ZSFG JOINT CONFERENCE COMMITTEE MEETING

January 23, 2024

MEDICAL STAFF Report

Contents:

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on January 23, 2024
December 2023- January 2024 MEC Meetings

I. CLINICAL SERVICE REPORT: Department of Medicine (DOM) – Neil Powe, MD, Service Chief

The Service's mission is to advance health by developing and supporting innovators in patient-centered care, scientific discovery, medical education, and public policy. Its ambition is to be the best internal medicine in the US and its vision is to transform medicine through innovation and collaboration. Moreover, its core values include creativity, teamwork, transparency, and others. The highlights of the report are as follows:

A. Organization and People

1. Leadership Team – There are 13 Medicine Division Chiefs of which 77% are women. The 13 divisions are the following: (1) Experimental Medicine, (2)Hematology-Oncology, (3) Pulmonary, (4) Cardiology, (5) HIV, Infectious Disease, and Global Medicine, (6) Vulnerable Populations, (7) Gastroenterology, (8) Endocrinology, (9) General Internal Medicine, (10) Occupational, Environmental, and Climate Medicine, (11) Hospital Medicine, (12) Nephrology, and (13) Rheumatology. In addition, there are Clinical Program Leaders, Educational Program Leaders, Research Leader, and Administrative Leaders. There are also 9 Division Managers to support the Division Chiefs.
2. Faculty and Staff – As of November 13, 2023, there are 888 faculty and staff . These include 200 salaried faculty members comprising 63.5 clinical FTEs. HIV, ID, and Global Medicine is the largest division (n=39) which is followed by Hospital Medicine (n=38), DGIM (n=29), and Pulmonary (n=20). The distribution by rank (Professor, Associate, Assistant) is spread evenly with the number of Associate Professors slightly less. Moreover, those in the Academic Senate Series are about 43% of total faculty.
   - There are many Medicine Division Clinical and Service-Line leaders.
   - There are 11 ACGME fellowship training programs that are each headed by a site fellow training director.
   - Many hold key ZSFG clinical leadership positions, notably Drs. Lukejohn Day (CMO, ZSFG) and Claire Horton (CMO, SFHN).
   - There are UCSF DOM at-large leaders at ZSFG for Faculty Affairs, Research Affairs, and Education Affairs.

   The communication strategies include division email/Listserv, chief meetings, division meetings, department meetings/retreats, monthly newsletter, and more.

B. Budget and Finances: FY23

1. Revenues - The ZSFG medicine revenue sources amount to $205M with the following breakdown: (1) ZSFG affiliation agreement of $46.2M (23%), (2) clinical and affiliation revenue of $15M (7%), (3) sponsored project revenue of $130M (63%), and (4) other: state, ICR, gifts, etc. of $13.7M (7%). The $205M is 29% of the total UCSF Department of Medicine revenue.
2. Expenses – The total expenses amount to $209.2M with most arising from salaries and benefits in faculty ($53.9M) and staff ($55.8M). The core administration staff cost comprises only 3.3% ($6.9M) of total expenses which is indicative of the staff's efficiency.

   The annual revenues and expenses from 2019-2023 have grown modestly and evenly for both categories. A graph depicting FY23 division expenditures by mission was presented. In comparing Medicine's budget, the Medicine Service represents 23% of the total School of Medicine's (SOM's) Clinical Enterprise and 62% of the SOM's Research Enterprise.

C. Clinical Services, Performance Improvement, and Patient Safety

1. Clinical Services
   - Inpatient Principal Care – This includes General Internal Medicine Services (5 Resident Inpatient Services and 3 Faculty Inpatient Services), Cardiology, and Critical Care (MICU). From 2020-2023, the annual admissions and discharges have been relatively stable. However, hospital days and average LOS have increased for the same period. In addition, the average daily census has grown particularly for General Medicine Services (averaging 82.5 patients in 2023 YTD through October). The other clinical operations are Inpatient Consultative Care, Primary Ambulatory Care, and Specialty Ambulatory Care.
   - ZSFG Palliative Care Service Interdisciplinary Team – The Team was reestablished with Dr. Sandra Moody as its Director.
   - Addiction Care Team (ACT) – The team provides evidence-based treatment, harm reduction, and more.
   - Primary Care Programs – These are the Richard Fine Peoples Clinic (RFPC) and Positive Health Program(PHP). RFPC has almost 30K visits/year, while PHP has about 14K visits/year.
   - Ward 86 – In celebration of the 40th anniversary of Ward 86, January 25, 2023 was declared as WARD 86 HIV Clinic Day in SF.
   - Specialty Care – In FY 2023, there are 52K clinic visits. Majority are from Nephrology due to dialysis patients and followed by Gastroenterology and Endocrinology.
   - Ambulatory Specialty Care – The clinic volumes continue to grow with about 31K in FY22-23.

- eConsult – The consult volume continues to grow from about 7K in FY08-09 to almost 18K in FY22-23.
- Occupational Health Services- The services include the following: physical exams to a large number of departments in the City, monitoring COVID-19 diagnoses, compliance with influenza vaccine and TB surveillance.

2. Performance Improvement
   - PIPS Projects - All 11 clinical divisions maintain active QI/PS initiatives. Some examples are as follows:
     - Internal Medicine Inpatient Census Management- This is to manage the growing inpatient census. The challenges/drivers, along with the countermeasures, were relayed. The countermeasures were in part developed during a faculty retreat in October 2023. Countermeasures include cohorting of LLOC patients on 1 faculty team, DoCC and LLOC huddles, resident surge moonlighter role, and more.
     - Reducing Readmissions for Heart Failure – The readmission rate was reduced from 33% to 20%, a significant reduction compared to other similar hospitals in the state. Also, there has been significant progress on racial disparities in B/AA to other populations; differences no longer exist. This has led to retention of ≈ $8M in at risk funding.
     - Inpatient Care for People with Substance Use Disorder: Impact of the Addiction Care Team – Evidence-based medication treatment is much higher for patients who have received consult services bv the Addiction Care Team.
     - RFPC Programs – These include Hypertension Control, Diabetes-A1C Control, and Health Screening (for breast cancer, etc). There have been extensive efforts for improvement, and the gap between Black/African American and other patients has been narrowed but not closed completely. And disparities persist for breast cancer, colon cancer, and cervical cancer screening rates. More work needs to be done.

     Other initiatives include those from Specialty Ambulatory Care and Specialty Care.
   - Workforce Care and Development – The problems include workload, salary, lack of support staff, and more. The following have been done to address these: (1) challenges/drivers and countermeasures identified for recruiting new faculty and retention, (2)various faculty awards and staff awards bestowed annually, (3) recent brainstorming of division QI leads on ways to enhance DOM QI/Patient Safety, and (4) ACGME-based OPPE metrics.
   - Med Staff Committee Membership- An extensive list was presented.
   - UCSF DOM Master Clinicians- Every year, the professional excellence of clinicians is recognized.

D. Educational Programs
   1. Medical Students and Residents
      - Medical Students - A third (n=52) of each Medical School Class rotates annually, and half of the students at ZSFG are on a medicine rotation. The *Model ZSFG,* an integrated clerkship that provides care for underserved patients, is very popular.
      - Residents - There are 3 chief residents, 31 residents/month on inpatient services, and 50 students with continuity clinics, and 10 clinical fellows.
   2. Programs - The Internal Medicine Program at UCSF is ranked 3rd by the US News and World Report. Moreover, the Primary Care Internal Medicine Residency Program is based in RFPC, and there has done extensive work in enhancing primary care mental health training. Other programs include UCSF Primary Care Addiction Medicine Fellowship and Bridges Curriculum Clinical Microsystem Clerkship.

   There are 16 faculty who are in the Academy of Medical Educators. Other lists presented include teaching awards, other awards and honors, and membership in prestigious honor societies.

E. Research Enterprise
   1. Scope - The research goes across the translational spectrum, encompassing laboratory research, clinical settings, practice, and populations. Research is done on infectious diseases, chronic diseases, cancer, and other conditions. Also, research is best described as crosscutting themes in disparities and health equity, prevention, social and environmental exposures, health care delivery, disease mechanisms, methods, and interventions.
   2. Funding- In 2021, research funding from NIH and non-NIH groups increased to $141.5M due to COVID research. In 2023 (until 9/23), funding is $126M, and the HIV/ID/GM Division received $53M. Two of the top 10 UCSF DOM recipients of NIH Research Funds are based at ZSFG (Drs. Monica Gandhi and Steven G. Deeks).
   3. Research Centers and Publications - There are various research centers (e.g., Vascular Research, Vulnerable Populations, TB Center, Liver Center, Experimental and Population-based Pathogen Investigation Center, AIDS Research, and the PRISE Center) that break down disciplinary boundaries, along with a new course to assist UCSF junior faculty investigators during the NIH K to R transition. The number of publications increased in 2022 (n=989) which is mostly likely due to COVID. A list of select publications was presented.

F. Summary: Challenges and Goals
   1. Challenges – These include inpatient census increase; challenging space for ambulatory clinical operations; weariness from work; generating clinical and operational data in a timely fashion; adaptation to change of working in PRIDE Hall; and high cost of living.
   2. Goals – These include improvement of the well-being of faculty and staff; innovation and improvement of clinical care areas; recruitment, development, and retaining talent; and philanthropy advancement. The action plan includes improving communication, collaboration, and trust in leadership; right sizing clinical efforts support for alignment with

SFHN; improving care and well-being of faculty and staff; strengthening the research community, collaborations, and opportunities in Pride Hall; and maintaining resilience and economic stability.

Dr. Ortiz, along with other MEC members, acknowledged the extensive work and collaboration by Dr. Powe and the Medicine Service. Dr. Powe's leadership and comprehensive report were appreciated by all.

II. CLINICAL SERVICE REPORT: Department of Urology – David Bayne, MD, Interim Service Chief

The Service's mission statement is as follows: "The ZSFG Department of Urology is committed to offering the highest quality urologic care, innovative research programs, community engagement and an outstanding education for future leaders in the field."

A. Scope of the Clinical Service
   1. Clinical Services/Programs
      There is an attending on call 24/7/365 with OR services on Mondays, Wednesdays, and Thursdays. Also, the clinic is open on Tuesdays to Fridays with an afternoon procedure every other Friday to address past backlog. This afternoon procedure will be discontinued when deemed unnecessary.
      - Clinic – The most common diagnoses include bladder cancer, kidney and ureter calculus, urinary retention, benign prostatic hyperplasia, lower urinary tract symptoms , prostate cancer, and elevated prostate specific antigen. For the clinical volume (2020-2023), there were fluctuations in telephone visits relative to in-person visits, but volumes have stabilized over the past 2 years.
      - Operating Room – The most common diagnosis is kidney stones. However, there is a significant volume of prostate cancer referred out which is mostly due to robotic surgery needs, a current standard care of that is not currently offered at ZSFG.
   2. Clinical Service and Leadership – Dr. Ben Breyer is the UCSF Chair of Urology, while Dr. David Bayne is the Interim ZSFG Service Chief.

B. Faculty and Residents
   1. Faculty – There are 7 faculty members with various clinical specialties and FTEs ranging from .2 to .6.
   2. Education – Starting 2 years ago, the residency program has had 4 residents per year with 55% female residents (33% national average) and 45% URM residents (12% national average). The educational conferences include weekly didactics, bi-monthly tumor boards, and monthly journal clubs and conferences. The didactics are classroom-based (in-person and remote). These are also hands-on didactics with simulation education conducted in the labs and with take-home laparoscopic kits for each resident. In addition, a wellness curriculum is provided with 18 sessions per year dedicated to wellness and leadership.

   It was noted that the faculty of Urology ranked second in terms of lowest burnout at UCSF.

C. Performance Improvement and Patient Safety Initiatives – The Service has focused on equitable care to patients. For instance, the DOS (Day of Surgery) cancellation rates should be improved. Dr. Bayne has focused on research to determine how to apply current technology such as AI and Machine Learning for improved care and how data can be used to predict which patients are at risk for DOS cancellations and no shows following a urology clinic encounter after a referral for urology. An analysis of both standard demographic data and electronic medical record data significantly improved the ability to predict no shows for urology referrals.

D. Research – The latest rankings of NIH funding for Urology indicate UCSF as having the 3rd highest funding. Given recent grants, the Service will most likely regain the top spot for the next rankings. A $7M OHSU-led multi-site transgender study with Dr. Christi Butler as site PI for UCSF was noted. Moreover, the faculty research is funded by NIH, UCSF, DOD, and PCORI. In addition, a list of research/publications was relayed, including those that focused on the following: (1) income as a major predictor for worse outcomes for kidney stones, (2) challenges facing the urologist on low and middle-income countries, (3) training urologic surgeon in minimally invasive surgery in Guyana, and (4) application of technology to supplement absence of face-to-face learning that may exist when dealing with international borders, long distances, and travels.

E. Financial Report - In general, the inpatient RVUs declined during the COVID years. In FY 2022-23, these have slightly increased while working through the waitlist, and the numbers have normalized in FY 2023-24. The same trend was observed in monthly average financials. In FY 2022-23, the ZSFG Payor Mix posted Medicare at 31.42% (collected 16.89%), Medi-Cal at 7.19% (collected 4.95%), and Managed Care at 51.64% (collected 64.84%).

F. Summary
   1. Strengths – These include the following: (1) people, (2) dedicated and cohesive group, (3) world-class department, (4) curiosity-driven research, (5) ZSFG highlight of residency rotation, and (6) commitment to community.
   2. Challenges – These include the following: (1) reducing DOS cancellations, (2) increasing access of patients to standard of care for prostate/bladder cancer, (3) attendings across sites, and (4) space and equipment.
   3. Goals – These include the following: (1) intelligent utilization of EHR data, (2) increasing access to robotic surgery, (3) cystoscopy suite, (4) global urological surgery advancement with opportunity for philanthropy, and (5) recruitment of

faculty who specialize in reconstructive surgery and stone surgery. Robotic surgery was emphasized as an important future investment, and the main barrier is funding.

Dr. Ortiz and other MEC members praised the wonderful report, along with the leadership and contributions of Dr. Bayne.

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG January 23, 2024
DECEMBER & JANUARY 2024 MEC Meetings

Clinical Service Rules and Regulations

- Revised Department of OBGYN Rules & Regulations (attached)
- Department of Medicine Rules & Regulations (attached)
- Department of Urology Rules & Regulations (attached)

Credentials Committee –

- Standardized Procedures – (Summary of Changes for each SP Attached; Copies of SPs sent to Commissioners)
  - Summary of Changes for Ophthalmology SP
  - Department of Ophthalmology SP

- Privileges List – None

OB/GYN CLINICAL SERVICE RULES AND REGULATIONS

~~2021~~

2023

Zuckerberg San Francisco General
1001 Potrero Ave
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OB/GYN CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

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

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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.

Zuckerberg San Francisco General
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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

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Zuckerberg San Francisco General
1001 Potrero Ave
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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

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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.~~

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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.

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

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)

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

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~~sterilization, 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 *

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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~~

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_____ _____ 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~~**

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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

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San Francisco, CA 94110

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, MD~~Rebecca 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, M~~Margy 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) Committee	Ana Delgado, CNM. Perinatal Linkage Ana Delgado, CNM
Clinical Practice Group	Rebecca Jackson MD, MAS~~.~~
Risk Management Committee	Rebecca Jackson, MD, MAS

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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:_____

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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

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

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	☐	

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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

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 Department of Medicine Clinical Service Rules and Regulations*
Clinical Service:	Medicine
Date of last approval:	*December 13, 2021 (LMEC)*
Summary of R&R updates:	Updates were made to the Housestaff Educational Goals and Responsibilities reflective of current role assignments and performance expectations. Updates were made to the learning objectives, expectations, and responsibilities for students in the Medical Student Training Program, years 3 and 4.
Update #1:	Page 5. Hospital Medicine: Added "Palliative and Supportive Care Services"
Update #2:	Page 8, Section 2, Vice Chiefs of Medicine Service Deleted: Vice Chief, Population Health
Update #3:	Page 9, E, Attendance and Admission Policies: added "or medical student"
Update #4:	Page 26, Appendix B – Housestaff Educational Goals and Responsibilities" Deleted: The **Swing Resident** helps the post call team with work, admits patients from 4-9 PM and helps the on-call team with work so that they can leave the hospital on time. Added: "The **Swing Resident** assists medicine wards teams with work and procedures, cross-covers wards teams after they sign out, and admits patients after the on-call team has capped and before the Night admitting team arrives. The **Cardiology Night Resident** and **ICU Night Resident** provide care to patients on the Cardiology and ICU services, respectively, and admit patients to their respective services overnight. A **Medicine Consult Resident** provides consultative care to patients admitted to surgical or other non-medical services within the hospital. This is an optional elective rotation for 2nd and 3rd year residents.

	Deleted: Medicine residents and interns also care for patients in the Emergency Department and on elective rotations at Zuckerberg San Francisco General Hospital
Update #5:	Page 26, Housestaff training in procedures Added "or by an attending physician"
Update #6:	Page 28, C. General Medicine Ward Resident (R2 of R3), Professionalism Delete "70% of required"
Update #7:	Page 30, E. Cardiology Ward Resident (R2) Added: "R3"
Update #8:	Page 30, E. Cardiology Ward Resident (R2/R3) - Professionalism Deleted: "and non-medicine services requesting consultation during nights/weekends"
Update #9:	Page 31, G. Medicine Night float Resident (R2/R3) and H. Medicine Night float Intern (R1) Delete "and cardiac"
Update #10:	Page 32, I. Medicine Consult Resident (R2/R3) Added: "elective: Removed all references to J. Emergency Department Rotation Added role descriptions for the Cardiology Night Resident (R2/R3) and ICU Night Resident (R2/R3)
Update #11:	Page 33: Team Structure Updated team structure of the Faculty Inpatient Service, the Cardiology Ward team, Cardiology Night resident, ICU night resident and Medicine Consult team
Update #12	Pages 34-40 General updates include grammatical corrections, expectations of conference attendance for residents, and clarification of resident roles and coverage.
Update #13	Page 48 - 50, Appendix C – Medical Student Training Program, Medicine 110 Third Year Students All sections were updated to include current objectives, expectations, responsibilities and assessments
Update #14	Page 50 - 53, Appendix C – Medical Student Training Program, MS4 Sub-Internship (Active Intern) Summary All sections were updated to include current goals, objectives, responsibilities, and assessments.

MEDICINE SERVICE
RULES AND REGULATIONS

202~~3~~1-202~~5~~3

MEDICINE SERVICE RULES AND REGULATIONS

TABLE OF CONTENTS

I.ORGANIZATION OF THE DEPARTMENT

MISSION AND VISION
The Mission of the Medicine Service of Zuckerberg San Francisco General Hospital and Trauma Center is: To advance health by developing and supporting clinical innovators in patient-centered care, scientific discovery, medical education and public policy.

VISION
Patient care: Provide the highest quality clinical service that is patient-centered and culturally compassionate.
Research: Be the leading engine of scientific discovery to advance health and attract the world's best investigators For the problems we encounter.
Education: Be recognized as innovators in education, attracting and developing the next generation of leaders in medicine.
Public Policy: Be the most trusted and influential leaders in shaping public policy to advance health .

CORE VALUES

- **Creativity, fairness, respect for diversity and innovation**
- **Supportive and effective work life**
- **Teamwork and multidisciplinary approach**
- **Honest, open and truthful communication**
- **Transparency, accountability, fiscal discipline and timeliness**
- **Aligning incentives with best interest of our workforce**
- **Lifelong learning, mentoring and advocacy**
- **High ethical standards**
- **Caring, compassion and, commitment to social justice and responsibility**

A. SCOPE OF SERVICE

The Department of Medicine (DOM) provides physician and nursing services to adult medical patients along a continuum of care that ranges from prevention and health maintenance to acute inpatient and critical care to chronic care services. Medical services are organized among the following Department of Medicine Divisions and include evaluation and treatment of the following:

Cardiology
The Cardiology Division provides assessment, evaluation, consultation, and treatment of adult patients with cardiovascular disease through its three subdivisions: the adult cardiac laboratories (including invasive and noninvasive), the coronary care unit, and the outpatient adult cardiac clinic.

