santiago, MD	Pediatrics Chief Resident	Career Mentor	Clinical Supervisor and Career Mentor	UCSF Faculty (Assistant Prof)
2014 - 2016	Neeti Doshi, MD	Pediatrics R2	Project Mentor,Career Mentor	Residency Project Advisor	UCSF Faculty
2014 - 2016	Vivien Sun, MD	Pediatrics R2	Project Mentor,Career Mentor	Residency Project Advisor	Graduate

Dates	Name	Fellow	Mentor Role	Faculty Role	Current Position
2014 - present	Margaret Emmott, MD	Pediatrics Resident	Career Mentor	Career Mentor, Advisory Pod mentor	UCSF Faculty
2015 - 2018	Emma Steinberg, MD	Pediatrics Resident	Career Mentor	Advisory Pod Mentor	Kaiser Faculty
2015 - 2018	Emily Frank, MD	Pediatrics Resident	Project Mentor,Co-Mentor/Clinical Mentor	Clinical and Project Mentoring	Community Physician
2016 - 2020	Abi Dairo, MD	Pediatrics Resident	Career Mentor	Primary Residency Mentor	Community Physican
2019 - present	Denise Powell, MD	Pediatrics Resident	Career Mentor	Primary Residency Mentor	UCSF Pediatrics R3

FACULTY MENTORING

Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2013 - 2018	Eliza Hayes Bakken, MD	UCSF Assistant Clinical Professor	Project Mentor,Career Mentor	Project and Administrative Mentor	OHSU Associate Clinical Professor
2013 - 2019	Ellen Laves, MD	UCSF Assistant Clinical Professor	Career Mentor,Co-Mentor/Clinical Mentor	Clinical Mentor	UCSF Associate Clinicial Professor
2014 - 2016	Martina Steurer-Muller, MD	UCSF Assistant Professor of Neonatology		Peer Mentor	UCSF Assistant Professor of Neonatology
2015 - present	Eleanor Chung, MD	UCSF Assistant Clinical Professor	Career Mentor	Career Mentor	UCSF Assistant Clinical Professor
2018 - present	Margaret Gilbreth, MD	UCSF Assistant Clinical Professor	Career Mentor	Career Mentor	UCSF Assistant Clinical Professor

Dates	Name	Position while Mentored	Mentor Type	Mentoring Role	Current Position
2019 - present	Teresa Tuan, MD	UCSF Assistant Clinical Professor	Career Mentor	Career Mentor	UCSF Assistant Clinical Professor
2020 - present	David Gordon, MD	UCSF Asst/Assoc Clinical Professor	Career Mentor	Career Mentor	UCSF Associate Clinical Professor
2022 - present	Taylor Clark, MD	UCSF Assistant Clinical Professor	Project Mentor	QI Project and Career Mentor	UCSF Assistant Clinical Professor

RESEARCH AND CREATIVE ACTIVITIES

RESEARCH AND CREATIVE ACTIVITIES SUMMARY

I remain involved with several research studies taking place in the ZSFGH Children□s Health Center. Most of these projects center around issues related to urban health and health disparities. In particular, I have been working with Dr. Neal Benowitz and the Center for Tobacco Control on tobacco exposure among teens. We have done several studies in this area, first to screen teens in the primary care setting for tobacco smoke exposure and obtain novel data on the prevalence of passive or active smoke exposure in an urban underserved population. NNAL and cotinine levels in urine are used as markers of exposure. The project has now expanded to interview teens regarding smoking habits and other high risk behaviors and correlate urine levels and THC levels with other behavioral habits. The study has resulted in 3 papers published since 2020.

I am working within the Children's Health Center on new projects in the area of childhood trauma and mental health. Working through a grant from the Stupski foundation and with colleagues in the Department of Psychiatry, we have innovated and implemented a nationally-validated wraparound integrative behavioral health model for children 0-5 years old, called Healthy Steps. Through this program, we are piloting new care models around ACES and mental health screenings for both caregivers and children and integrating multidisciplinary team-based care models for treatment, and studying both the feasibility and effects of these interventions. This pilot has expanded into advocacy with local payers and at the state level to create new mental health codes for billing and potentially new policy initiatives in CA to provide increased reimbursement for dyadic care models in the pediatric setting. The project is now culminating in a creation of a state-wide Center for Excellence around early childhood mental health integration, centered at the Children's Health Center.