Clinical Pharmacology
The Clinical Pharmacology Division provides assessment, evaluation, consultation, and treatment of patients with toxicological conditions.

Endocrinology
The Endocrinology Division provides assessment, evaluation, consultation, and treatment of adult patients with conditions of the endocrine or metabolic systems.

Experimental Medicine

The Division of Experimental Medicine conducts clinical and basic science research focusing on the pathogenic mechanisms of chronic infectious diseases, including the human immunodeficiency virus type 1 (HIV). The activities of the research group include recruitment of human subjects, implementation of research protocols, collection of data and biological specimens, processing and analyzing data and specimens, and presentation of findings.

Gastroenterology

The Gastroenterology Division provides assessment, evaluation, consultation, and treatment of adult patients with illnesses, injuries and disorders of the gastrointestinal tract, including performing diagnostic and therapeutic procedures.

General Internal Medicine

The Division of General Internal Medicine provides assessment, evaluation, and continuing treatment of adults. The ambulatory medical services are organized into medical screening, urgent, and primary care. Services are directed toward health maintenance, early diagnosis and treatment of illness, as well as managing complicated adult patients with multi-system diseases.

Hematology/Oncology

Hematology provides assessment, evaluation, consultation, and treatment of adult patients with diseases of the blood and blood-forming tissues. Oncology services employ a multidisciplinary care model and provide service in the outpatient clinic and hospital wards for patients with malignancies.

HIV,ID and Global Medicine

The Division of HIV,ID and Global Medicine provides assessment, evaluation, consultation and continuing treatment of adult HIV infected individuals through a multidisciplinary model of care involving medical, nursing, and psychosocial support services. The Infectious Disease specialists provide assessment, evaluation, consultation, treatment and isolation expertise in the care of adult patients with infectious conditions.

Hospital Medicine

The Division of Hospital Medicine consists of medical practitioners with a special interest in inpatient medicine. Acute Care for the Elderly (ACE), Addiction Medicine, Palliative and Supportive Care , Medicine Consult and the Faculty Inpatient Service are patient care services within this division.

Nephrology

The Nephrology Division provides assessment, evaluation, consultation, and treatment of adult patients with renal diseases.

Occupational Medicine

The Occupational Medicine Division provides assessment, evaluation, consultation, and treatment of adult patients with work-related injuries, illnesses, conditions, and diseases.

Pulmonary and Critical Care Medicine

The Pulmonary and Critical Care Division provides assessment, evaluation, consultation, and treatment of patients with conditions and diseases related to the respiratory system and provides intensive care for severely ill adult patients.

Rheumatology

The Rheumatology Division provides assessment, evaluation, consultation, and treatment of adult patients with rheumatic diseases.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General Hospital and Trauma Center 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, Rules and Regulations, and accompanying manuals as well as these Clinical Service Rules and Regulations.

MINIMUM REQUIREMENTS

At a minimum, all physicians applying for a Medical Staff appointment through the Medicine Service of ZSFG must meet the following requirements:

The applicant must be fully licensed in the State of California.

The applicant must be board eligible, certified, or re-certified in the State of California. Minimum training requirements are Division specific and are listed in entirety within the Division privileges.

Current Basic Life Support Certification is required for all practitioners who hold the Procedural Sedation privilege.

Valid DEA and secure safety scripts are required for all physicians holding medical staff membership.

A practitioner must possess a National Provider Identifier (NPI) or must have submitted an application for a NPI in order to be considered for appointment or reappointment to the Medical Staff.

C. MEDICAL SERVICE LEADERSHIP

The Medical Service is organized under the Bylaws, Rules and Regulations of Zuckerberg San Francisco General Hospital and Trauma Center. All fully licensed physicians and other licensed health care providers who are members of the Medicine Service at ZSFG are bound by the Bylaws, Rules and Regulations and accompanying manuals of Zuckerberg San Francisco General Hospital and Trauma Center and the University of California, San Francisco. In addition, Medicine Service Rules and Regulations have been created to further delineate the proper conduct of medical staff professional activities at Zuckerberg San Francisco General Hospital and Trauma Center.

1. Chief of the Medicine Service

The Hospital Chief of Staff, the duly elected Medical Executive Committee of the Medical Staff and the Governing Body of ZSFG in accordance with the ZSFG Medical Staff Bylaws, appoints the Chief of the Medicine Service at ZSFG. The Chief of the Medical Service is subject to the Medical Staff process for reappointment to the ZSFG Medical Staff every two years.

The Chief of the Medical Service at ZSFG reports to the Chief Executive Officer of ZSFG as well as the Chair of the Department of Medicine/UCSF and the Dean of the School of Medicine, and is responsible for:

a. Supervision and evaluation of clinical work performed by medical staff members of the Medicine Service.

b. Screening all applicants for clinical privileges in the Medicine Service and for recommending clinical privileges to the ZSFG Credentials Committee. No appointment to the Medicine Service can be made without the recommendation of the Chief of Service.

c. Assuring that medical staff members of the Medicine Service practice within the limits of the clinical privileges assigned to them.

d. Assigning patient care responsibilities of any medical staff member who is unable to carry out these responsibilities due to disciplinary action, illness, or other causes.

e. Assuring adequate opportunities for continuing medical education (CME) for medical staff members of the Medicine Service.

f. Developing, maintaining and executing Medicine Service Quality and Utilization Management.

g. Receiving information, evaluating, and taking action, as may be appropriate, on issues of quality of care and professional standards regarding medical staff members of the Medicine Service.

h. Overseeing the development, management and implementation of the residency and fellowship training programs within the Medicine Service at Z and Department of Medicine at UCSF.

i. Calling for and presiding over meetings of the Medicine Service.

2. Vice Chiefs of the Medical Service

The Vice-Chiefs of the Medicine Service are appointed by the Chief of the Medicine Service and represent the Chief of the Medicine Service in his/her absence.

The Chief of the Medicine Service has currently appointed the following Vice Chiefs:

a. Vice Chief of Inpatient Medical Services – responsible for supervising the inpatient clinical programs at ZSFG.

~~Vice Chief, Population Health – responsible for the coordination of patient care and research relative to the DPH population.~~

The Vice Chiefs of the Medicine Service are reviewed by the Chief of Medicine and as members of the ZSFG Medical Staff. Their clinical work is evaluated every two years as part of the credentialing process at the time of reappointment.

3. Program and Residency Site Directors of Medical Service

Positions responsible for supervision and program oversight of the Resident training and education are as follows:

a. Residency Site Director - responsible for the supervision and guidance of the house staff during Residency-training on the Medicine Clinical Service at ZSFG.

b. Associate Program Director (APD) for Residency Program – responsible for the oversight of programmatic development and curriculum innovation. There are 5 APDs across the ZSFG, Parnassus and VA campuses. Each is in charge of different aspects of the residency program: APD for Inpatient Affairs, Ambulatory Affairs, Research and Academic Development, Curriculum and Special Projects, and Resident Evaluations and Wellbeing. Currently the APD of Curriculum and Special Projects is a member of the Department of Medicine at ZSFG.

c. Program Director for ZSFG Primary Care Medicine Residency Program - responsible for the supervision and guidance of the house staff during Primary Care Residency-training on the Medicine Clinical Service at ZSFG.

4. Division Chiefs

The Chief of the Medicine Service appoints Division Chiefs. Division Chiefs report directly to the Chief of the Medicine Service and are reviewed by the Chief of Service at the time of their annual academic review. As members of the ZSFG Medical Staff, their clinical work is evaluated every two years as part of the credentialing process at the time of reappointment.
Division Chiefs are responsible for:

a. Supervising and evaluating the clinical work performed by the medical staff members of their division.

b. Screening all applications for clinical privileges in the division and making recommendations to the Chief of the Medical Service.

c. Assuring that medical staff members of the division practice within the limits of the privileges assigned to them.

d. Developing, maintaining and executing a divisional quality management plan

e. Administration of the division.

f. Assuring that faculty and staff in their division who are involved in patient care practice within the policies and procedures as set forth by ZSFG.

g. Performing such tasks as assigned by the Chief of the Medical Service.

E. ATTENDANCE AND ADMISSION POLICIES

All Medicine Service Attending physicians and other individual licensed health care providers working in the Medicine Service and in outpatient clinics shall be responsible for providing the highest standard of care to all patients at Zuckerberg San Francisco General Hospital and Trauma Center regardless of financial, social, or medical status. All health care providers are bound to follow the ZSFG Medical Staff Bylaws, Rules and Regulations and accompanying manuals as they pertain to patient care. Each inpatient shall be seen daily by an Attending and a note shall be placed in the ~~Medical~~medical record. This note shall reflect the involvement of the attending. Each Clinical Service that has a patient in the Hospital shall have an Attending present in house for some portion of each day and an Attending physician from the admitting Service shall be available on call twenty-four hours per day to meet the needs of the patient.

The Department of Medicine authorizes the UCSF Clinical Practice Group to bill for professional services delivered for inpatient services and selected outpatient services, e.g. hemodialysis, pulmonary function testing, cardiology and gastroenterology diagnostic services. The Department authorizes the trained and certified professional coders to assign appropriate CPT codes based on the documentation provided in the clinical record.

For the purposes of payment, Evaluation and Management services billed by the attending physician require the attending to have either performed the service or be physically present during the key or critical portions of the service when performed by a ~~resident/fellow.~~resident, fellow, or medical student. The attending provides such documentation in the attestation portion of the billing template and links to the resident/fellow note by indicating review of the note and discussion of the findings.

F. INFECTION CONTROL

Each member of the ZSFG Medical Staff has a personal responsibility to prevent the transmission of infection in patients and staff. Basic infection control practices are an integral part of patient care and must be practiced by everyone per ZSFG Hospital Policy No. 9.02 and 9.07. A detailed Infection Control manual is available electronically on the CHN website.
Each provider is required to complete annual training and testing as required by Joint Commission, the state of California, and other regulatory bodies.

G. INFORMED CONSENT

It is the responsibility of the Attending physician to ensure that informed consent is obtained for all procedures requiring patient consent and that hospital policy regarding patient identification is followed. The signed consent form will be placed in the medical record. Emergency procedures may be performed when signed consent has not been obtained if, in the opinion of the Attending physician, delay of a matter of hours may result in the loss of life, limb, or function. The need for the emergency procedure shall be documented in the medical record.

H. CONFIDENTIALITY

In compliance with HIPAA regulations, "DPH Confidentiality Agreement" is signed prior to issuance of CHN numbers, allowing LCR access for faculty, house staff, and students.

I. PROCEDURAL SEDATION

All members of the Medicine Service will abide by the "Sedation Guideline: Sedation Administration" of Zuckerberg San Francisco General Hospital. The divisions Cardiology, Gastroenterology, HIV/AIDS, Oncology, and Pulmonary and Critical Care Medicine have developed and implemented Procedural sedation protocols and ~~privileges, and~~privileges and are in accordance with the ZSFG Sedation Policy 19.08.

J. ADVANCE DIRECTIVES

The Federal "Patient Self-Determination Act" enacted in 1992 makes it mandatory that all health care facilities that participate in Medicare or Medi-Cal programs give all adult inpatients information on state laws and the facility's policies regarding advance directives. California legally recognizes the Durable Power of Attorney for Health Care and a Declaration pursuant to the Natural Death Act as advance directives for adults as per ZSFG Policy No. 1.8.

K. RESUSCITATION OF PATIENTS (DNAR) POLICY

It is the policy of Zuckerberg San Francisco General Hospital that all patients are presumed to be candidates for cardiopulmonary resuscitation unless a "Do Not Attempt Resuscitation" order has been written. Guidelines of the SFGH Resuscitation Policy No. 3.12 must be followed.

L. DISCHARGE OF PATIENTS

All medical records for patients hospitalized for longer than 48 hours require a discharge summary, which must be completed by a provider within 24 hours of discharge.

M. PROTECTION OF PATIENT PRIVACY

1. Members of the Medical Staff shall comply with the DPH Notice of Privacy Practices, the Hospital policies and procedures regarding patient privacy and the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA)

2. Members of the Medical Staff shall abide by the following:
   a. Protected health information shall only be accessed, discussed or divulged as required for the performance of job ~~duties;~~duties.

   b. Members shall not log into hospital information systems or authenticate entries with the user ID or password of another; and

   c. Members shall only install software on hospital computers that have been appropriately licensed and authorized by Hospital Information Systems staff.

3. Members agree that violation of this section regarding protection of patient privacy may result in corrective action as set forth in Articles VI and VII of the Medical Staff Bylaws.

N. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

An appropriate screening exam shall be provided to all persons who present themselves to the Emergency Department, Psychiatric Emergency Service and designated urgent care centers in the hospital and who request, or have a request made on his/her behalf for examination or treatment of a medical condition. Where there is no verbal request, a request will nevertheless be considered to exist if a prudent layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment.

O. NATIONAL PATIENT SAFETY GOALS

The DOM providers follow the National Patient Safety Goals and Joint Commission standards as instituted by ZSFG.

II. CREDENTIALING

A. INITIAL APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Medicine Service is in accordance with ZSFG Bylaws Article II, *Medical Staff Membership* and ZSFG Credentialing Manual, Article V, Section A-*Initial Appointments* and accompanying manuals as well as these Medicine Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Medicine Service is in accordance with ZSFG Bylaws, Rules and Regulations, Credentialing Manual, Article V, Section B- *Reappointments,* and accompanying manuals as well as these Medicine Service Rules and Regulations

C. STAFF CATEGORIES

The members of the Medicine Service shall fall into the same staff categories that are described in Article III of the ZSFG Bylaws, Rules and Regulations and accompanying manuals as well as these Medicine Service Rules and Regulations.

DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF MEDICINE SERVICE PRIVILEGE REQUEST FORM

The division chiefs shall review the Medicine Services Privilege Request Form annually. Privileges and Standardized Procedures for Medical staff and Affiliated Providers can be found on the Medical Staff Lookup on the Medical Staff Office website.

C. CLINICAL PRIVILEGES

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

D. TEMPORARY PRIVILEGES

Temporary Privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Article V, Section 5.2, Rules and Regulations and accompanying manuals.

IV. PROCTORING

A. PROCTORING REQUIREMENTS

Proctoring requirements for the Medicine Service shall be in accordance with ZSFG Medical Staff Bylaws, Article V, Section 5.6 Rules, and Regulations and shall be the responsibility of the Chief of the Service and the Chief of each Division. (*Refer to Division Specific proctoring requirements in Divisional Criteria Based Privileges – Appendix A*)

Proctoring plans for attendings with clinical gaps shall be composed by the responsible service chief, or designee, with the approval of the Zuckerberg San Francisco General Hospital Credentials Committee when indicated. Attendings with clinical gaps will adhere to the orientation practices described under Section X. In addition, these faculty may arrange for recurring meetings and/ or additional orientation with the Medical Service Vice Chief or designee.

B. ADDITIONAL PRIVILEGES

Requests for additional and/or new privileges for the Medicine Service shall be in accordance with the ZSFG Bylaws, Rules and Regulations and accompanying manuals. The request must be accompanied with documentation of training and/or experience related to that privilege.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges from the Medicine Service shall be in accordance with the ZSFG Bylaws, Rules and Regulations and accompanying manuals. The request must be in writing and requires approval by the Division and Medicine Service Chief or Vice Chiefs.

V. MEDICINE SERVICE INPATIENT CONSULTATION CRITERIA

Consultations should be obtained whenever the consultation might reasonably be expected to assist in the patient's continuing care or is required by specific policies or procedures per ZSFG Policy No. 9.12.

1. An emergent or urgent request for consultation must be responded to in person as soon as possible, and the initial respondent will be a resident, fellow, Attending Physician, or a qualified mid-level provider (nurse practitioner or physician assistant).
2. When a non-emergent consultation is requested, the patient should be evaluated within 24 hours.
3. If a full consultation report cannot be completed at the time of consultation, the consulting provider will write a brief note in the patient's medical record. The complete consultation report will be in the patient's medical record within 48 hours.
4. The written consultation must include the name of the requesting service and the name of the requesting attending. The consulting Attending Physician signs the initial consultation.
5. The referring provider is contacted by phone if the information must be shared immediately.

VI. DISCIPLINARY ACTION

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

VII. PERFORMANCE IMPROVEMENT AND UTILIZATION REVIEW

(Refer to Appendix A– Medicine Service Performance Improvement & Utilization Review)

VIII. MULTIDISCIPLINARY CARE ROUNDS- Inpatient Medicine Service

Multidisciplinary Care Rounds are held each weekday to review patient progress and develop a comprehensive discharge plan for patients on the Resident Inpatient Service (RIS) and Faculty Inpatient Service (FIS). Members of the care team include physicians or mid-level providers caring for the patient, Social Services, Physical Therapy, Respiratory Therapy and Occupational Therapy.

IX. MEETING REQUIREMENTS

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.

X. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

The Medicine Service has several functions that are specific to the department.

A. Operational:

1. The Medicine Service has created monthly orientations for new and returning inpatient attendings on the ~~RIS; attendings~~RIS; attendings for the month will attend the sign-In and sign-Out meetings described below. If attendings are unable to attend the scheduled meetings, they may request a separate sign-in orientation at a mutually agreeable time. The meetings are run by the Vice Chief of the Inpatient Medical Services
2. The sign-in meeting is held prior to the beginning of the attending rotation. Its purpose is to provide an orientation and updates on performance improvement, billing practices, trainee supervision practices, and other pertinent hospital and service information. This is a time when faculty may ask specific questions and review any changes to policy since last attending.

   The sign-out meeting is held at the close of the rotation. The attendings reconvene to review any patient deaths that occurred while on service, provide feedback on the performance of members of their clinical teams, and note any systems issues in need of review.
3. The Medicine Service orients the house staff on the first day of the rotation

B. Clinical:

1. Clinical care provided by the attending and the house staff is documented in the electronic clinical documentation system, and charges for inpatient physician services are submitted for professional fee billing.
2. Primary Care Providers are contacted by the admitting clinicians when their patients are admitted to the Medicine Service.

XI. EDUCATION – HOUSE STAFF TRAINING COMPETENCIES & SUPERVISION

The Medicine Service complies with the ZSFG Graduate Medical Education Supervision Policy Objective: in order to maintain high clinical and educational standards and to assure compliance with applicable regulations in these areas, ZSFG assures adequate house staff supervision appropriate to each level of training, recognizing that graduate medical education is based on a system of graded responsibility in which the level of resident responsibility increases with years of training. *(Refer to Appendix B – Housestaff Educational Goals and Lines of Supervision)*

XII. MEDICAL STUDENT TRAINING PROGRAM AND SUPERVISION

The Medicine Service complies with the ZSFG Undergraduate Medical Education supervision Policy Objective: in order to maintain high clinical and educational standards and assure compliance with applicable regulations in these areas, ZSFG assures adequate student supervision appropriate to each level of training. *(Refer to Appendix C – Medical Student Training Program and Supervision)*

XIV. APPENDICES

Appendix A	**Medicine Service, Performance Improvement and Utilization Review**
Appendix B	**Housestaff Educational Goals and Lines of Supervision**
Appendix C	**Medical Student Training Program and Supervision**

A. DELIVERY OF INPATIENT CARE

Commented [U1]: This will all change, of course, in Building 25. Do you want to update it now?

~~Twenty-four hour~~Twenty-four-hour **inpatient care is delivered by Medicine in Building 25.**

B. DELIVERY OF OUTPATIENT CARE

Adult Medical Center (1M and Ward 92)
The Center offers a variety of clinical services to adults at two hospital-based clinic sites.

1M clinics include: Primary care (Richard H. Fine People's Clinic)) and the specialty services of Cardiology, Anti-coagulation, Pulmonary, Diabetes and Bridge Clinic.

Ward 92 specialty clinics include: Endocrine, Lipid, Pain Consultation, Renal, and Rheumatology.

Ambulatory Treatment Center 4C
The Day Treatment Center cares for adult and pediatric patients (>12 years of age) with a focus on patients requiring intravenous therapy or nursing observation after an invasive procedure. Care delivery services include cancer chemotherapy, antibiotic and antifungal infusion, blood and blood product transfusion, and invasive post-procedure observation.

The **GI Diagnostic unit** includes GI invasive procedures and Gastroenterology and Liver clinics. Ambulatory bronchoscopy by the Pulmonary Division is also done here.

The **Pulmonary Function Lab** provides comprehensive Pulmonary Function Testing.

The **Cardiology Lab** provides Echocardiography, treadmill testing, cardiac ambulatory monitoring, cardiac catheterization, pacemaker placement and emergency angioplasty.

Hematology/Oncology Clinic (Ward 86)
Hematology Clinic provides consultation ~~for~~for, and treatment of patients referred with hematological problems. Oncology services provide treatment of solid tumors and hematological malignancies as well as chemotherapy administration.

HIV/AIDS (Ward 86)
The Positive Health Clinic provides primary medical care to approximately 2,500 HIV infected San Francisco residents. This clinic provides expertise in antiviral therapy and prophylaxis against opportunistic infections. The clinic provides access to care by providing drop-in services for acute medical needs, psychosocial, and social services.

Occupational Medicine Clinics (Bldg. 9)
The Occupational Medicine Clinic provides urgent care/workers compensation care to injured workers employed by the City and County of San Francisco.

Renal Center (Ward 17)

Services include 13 hemodialysis stations, offers peritoneal dialysis, and nutritional consultation services for patients with chronic renal disease.

C. MEMBERS OF THE CLINICAL CARE TEAM

1. Staff physicians are responsible for oversight and coordination of the Medical team.

2. Medical Trainees include Fellows, Resident Physicians, and Medical Students.

3. Affiliated Staff including Nurse Practitioners, Physician Assistants, and Clinical Pharmacists.

D. CARE PROVIDER CREDENTIALING AND EDUCATION

Affiliated professional staff in the Department of Medicine (Nurse Practitioners, Physician Assistants, and Clinical Pharmacists) must have a current California license and a protocol approved by the Committee on Interdisciplinary Practice, Subcommittee to the Credentials Committee. A member of the Department of Medicine directs their proctoring and evaluation as detailed in the ZSFG Medical Staff Bylaws.2. educational requirements for Medical Staff physicians are defined in division specific criteria-based privileges. Each privileged provider is required to complete annual training determined by ZSFG Housestaff and fellows practice within the scope of practice as defined by their training programs.

E. ACCOUNTABILITY AND RESPONSIBILITY

1. Departmental Level

   The Department of Medicine administration oversees the performance improvement program. Responsible staff include: The Director of Performance Improvement and the Clinical Operations Manager for Inpatient Services, the Medical Director of Adult Medical Clinics for Outpatient Services, and the Vice Chief, Inpatient Medical Services

   Coordination of Department of Medicine PI activities is the responsibility of the Medical Director of Performance improvement. The ZSFG Department of Quality Management provides facilitation of and assistance with performance improvement activities as needed.

   The Department of Medicine Inpatient Performance Improvement Committee is a multidisciplinary committee that meets regularly to review inpatient PI activities and to address patient safety and quality of care issues relevant to the medical patient. The Committee prioritizes department-wide concerns appropriate for the performance improvement process, in accordance with the hospital-wide Performance Improvement Plan. Members of focused task forces may include physicians, nurses, clinical pharmacists, social workers, dieticians, respiratory therapists, and others. These groups work with Quality Management staff and others to address specific performance improvement activities that require their expertise.

2. Division/Unit Level

   On a yearly basis, each division is responsible for review and update of their individual PI plan that is comprised of:

   - Scope of Service
   - PI Activities
   - PI Reporting calendar

Each of the divisions and units included in the spectrum of inpatient and outpatient care is responsible for the measurement, assessment, and improvement of systems and processes to improve patient outcomes in their respective areas.

In addition to on-going PI activities, each division is responsible for proctoring new physician members, and assessing the current clinical competence of physicians applying for reappointment.

F. INTEGRATED PERFORMANCE IMPROVEMENT & PATIENT SAFETY (PIPS)

1. Performance Improvement Process

The goal of the Dept. of Medicine PIPS plan is to improve the overall outcome quality of patient care through continuous improvement of patient care processes and systems. The DOM promotes a coordinated and collaborative approach to performance improvement activities that is based on the combined efforts of multidisciplinary clinicians involved in the continuum of patient care delivery. The Department's PIPS process is supportive of the hospital's mission, goals, and strategic plan and participates in organization-wide performance improvement activities.

The performance improvement program within the Dept. of Medicine is comprised of multidisciplinary activities aimed at improving patient outcomes within the individual clinical divisions and nursing units. Performance improvement efforts are systematic and characterized by process improvement strategies such as LEAN -PDSA: Find a process to improve; Organize to improve the process; Clarify current knowledge of the process; Understand the source of process variation; Select the process improvement; Plan the improvement; Do the improvement according to the process; Study the results; Act to hold the gain and continue to improve the process.

a. Objectives

Incorporate the needs, expectations, and feedback of patients, families, and staff into the design of new systems and the improvement of existing processes.

Determine the systems and processes that are the priorities for design and improvement of the Department of Medicine.

Conduct ongoing measurement, assessment, and improvement of the DOM's performance of selected patient care processes and outcomes.

Identify key elements of information, (e.g. indicators) required to support the performance improvement process.

Ensure compliance with requirements and standards related to accreditation and licensure.

b. Design of New Patient Care Processes

Processes that are new or require significant changes are designed in keeping with the mission and strategic plan of the hospital and the San Francisco Department of Public Health. The design of such processes addresses the expressed needs and expectations of patients and ~~staff, and~~staff and incorporates established practice guidelines and community performance standards.

c. Measurement of Performance

Measurement of performance, accomplished through the collection of data, is focused on functions and processes that are of integral importance to patient outcomes. Processes and outcomes of patient care that are high volume, high risk, or problem prone are priorities for analysis, so that stability, predictability, and opportunities for improvement can be determined. Specifically, data is collected to provide information on:

Productivity/Continuity of Care
Provider specific productivity is documented and measurement of continuity of care efforts are collected in accordance with the Medical Group Practice standards.

Clinical Indicators
Indicators are selected from identified aspects of care determined to be of high priority by the PI Committee, divisions, and nursing units. In addition to selecting indicators based on high volume, high risk, or problem prone aspects of care, indicators and outcomes recommended or mandated by regulatory bodies are monitored, as appropriate.

Use of Medications and Error Avoidance
The systematic measurement of the processes of medication use, including prescribing/ordering, preparing and dispensing, administering, and monitoring of medication effects on patients, is accomplished through department participation in multidisciplinary, cross-departmental study(s) that include the involved divisions and disciplines and pharmaceutical services. In addition to medications which are high volume, high risk, high cost, or problem-prone, those identified through review of Adverse Drug Reactions (ADRs) reported by the hospital Pharmacy and Therapeutics Committee, as well as those identified by the antibiotic order and ARV order sheet process, are of priority for measurement and assessment. The Department upholds the ADR Reporting Program and the Trigger Drug Program updated by the Pharmacy Service that has significantly reduced ADRs. Providers are informed and counseled if they are deemed noncompliant with ZSFG Do Not Use Abbreviations and Medical Record policies. Persistent non-compliance is referred to the Division Chief and the Chief of Medical Service. The DOM encourages the development and implementation of computerized ordering to ensure medication use and patient safety. The department participates in the hospital-wide Medication Safety Project.

Use of Blood and Blood Components
The Hospital measures the processes associated with the use of blood and blood components. Performance criteria are addressed by the disciplines involved in each stage of the process, and include appropriateness, distribution, administration, and monitoring of patient outcome. Review of transfusions that do not meet Transfusion Committee guidelines are reviewed by the Dept. of Medicine PI Committee and with the Attending. Results of the review and action summary are kept in the specific Attendings' Performance Improvement file.

Radiation Oncology Services
The ZSFG Cancer Committee reviews the performance improvement activities of the UCSF/ZSFG Radiation Oncology Service where Department of Medicine patients requiring this service are referred for treatment.

Cardiology Surgical/Invasive Procedures
The Division of Cardiology reviews complications and the performance improvement activities of the UCSF/ZSFG Cardiovascular Service when Department of Medicine patients requiring this service are referred for treatment during the Cath Conference discussion.

Patient Experience
The needs and expectations of patients and families are incorporated into the overall performance improvement process within the Department of Medicine. The Department of Quality Management conducts patient Satisfaction surveys. Patient satisfaction is also monitored through data collected from the hospital patient feedback processes.

Utilization Review
Appropriate use of hospital resources by Department of Medicine patients is monitored through the hospital's Utilization Review Department. Utilization data collected is presented at the PI Committee and assessed for issues and trends. Areas for improvement are addressed in the Dept. of Medicine PI and Clinical Operations meetings.

Risk Management
Patient care issues or incidents with risk management implications are monitored internally, by the Department of Medicine, as well as by ZSFG and UCSF Risk Management Programs. Sentinel events related to patient care, trigger an intensive, multi-disciplinary review and are assessed for any necessary action through the Risk Management Committee and the Dept. of Medicine Quality Improvement Committee. The QI Committee reviews the incidents and complications, which are documented during the following committee meetings: the weekly DOM Morbidity and Mortality conferences, the weekly Cardiac Catheterization meetings, and the other invasive procedure division meetings (Pulmonary and GI). These meetings are protected from disclosure under "Confidential Document" protected by California Evidence Code 1157".

The DOM adheres to HIPAA guidelines.

d. Assessment

The assessment process within the Department of Medicine includes the review of data collected to determine:

- Trends and patterns of performance over time within the department and in comparison to other areas of the ~~hospital;~~hospital.
- Comparison of performance with community practice standards and guidelines (e.g. Core Measures, UHC). Community Acquired Pneumonia (CAP), Chronic Heart Failure (CHF), and Acute Myocardial Infarction are among the measures in which the Department and Hospital participate.
- Systems or processes which require ~~improvement;~~improvement.
- Efficacy of newly designed or improved processes.

Intensive assessment occurs when patterns vary significantly from expectations or external standards, when the divisions/units wish to improve performance, or when sentinel events occur.

Assessment of clinical sentinel events and Unusual Occurrences (UO) are conducted as identified by the Hospital's Quality Management Department and are analyzed by the Department of Medicine's QI Committee and at the Morbidity and Mortality Conference. UO's are categorized and entered into a database for aggregate and systemic analyses.

e. Improvement

The Department of Medicine representatives participate in CHN improvement activities as outlined. In addition, improvement of patient care processes can occur within or among the Department of Medicine ~~divisions, and~~divisions and involve other appropriate departments and/or disciplines as well. Potential improvements are identified during the assessment process, and changes in practice are initiated on a pilot basis in the appropriate areas. If data collected from the changed practice indicates improvement, the changed process is finalized and implemented on a division/unit, department, or hospital-wide level.

2. Program Reporting Structure

Reporting of the Department of Medicine's quality improvement (QI) activities takes place through an established committee structure:

Department of Medicine Inpatient QI Committee
The QI Committee receives periodic summary reports on the status of performance improvement activities that have been undertaken in all of the department divisions/units. The committee also reports at the Departmental Service meetings and informs department members via email (*See PI Plan Accountability and Responsibility.)*

Hospitalists' Group
Faculty hospitalists and Inpatient Acute Medicine Nurse Practitioners in the Department of Medicine meet monthly to improve the quality of inpatient care and patient satisfaction. Hospitalists also serve on the Quality Improvement committee.

Nursing Quality Assessment
Clinical Nursing leaders participate in Nursing PI activities and as members of the PI Committee. They provide continuity and cohesiveness between clinical nursing efforts and Attending/Housestaff patient care. Issues and trends are identified and reported to PI Committee and may become interdisciplinary improvement activities.

Ambulatory Care Committee (ACC) of the Community Health Network
The ACC serves as a forum to identify and address operational and quality of care issues that affect the delivery of ambulatory care. Performance improvement activities created in response to these issues are evaluated by the Dept. of Medicine PI Committee, while concerns relating to services provided by the ambulatory care clinics, which are discussed at the department PI committee are reported to the ACC by the assigned Adult Medical Center representative. Issues that affect Medicine subspecialties are taken back to the appropriate division for action.

Performance Improvement and Patient Safety Committee
The Department of Medicine reports annually to the hospital's Performance Improvement and Patient Safety Committee (PIPS) through its appointed medical staff representative, and other participating department members. A summary of department PI activity is reported from PIPS to the Hospital Executive Committee and to the Governing Body through the Joint Conference Committee.

Reporting of PI activities includes a description of the process or function and/or indicator(s), results and analysis of measurement, and summary of actions taken and planned. Reports include a review of action plans, Rules and Regulations, Credentialing, and current indicators for all divisions and nursing units as well as other PI activities that may be interdepartmental or relate to a hospital-wide CPI project.

3. Program Evaluation

The Department of Medicine Performance Improvement Plan is evaluated regularly at the monthly Quality and Performance Committee meeting with a complete, programmatic review and PIPS Plan review every year. The program is assessed ~~in regards to~~in regard to:

1. Effectiveness in resolving problems as they relate to PI ~~monitors;~~monitors.

2. Effectiveness in detecting and monitoring individual and generalized patient care problems and systems ~~issues;~~issues.

3. Problem solving ability.

Any problem that requires corrective action will be re-assessed, re-audited or monitored as stated to ensure that the desired results for high quality patient care have been achieved and sustained.

IN-PATIENT OPERATIONAL PERFORMANCE IMPROVEMENT PLAN

The following describes the Performance Improvement operational plan for the inpatient service of the Department of Medicine at Zuckerberg San Francisco General Hospital. This plan includes monitoring the multidisciplinary care of patients in all the inpatient areas of the Department of Medicine at Zuckerberg San Francisco General Hospital.

A. CONCURRENT REVIEW

1. Best practice treatments and complications will be discussed at Residents' Report on as well as with participating members of the Faculty and Housestaff, held by the Vice Chief of Inpatient Medicine or designee.

2. Unexpected deaths and/or major complications will be reviewed weekly at the Wednesday Morbidity & Mortality conference. The Chief Residents will be responsible for keeping a log of cases discussed at each conference. Cases with medical error or performance improvement issues are reviewed by the PI Medical Director or brought to the PI Committee if necessary and communicated to the physician of record. The PI Committee also evaluates trends and system wide issues related to PI.

B. RETROSPECTIVE REVIEW PROCESS

1. The Department of Medicine's goal is to achieve comprehensive review and obtain worthwhile information that will note any trends in deaths and end of life care.
2. Faculty attending on the inpatient Medicine Service complete a Mortality Review for each patient death and are asked to present in the monthly Attending Sign Out meeting. All deaths where questions have been raised about the quality of care, systems issues, and/or iatrogenic occurrences are reviewed by the Medicine Director of PI and further action taken as appropriate. The DOM uses the hospital approved death reviews to gather the aggregate data for trend and systemic analysis.

3. All incident reports and Unusual Occurrences will continue to be logged and reviewed by the Medicine Director of the PI Committee. Management of Unusual Occurrences is in compliance with ZSFG Hospital Policy.
4. As part of the individual attending performance evaluation, access to information gathered through the Resident and Student computerized evaluation system, Med Hub is available to the Chief of Medicine and the Division Chiefs.

5. The Dept. of Medicine and the Quality Management Dept. of ZSFG participate in independent medical review audits conducted by external peer reviews organizations such as the San Francisco Health Plan. The purpose is to assess care to inpatient Medicare beneficiaries for specific patient care issues and to compare outcomes with other facilities statewide. When necessary, improvement action plans may be required by the division or Department.
6. The other sources of data that the DOM uses to improve care are: Core Measures, UHC and Utilization Management

C. EVALUATED ASPECTS OF CARE

Review of Clinical Pertinence:

PLAN: Each record for patients admitted to the Medicine wards should contain clinically pertinent elements that document good patient care in an adequate manner. This documentation should be accurate, clear, and complete, ~~including:~~including accurate diagnoses, results of diagnostic tests, therapy rendered, conditions and in-hospital progress of the patient,

condition of the patient at discharge, and plan for follow-up care.

MONITOR: Attending specific concurrent and retrospective chart reviews will be in accordance with Hospital Policy and Joint Commission guidelines and results kept in the physicians' files.

D. PROCTORING, EVALUATING AND REAPPOINTING

Proctoring, ongoing evaluation, and credentialing of staff physicians are a major part of the PI activities of the Department of Medicine and are an important part of ensuring quality of patient care.

1. Proctoring

   a. Proctoring of newly appointed members of the Department of Medicine is performed based on department proctoring forms designed for this purpose. Proctoring is also dependent on Division specific privileges and starts with appointment to Medical Staff.

   b. Proctoring will be completed in accordance with the Hospital Rules and Regulations.

2. Ongoing Evaluation of Appointed Members

   a. Ongoing evaluation of staff physicians will be accomplished by reviewing the physician-specific information generated by the above-mentioned monitoring ~~processes;~~processes, clinical teaching evaluations, and other divisional documented performance improvement issues.

3. Reappointments

   a. Appointed members of the Department of Medicine will be reviewed bi-annually by the Division Chief and the Chief of Medicine for reappointment to the Medical Staff. Divisional and Departmental PI activities as well as provider specific peer review are considerations in the reappointment process.

Approved and respectfully submitted by:

_____ _____

Neil R. Powe, MD, MPH, MBA Date
Chief, Medical Services, Zuckerberg San Francisco General Hospital
Constance B. Wofsy Distinguished Professor and
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APPENDIX B - Housestaff Educational Goals and Responsibilities

The Medical Service at Zuckerberg San Francisco General Hospital consists of five medical ward teams, four cardiology teams and one critical care team providing comprehensive inpatient care to acutely ill medicine patients.

The **Swing Resident** assists medicine wards teams with work and procedures, cross-covers wards teams after they sign out, and admits patients after the on-call team has capped and before the Night admitting team arrives.

The **Medicine Night float Intern and Resident** assist in providing care for patients on the Medicine Service and do overnight admissions, respectively.

~~The **Swing Resident** helps the post call team with work, admits patients from 4-9 PM, and helps the on-call team with work so that they can leave the hospital on time.~~The **Cardiology Night Resident** and **ICU Night Resident** provide care to patients on the Cardiology and ICU services, respectively, and admit patients to their respective services overnight.

A **Medicine Consult~~ant~~ Resident** provides consultative care to patients admitted to surgical or other non-medical services within the hospital. This is an optional elective rotation for 2nd and 3rd year residents.

Medicine residents and interns also care for patients ~~in the Emergency Department and~~ on elective rotations at Zuckerberg San Francisco General Hospital.

Housestaff training in procedures:

All interns have a half day of competency training in central line placement, which includes a didactic session, video, hands on central vein identification with ultrasound supervised by an attending. Most interns additionally have a month-long procedure rotation, where they learn the most common procedures done by internists while supervised by a proceduralist attending. All house staff rotate through the Moffitt ICU and have line placement supervision by an ICU attending; senior residents can take an elective in Interventional Radiology to increase procedural skills. Other procedures – e.g. lumbar puncture, paracentesis, and thoracentesis – are supervised by the senior ward resident on the team, who have demonstrated competency by performing a requisite number of procedures, or by a ~~faculty~~n attending physician.

I. EDUCATIONAL GOALS

A. Critical Care Resident - Third-year house officer (R3) or Second-year house officer (R2) with prior ICU experience

By the end of the ZSFG ICU rotation the R2 / R3 Resident will be able to:

Patient Care

- Evaluate and treat complex critically ill patients with illnesses including (but not limited to):
  - Infectious diseases (HIV, TB, community-acquired pneumonia)
  - Substance use and its sequelae, liver disease / cirrhosis
  - Acute complications of obesity-related diseases like diabetes
  - Illness in recent immigrants and homeless populations in the United States.
- Demonstrate competency in the acute management of respiratory failure, hemodynamic instability and life threatening metabolic and hematologic abnormalities.
- Demonstrate competency in the triage of critically ill patients and the appropriate use of critical care and step down units based on local staffing levels and expertise.