CREATIVE ACTIVITIES (QUALITY IMPROVEMENT)

In addition to the above, I have continued to stay involved in numerous quality improvement initiatives in the Children□s Health Center at SFGH (such as including improving clinician-nurse communication and inpatient-outpatient communication, implementation of huddles, decreasing patient cycle time, improving anemia screening and treatment, improving rates of

fluoride varnish, development of an asthma screening protocol, to name a few). I have expanded my QI reach to involve pediatric care throughout the San Francisco Health Network, and also serve on the advisory board for pediatric QI programs for both San Francisco Health Plan and for the SFDPH. Since my last advancement, I, along with colleagues, innovated expanded access to routine childhood immunizations during the pandemic by implementing by implementing a vaccination program in pediatric urgent care, with a goal of expanding this process to the emergency room. I served as senior author on this work which was presented both at the American Public Health Association and Pediatric Academic Societies.

RESEARCH AWARDS - PAST

1.	co-PI	5% % effort	Jain (PI)
	Opportunity Institute - Clinton Foundation	7/1/2016	6/30/2018
	"Too Small to Fail" - Early Childhood		$ 250,000 total

Foundation-sponsored (Clinton Foundation), IRB-approved initiative that aims to increase messaging in the primary care setting around early literacy and language development by encouraging reading, teaching, and singing by parents, and then evaluates the impact of those interventions. Part of a broader national campaign to promote early literacy among underserved populations, and I also serve in a broader advisory capacity for the San Francisco project. This project was extended to included early Math intervention as well. The project \culminated in an site visit by Chelsea Clinton, representing the Clinton Foundation, and article in the SF Chronicle highlighting our work in this area.

Project Manager

2.	co-PI	5% % effort	Benowitz (PI)
	FAMRI (Flight Attendant Medical Research Institute)	07/01/2015	06/30/2018
	FAMRI Bland Lane Center of Excellence on Secondhand Smoke		

Spans several projects working on smoke exposure among adolescents. First project involved screening teens in the primary care setting for tobacco smoke exposure and obtain novel data on the prevalence of passive or active smoke exposure in an urban underserved population. NNAL and cotinine levels in urine are used as markers of exposure. The project has now expanded to interview teens regarding smoking habits and other high risk behaviors and correlate urine levels and THC levels with other behavioral habits. The study has resulted in 3 papers published since 2020

Developed SOPs around adolescent recruitment, consent, and study design process. Trained study coordinators and worked with clinical leadership to recruit and interview for study.

PEER REVIEWED PUBLICATIONS

1. **Agarwal, S., Trucco, S., Longhurst, C., Sectish, T. Index of Suspicion: Dystonic reaction to metaclopromide in an infant. Pediatrics in Review. October, 2004.**
2. Benowitz NL, Jain S, Dempsey DA, Nardone N, Helen GS, Jacob P 3rd. Urine Cotinine Screening Detects Nearly Ubiquitous Tobacco Smoke Exposure in Urban Adolescents. Nicotine Tob Res. 2017;19(9):1048-1054. doi:10.1093/ntr/ntw390
3. Benowitz NL, Nardone N, Jain S, et al. Comparison of Urine 4-(Methylnitrosamino)-1-(3)Pyridyl-1-Butanol and Cotinine for Assessment of Active and Passive Smoke Exposure

in Urban Adolescents. Cancer Epidemiol Biomarkers Prev. 2018;27(3):254-261. doi:10.1158/1055-9965.EPI-17-0671

4. Benowitz N, Nardone N, St Helen G, Addo, N, Jacop B, Liakoni, E, Jain S, Hooshfar S, Lynch K. Quantitative biochemical screening for marijuana use and concordance with tobacco use in urban adolescents. Drug Alcohol Depend. 2019;205:107583. doi:10.1016/j.drugalcdep.2019.107583
5. Nardone N, Jain S, Benowitz NL. Biomarkers of Exposure to Nicotine and Tobacco-Specific Nitrosamines in Adolescent Blunt Users. Nicotine Tob Res. 2020 Jul 16;22(8):1428-1429. doi: 10.1093/ntr/ntz144. PMID: 31433049.
6. Nardone N, Giberson J, Prochaska JJ, Jain S, Benowitz NL. A Mobile Health Intervention for Adolescents Exposed to Secondhand Smoke: Pilot Feasibility and Efficacy Study. JMIR Form Res. 2020 Aug 19;4(8):e18583. doi: 10.2196/18583. PMID: 32812888; PMCID: PMC7468632.
7. Nardone N, Jain S, Addo N, St Helen G, Jacob P 3rd, Benowitz NL. Sources and Biomarkers of Secondhand Tobacco Smoke Exposure in Urban Adolescents. Acad Pediatr. 2020 May-Jun;20(4):493-500. doi: 10.1016/j.acap.2019.12.006. Epub 2019 Dec 20. PMID: 31866460; PMCID: PMC7967984.
8. Yonek JC, Velez S, Satre DD, Margolis K, Whittle A, Jain S, Tolou-Shams M. Addressing adolescent substance use in an urban pediatric federally qualified health center. J Subst Abuse Treat. 2022 Apr;135:108653. doi: 10.1016/j.jsat.2021.108653. Epub 2021 Oct 28. PMID: 34840042.