Medical Knowledge

- Demonstrate understanding of the basic pathophysiology of common critical care illnesses such as (but not limited to):
  - Severe sepsis
  - Upper GI bleed
  - Severe pneumonia and ARDS.
- Demonstrate an understanding of basic concepts regarding invasive and non-invasive mechanical ventilation, invasive hemodynamic monitoring and support.

- Demonstrate the ability to assimilate up-to-date research evidence and risk benefit analysis in making clinical decisions for critically ill patients.
- Show competency in basic ethical tenets and end of life care.

Practice-Based Learning and Improvement:

- Lead the team in reflection on the types and outcomes of cases admitted during the month and develop action items for changing future practice, using feedback from the ward teams, LCR data, and primary care physicians.

Communication and Interpersonal Skills:

- Collaborate effectively with health care members from nursing, respiratory therapy, pharmacy, dietary and social work to elicit bedside data and establish shared daily goals and long-term care plan.
- Communicate effectively with other physicians such as consultants, emergency room and ward physicians to ensure the delivery of safe and expedient interventions and transitions of care into and out of the ICU.
- Appropriately counsel patients about the risks and benefits of tests and procedures.

Professionalism

- Demonstrate leadership and integrity, serving as a role model in the triage and management of patients across the hospital setting, including:
    - Responding in a timely and collegial manner to calls from ward and emergency department services.
    - Assisting and supervising procedures on other medicine services.
    - Facilitating the transfer of patients with evolving needs to the appropriate clinical setting.
    - Providing effective handoffs to ward teams.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

System-Based Practice

- Understand and use hospital practice guidelines, protocols and forms to provide high quality care to critically ill patients.
- Provide critical care leadership with constructive feedback to the team regarding these practices when deemed necessary.
- Describe quality improvement projects that are ongoing in the ICU, including incorporation of cost-awareness principles into complex clinical scenarios.

B. Critical Care Intern (R1)

By the end of the ZSFG ICU rotation the R1 Resident will be able to:

Patient Care:

- Demonstrate effective collection, synthesis, and presentation of data on complex critically ill patients from critically ill underserved populations including (but not limited to):
    - Infectious diseases (HIV, TB, community-acquired pneumonia)
    - Substance use and its sequelae
    - Liver disease / cirrhosis
    - Illness in recent immigrants and homeless populations in the United States
- Under the guidance of a senior resident and attending physician learn to evaluate and manage critically ill patients with respiratory failure, hemodynamic collapse and multi-organ dysfunction.

Medical Knowledge:

- Describe the basic pathophysiology of common critical care illnesses such as (but not limited to):
    - Severe sepsis
    - Upper GI bleed
    - Severe pneumonia and ARDS
- Describe basic aspects of triaging critically ill patients and differences in staffing and expertise present at different levels of care in the hospital.
- Understand indications for and basic interpretation of common diagnostic testing used in the ICU setting.

- Describe basic concepts regarding invasive mechanical ventilation and invasive hemodynamic monitoring and support.

Practice-Based Learning and Improvement:

- Seek feedback from ward medical teams after transfer from ICU about effectiveness of communication, quality of care plan, and areas for improvement, including timely and effective transfer summaries.
- Respond welcomingly and productively to feedback from all members of the health care team.

Communication and Interpersonal Skills:

- Collaborate effectively and effectively communicate plan of care to all members of the health care team, including nursing, respiratory therapist and other health care providers to elicit bedside subjective and objective data and establish shared daily goals and overall care plan.
- Deliver appropriate, succinct, hypothesis-driven oral presentations.

Professionalism

- Demonstrate integrity in the triage and management of patients across the hospital setting, including:
    - Responding in a timely and collegial manner to calls from ward, emergency department, and consult services.
    - Participating in the transfer of patients with evolving needs to the appropriate clinical setting.
    - Providing effective handoffs to ward teams.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.
- Recognize the scope of his/her abilities and ask for supervision and assistance appropriately.
- Recognize that disparities exist in health care among populations and that they may impact care of the patient.

System-Based Practice

- Demonstrate proficiency in applying and giving constructive feedback on hospital practice guidelines, protocols, forms, and quality improvement projects to provide high quality care to critically ill patients.

C. General Medicine Ward Resident (R2 or R3)

By the end of the ZSFG medicine rotation the R2 / R3 Resident will be able to:

Patient Care:

- Provide compassionate, appropriate, and effective care to hospitalized underserved patients with diseases including (but not limited to):
    - Infectious diseases (HIV, TB, community-acquired pneumonia)
    - Substance use and its sequelae
    - Liver disease / cirrhosis
    - Acute complications of obesity-related diseases like diabetes
    - Illness in recent immigrants and homeless populations in the United States.
- Triage patients to the appropriate level of care based on their degree of illness.

Medical Knowledge:

- Demonstrate adequate knowledge to care for the patients with the above problems.

Practice Based Learning:

- Lead the team in reflection on the types and outcomes of cases admitted during the month and develop action items for changing future practice, using feedback from the Bridge clinic, LCR data, and primary care physicians.
- Cite the literature to customize clinical evidence for an individual patient each admission cycle.

Communication and Interpersonal Skills:

- Provide effective teaching and leadership on daily work rounds, including bedside teaching, teaching to multiple levels of learners, and provision of feedback to learners about efficient presentation skills.
- Demonstrate sensitivity to differences in patients.

Professionalism

- Provide leadership for a team that respects patient dignity and autonomy, including recognizing and managing conflict when patient values differ from their own.

- Attend and participate as appropriate in ~~70% of required~~ medical conferences which include: attending rounds, resident report, M&M, Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

Systems Based Practice:

- Demonstrate effective collaboration with multidisciplinary services during and outside of multidisciplinary rounds (MDR), including nursing, social work, utilization review, rehabilitation services, and pharmacy.
- Supervise and give interns feedback on discharge plan and medication reconciliation process.
- Supervise and give feedback to interns regarding:
  - Sign-out during shift changes, transfers between services, or end of month transfers.
  - Communication with outpatient primary care or subspecialist providers in the Richard H. Fine People's Clinic, Ward 86, Community Health Network clinics, and other clinics.
  - Timely documentation of medications and discharge summary information in ~~the Invision LCR~~EPIC system.

D. General Medicine Ward Intern (R1)

By the end of the ZSFG medicine rotation the R1 Resident will be able to:

Patient Care:

- Provide compassionate, appropriate, and effective care to patients with diseases found in underserved populations including (but not limited to):
  - Infectious diseases (HIV, TB, community-acquired pneumonia)
  - Substance use and its sequelae
  - Liver disease / cirrhosis
  - Acute complications of obesity-related diseases like diabetes
  - Illness in recent immigrants and homeless populations in the United States

Medical Knowledge:

- Demonstrates adequate knowledge to care for the patients with the above problems.
- Cite at least one resource from the medical literature for patient care purposes in the chart each admission cycle.

Practice-Based Learning and Improvement:

- Incorporate feedback and communication with primary care providers into improving discharge planning for patients, including the creation of timely and effective discharge summaries.
- Meet at least every other week with supervising physician for feedback on ward performance.

Communication and Interpersonal Skills:

- Elicit information about the patient as a person – including cultural and socioeconomic background – to inform shared decision-making discussions.
- Communicate effectively with patients with limited English proficiency and/or low health literacy, including appropriate use of interpreter services and demonstrating sensitivity to how ethnic/cultural background influences health/illness.

Professionalism

- Treat patients with dignity, civility, and respect, regardless of race, culture, gender, ethnicity, age, or socioeconomic status, and recognize when it is necessary to advocate for individual patient needs.
- Attend and participate as appropriate in ~~70% of required~~ medical conferences which include: attending rounds, interns report, M&M, Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

System-Based Practice

- Recognize awareness of common socioeconomic barriers that impact healthcare, and advocate for patients with complex psychosocial needs by identifying appropriate referral resources for access to health system and community resources, including Bridge clinic and Treatment Access Program (TAPS).

- Communicate and partner with multidisciplinary team above to identify appropriate referral resources for access to:
    - Subacute and long-term care
    - Medical and psychiatric care
    - Substance use intervention and treatment
    - Social support resources
- Seek out feedback from supervising physicians concerning sign-out during shift changes, transfers between services, or end of month transfers.

E. Cardiology Ward Resident (R2/R3)

By the end of their ZSFG Cardiology rotation, R2 / R3 will be able to:

Patient Care:

- Evaluate and treat patients with cardiac diseases found in underserved populations including (but not limited to):
    - Acute coronary syndromes
    - Congestive heart failure
    - Endocarditis
    - Cardiac complications of substance use
- Triage these patients to the appropriate level of care: floor, telemetry, CCU.
- Demonstrate and teach how to elicit important physical findings for junior member of the health care team.

Medical Knowledge:

- Formulate a differential diagnosis and outline a plan for evaluating and managing cardiology-related problems appropriate for each resident's level of training, including (but not limited to):
    - Management of acute coronary syndromes due to coronary artery disease from stimulant ingestion
    - Valvular heart disease
    - Congestive heart failure
- Achieve skills with competency and teaching in electrocardiogram interpretation.

Practice Based Learning:

- Learn to co-manage patients in a team-care approach on the cardiology service.

Communication and Interpersonal Skills:

- Facilitate and oversee effective communication among team members, including interns, residents, attendings, nurse practitioners, and primary care providers, to ensure effective continuity of care within the hospital and across transitions of care.

Professionalism

- Collaborate effectively with other hospital services to triage and assist in the management of patients with presentations concerning for cardiac disease, including ED nurses and attendings ~~and non-medicine services requesting cardiology consultation during nights/weekends~~.
- Advocate for appropriate allocation of limited health care resources.
- Participate in organized teaching conferences for this rotation as well as required conferences for the ~~SFGH~~ ZSFG medicine department such as M&M and Grand Rounds.
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

Systems-Based Practice

- Collaborate effectively with nurse practitioners to ensure appropriate transitions of care from the hospital setting, including medication reconciliation, follow-up care, and referral to community resources.
- Demonstrate the incorporation of cost-awareness principles into standard clinical decision-making.

F. Cardiology Ward Intern (R1)

By the end of the ZSFG cardiology rotation the R1 Resident will be able to:

Patient Care:

- Under supervision of an attending cardiologist and resident, evaluate and treat patients with cardiac diseases found in underserved populations including:
    - Acute coronary syndromes
    - Congestive heart failure
    - Endocarditis
    - Cardiac complications of substance use

Medical Knowledge:

- Formulate a differential diagnosis and outline a plan for evaluating and managing Cardiology related problems appropriate for each resident's level of training, including (but not limited to):
    - Management of acute coronary syndromes due to coronary artery disease from stimulant ingestion
    - Valvular heart disease
    - Congestive heart failure
- Achieve skills with baseline competency in electrocardiogram interpretation.

Practice Based Learning:

- Learn to co-manage patients in a team-care approach on the cardiology service.
- Determine if clinical evidence can be generalized to an individual patient.
- Meet at least every other week with supervising physician for feedback on ward performance.

Communication and Interpersonal Skills:

- Elicit information about the patient as a person – including cultural and socioeconomic background – to inform shared decision-making discussions
- Communicate effectively with patients with limited English proficiency and/or low health literacy, including appropriate use of interpreter services and demonstrating sensitivity to how ethnic/cultural background influences health/illness

Professionalism:

- Recognize that disparities exist in health care among populations and that they may impact care of the patient, and treat patients with dignity, civility, and respect.
- Attend and participate as appropriate in ~~70% of required~~ medical conferences which include: attending rounds, interns report, M&M, Grand Rounds
- Ensure compliance with stated duty hour regulations and seek assistance from residents, attendings, chief residents, and site director for concerns.

Systems-Based Practice

- Recognize awareness of common socioeconomic barriers that impact health care, and work with team resident to ensure appropriate transitions of care from the hospital setting, including medication reconciliation, follow-up care, and referral to community resources.

G. Medicine Night float Resident (R2/R3)

At the completion of this rotation, the Medicine Night float Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical and cardiac problems.
2. Demonstrate organizational skills necessary for the care of medicine ~~and cardiac~~ inpatients.
3. Efficiently and effectively document findings and clinical decisions in the medical record.
4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. Supervise the Medicine Night float Intern in management of acutely ill inpatients overnight. When indicated, residents should gain competence in supervising procedures performed by the Medicine Night float Intern including venipuncture, arterial puncture, lumbar puncture, paracentesis, joint aspiration, thoracentesis, placement of central lines, placement of nasogastric tubes, and placement of Foley catheters.

H. Medicine Night float Intern (R1)

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical problems.
2. Demonstrate organizational skills necessary for the care of medicine ~~and cardiac~~ inpatients.
3. Efficiently and effectively document findings and clinical decisions in the medical record.
4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. When indicated, R1's should gain competence in performing venipuncture, arterial puncture, lumbar puncture, paracentesis, joint aspiration, thoracentesis, placement of central venous catheters, placement of nasogastric tubes, and placement of Foley catheters by the completion of the R1 year. They should also be capable of explaining the indications, contraindications, and risks of these procedures.

I. Medicine Consult Resident (R2/R3)

At the completion of this elective rotation, the Medicine Consult Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse medical problems occurring on non-medical services.
2. Evaluate patients preoperatively and provide an assessment of their surgical risk.
3. Demonstrate knowledge of perioperative management of chronic medical conditions including coronary artery disease, pulmonary disease (COPD and asthma), diabetes mellitus, hypertension, and other medical conditions.
4. Demonstrate knowledge of post-operative medical complications and their management.
5. Function as an effective consultant to non-medical services.

~~**J. Emergency Department Resident (R2)**~~

~~At the completion of this rotation, the Emergency Department Resident should be able to:~~

~~1. Function as an effective leader and teacher of interns and students rotating through the emergency department and as an effective manager of the "patient flow" through the ED.~~
~~2. Discuss the differential diagnosis and direct the evaluation and triage of diverse urgent care and emergency medical problems. Residents will learn to accurately and quickly identify problems that are emergencies and to prioritize those diagnostic and life supporting measures that are most urgent. Specifically, residents will learn the initial management for patients with urgent and emergent conditions, such as, but not limited to diabetic ketoacidosis, acute coronary syndrome, respiratory diseases, sepsis, and altered mental status, and other medical problems. Residents will improve emergency technical skills such as central line placement as indicated.~~
~~3. Demonstrate baseline competency and improvement in physical diagnosis and medical interviewing skills, including performing a focused history and physical examination for a patient in the Emergency Department with an undifferentiated medical illness.~~
~~4. Demonstrate baseline competency and improvement in managing the wide range of medical conditions seen in the Emergency Department setting utilizing an evidence-based and humanistic approach.~~
~~5. Demonstrate baseline competency and improvement in knowledge and clinical skills relating to Emergency Medicine and Urgent Care.~~
~~6. Work effectively as a member of a health care team to ensure proper care and welfare of patients.~~
~~7. Demonstrate an ability to effectively and efficiently use consultants.~~
~~8. Learn to organize the care of multiple patients simultaneously.~~
~~9. Demonstrate appropriate use of body fluid substance precautions.~~
~~10. Learn to admit patients to the hospital appropriately and promptly.~~
~~11. Learn to organize and direct and medical resuscitation under the supervision of the Emergency Department attending physician.~~

JK. Swing Resident (R2)

At the completion of this rotation, the Medicine Swing Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient medical and cardiac problems.
2. Demonstrate organizational skills necessary for the care of medicine and cardiac inpatients.
3. Efficiently and effectively document findings and clinical decisions in the medical record.
4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. When indicated, residents should further competence in performing procedures including venipuncture, arterial puncture, lumbar puncture, paracentesis, joint aspiration, thoracentesis, placement of central lines, placement of nasogastric tubes, and placement of Foley catheters.

K. Cardiology Night Resident (R2/R3)
At the completion of this rotation, the Cardiology Night Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse inpatient cardiac problems.
2. Demonstrate organizational skills necessary for the care of cardiology inpatients.
3. Efficiently and effectively document findings and clinical decisions in the medical record.
4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. Triage cardiology admissions to the appropriate level of care (CCU, telemetry, etc).

L. ICU Night Resident (R2/R3)
At the completion of this rotation, the ICU Night Resident should be able to:

1. Formulate a differential diagnosis and outline a plan for evaluating and managing diverse critical care problems.
2. Demonstrate organizational skills necessary for the care of critically ill patients.
3. Efficiently and effectively document findings and clinical decisions in the medical record.
4. Evaluate patients for acute changes in their medical status, triage patients appropriately, and call for assistance when it is needed.
5. Utilize consult services and diagnostic studies appropriately.
6. Triage critically care admissions to the appropriate level of care.

A. ~~II.~~ TEAM STRUCTURE AND RESPONSIBILITIES

B. ~~A.~~ Team Structure:

The Critical Care team consists of one critical care attending, four residents, and three to four interns (two to three Internal Medicine, one Family Medicine R1 or R2 acting as an intern).

The five General Medicine Ward teams consist of one medicine attending, one resident, two interns, one to two third year medical students (MS3), and a sub-intern (MS4). A social worker and care coordinator RN are~~is~~ assigned to each team to aid in identifying and meeting discharge needs.

Division of Hospital Medicine attendings also admit patients to the Faculty Inpatient Service (FIS). A social worker and care coordinator RN are~~is~~ assigned to help care for patients on the FIS.

The Cardiology Ward team consists of one cardiology attending, ~~two~~ three cardiology fellows; four teams consisting of one resident and one intern each, one to two third year medical students (MS3), and occasionally a sub-intern (MS4). A social worker and care coordinator RN are~~is~~ assigned to the team to aid in identifying and meeting discharge needs. ~~One nurse practitioner assists in ensuring follow-up and access to follow-up testing after discharge.~~

A Night float Intern provides supervised coverage of the Resident Inpatient Service at night.

A Night float Resident and one hospitalist attending admit patients to the medicine service in the overnight hours (9 PM to 6~~7~~AM).

A Cardiology Night resident provides coverage of the Cardiology service and admits patients to the Cardiology service in the overnight hours (9PM to 6AM).

An ICU Night resident provides coverage of the ICU service and admits patients to the ICU service in the overnight hours (9PM to 6AM).

The Medicine Consult team consists of one attending ~~and~~ +/- one resident~~.~~ (optional resident elective).

~~Medicine Residents rotating in the Emergency Department are a part of a multi-disciplinary team composed of attending and training physicians from both medical and other departments at UCSF, as well as numerous residents and interns from training programs outside of UCSF. The housestaff schedule is determined by the Department of Emergency Medicine at ZSFG and varies according to the time of day and the time of year. There is always at least one Emergency Department attending physician present for supervision of patient care.~~

B. Critical Care Attending Physician:

1. Holds appropriate clinical privileges at ZSFG with an academic appointment at the University of California, San Francisco (UCSF) School of Medicine.
2. Supervises and assumes ultimate responsibility for the care of inpatients admitted to the medical ICU, including appropriate continuing care, discharge planning or planning for transfer from the ICU, and medical follow-up. To achieve this, the attending should conduct daily management rounds that include the following:
    a) Interaction at regular intervals with ICU patients each day.
    b) Effective and frequent communication with the resident staff regarding management.
3. Conducts daily teaching rounds:
    a) Rounds must consist of both patient-based and didactic teaching. Points for discussion include interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient, and appropriate use of technology and disease prevention.
    b) The attending should work with the resident physicians to establish and achieve didactic goals for teaching rounds.
    c) Teaching rounds must include direct resident and attending interaction with the patient. The teaching sessions must include demonstrations and evaluation of each resident's interview and physical examination skills, i.e. teaching rounds must include bedside teaching.
4. Oversees order writing, but residents and interns routinely write all orders for patients under their care. In those unusual circumstances when the attending writes an order on the team's patient, the attending must communicate his or her action to the resident in a timely manner.
5. Responsible for providing verbal feedback and written evaluation of the resident physicians participating in ICU care. Resident evaluations must include assessments of interview and physical examination skills, communication of treatment plans, and discharge planning.
6. Responsible for completing on-service and admission notes. Admission notes should be completed by the end of the day following admission. On-service notes should be completed daily.
7. Responsible for co-signing and ensuring dictation of discharge summaries for each patient in a timely fashion.

8. Responsible for signing orders relating to the withholding of resuscitative efforts (~~DNR~~DNAR orders).
9. The attending physician will be available by pager at all times.
10. Responsible for providing feedback and written evaluation on the performance of interns and residents.

C. Critical Care Resident - Third-year house officer (R3) or Second-year house officer (R2) with prior ICU experience

Under the guidance of the attending critical care physician, this resident directs the comprehensive ICU care of critically ill medicine patients. The Critical Care Resident also assists with the care of cardiology patients admitted to the ICU, under the guidance of the attending cardiology physician. Specific responsibilities include:

1. Responsible for coordinating the day-to-day function of the Critical Care Unit and directly supervising interns, and responsible for determining the assignment of critically ill patients to monitored beds in the ICU and step-down care unit.
2. Directs the admission and initial evaluation of patients to the medical ICU:
   a) The Critical Care Resident will oversee the initial history, physical examination and review of the laboratory data and medical records for all patients admitted to the medical ICU. The resident will write an admission note for all patients admitted to the medical ICU.
   b) The Critical Care Resident will be on-call every fourth night.
   c) The Critical Care Resident will provide assistance to the Medicine Night float Resident if needed.
   d) The Critical Care Resident will respond in person to "Code Blue" alarms and will function as the lead physician coordinating resuscitations. The Critical Care Resident will also document the events that occur during the code.
   e) Resident physicians will be responsible for ensuring that individual intern and sub-intern patient loads do not compromise patient care and educational goals.
   f) In the event that the Critical Care Resident is called to evaluate a patient whom they deem does not require ICU-level care, the Resident will leave a consultation note in the chart.
3. Directs the interns in providing continuing intensive care to all of the patients in the medical ICU:
   a) Oversees the daily interval history, focused physical examination, and new laboratory data for each patient on the team.
   b) Oversees the rational use of consultants and laboratory tests.
   c) Oversees the discharge planning and transitional care of all patients.
   d) Ensures compassionate communication with patients and families regarding the ongoing status and care of patients.
4. Ensures adequate communication of patient care issues among members of the team, including the attending physician, other Critical Care residents, and the interns.
5. Assists the ~~General Medicine/~~Cardiology Resident with the admission and initial evaluation of patients to the Cardiac ICU and with the ongoing care of cardiology ICU (CCU) patients:
   a) The Critical Care Residents will participate in taking the initial history, performing a physical examination, and reviewing of the laboratory data and medical records for all patients admitted to the CCU.
   b) The Critical Care Residents will assist with placement of central lines for hemodynamic monitoring, and will be instructed in the use of ultrasound guidance for safe placement.
   c) Although the Cardiology Resident will have primary responsibility for making management decisions on Cardiology ICU patients, the Critical Care Resident team will assist as needed with bedside management and critical care decision-making. The Critical Care team will be responsible for ventilator management for intubated Cardiology ICU patients.
6. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents ~~will need to demonstrate at least 70% attendance at each of the required conferences and~~ will be expected to attend as many teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
   a) Weekly Morbidity and Mortality conference.
   b) Weekly Pulmonary/Critical Care conference.
   c) Weekly Grand Rounds.

7. Responsible for providing feedback and written evaluation on the performance of interns.
8. Responsible for providing written evaluation of attending physicians.
9. Residents will not work in excess of an average of eighty hours per week during any inpatient ward month.
10. Residents will have at least one day off per every seven averaged over the month.
11. Residents will have a break of at least eight hours between shifts.
12. The on call period will consist of 24 hours of patient care/new admissions, followed by no more than four additional hours for education and sign out.

D. General Medicine Ward Attending:

1. Holds appropriate clinical privileges at ZSFG with an academic appointment at the University of California, San Francisco (UCSF) School of Medicine.
2. Supervises and assumes ultimate responsibility for the care of medical inpatients admitted to the medical wards ~~and step-down~~ unit, including discharge/transfer planning and medical follow-up. To achieve this, the attending should conduct daily management rounds that include the following:
    a) Interaction at regular intervals with medical ward patients.
    b) Effective and frequent communication with the resident staff regarding management.
3. Conducts teaching rounds:
    a) Rounds must consist of both patient-based and didactic teaching. Points for discussion include interpretation of clinical data, pathophysiology, differential diagnosis, and specific management of the patient, appropriate use of technology and disease prevention.
    b) The attending should work with the resident physician to establish and achieve didactic goals for teaching rounds.
    c) Teaching rounds must include direct housestaff and attending interaction with the patient. The teaching sessions must include demonstrations and evaluation of each trainee's interview and physical examination skills, i.e. teaching rounds must include bedside teaching.
4. Oversees order writing, but housestaff routinely write all orders for patients under their care. In those unusual circumstances when the attending writes an order on the team's patient, the attending must communicate his or her action to the resident in a timely manner.
5. Responsible for providing verbal feedback and written evaluations of the residents, interns, and students on the team. Evaluations of housestaff must include assessments of interview and physical examination skills, communication of treatment plans, and discharge planning.
6. Responsible for writing on-service and admission notes. Admission notes should be completed by the end of the day following admission. On-service notes should be completed daily.
7. Responsible for ensuring dictation of discharge summaries for each patient in a timely fashion.
8. Responsible for attending Multidisciplinary Rounds Monday-Friday.
9. Responsible for signing orders relating to the withholding of resuscitative efforts (DNAR orders).
10. The attending physician will be available by pager or cell phone at all times.
11. Attends monthly sign-in and sign out session organized by the Vice Chief of service.

E. General Medicine Ward Resident (R2/R3):

Under the guidance of the attending physician, the R2/R3 directs the comprehensive inpatient care of acutely ill medicine patients on the wards and assists with patients admitted to the MICU. The specific responsibilities include:

1. Responsible for coordinating the day-to-day function of the team and directly supervising interns and sub-interns.
2. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents ~~will need to demonstrate at least 70% attendance at each of the required conferences and~~ will be expected to attend as many teaching conferences as allowed by patient care responsibilities. -Expected attendance at the following conferences:

~~Required conferences are designated as:~~

    a) Weekly Morbidity and Mortality conference.
    b) Weekly Grand Rounds.
    c) Residents' Report
3. Directs the admission and initial evaluation of patients to the medical service:

a) Oversees the initial history, physical examination and review of the laboratory data and medical records for all patients admitted to the team.

b) Residents will take daytime call every fifth day (7am-6pm) of every call cycle. They will accept additional holdover patients admitted overnight on Days 2 and 3 of the call cycle, and will be eligible to receive post-call holdovers ~~if they did not reach their cap on call.~~for readmissions or during admissions surges. The medicine teams will admit all medical ward ~~and step-down~~ patients not admitted by the Faculty Inpatient Service (FIS) of attending hospitalists.

c) Resident physicians will distribute admissions among members of their individual teams:

i) Interns will be responsible for no more than five admissions per twenty-four hour period and no more than eight admissions per forty-eight hours.

ii) Sub-interns will be responsible for no more than five admissions per twenty-four hours and no more than eight admissions per forty-eight hours.

iii) Resident physicians will be responsible for admitting patients and writing detailed admission notes in excess of five admissions per intern or sub-intern per twenty-four hour period up to a maximum of ten new patients.

iv) Total admissions per medicine team will not exceed seven per eleven hour call day; additional patients will be admitted by the hospitalists on ~~the~~ FIS and the Swing resident. ~~I~~If the admission threshold is exceed, backup admitting guidelines will be employed. ~~more than seven patients are admitted by swing resident and the FIS before 9 PM, a Jeopardy Resident may be activated.~~

v) Resident physicians will be responsible for ensuring that individual intern and sub-intern patient loads do not compromise patient care and educational goals.

4. R2's/R3's direct the interns and medical students in providing continuing hospital care to all of the patients on his/her team:
   a) Oversees the daily interval history, focused physical examination, and new laboratory data for each patient on his/her team.
   b) Oversees the rational use of consultants and laboratory tests.
   c) Oversees the discharge planning and transitional care of all patients.
   d) Ensures compassionate communication with patients and families regarding the ongoing care of patients.
5. Ensures adequate communication of patient care issues among members of the team, including the attending physician.
6. Assumes primary responsibility for supervising sub-interns (MS4s) and will write admission notes for all patients admitted by sub-interns.

~~7. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents will need to demonstrate at least 70% attendance at each of the required conferences and will be expected to attend as many teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:~~

~~a) Weekly Morbidity and Mortality conference.~~

~~b) Weekly Pulmonary/Critical Care conference.~~

~~c) Weekly Grand Rounds.~~

7~~8~~. Responsible for providing feedback on the performance of the interns, MS4, and MS3s.

9.

8. Responsible for providing written evaluation of the attending physician, interns, MS4, and MS3s.

9. Residents will not work in excess of an average of eighty hours per week during any inpatient ward month.

10. Residents will have at least one day off per every seven averaged over the month and will be covered by the attending physician on those days.

11. Residents will have a break of at least eight hours between shifts.

12. The on call period will consist of no more than 16 hours of patient care, new admissions, education, and sign out.

F. General Medicine Ward Intern (R1):

1. All responsibilities and clinical privileges of the intern are under the guidance and supervision of the Attending and Resident physicians.

2. Responsible for patient care in concert with other members of the team.
3. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Interns ~~will need to demonstrate at least 70% attendance at each of the required conferences and~~ will be expected to attend as many additional teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
    a) Weekly Morbidity and Mortality conference.
    b) Weekly Grand Rounds.
    c) Monthly Intern Half-Days.
    d) Weekly Intern Report
4. Responsible for up to five admissions per twenty-four hour period, or up to eight admissions per forty-eight hour period.
5. Responsible for writing up to five admission notes; supervising residents will be responsible for admitting patients and writing admission notes in excess of five per twenty-four hour period.
6. Responsible for writing or co-signing medical students' daily progress notes.
7. Has primary responsibility for supervising MS3s.
8. Responsible for completing discharge summaries for each patient within forty-eight hours of discharge.
9. Has primary responsibility for writing orders in the medical record and will co-sign all medical student orders promptly.
10. Interns will not work in excess of an average of eighty hours per week during any inpatient ward month.
11. Interns will have at least one day off in every seven averaged over the month and will be covered by his/her/their supervising resident on those days.
12. Interns will have a break of at least eight hours between shifts.
13. The on call period will consist of no more than 16 hours of patient care, new admissions, education, and sign out.

G. Cardiology Ward Attending:

1. Holds appropriate clinical privileges at ZSFG with an academic appointment at the University of California, San Francisco (UCSF) School of Medicine.
2. Supervises and assumes ultimate responsibility for the care of inpatients admitted to the Cardiac ICU, including appropriate continuing care, discharge planning or planning for transfer from the CCU, and medical follow-up. The cardiology attending also has primary responsibility for cardiology patients admitted to the wards. The attending should conduct daily management rounds, which include the following:
    a) Interaction at regular intervals with ~~CCUand~~CCU and ward patients.
    b) Effective and frequent communication with the cardiology fellows and resident staff regarding management.
    c) Review of electrocardiograms and other cardiac testing with the housestaff.
3. Conducts daily teaching rounds:
    a) Rounds must consist of both patient-based and didactic teaching. Points for discussion include interpretation of clinical data, pathophysiology, differential diagnosis, specific management of the patient, appropriate use of technology, and disease prevention.
    b) The attending should work with the resident physician to establish and achieve didactic goals for teaching rounds.
    c) Teaching rounds must include direct housestaff and attending interaction with the patient. The teaching sessions must include demonstrations and evaluation of each trainee's interviewing and physical examination skills, i.e. teaching rounds must include bedside teaching.
4. Oversees order writing, but housestaff routinely write all orders for patients under their care. In those unusual circumstances when the attending writes an order on the team's patient, the attending must communicate his or her action to the resident in a timely manner.
5. Responsible for providing verbal feedback and written evaluation of the resident physicians and interns participating in the care of cardiology patients. Resident evaluations must include assessments of interview and physical examination skills, communication of treatment plans, and discharge planning.
6. Responsible for writing or dictating on-service and admission notes. Admission notes should be completed by the end of the day following admission. On-service notes should be completed daily.

7. Responsible for co-signing and ensuring dictation of discharge summaries for each patient in a timely fashion.
8. Responsible for signing orders relating to the withholding of resuscitative efforts (~~DNR~~DNAR orders).

H. Cardiology Ward Resident (R2):

Under the guidance of the attending Cardiology physicians and the Cardiology fellows, the R2 directs the comprehensive inpatient care of acutely ill medicine and cardiology patients on the wards and CCU. The specific responsibilities include:

1. Responsible for coordinating the day-to-day function of the team and directly supervising interns and sub-interns.
2. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Residents ~~will need to demonstrate at least 70% attendance at each of the required conferences and~~ will be expected to attend as many teaching conferences as allowed by patient care responsibilities. ~~Required~~ Expected attendance at the following conferences~~conferences are designated as~~:
    a) Weekly Morbidity and Mortality conference.
    b) Weekly Grand Rounds.
    c) Residents' Report.
3. Directs the admission and initial evaluation of patients to the ~~medical and~~ cardiology service~~s~~:
    a) Will oversee the initial history, physical examination and review of the laboratory data and medical records for all patients admitted to the team.
    b) Residents will be on-call every fourth day and will admit all patients with primary cardiology issues.
    c) Will communicate frequently with the members of the Critical Care team, who will assist with the care of CCU patients.
    d) Resident physicians will distribute admissions among members of their individual teams:
        i) Interns will be responsible for no more than five admissions per twenty-four hour period and no more than eight admissions per forty-eight hours.
        ii) Sub-interns will be responsible for no more than five admissions per twenty-four hours and no more than eight admissions per forty-eight hours.
        iii) Resident physicians will be responsible for admitting patients and writing detailed admission notes in excess of five admissions per intern or sub-intern per twenty-four hour period up to a maximum of ~~eight~~ seven new patients.
        iv) Total admissions per admitting resident will not exceed ~~ten~~ seven per 24-hour call day; a ~~Jeopardy Resident will be activated for any admissions in excess of eight per cardiology admitting resident per twenty-four hour call day~~backup admitting system will be activated for admissions in excess of this threshold~~; it is the responsibility of the Cardiology Ward Resident to notify the Chief Medical Resident on call in order to activate the Jeopardy system.~~.
        v) Resident physicians will be responsible for ensuring that individual intern and sub-intern patient loads do not compromise patient care and educational goals.
4. R2's direct the interns and medical students in providing continuing hospital care to all of the patients on his/her team:
    a) Oversees the daily interval history, focused physical examination, and new laboratory data for each patient on his/her team.
    b) Oversees the rational use of consultants and laboratory tests.
    c) Oversees the discharge planning and transitional care of all patients.
    d) Ensures compassionate communication with patients and families regarding the ongoing care of patients.
5. Ensures adequate communication of patient care issues among members of the team, including the attending physician.
6. Assumes primary responsibility for supervising sub-interns (MS4s) and will write an admission note for all patients admitted by sub-interns.
7. Responsible for providing feedback on the performance of the intern, MS4 and MS3s.
8. Responsible for providing written evaluation of the attending physician, intern, MS4 and MS3s.
10. Residents will not work in excess of an average of eighty hours per week during any inpatient ward month.

11. Residents will have at least one day off in every seven averaged over the month ~~and will be covered by the attending cardiology physician~~. Residents will have a break of at least eight hours between shifts.
8. The on call period will consist of 24 hours of patient care and new admissions, plus up to four hours for sign out and educational activities.
9. 13. Will carry a "Code Blue" pager and respond to all codes; will assist the critical care resident in these situations but does not have primary responsibility for leading the code.

I. Cardiology Ward Intern (R1):

1. All responsibilities and clinical privileges of the intern are under the guidance and supervision of the Attending and Resident physicians and the Cardiology Fellows.
2. Responsible for patient care in concert with other members of the team.
3. Responsible for attending conferences as required by the Medical Service and the national Internal Medicine Residency Review Committee. Interns ~~will need to demonstrate at least 70% attendance at each of the required conferences and~~ will be expected to attend as many additional teaching conferences as allowed by patient care responsibilities. Required conferences are designated as:
    a) Weekly Morbidity and Mortality conference.
    b) Weekly Grand Rounds.
    c) Monthly Intern Half-Days.
    d) Weekly Intern Report
4. Responsible for up to five admissions per twenty-four hour period, or up to eight admissions per forty-eight hour period.
5. Responsible for writing up to five admission notes; supervising residents will be responsible for admitting patients and writing admission notes in excess of five per twenty-four hour period.
6. Responsible for reviewing and co-signing medical students' daily progress notes.
7. Has primary responsibility for supervising MS3s.
8. Responsible for dictating discharge summaries for each patient within forty-eight hours of discharge.
9. Has primary responsibility for writing orders in the medical record and will ~~co-~~sign all medical student orders once reviewed promptly.
10. Interns will not work in excess of an average of eighty hours per week during any inpatient ward month.
11. Interns will have at least one day off in every seven averaged over the month and will be covered by the supervising resident
12. Interns will have a break of at least eight hours between shifts.
13. The on call period will consist of no more than 16 hours of patient care, new admissions, education, and sign out.

J. Night float Resident (R2/R3):

1. Will arrive in the hospital at 8PM and leave at 10AM.
2. No resident will serve as Night float Resident for more than 6 consecutive days.
3. Will take sign out from the Swing Resident and cross-cover on those new admissions in addition to following up on any pending studies as directed by the Swing Resident.
4. Will take sign out from the on-call team directly and cross-cover these patients in addition to following up on any pending studies as directed by the on-call team.
5~~3~~. The Night float Resident will admit general medicine ~~and/or cardiology~~ patients to the wards ~~and step-down unit~~ between the hours of 9PM-6~~7~~AM.
6~~4~~. Will assist the Night float Intern with any complicated patient care issues, and will supervise any procedures performed by the Night float Intern as necessary.
7.~~5~~. The ~~Critical Care Resident~~FIS hospitalist attending is responsible for assisting the ~~Resident n~~Night float Resident if necessary. If patient care issues or new patient admissions exceed the Night float Resident's ability to provide safe and comprehensive medical care to those patients despite the assistance of the ~~Critical Care Resident and the~~ FIS hospitalist attending, the Night float Resident will ~~call the Jeopardy Chief Resident to activate the Jeopardy system.~~employ the backup admitting system (Admission Surge Guidelines).
6. The Night float Resident will personally sign out patients to the ward teams and FIS between 8AM-10AM.
7. ~~Will attend morning report at 7:30AM if patient care allows.~~

K. Night float Intern (R1):

1. Will arrive at the hospital 8:00 PM or 9:00 PM depending on the role and leave at 7:30 AM or 10:00 AM depending on the role; the maximum shift length will be 14 hours.
2. No intern will serve as Night float Intern for more than 6 consecutive days.
3. Responsible for taking care of medicine ~~or cardiology~~ patients on the wards ~~and in the step-down unit~~.
4. Will receive written sign-out on all patients.
5. Will check laboratory results, radiology results, monitor fluid status, etc. as specifically directed by the sign-out from the primary team.
6. Will respond to all nursing pages regarding patients under his/her/their care and will personally evaluate patients for whom there are any concerns.
7. If the Night float Intern is called to evaluate any patient who has had a significant change in condition, the Night float will clearly document any procedures, interventions, and/or studies in the chart and notify the supervising resident.
8. The Night float Resident is responsible for assisting the Night float intern if necessary. If the Night float Intern requires assistance or supervision for a procedure, the Night float Resident should be called promptly.

L. Medicine Consult Attending:

1. Holds appropriate clinical privileges at ZSFG.
2. Supervises and assumes ultimate responsibility for General Medicine consultations on inpatients and Orthopedic Surgery co-management.
3. Conducts daily teaching rounds with the medical consult resident.
4. Is responsible for completing of initial consultation templates and follow-up consultations.
5. Is responsible for providing verbal feedback and a written evaluation of the medical consult resident.
6. The medicine consult attending physician will be available by pager at all times.