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1. Jain, SA. Fine, Bumpy Rashes. In: Chung EK, Atkinson-McEvoy L, Boom JA, Matz PS, eds. Visual Diagnosis in Pediatrics, second edition. Lippincott Williams & Wilkins. 2009.
2. **Jain, SA. Fine, Bumpy Rashes. In: Chung EK, Atkinson-McEvoy L, Boom JA, Matz PS, eds. Visual Diagnosis in Pediatrics, third edition. Lippincott Williams & Wilkins. 2014.**
3. Jain, SA. Conjunctivitis. In: Schwartz, MW (Chief Ed), Bell, LM, Bingham, P, Chung, EK, Friedman, D, Mulburg, A, Schwartz, C and Tanel, R (Assoc Eds.). The 5-Minute Pediatric Consult. 7th Edition. Philadelphia: Lippincott Williams and Wilkins, 2014.
4. Jain, SA. Conjunctivitis. In: Schwartz, MW (Chief Ed), Bell, LM, Bingham, P, Chung, EK, Friedman, D, Mulburg, A, Schwartz, C and Tanel, R (Assoc Eds.). The 5-Minute Pediatric Consult. 8th Edition. Philadelphia: Lippincott Williams and Wilkins, 2018.
5. Han, A. and Jain, SA. Conjunctivitis. In: Schwartz, MW (Chief Ed), Bell, LM, Bingham, P, Chung, EK, Friedman, D, Mulburg, A, Schwartz, C and Tanel, R (Assoc Eds.). The 5-Minute Pediatric Consult. 9th Edition. Philadelphia: Lippincott Williams and Wilkins, (in press).

OTHER PUBLICATIONS

1. Laves, E, Taber, B, Higashi, J, Jain, SA. Guidlines for Diagnosis and Management of Pediatric Latent Tuberculosis Infection: DPH Clinical Protocol. Created and disseminated with San Francisco Department of Public Health.

2. **Agarwal, S., Vollinger, E., et al. State government responses to the food assistance gap 2000: annual report and 50 state survey. 2000. Published by Food Research Action Center (FRAC) and America's Second Harvest. Washington, D.C.**

SIGNIFICANT PUBLICATIONS

1. Benowitz, N., Nardone, N., Jain, S., Dempsey, D., Addo, N., St. Helen, G., Jacob, P. Comparison of Urine 4-(Methylnitrosamion)-1-(3) Pyridyl-1-Butanol and Cotinine for Assessment of Active and Passive Smoke Exposure in Urban Adolescents. Cancer Epidemiol Biomarkers Prev; 27(3) March 2018. 254-261.

   I designed the study and data collection (though not statistical methods), recruited and trained all of research coordinators and supervised recruitment, and helped with manuscript review.

2. Nardone, N., Jain, S., Addo, N., St. Helen, G., Jacob, P., Benowitz, N. Sources of Second Hand Smoke Exposure and Biomarkers in Urban Adolescents. Academic Pediatrics. Submitted.

   I designed the study and data collection (though not statistical methods), recruited and trained all of research coordinators and supervised recruitment, and helped with manuscript review.