M. Medicine Consult Resident (R2/R3):

1. Will see all medicine consult patients, 7:30 AM to 5:30 PM Monday ~~Saturday~~Friday.
2. Will discuss each case with the medicine consult attending ~~or FIS hospitalist attending if urgent and the medicine consult attending is unavailable~~.
~~3. Will provide cross coverage for Critical Care Residents, Medicine Ward Residents, or Cardiology Ward Residents when needed.~~
~~4.~~3. Will write appropriate orders with agreement of primary team.
~~5.~~4. Will give written sign-out to the FIS ~~nocturnist nightly~~Swing ~~nightly~~cross-cover provider.
~~6.~~5. Will initiate transfers to the Medicine Service when appropriate**.**

~~**N. Emergency Department Resident (R2):**~~
~~1. Will work no more than 65 hours per week and will have at least one day off in every seven averaged over the month..~~
~~2. Responsible for directing patient care on the medical side of the Emergency Department including:~~
~~a) Assisting the nursing staff with triage when appropriate.~~
~~b) Responding promptly when called to the "Trauma Rooms" to care for the most acute patients.~~
~~c) Managing patient flow through the Emergency Department and facilitating admissions and discharges.~~
~~3. Supervises and teaches interns and medical students who are working on the medical side of the Emergency Department. This includes overseeing the history, physical examination, review of laboratory data, and review of medical records for all patients evaluated.~~
~~4. Ensures that appropriate studies and necessary consultations are obtained quickly.~~
~~5. Discusses all patients with the Emergency Department attending.~~
~~6. Will learn to organize and direct and medical resuscitation.~~

O. Swing Resident (R2):

1. Will arrive at the hospital at ~~2~~12:00 PM and leave by 12:00 AM.
2. Will assumes primary cross cover responsibilities until 9:00 PM for the non-call teams after receiving written sign out from the team intern or resident.

3. Will check laboratory results, radiology results, monitor fluid status, etc. as specifically directed by the sign-out from the primary team.
4. Will respond to all nursing pages regarding patients under his/her/their care and will personally evaluate patients for whom there are any concerns.
5. If the Swing Resident is called to evaluate any patient who has had a significant change in condition, the Swing Resident will clearly document any procedures, interventions, and/or studies in the chart and notify the supervising attending.
6. Will alternate admissions with the Swing Hospitalist between 6~~4~~-9 PM or when the on-call team has capped.
7. Will sign out admitted patients to the Night float Resident at 9 PM.

APPENDIX C – MEDICAL STUDENT TRAINING PROGRAM
SAN FRANCISCO GENERAL HOSPITAL
Medicine 110- Third Year Students

Commented [U2]: Likewise, it would be great if Margaret could take a quick look at this section to see if updates are needed.

Contents:

INTRODUCTION

Goals (or where to direct your energies)

1. Develop ease in dealing with sick persons and working with health care personnel in relation to delivering optimum medical care in an inpatient hospital setting.
2. Be able to obtain, organize, record and present (written and oral) a complete history, physical examination and diagnostic and therapeutic formulations. A complete differential diagnosis and understanding of the pathophysiology is more important at this stage than a complete therapeutic plan.
3. Continue to learn a body of knowledge in Internal Medicine.

HOW WILL YOU LEARN THIS?

1. General - Through close contact with patients.

Digression #1 -

Not all students will be exposed to the same types of patients, necessarily making the experience different for each student. Goals 1 and 2 can be realized through a variety of patients. Goal 3 will be accomplished through a combination of ward contact and didactic sessions (conferences and seminars) through which you will be exposed to at least a minimum amount of basic facts in Internal Medicine.

Digression #2 -

At all times, all patients must be treated with dignity and respect whether or not their personalities or attitudes coincide with yours. Less will not be tolerated.

Patient care comes before education. Through this order of priorities will come your most important learning.

2. Specifics

A. Ward work - Each Medicine ward team consists of a PGYII/III medical resident, two interns, a 4th year student, one or two 3rd year students, and an attending (faculty) physician. Each team may have patients on one or more wards .Each 3rd year clerk will be assigned to work with a specific team.

~~There are five Medicine teams. There is no overnight call. Overnight a covering resident team and a faculty hospitalist admits patients. Each team admits every fifth day ("long call"). Long call begins in the morning of call. Patients can be admitted to the long call team until 6pm. The team must sign out to the covering night team at 9 pm. All team members leave the hospital and return the next morning for their post-call day. Each team also admits holdover patients and patients admitted early in the morning ("short call" and "tiny call") on the third and fourth day of a five-day call cycle. There are four Cardiology teams, each with one resident (PGYII) and one intern. There is one Cardiology attending for all four teams. Cardiology teams take overnight call every fourth night. Third year students will spend six weeks on a Medicine Team and two weeks on a Cardiology team.~~

~~B. There is also an ICU (Intensive Care Unit) team. No students are on this team.~~

~~C. Conferences - There will be seminars most days, Monday through Friday, usually from 1:30 - 2:30pm or1:30 – 3:00pm1-2pm00pm in which topics basic to medicine will be discussed. Please see schedule outside of the Housestaff Coordinator's office (5H22) for specific topics and their dates. You will meet with Dr. Wheeler's for Patient Presentations Wednesdays at1:30pm. You will also meet with the Chief Residents for basic EKG instructions and Physical Diagnosis Rounds. YOUR PUNCTUAL ATTENDANCE AT THESE CONFERENCES IS IMPORTANT.~~

~~C. Standardized Patients - The School of Medicine has arranged for actors to play the part of patients in these half-day exercises. Sessions will be held on history taking and physical examination as well as discussion of advanced directives. These assignments will be based on call schedule and will come from Student Programs. If, for any reason, you are unable to attend this required program please call Lisa Carella at 476-1964.~~

~~D. BSCO (Brief Structured Clinical Observation) - Each student will be observed by their attending and a peer interacting with a patient. This exercise will include a part of the history and physical exam chosen by the student and attending, and should take no more than 10 minutes. These can be done as a separate exercise or in the course of normal clinical care such as during morning rounds. After the observed interaction the attending or peer will provide feedback to the student and fill out a form given to him/her by the student. Two BSCOs from an attending and one from a peer are required...The idea of this exercise is to increase the number of observed student-patient encounters. It does not count towards your grade, but you are required to turn in the BSCO cards to pass the course.~~

Objectives

Major objectives

- Perform a complete admission history and physical examination
- Select and interpret appropriate diagnostic tests
- Develop an assessment/differential diagnosis, based on H & P, lab data
- Write up each admission and daily progress notes
- Give a complete new admission oral presentation
- Follow the patient daily throughout the hospital stay
    - Perform focused daily H and P, interpret relevant tests
    - Present the patient in SOAP format on daily rounds, with updated problem list
    - Write a daily note
    - Participate in coordination of care including discharge planning
    - Communicate with patients and families about the hospital experience and their perspective on their care

Priority patients (Core Experiences, Procedures that will be logged in MedHub):

- Acute non-surgical GI/liver symptoms (nausea/vomiting, abdominal pain, diarrhea, GI bleed, abnormal LFTs)
- Chest pain
- Chronic coronary artery disease and/or metabolic syndrome (hypertension, diabetes, hyperlipidemia)
- Common arrhythmia (~~e.g.~~e.g., atrial fibrillation)
- Dyspnea (COPD exacerbation, CHF, PE, asthma, ~~etc~~etc.)
- Electrolyte abnormalities and/or acute or chronic renal failure
- Fever
- Geriatric patient
- I was observed doing a relevant history and cardiopulmonary physical exam for a cardiac or pulmonary complaint.
- Life threatening or terminal illness
- Meet with site director or longitudinal medicine preceptor for midpoint feedback

Knowledge objectives

The following are topic areas covered on the final examination:

Laboratory data interpretation: Complete blood count and peripheral blood smear, Arterial blood gas (oxygenation, ventilation, and acid-base status), pleural fluid, peritoneal fluid, pulmonary function tests, EKG, chest X-ray

Clinical Symptoms, signs, and disease:

- Gastrointestinal: Upper & lower GI bleeding, acute and chronic pancreatitis, cirrhosis
- Cardiac: Chest pain, coronary artery disease/ischemic heart disease, congestive heart failure, valvular heart disease, atrial fibrillation
- Endocrine: DM, hyper- and hypothyroidism, adrenal insufficiency/excess
- Hematology/Oncology: Anemia and transfusions, platelet disorders, lymphadenopathy, lung cancer (not chemotherapy regimens)
- Infectious Disease: Pneumonia, UTI, sepsis and bacteremia, endocarditis, HIV/AIDS, TB
- Pulmonary: Dyspnea, asthma, COPD, DVT and PE
- Renal/ Electrolytes: Hyper- and hyponatremia, hyper- and hypokalemia, hyper- and hypocalcemia, acute and chronic renal failure, acid base disorders, management of intravenous fluids
- Other: Altered mental status (atypical presentation of common illnesses in the elderly), end-of-life decision-making, managing physical symptoms at the end of life, teaching patients and families about illness, treatment, and prognosis

Expectations and Responsibilities

1. Call expectations

- Admit 1 patient per long or short call; and depending on their census and patient complexity, may be able to admit another patient on other days of the cycle (e.g., pick up a holdover or short call patient). Average census is anywhere from 1-3 (ideal patient census ~2).
- The time a student leaves on call days will vary depending on the clinical workflow and team; may write note and read about patients at home.
- Review admission H&P note with resident or intern.
- Practice oral presentation on and be expected to present either on-call day or post-call day.
- Should have note in the patient chart immediately following attending rounds on the post-call day.
- Follow admitted patients daily including presenting and writing notes.

2. Student education

- Core afternoon student lectures: Attendance is required; students are excused from patient activities during this time.
- Conference:
  - Resident and intern report: Students highly encouraged to attend.
  - Noon conferences and grand rounds report.
- BBOTs:
  - Twice a week, students are required to be observed by the attending or resident (not intern) while interviewing and examining a patient (15 min observation, 5 min feedback). These should be filled out online and should cover skills in history taking, the physical exam, communication in general, presenting, and note writing.
- Serious Illness Communication Workshop: Students will participate in a program to learn about how to talk to your patients about code status and end of life decision-making.
- Consideration of Social Risk in Diagnosis Assignment: Students will practice evaluating the impact of social context on the diagnostic process through a clinical case. Students will present their patient at a student case presentation and complete a post-activity survey.

3. Days off

- 1 day off per week (4 per month) assigned by the resident; weekend days are preferred but will depend upon resident and intern schedules. This should not be on FCM clinic day or FS day.
- 1 full day to attend Family Community Medicine or FS didactics day.
- Complete Absence Request Form for an absence for one or more required clinical dates due to planned or emergent absences.
  https://ucsf.co1.qualtrics.com/jfe/form/SV_8dfouJ4OU19XZWd)
- Students who are away on a post-call day should try to admit an early patient on call so that they can work up their patient and potentially present their patient.

4. Feedback

- Students should meet with each attending and senior resident at the start and end of their time together to discuss expectations and feedback. If they work together more than 2 weeks, there should also be a mid-point feedback meeting.
- Interns can give regular feedback to students during routine patient care.

5.Work Hour Policy:

- Work hours are defined as all clinical and academic activities related to the rotation. This is defined as patient care (including patient-related administrative duties such as patient notes) and scheduled activities (such as conferences). It does NOT include time spent studying for exams, reading, preparing for oral presentations, or commute time.
- Clinical and educational work hours must be limited to no more than 80 hrs/week; medical students should be scheduled for no more than 72 hrs/week.

Student Evaluation

- After the first week of the rotation, residents, and attendings who work with a student for at least 7 days will be asked to evaluate the student on MedHub and in turn will be evaluated by the student. Note that in some cases because of days off, students might be evaluated by a team member who ends up working with them <7 days. This 7-day calendar day rule is applied across all clerkship sites.
- Cardiology attendings do not fill out MedHub evaluations because of the structure of the service (more direct interactions with residents/interns than attending; sharing of attendings between teams).
- Grading committee reviews composite evaluations together. If question exists about passing, grading committee confers on final grade and next steps if necessary.
- The site director compiles the final evaluation based on team evaluations and exam score.

- To pass the course, you must also pass the shelf exam. A passing grade is two standard deviations below the national mean.

Maximizing Clerkship Experience

- Participate actively: look up questions that arise on rounds and share what they read with their team.
- Think of the patients as their patients.
- Ask their team to involve them in their patient's workup.
- Sit down with the resident and attending early on to set goals and expectations.
- Remind the team about conference schedule and other responsibilities.
- Be active in patient care; know their patient's conditions better than anyone else on the team.

Zuckerberg San Francisco General Hospital and Trauma Center

MS4 Sub-Internship (Acting Intern) Summary~~Summary Page~~
~~San Francisco General Hospital~~

~~A major difference between your MS3 and MS4 experience is that you will truly be "learning on the job"- and you will really be assuming primary ownership of your patients. They will be YOUR patients (along with resident supervision). A new emphasis will be on your critical role in~~

- ~~Communication (with your resident, consultants, patients and families)~~
- ~~Coordination of care~~
- ~~Information management (timely notes, verbal and written sign-out)~~

~~Goals:~~

- ~~Assume primary responsibility for patient, including new emphasis on communication, coordination of care, and information management~~
- ~~Develop comfort in being first-call for ward patients, including learning how to assess and manage common on-call issues that arise~~
- ~~Develop efficiency and effectiveness in prioritizing tasks on multiple patients~~

~~Responsibilities at ZSFG:~~

1. ~~Call expectations:~~
   - ~~On average, admit 3 at least 2 patients on call, at discretion of supervising resident who understands the overall team/other intern census and complexity of patients~~
   - ~~Expectation to pass the rotation is that you can admit and manage 2 patients a call night Daily census may range on average 3-6 patients, depending on call cycle~~
   - ~~Go home post-call at same time as team; sign-out to covering intern with the rest of the team~~
   - ~~No cross-cover; cover your patients only~~
2. ~~Orders:~~
   - ~~Write admit and daily orders with your resident. The current electronic ordering system does not allow order entry by students. Legible co-signatures with "MS4" for each order~~
   - ~~(when written on 4B or other wards without electronic ordering)~~
3. ~~Discharge summaries:~~
   - ~~You are responsible for discharge summaries at SFGH~~
   - ~~All patients must have discharged summaries in the LCR within 24 hours of discharge.~~
   -
4. ~~Days off:~~
   - ~~1 day off per week; specific days are decided with your resident because the resident needs to consider days off/clinic days for other team members~~
5. ~~Set expectations early with your team~~
   - ~~Sit down with your resident and your attending to set up goals/expectations (yours and theirs)~~
   - ~~As you know, every team has its own dynamic and expectations, so check in with your resident and attending at beginning, midway, and at the end~~
   - ~~If you have a light census, ask your interns, MS3, and resident to see how you can help – they will appreciate your interest in helping the team~~
   - ~~Midway through your rotation you will be required to have your resident and attending give you feedback on your performance. There is a Midpoint Feedback card that should document these conversations with items of feedback. If the resident or attending feel you are not able to fulfill the expectations of the rotation at the midpoint you should schedule an appointment with me immediately.~~
   -

~~Thank you for joining us, and we hope you learn a lot on your subinternship. Have a great month!~~

~~Please contact me, the House staff coordinator or the Chief Residents with any questions:~~

~~Margaret Wheeler~~ ~~Medicine Clerkship~~ ~~mwheeler@medsfgh.ucsf.edu~~
~~Site Director,~~ ~~(415) 206-3457~~

Goals:

- Assume primary responsibility for patient, including new emphasis on communication, coordination of care, and information management.
- Be the main person updating patients and families, contacting consultants and outpatient providers, and coordinating with interdisciplinary team members.
- Develop comfort in being first-call for ward patients, including learning how to assess and manage common on-call issues that arise.
- Develop efficiency and effectiveness in prioritizing tasks on multiple patients
- Students will be supervised in these tasks, especially early on, but the goal is for them to develop independence.

Objectives:

Patient Care

- Acquire accurate and relevant histories from patients in an efficiently customized, prioritized, and hypothesis-driven fashion
- Perform accurate physical examinations that are appropriately targeted to the patient's complaints and medical conditions. Identify pertinent abnormalities
- Recognize situations which need urgent or emergent medical care, including life threatening conditions
- Recognize when to seek additional guidance
- Request and provide consultative care
- Recognize tasks that are needed to be completed to advance patient care
- Make appropriate priorities in tasks that are needed to be done to advance patient care
- Execute tasks needed to advance patient care

Medical Knowledge

- Understand the relevant pathophysiology and basic science for common medical conditions
- Select, order, and interpret appropriate diagnostic tests, paying attention to how the results will affect management.

Interprofessional and Interpersonal Communication

- Deliver appropriate, succinct, hypothesis-driven oral presentations
- Provide legible, accurate, complete and timely written communication that is congruent with medical standards
- Request consultative services in an effective manner
- Actively seek to understand patient differences and views and reflect this in respectful communication and shared decision-making with the patient and the healthcare team
- Communicate compassionately, and in language appropriate for each person, with patients and their families about their illness experience, clinical situation, and goals.
- Provide patients and their families with anticipatory guidance for diagnosis, prognosis and treatment.
- Communicate appropriately with each patient depending on their needs including the using interpreters, low literacy language and resources and culturally sensitive approaches.
- Effectively communicate plan of care to all members of the health care team.
- This includes planning and communicating effectively with other providers to facilitate safe transitions of care for patients within the hospital (i.e., morning hand-offs for patients admitted by another team; evening sign-outs) and on discharge.
- Communicate respectfully and clearly with consultants, primary care providers, and allied health professionals to advance patient care and provide safe and continuous care.

Systems Based Care

- Work effectively as a member within the interprofessional team to ensure safe patient care
- Appreciate the variety of health care provider roles, including, but not limited to, consultants, therapists, nurses, home care workers, pharmacists, and social workers
- Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, subacute, acute, rehabilitation and skilled nursing

Practice Based Care

- Actively seek to expand knowledge, through supplemental reading and consultation of the literature, soliciting and responding to feedback and self-reflection

Professionalism

- Recognize when it is necessary to advocate for individual patient needs
- Respond promptly and appropriately to clinical responsibilities, including but not limited to calls and pages
- Ensure prompt completion of clinical, administrative, and curricular tasks
- Carry out timely interactions with colleagues, patients and their designated caregivers
- Recognize and address personal, psychological, and physical limitations that may affect professional performance
- Recognize the scope of abilities and ask for supervision and assistance appropriately

Patient Advocacy

- Recognize the social determinants of health that may be contributing to health, illness and the effectiveness of care for an individual patient.
- Construct patient-centered diagnostic, treatment and discharge plans based upon recognition of influential social determinants of health for individual patients. Promote variations in plans and mobilize and provide resources to execute patient-centered care.
- Minimal Competency expected at end of the rotation
- The Acting Intern will be able to admit 2 patients on a call day and manage them semi-independently, while maintaining responsibility for the patients they have previously admitted.

Responsibilities and Assessments:

1. Call expectations:
   - Work up to admit 2 patients on call, at discretion of supervising resident who understands the overall team/other intern census and complexity of patients
   - By end of rotation, must be able to semi-independently admit 2 patients
   - Daily census may range on average 2-5 patients, depending on call cycle
   - Go home on-call and post-call at same time as team; sign-out as interns do

2. Orders:
   - Acting interns can pend orders in EPIC

3. Documentation/Discharges:
   - Be responsible for writing discharge summaries and review with resident

4. Days off:
   - 1 day off per week for total of 4 days during 28-day rotation; specific days are decided with your resident because the resident needs to consider days off/clinic days for other team members

5. Absences:

a. Students should notify their teams (attending/resident), site director, and course coordinator (Amy Zhen) of any planned or emergency absences.
b. Turn in SOM absence request at this link: https://ucsf.co1.qualtrics.com/jfe/form/SV_b8EFcYYTn9bEGiN

6. Expectations
   - Sit down with resident and attending to set up goals/expectations
   - Check in with resident and attending at beginning, midway, and at the end

7. Assessments and feedback
   - This is a purely clinical rotation without a final exam. Students are evaluated by resident/s and attending/s only. It is graded H/P/F.
   - Residents and attendings who have been assigned for 7 days or more on the calendar will be assigned an evaluation. Usually this entails fewer than 7 days actually working together because of days off (e.g., the number of actual work days together is shorter, e.g., 4-5)
   - Fill out the midpoint attending feedback card and turn it in to Amy Zhen.
   - Fill out one BBOT on the ability to identify and execute tasks. Verbally request one task-oriented BBOT from either a resident or attending during the rotation. Then summarize their feedback under "Other" using BBOT QR code.

8. Work Hour Policy
   - Work hours are defined as all clinical and academic activities related to the rotation. This is defined as patient care (including patient-related administrative duties such as patient notes) and scheduled activities (such as conferences). It does NOT include time spent studying for exams, reading, preparing for oral presentations, or commute time.
   - Clinical and educational work hours must be limited to no more than 80hrs/week; medical students should be scheduled for no more than 72 hours/week.

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 :	*Department of Urology*
Date of last approval:	*February 2022*
Summary of R&R updates:	*Updates to dates (2024), Scope of Services, Circumcision patient population, & minor pronoun / other grammatical changes.*
Update #1:	The Urology Clinical Service is staffed to provide complete care for all urological problems ~~in female and male genital~~ urinary ~~problems~~. The services include adult and pediatric care in both outpatient and inpatient ~~care~~ environments. All necessary surgical procedures for appropriate care in urological and genital surgery is provided.
Update #2:	**MALE GENITAL SYSTEM** **PENIS** Circumcision ~~infant and adult~~

~~2022~~ 202~~4~~~~20~~

UROLOGY CLINICAL SERVICE
RULES AND REGULATIONS

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

UROLOGY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

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

I. UROLOGY CLINICAL SERVICE ORGANIZATION

A. PREAMBLE

1. The Rules and Regulations of the Urology Clinical Service define certain standards of practice and other rules for the organization of the department and the duties of its members.
2. Standards of clinical practice will be consistent with those standards established by the American College of Surgeons as set forth in the document "Hospital and Pre-hospital Resources for Optimal Care". If an apparent conflict exists, the standards defined in this document will prevail.
3. The Urology Clinical Service Rules and Regulations will supplement those set forth in the Bylaws and Rules and Regulations of the Medical Staff of Zuckerberg San Francisco General.
4. 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 department adopts a more stringent standard.

B. SCOPE OF SERVICE

The Urology Clinical Service is staffed to provide complete care for all urological problems ~~in female and male genital urinary problems~~. The services include adult and pediatric care in both outpatient and inpatient ~~care~~ environments. All necessary surgical procedures for appropriate care in urological and genital surgery is provided.

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C. MEMBERSHIP REQUIREMENTS

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

D. ORGANIZATION AND STAFFING OF THE UROLOGY CLINICAL SERVICE

The Urology Clinical Service consist of the following officers:

- Chief of Service
- Director of Performance Improvement & Patient Safety
- Attending Physician

1. Chief of Service
   a. Appoint and review
      Appointment and review of the Chief of Service will occur by the process specified in the ZSFG Medical Staff Bylaws.

      Responsibilities
      1) Overall direction of the clinical, teaching and research activities for the Urology Clinical Service.
      2) Review and recommendation on all new appointments, requests for privileges and reappointments of the Urology Clinical Service.

3) Appointment of the remaining officers of the Urology Clinical Service and of the Urology Clinical Service committee members.
4) Financial affairs of the Urology Clinical Services.
5) Disciplinary actions as necessary, as set forth in the Urology Clinical Service Rules and Regulations and in the Bylaws and Rules and Regulations of the Medical Staff.
6) Chief, Urology Clinical Service job description – see ATTACHMENT D

2. Director of Performance Improvement and Patient Safety
   a. Responsibilities
      1) Assists in the reappointment process of the Urology Clinical Service members.
      2) Provide overall direction to the Performance Improvement and Patient Safety of the Urology Clinical Service.

3. Attending Physician
   a. Responsibilities
      1. Overall direction of clinical care is the responsibility of the attending staff of the Urology Clinical Service. In order to discharge that responsibility, close supervision and active participation in decision-making is required in all surgical cases.
      2. Death and Complications shall be presented monthly to the entire Attending staff for discussion and recommendation.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

B. REAPPOINTMENTS

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

1. Modification of Clinical Service
   The process for Modification of Urological Clinical Service is requested through the appropriate review process.

2. Staff Status Change
   The process for Staff Status Change for members of the Urology Services is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

3. Modification/Changes to Privileges

The process for Modification/Change to Privileges for members of the Urology Services is in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

C. PRACTITIONER PERFORMANCE PROFILES

Refer to IX D, Clinical Service Practitioner Performance Profiles

D. AFFILIATED PROFESSIONALS

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

E. STAFF CATEGORIES

Members of the Urology Service fall into the same staff 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

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Urology Clinical Service Privilege Request Form shall be reviewed annually.

C. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

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

1. Privileges to practice in the Urology Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice. The specifics of the process and the privileges, which will be assigned, are described in detail in the *Delineation of Privileges, Urology Service - Attachment A.*

2. Privileges are delineated by consensus of the active members of the Urology Clinical Service, and are approved by the Chief of Urology, subject to the approval of the Credentials Committee of the medical staff.

3. Individual privileges are subject to review and revision at the time of initial appointment, throughout the period of proctoring, and at the time of reappointment. In addition, the Chief of Service, with consensus of the Urology

attendings, at any time judged necessary may also review and ~~revised~~ revise individual privileges.

4. The process for modification/change to the privileges for members of the Urology Service is in accordance with the ZSFG Medical Staff Bylaws and Rules and Regulations.

D. TEMPORARY PRIVILEGES

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

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IV. PROCTORING AND MONITORING

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A. REQUIREMENTS

Proctoring and monitoring requirements for the Urology Clinical Service shall be the responsibility of the Chief of the Service. All requirements and details of proctoring are delineated in the document *Proctoring Procedure Urology Service - Attachment B.*

1. All new privileges whether at the time of initial appointment or later will be proctored for a period one (1) year or until an adequate number of operative cases have been proctored.
2. If failure to achieve proctoring due to lack of opportunity to proctor (i.e., too few cases to evaluate performance) during the first year of appointment, an extension of six months may be granted by the Chief of Urology.

Any applicant who has successfully completed residency training at UCSF and has been evaluated by the Urology Faculty here at ZSFG during that training shall be exempt from the proctoring process. All other requirements in the process shall be completed. Residency training evaluations will satisfy the major portion of proctoring requirements. All requirements and details of proctoring are delineated in the document ~~-~~*Proctoring Procedure Urology Service - Attachment B.*

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Urology Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations.

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION OF MEDICAL STAFF

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All members of the Urological Clinical Service are ~~-~~afforded the opportunity to attend UCSF departmental courses for CME credits.

~~IV.~~VI. CLINICAL SERVICE HOUSE STAFF TRAINING PROGRAM AND SUPERVISION

(Refer to CHN Website for Housestaff Competencies link.)

A. The Chief of Urology is responsible for training and teaching activities of the Urology Clinical Service. Training of House Staff is done in conjunction with the Chair of Urology at UCSF and the UCSF training program.

B. Attending faculty shall supervise house staff in such a way that house staff assume progressively increasing responsibility for patient care according to their level of training ability and experience. For House Staff competencies, contact the patient's Attending Physician.

C. All surgical cases and invasive procedures done by the Urology Clinical Service House Staff shall have an attending responsible faculty member present during the procedure.

D. Each resident is evaluated by all members of ~~the of~~ the attending staff during ~~his/her~~their rotation. Each of the staff completes an evaluation and the summary of this information is presented to the house staff by the Chief of Service.

1. Wednesday conferences are directed to ~~inservice~~in-service training and lectures by residents. These meetings are to discuss cases, evaluate management, and provide a means to improve care.
2. M/M Conference includes evaluation and discussion of all department wide deaths and appropriate cases with an emphasis on specific problems and/or possible changes in practice and improvement of care.
3. Ability to write patient care orders: House staff members may independently write patient care orders with the following exceptions: DNR, emergent medical necessity.

~~V.~~VII. CLINICAL SERVICE CONSULTATION CRITERIA

Urological consultation may be requested by contacting the on-call Urologist. All consults will be seen promptly 24 hours per day.

~~VI.~~VIII. DISCIPLINARY ACTION

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

~~VII.~~IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY (PIPS), AND UTILIZATION MANAGEMENT

The Urology Clinical Service is committed to the maintenance of the highest standard possible of practice. The Urology Clinical Service Performance Improvement and Patient Safety Program is detailed in the document *Performance Improvement and Patient Safety Plan, Urology Clinical Service, Zuckerberg San Francisco General - Attachment C.*

The Chief of Service, or designee, is responsible for ensuring solutions to quality care issues. As necessary, assistance is invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization such as: Executive Committee; OR Committee, etc.

Patient care is provided chiefly in 3M Clinic, the operating room and Cysto suite, but also includes other areas such as Emergency Room; intensive care units, Radiology, etc. Efficiency in delivery of service is a prime objective: to minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care.

A. REPORTING / MEDICAL RECORDS

The members of the Urology Clinical Service are committed to the maintenance of completed, accurate and timely medical records. The requirement as set forth in the ZSFG Bylaws, and Rules and Regulations as well as these Clinical Service Rules and Regulations.

B. RESPONSIBILITY / INFORMED CONSENT

All decisions for treatment should involve the active participation of the patient, and should be made after appropriate discussions or risks, benefits and alternatives as set forth in the ZSFG Bylaws and Rules and Regulations.

C. CLINICAL INDICATORS

Urological Clinical Indicators are outlined in the *Performance Improvement and Patient Safety Plan - Urology Clinical Service – Attachment C.* In addition, clinical care is monitored and evaluated by:

1. Preoperative Care
2. Appropriate Indicators for Surgery
3. Operative Complications
4. Operative Results
5. Post-operative Complications
6. Post –operative Care
7. Tissue Review

Clinical Indicators which are reviewed for reappointment in addition to the above include:

1. Operative Complications
2. Blood Usage
3. Returns to the Operating Room
4. Record Monitoring

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Urological Clinical Indicators are outlined in the Performance Improvement and Patient Safety Plan - Urology Clinical Service -Attachment C.

E. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

Monitoring and evaluation of appropriate patient care services of physicians and housestaff are done monthly by a morbidity and mortality conference with complete discussion of case histories and outcomes. *Refer to Performance Improvement and Patient Safety Plan - Urology Clinical Service – Attachment C.*

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

Monitoring and evaluation of professional performance and housestaff are done monthly by a morbidity and mortality conference with complete discussion of case histories and outcomes. Refer to *Performance Improvement and Patient Safety Plan – Urology Clinical Service -Attachment C.*

~~VIII.~~X. MEETING REQUIREMENTS

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

The Urology 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.

~~IX.~~XI. ADDITIONAL CLINICAL SERVICE INFORMATION

The Chief of Urology is responsible for training and teaching activities of the Urology Clinical Service.

The Urology Clinical Service Performance Improvement and Patient Safety Program is detailed in the document *Performance Improvement and Patient Safety Plan, Urology Clinical Service, Zuckerberg San Francisco General - Attachment C.*

All decisions for treatment should involve the active participation of the patient, and should be made after appropriate discussions or risks, benefits and alternatives as set forth in the ZSFG Bylaws and Rules and Regulations.

~~X.~~XII. ADOPTION AND AMENDMENT

The Urology Clinical Service Rules and Regulations will be adopted and revised by a majority vote of all Active members of the Urology Service annually at a quarterly held Urology Clinical Service meeting.

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

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

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.

UROLOGY 2010

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.

40.00 URINARY SYSTEM:

40.10 GENERAL PROCEDURES

_____ _____ Preoperative, operative and post-operative care of all patient with urological and genital diseases and conditions. This includes cystoscopy, transurethral resection of prostate and bladder, ureteroscopy, neprhoscopy, scrotal surgery including orchiectomies, nephrectomies, open prostatectomies, transrectal ultrasound and prostate biopsy, penile and urethral surgery, urological and genital trauma, percutaneous renal surgery.

Requested	Approved	
		KIDNEY
_____	_____	Renal exploration
_____	_____	Drainage of perirenal or renal abscess
_____	_____	Nephrotomy, Nephrolithotomy, PNL
_____	_____	Pyelotomy with exploration or drainage, pyelolithotomy
_____	_____	Nephrectomy-simple, partial, radical, laparoscopic
_____	_____	Repair of renal injury
_____	_____	Pyeloplasty-open or laparoscopic
_____	_____	Renal endoscopy
_____	_____	Lithotripsy
		URETER
_____	_____	Utererotomy with exploration or ~~draimage~~drainage
_____	_____	Ureterolithotomy, open or laparoscopic
_____	_____	Ureterectomy with bladder cuff
_____	_____	Ureterectomy-total, ectopic, abdominal, vaginal or perineal approach
_____	_____	Repair of ureter-open and laparoscopic
_____	_____	Ureteral endoscopy
		BLADDER
_____	_____	Cystostomy-with fulguration, cryosurgical destruction, drainage, basket extraction of calculus
_____	_____	Cystolithotomy
_____	_____	Transvesical ureterolithotomy
_____	_____	Cystectomy-partial or complete
_____	_____	Pelvic exenteration
_____	_____	Repair of bladder-open and laparoscopic
_____	_____	Urodynamics
_____	_____	Endoscopy-cystoscopy, urethroscopy, cystourethroscopy
		~~Tansurethral~~Transurethral surgeries of bladder and urethra, ureter and pelvis, vesical neck and prostate.
		URETHRA
_____	_____	Urethrotomy, meatotomy ~~infant and adult~~
_____	_____	Drainage of periurethral, perineal and Skene's gland abscess
_____	_____	Urethrectomy, biopsy of urethra

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_____ _____ Excision of diverticulum, Cowper's and Skene's glands, caruncle, urethral prolapse
_____ _____ Urethral repair- urethroplasty, urethrolysis, urethromeatoplasty, sling and sphincter
_____ _____ Repair of urethral injury
_____ _____ Closure of urethrostomy or urethrocutaneous fistula.

MALE GENITAL SYSTEM

PENIS

_____ _____ Circumcision~~- infant and adult~~
_____ _____ Destruction of lesions-electrodesiccation, cryosurgery, laser and surgical
_____ _____ Penile amputation-partial, complete, radical with lymphadenectomy
_____ _____ Penile repair- chordee, hypospadias, urethroplasty with graft or flap
_____ _____ Plastic surgery to correct angulation with or without skin grafting
_____ _____ Plastic operation for epispadias distal to external sphincter
_____ _____ Insertion, removal and replacement of penile prosthesis
_____ _____ Corpora cavernosa vein shunt - unilateral or bilateral
_____ _____ Penile operation for injury.

TESTIS

_____ _____ Orchiectomy- simple, partial or radical. Inguinal, abdominal or laparoscopic
_____ _____ Exploration for undescended testis-inguinal or scrotal
_____ _____ Exploration for undescended testis with abdominal exploration
_____ _____ Orchiopexy for spermatic cord torsion with fixation of contralateral testis
_____ _____ Orchiopexy-inguinal with or without hernia repair
_____ _____ Orchiopexy-abdominal or laparoscopic
_____ _____ Transplantation of testis to thigh
_____ _____ Repair of testicular injury

EPIDIDYMIS

_____ _____ Incision and drainage of epididymis, testis or scrotal space
_____ _____ Excision of spermatocele, lesion of epididymis
_____ _____ Epididymectomy-unilateral or bilateral
_____ _____ Exploration of epididymis
_____ _____ Epididymoasostomy, ~~anatomosis~~anastomosis of epididymis to vas deferens

TUNICA VAGINALIS

_____ _____ Aspiration of hydrocele, tunica vaginalis
_____ _____ Excision of hydrocele-unilateral or bilateral with or without hernia repair
_____ _____ Repair of tunica vaginalis hydrocele-unilateral or bilateral

SCROTUM

_____ _____ Drainage of scrotal abscess
_____ _____ Scrotal exploration and removal of foreign body
_____ _____ Resection of scrotum
_____ _____ Scrotoplasty-simple or complicated, with or without skin grafting

VAS DEFERENS

_____ _____ Vasotomy with or without incision of vas deferens, unilateral or bilateral
_____ _____ Vasectomy- unilateral or bilateral

_____	_____	Repair of vas deferens -vasovasostomy, vasovarrhaphy
_____	_____	Ligation (~~percutaenous~~percutaneous) of vas deferens-unilateral or bilateral

Requested Approved

SPERMATIC CORD

_____	_____	Excision of hydrocele of spermatic cord
_____	_____	Excision of lesion of spermatic cord
_____	_____	Excision of varicocele or ligation of spermatic veins, abdominal or laparoscopic
_____	_____	Excision of varicocele with hernia repair

SEMINAL VESICLES

_____	_____	Vesiculotomy-simple or complicated
_____	_____	Vesiculectomy
_____	_____	Excision of Mullerian duct cyst

PROSTATE

_____	_____	Biopsy needle, punch or any other approach
_____	_____	Prostatectomy-perineal subtotal or radical w/ bilateral pelvic lymphadenectomy
_____	_____	Prostatectomy-retropubic subtotal or radical w/ bil pelvic lymphadenectomy
_____	_____	Laparoscopic ~~prostatectom~~prostatectomy retropubic radical, including "nerve sparing" ~~sparing~~
_____	_____	Exposure of prostate, any approach

FEMALE GENITAL SYSTEM

_____	_____	Incision and drainage of gland cyst
_____	_____	Marsupialization of gland cyst
_____	_____	Suture of vagina and or perineum
_____	_____	Colporrhaphy-anterior or posterior
_____	_____	Paravaginal defect repair abdominal/vaginal approach
_____	_____	Sling operation, fascia or synthetic
_____	_____	Removal or revision of sling

PREREQUISITES: Currently Board Qualified, Board Certified or Recertified by the American Board of Urology or a member of the Clinical Service prior to July 1, 2000.
PROCTORING: Five (5) observed operative procedures or 15 retro-operative review of operative procedures.
REAPPOINTMENT: Fifty (50) operative procedures the past two years at UCSF Hospitals or ZSFG.

_____ _____ 40.20 RADICAL PROCEDURES AND URINARY DIVERSION

Preoperative, operative and post-operative care of patients with major urological and genital diseases. This includes radical cystectomy, radical prostatectomy, radical nephrectomy, urinary diversions including use of large and small bowel segments, retroperitoneal lymphadenectomy, radical penectomy, radical groin dissection and pelvic exenterations.
PREREQUISITES: Currently Board Qualified, Board Certified or Recertified by the American Board of Urology or a member of the Clinical Service prior to July 1, 2000.
PROCTORING: Five (5) observed operative procedures.

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

REAPPOINTMENT: Three (3) cases in the past two years at UCSF Hospitals and ZSFG.

_____ _____ 40.30 LASER SURGERY
Laser procedures including CO2, Holmium, KTP and Argon
PREREQUISITES: Appropriate training, viewing of the laser safety video prepared by the ZSFG Laser Safety Committee, and baseline eye examination
PROCTORING: 2 observed procedures
REAPPOINTMENT: 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 exam within the previous 6 months

_____ _____ **41.00 SPECIAL PRIVILEGES**

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Requested Approved

_____ _____ 41.10 LAPAROSCOPIC UROLOGICAL PROCEDURES
PREREQUISITES: Currently Board Qualified, Board Certified or Recertified by the American Board of Urology. Demonstrates competence in laparoscopic urological surgery and completion of urological residency/fellowship that incorporates structured experience in laparoscopic surgery. For those without formal training during residency or fellowship in laparoscopic procedures, the minimum of successful completion of twenty five (25) cases.

PROCTORING: Two (2) observed operative procedures.
REAPPOINTMENT: Five (5) operative procedures in the past two years at UCSF

_____ _____ 41.20 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY
PREREQUISITES: Currently Board Qualified, Board Certified or Recertified by the American Board of Urology or a member of the Clinical Service prior to July 1, 2000 and current x-ray/fluoroscopy certificate.
PROCTORING: One (1) observed procedure.
REAPPOINTMENT: Two (2) procedures in the previous two years and possession of an x-ray/fluoroscopy certificate.

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.