CONFERENCE ABSTRACTS

1. Gordon, D., Gilbreth, M., Jain, S. Implementation of routine immunization services through a pediatric urgent care clinic during the COVID-19 pandemic. Oral Poster Symposia, Pediatric Academic Societies Conference, Denver, CO, April 23, 2022
2. Gordon, D., Gilbreth, M., Jain, S. Implementation of routine immunization services through a pediatric urgent care clinic during the COVID-19 pandemic. Oral presentation, 2021 APHA Conference, Denver, CO, USA, Oct 21, 2021
3. Nardone, N., Jain, S.A., Dempsey, D.A., Jacob, P. & Benowitz, N.. Second hand smoke exposure among a vulnerable population of adolescents. Poster presented at the 15th Annual Flight Attendants□ Medical Research Symposium, Miami, F.L., May 2016.
4. Ranji, S, Jain, S, Leard, L, Chen, L, Tabas, J. An introductory curriculum in continuous process improvement. Presentation at UCSF Education Showcase, San Francisco, CA, April 2016
5. Sun, V., Doshi, N. Jain, SA, Bardach, N. Capturing Resilience: a pilot program to promote resilience in adolescents with depression through photovoice. Oral presentation at the APA Region IX/X Meeting, Monterey, CA, Jan 2016
6. Dempsey, DA, Jain, SA, Jacob III, P, Benowitz, NL. Routine Biochemical Screening to Assess Smoking and Secondhand Smoke Exposure among Young Children and Adolescents in an Urban Public Hospital. Poster Presentation at FAMRI Thirteenth Scientific Symposium, Miami, FL, May 5-7, 2014.
7. Jain, SA, Tayama, T, et.al. Implementing a Resident Teaching Observation Program: Feedback and Mentoring to Improve Medical Education Skills Among Housestaff. Poster Presentation at Medical Education Day, UCSF, April 27, 2009.

ACADEMIC LEADERSHIP

I was recently named Interim Chief of the the Department of Pediatrics at Zuckerberg San Francisco General Hospital and Interim Vice-Chair for ZSFG in the UCSF Department of Pediatrics. In this role, I serve as the primary department liaison between ZSFG and UCSF Pediatrics as well as collaboration with other departments at the ZSFG. I also serve as the the Department Quality Improvement Lead, spearhead faculty evaluation and feedback, and faculty staffing and hiring, and budget management. I also work with our medical directors on clinical initatives. As the Medical Director for the Children's Health Center, I additionally take a primary role in Pediatric Ambulatory Care at ZSFG, working with DPH, hospital and nursing leadership to scrutinize overall clinical operations and workflow.

OTHER CREATIVE ACTIVITIES

1. 2014: Interprofessional Education at SFGH: Bridging NP and Medical Learners in the Clinical Setting - grant from Academy of Medical Educators to to establish a formal IP (Interprofessional) clinical experience between medical and NP learners in our urgent care clinic, as well as providing needed faculty development on IPE. Project published in Nursing Education in Practice Journal by project leads.
2. 2014 - 2015: Capturing Resilience - mentored resident project to address mental health needs of adolescents in urban pediatric clinic, using PhotoVoice methodology and guided discussion groups. Funded by CTSI Resident Research Award. Project is now on permanent exhibit at SF Public Library.
3. 2016 - 2018: Too Small to Fail - I am one of the co-investigators in the Too Small to Fail Initiative, a project in which I serve as Project Manager. This is a foundation-sponsored (Clinton Foundation), IRB-approved initiative that aims to increase messaging in the primary care setting around early literacy and language development by encouraging reading, teaching, and singing by parents, and then evaluates the impact of those interventions. It is part of a broader national campaign to promote early literacy among underserved populations, and I also serve in a broader advisory capacity for the San Francisco project. This project has now expanded into early Math intervention as well. The project recently culminated in an site visit by Chelsea Clinton, representing the Clinton Foundation, and article in the SF Chronicle highlighting our work in this area.
4. 2015 - present: Clinical Practice Guideline Development - worked with colleagues at ZSFG and the SF Department of Public Health to develop clinical practice guidelines for Pediatric LTBI, Pertussis screening and treatment, and pediatric COVID-19 screening and testing, among others. Protocols are disseminated and utilized throughout DPH SFHN clinics county-wide as well as other public health consortium clinics that see children. Continue to develop and update these as requested by SFDPH leadership.
5. 2016 - present: Mental Health Integration - In 2012, I first worked with Elida Bautista, PhD to pilot a new model of interprofessional training by embedding psychology pre and post doctoral students into our Pediatric Residency Continuity Clinics. The CAS students provide consultation services and brief interventions to our patients in continuity clinic while the residents help the students learn more about the patient's medical diagnoses and management. The students and the residents learn together about team based models of primary care and service delivery to our patients. This partnership has been the basis from which a more integrated model of behavioral health care has now been created and significantly expanded in the clinic. We now have a multi-member behavior health team available for consultation in our clinic 5 days a week. I continue to play an advisory role but the leadership has now been taken on by the members of that team. Currently this

model is being developed into a Center of Excellence for Behavioral health which will be based in ZSFG peds and serve as a State-wide model for care.