APPROVED BY:

_____	_____
Division Chief	~~date~~Date
_____	_____
Service Chief	~~date~~Date

ATTACHMENT B – PROCTORING PLAN – UROLOGY CLINICAL SERVICE

New applicants to the Urology Clinical Service of Zuckerberg San Francisco General Hospital requesting hospital privileges in urological surgery shall:

1. Obtain a copy of the Medical Staff Bylaws of Zuckerberg San Francisco General Hospital and the Urology Clinical Service Rules and Regulations.

2. Have completed a residency training program in Urology except for Class 1A Privileges.

3. Receive a definition of privileges from the Chief of Urology.

4. Work within the frame of the Urology Residency Training Program of the University of California, San Francisco.

5. Be recommended by the Chief of Urology Service for Active or Courtesy Staff

Any applicant who has successfully completed residency training at UCSF within 3 years and has been evaluated by the Urology Faculty at ZSFG during that training shall be exempt from the proctoring process. All other requirements in the process shall be completed. Residency training evaluations will satisfy the major portion of proctoring requirements.

Appointment and Responsibilities of Proctors:

1. Proctor Qualifications:

   a. Member ~~of the~~of the Active Staff or member of UC Faculty with Courtesy staff appointment.

2. Proctor(s) will be appointed by the Chief of the Urology Service.

3. Prior to scheduling a case for surgery, the applicant must have contacted and arrange for one of the appointed proctor(s) to be present during surgery.

4. After one year, the proctor's reports and ~~a recommendations~~recommendations from the Chief of Urology Service shall be sent to the appropriate committee for staff membership action.

5. Anyone performing urological surgery can be placed under observation at any time when it is deemed indicated by the Chief of Urology Service, or

   a. Credentials Committee
   b. Medical Executive Committee
   c. Operating Room Committee

   The duration of the observation shall be at the discretion of the Chief of Urology, and a report shall be made to the requesting committee.

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

REPORT FORM FOR PROCTORS – UROLOGY CLINICAL SERVICE

_____
Applicant's Name

_____
Date

Patient's Name: _____

Date ~~of Birth~~of Birth: _____

ZSFG B #_____

Pre-Operative Work-up and Care:

Satisfactory _____
Unsatisfactory _____

Pre-Operative Diagnosis Appropriate:

Satisfactory _____
Unsatisfactory _____

Indications for Surgery Appropriate:

No _____
Yes _____

OPERATION:_____

Post-Operative Care

Satisfactory _____
Unsatisfactory _____

COMMENTS:

RECOMMENDATION
Satisfactory _____
Unsatisfactory _____

_____
Signature of Proctor **Date**

ATTACHMENT C – PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN
UROLOGY ~~CLINICAL SERVICE~~CLINICAL SERVICE

The purpose of this Performance Improvement and Patient Safety Plan is to monitor the activities of the Urology Clinical Service in order that the highest quality of medical care be provided for the patients on the Service. The Chief of Urology is responsible for carrying out this program.

The thrust of this program will focus on known or suspected patient care problems.

1. A monthly review of all complications and deaths is carried out with the entire faculty present. Each case is presented in detail, including x-rays, pathology and surgical procedures in each to explore all issues. Presentations are designed to facilitate discussions regarding problem areas in each case.

2. Tissue reports from pathological specimens of all surgical cases is reviewed by the Chief of Urology Service. Also reviewed are all cases of surgical procedures where pathologic specimens are not submitted for tissue evaluation.

3.~~4.~~ The Chief of Urology Service reviews all operative reports done within the service.

4.~~5.~~ Following discharge of the patient, each chart is carefully reviewed by the Chief of Urology Service ~~in regards to~~in regard to appropriate diagnosis and treatment of the patient's specific disease process.

5.~~6.~~ Clinical surveys are done at the discretion of the Chief of the Urology Service when patterns and trends ~~suggests~~suggest more clinical data is necessary to assess problems.

6.~~7.~~ The Chief of Urology or faculty member at ZSFG makes daily rounds on all patients and inserts appropriate progress notes regarding the care of such patients.

7.~~8.~~ Weekly rounds are made with all residents, and all patients on the service are presented and discussed.

8.~~9.~~ The fourth Wednesday of every month, an hour and a half clinical conference presentation on difficult cases and interesting cases are made before the clinical attending faculty. Complete case discussions are done at this conference which includes appropriateness of care.

If problem patterns and trends are identified, the remedial action plan includes:

a. Education and training programs
b. Newly revised polices and procedures
c. Staffing changes
d. Equipment changes within the facility
e. Counseling and proctoring

Once the remedial action plan has been initiated, follow-up and monitoring ~~is~~are done to insure the desired results have been achieved and sustained.

Problem trends and occurrences as well as remedial action and follow-up are reported to the PIPS Committee on an as needed basis. Records of these reports are maintained. The Executive Committee is presented an annual report at the discretion of the PIPS Committee.

Inter-departmental quality and utilization management issues and problems are managed by direct consultation with the Chief of the other department to resolve the problem. Should this be unsuccessful, a direct report to the PIPS Committee is made and an attempt to solve the problems through the PIPS Committee is made.

REPORTING

Evidence of all departmental quality and utilization management activity will be maintained in the department. A portion or all of this material may be reported during the monthly departmental staff meeting. These meetings are in conjunction with the University of California, Department of Urology. Minutes of the meeting will be kept on file in the Department of Urology office.

PEER REVIEW

House staff in the Urology Service at ZSFG are full-time residents in the University of California, San Francisco, Department of Urology training program. These residents spend four months per rotation on the Urology Service at this institution. All patient care is under the direct supervision of an attending physician. After completion of each resident's rotation, a full evaluation form is completed by the Chief of Service and forwarded to the Chair of the Department of Urology, UCSF. In addition, at termination of each rotation, each resident is individually counseled by the Chief of Urology Service at ZSFG regarding his performance and at that time, suggestions for improvements or changes are made. Provisions exist within the department to place residents on probation and/or suspension if indicated and necessary.

All medical staff members of the Urology Service at ZSFG hold faculty appointments at UCSF. Each faculty member is evaluated by the Chair of the Department of Urology at the time of initial appointment and periodically in connection with merit and promotional reviews in accordance with the standard of the University of California. Each staff member of the Urology Service submits an annual request for renewal of his appointment with appropriate documentation of required information. In addition, the Chief of Urology Service reviews each application and also reviews in detail the clinical performance of the individual staff member.

Clinical care is evaluated by:

(1) Preoperative care
(2) Appropriate indications for surgery
(3) The operative complications
(4) Operative results
(5) Post-operative complications
(6) Post-operative care
(7) Tissue review
(8) Number of Cases
(9) Blood Usage
(10) Length of Stay
(11) Record Keeping

All patient~~'~~s cared for by an individual staff member are reviewed by the Chief of the Urology Service at ZSFG. Recommendations regarding reappointment are based on the staff ~~members~~member's clinical judgement and the professional performance.

The Urology Service ~~departmental~~Departmental Performance Improvement and Patient Safety Plan is evaluated and updated annually in order to meet the needs of the service.

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

ATTACHMENT D – CLINICAL SERVICE CHIEF JOB DESCRIPTION

Chief of Urology Clinical Service

Position Summary:

The Chief of Urology Clinical Service directs and coordinated the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General (ZSFG) and the Department of Public Health (DPH). The Chief also 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 Urology Clinical Service reports directly to the Vice Dean and the University of California, San Francisco (UCSF) Department Chair. The Chief is reviewed not less than every four years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Vice 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 Urology 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 Urology 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.

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

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

1. *Summarize the content changes using the table in Section I that were made to the SP/protocols or Privileges*
2. *Complete Section II: Follow instructions outlined in table*
3. *Email the revised SP with track changes and this completed form to the Medical Staffing Office (zsfg-credentialing@sfdph.org), the CIDP Coordinator (justin.dauterman@sfdph.org), and CIDP Co-Chairs (vagn.petersen@sfdph.org).*

Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:	
Person completing this form:	
Standardized Procedure Title:	Standardized Procedure- Nurse Practitioner/Physician Assistant: Combined Otolaryngology
Department:	Otolaryngology-Head and Neck Surgery
Dept Chief:	Megan Durr, MD
SP Author(s):	Megan Durr, MD and Patricia Loftus, MD
Update #1:	Addition of Protocol #17: Botox injection for sialorrhea with prerequisites/proctoring/reappointment documentation to match the UCSF Health protocol
Update #2:	Addition of Protocol #18: Botox injection for temporomandibular joint disorder with prerequisites/proctoring/reappointment documentation to match the UCSF Health protocol
Update #3:	Minor grammar and spelling updates throughout

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below.

Preamble	2023 CIDP SP Preamble DRAFT (1). • The Preamble is the portion of the SP that precedes the Protocols, the first pages of the SP, outlined I-VII, includes sections "Policy Statement, "Functions to be Performed," etc.. • The Preamble was updated in 2023 to include changes in legislation, regulations, and practice. (CIDP, 10/2023)
Equity	Ensure language within the SP is inclusive. Examples include but are not limited to: • Do not use race/ethnicity descriptors unless necessary • Do not use sex assigned at birth unless necessary • Use "their" rather than "him/her" (CIDP, 8/2022)
ZSFG	Change "San Francisco General Hospital" to "Zuckerberg San Francisco General Hospital" and SFGH to ZSFG (CIDP, 10/2016)
Qualified Provider	Insert the following after every use of words "qualified provider:" who has completed proctoring and subsequently maintained their eligibility for performing the procedure. *Example: 2 direct observations of procedure by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure*. (Credentials Committee, 11/2023)
Prerequisites	Onsite training no longer to be listed as a prerequisite. Instead, the training to be completed once procedure is approved for the provider and then before the provider initiates proctoring. Update protocols to reflect this change (Credentials Committee, 11/2023)

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Combined Otolaryngology

I. Policy Statement

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

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Otolaryngology/Head and Neck Surgery 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 primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

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

conditions requiring the Nurse Practitioner to seek physician consultation.

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

The NP/PA conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventative health care, assist in surgery, perform invasive procedures and furnish medications/issue drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting
   1. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center.
   2. Role in the inpatient and outpatient setting may include performing physical exams, ~~diagnosing~~diagnosing, ~~and~~ treating illnesses, ordering and interpreting tests, counseling on preventative health care, assisting in surgery, performing invasive procedures and furnishing medications or issuing drug orders for the Otolaryngology patient as well as admitting, transferring, and discharging Otolaryngology patients within the hospital setting.

B. Supervision

   1. Overall Accountability:
      The NP/PA is responsible and accountable to: the Chief of Otolaryngology.

2. A consulting physician that may include attending and fellows with Clinical instructor status will be available to the NP/PA, by phone, in person, or by other electronic means at all times.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical, or laboratory findings.
   d. Upon request of patient, affiliated staff, or physician.
   e. Problem requiring hospital admission or potential hospital admission.
   f. Acute, severe respiratory distress.
   g. An adverse response to respiratory treatment, or a lack of therapeutic response.

IV. Scope of Practice

~~1. HCM: Acute/Urgent Care/Inpatient Care/Outpatient Care~~
~~2. Furnishing Medications/Drug Orders~~
~~3. eReferral Review~~
~~4. Nasopharyngoscopy~~
~~5. Rigid Nasal Endoscopy~~
~~6. Chemical Nasal Cautery with Silver Nitrate~~
~~7. Manual Cerumen Disimpaction under ear microscope~~
~~8. Manual removal of a foreign body under ear microscope~~
~~9. Debridement of Nasal Mucous or Crusts with Use of Rigid Endoscope following endoscopic sinus Surgery~~
~~10. Nasal Biopsy obtained under guidance of Rigid Nasal Endoscopy~~
~~11. Punch Biopsy, Incisional Biopsy or Excisional Biopsy less than 5mm~~
~~12. Tracheotomy Tube Change~~
~~13. Myringotomy with and without tube placement~~
~~14. Inferior turbinate coblation~~
~~15. Limited diagnostic ultrasound of the neck~~
~~16. Ultrasound-guided needle placement~~
~~17. Botox injection~~

1. Health Care Management – Acute/Urgent Care/Inpatient and Outpatient Care
2. Furnishing Medications/Drug Orders
3. eReferral Review
4. Nasopharyngoscopy

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5. Rigid Nasal Endoscopy
6. Chemical Nasal Cautery with Silver Nitrate
7. Manual Cerumen Disimpaction under Ear Microscope
8. Manual removal of a Foreign Body under Ear Microscope
9. Debridement of nasal mucous or crusts with use of Rigid Endoscope following endoscopic sinus surgery
10. Nasal Biopsy Obtained under Guidance of Rigid Nasal Endoscopy
11. Punch Biopsy, Incisional Biopsy or Excisional Biopsy less than 5mm
12. Tracheostomy Tube Change
13. Myringotomy with and without tube placement
14. Inferior turbinate coblation
15. Diagnostic ultrasound of the neck
16. Ultrasound-guided needle placement
17. Botox injection for temporomandibular joint disorder
18. Botox injection for sialorrhea

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
1. Active California Registered Nurse/Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider
5. Possession of a National Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number within 12 months of hire.
8. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center Practice Agreement. Copies of Practice Aggreement must be kept at each practice site for each PA.

B. Specialty Training
   1. Specialty requirements: ANP, FNP, or Acute Care
      a. Certification as a Certified Otorhinolaryngology Nurse (CORLN) within 3 years of hire via the National Certifying Board of Otorhinolaryngology and Head-Neck Nurses (NCBOHN).
   2. Experience
      a. NP/PA must have 2 years' experience, either as an NP/PA or registered nurse (RN) in an acute care setting and an interest in head and next medicine and surgery.
      b. If above criteria in (a) not met (inexperienced NP/PA) additional proctoring is required as further delineated.

VI. Evaluation

A. Evaluation of NP/PA Competence in performance of standardized procedures.
   1. Initial: at the conclusion of the standardized procedure training, the Medical Director or physician designee will assess the NP/PA's ability to practice.
      a. Clinical Practice
         1. Length of proctoring period will be three months for an experienced NP/PA and six months for a newly graduated NP/PA. The NP/PA will be supervised by the Chief of Otolaryngology, Otolaryngology Service Attending's and Otolaryngology Fellows with Clinical Instructor status.
         2. The evaluator will be the Chief of Otolaryngology or a designated Otolaryngology physician
         3. The method of evaluation in clinical practice will be:
            - A total of 10 cases will be evaluated during the proctoring period. For an inexperienced NP, a strict proctoring protocol will be enacted where all cases for the first 60 clinic sessions will be proctored by an attending physician in a concurrent and consecutive manner.
            - Direct supervision by the evaluator will occur while providing patient care during the first three months for an experienced NP and 6 months for an inexperienced NP.
            - All cases will be presented to the evaluating physician
            - All patient documentation including history and physicals, progress notes, discharge

summaries, consultation requests and patient orders will be co-signed concurrently to patient care.

- In the case of a six month proctoring period, cases may be evaluated by chart review process by the Chief of Otolaryngology or the designated Otolaryngology physician.

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

3. Biennial Reappointment: Medical Director, and/or designated physician must evaluate the NP/PA's clinical competence as noted in the specific procedures.

Commented [SR1]: Removed paragraph regarding PA, NP supervision as no longer relevant

VII. Development and Approval of Standardized Procedure

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

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

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

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

Protocol #1: Health Care Management – Acute/Urgent Care/Inpatient and Outpatient 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 within the emergency room, inpatient and outpatient services.

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.
   c. Pain history to include onset, location and intensity.

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

C. DIAGNOSIS

Assessment of data from the subjective and objective findings to identify disease processes. This may include a statement of current status of disease. Status of disease may be stable, unstable or uncontrolled.

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation

b. Problem that is not resolved after reasonable trial of therapies
c. Unexplained historical, physical or laboratory findings
d. Uncommon, unfamiliar, unstable and complex patient conditions.
e. Upon request of patient, NP, PA, or physician
f. Initiation of change of medication other than those in the formularies.
g. Outpatient requiring hospital admission or potential hospital admission.
h. Acute, severe respiratory distress

3. Clinical Consultations requiring OHNS MD consultation.
NP may participate in the initial evaluation and triage: encounter must be also staffed with an OHNS Resident or Attending.
a. Patients requiring inpatient admission from the emergency department, acute care or outpatient clinic setting.
b. Acute airway distress
c. Deep neck space infection
d. Epistaxis refractory to initial management
e. Facial trauma with closed head injury or multi-system trauma

4. 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.

5. 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)

Protocol #2: Furnishing Medications/Drug Orders

A. DEFINITION

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

B. DATA BASE

1. Subjective Data
   a. Age a~~A~~ppropriate 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 Zuckerberg San Francisco General Hospital~~SFGH~~ POCT policy and procedure 16.20.

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

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

2. Patient conditions requiring Consultation
   a. Problem which is not resolved after reasonable trial of therapies.
   b. Initiation or change of medication other than those in the formulary.

c. Unexplained historical, physical or laboratory findings.
d. Upon request of patient, NP, PA, or physician.
e. Failure to improve pain and symptom management.
f. Acute, severe respiratory distress
g. An adverse response to respiratory treatment or a lack of therapeutic response.

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

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

E. RECORD KEEPING
All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record\LCR\MAR as appropriate

Protocol #3: eReferral Review

A. DEFINITION
eReferral review is defined as the review of new outpatient consultation requests via the online eReferral system. A new outpatient is defined as a patient that has not been consulted upon by the Otolaryngology service, admitted to the Otolaryngology service nor seen in the Otolaryngology clinic within the previous two years.

1. Prerequisites:
   a. Providers reviewing eReferrals will have six months experience with patients in the Otolaryngology Service at Zuckerberg San Francisco General Hospital and Trauma Center or elsewhere before being allowed to do eReferrals independently.
   b. Providers reviewing eReferrals will be licensed as stated in the Standardized Procedure-Nurse Practitioner/PA Preamble.
   c. Providers reviewing eReferrals will consistently provide care to patients in the specialty clinic for which they are reviewing.
   d. Providers reviewing eReferrals will have expertise in the specialty practice for which they are reviewing.

2. Educational Component: Providers will demonstrate competence in understanding of the algorithms or referral

guidelines developed and approved by the Chief of Service which will be used to facilitate screening, triaging and prioritizing of patients in the eReferral system.

3. Proctoring: A review of 5% of the eReferral consultation decisions will be performed by the Chief of Service or designee concurrently for the first three months.

4. Reappointment: A review of 5 eReferral consultations every two years.

B. DATA BASE

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

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

C. DIAGNOSIS

A diagnosis will not be determined at the time of eReferral review. Differential diagnosis will be provided at the time the patient is seen in clinic by the consulting provider. Assessment of the subjective

and objective data as performed by the consulting provider in conjunction with identified risk factors will be evaluated in obtaining a diagnosis.

D. PLAN

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

2. Patient conditions requiring Attending Review
   a. Acute decompensation in patient condition
   b. Unexplained historical, physical or laboratory findings
   c. Upon request of the referring NP, PA, or physician
   d. Problem requiring hospital admission or potential hospital admission
   e. Problem requiring emergent/urgent surgical intervention
   f. As indicated per the algorithms developed by the Chief of Service.

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

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

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

E. RECORD KEEPING

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

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

Protocol #4: Procedure: Nasopharyngoscopy

A. DEFINITION

"Nasophayrngoscopy" is the examination of a patient's nasopharyngeal structures with the use of a flexible, lighted fibro-optic camera that is passed through the patient's nose and nasopharyngeal space. This is done ~~in order to~~to assess for masses of the head and neck and structural abnormalities of the head and neck that may contribute to the patient's symptoms—such as a deviated septum, allergic rhinitis, sinusitis, nasal polyps, sources of nasal bleeding, gastroesophageal reflux disease, laryngeal polyps, nodules, or paralysis, or the presence of a foreign body.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or inpatient units.

2. Performance of procedure:
   a. Indications: voice hoarseness, sinusitis, "chronic cough, recurrent expectoration, previous head and neck cancer, recurrent or persistent serous otitis media in adults, hemoptysis, and bad breath not associated with dental disease" (Patton, 1997), allergy symptoms, epistaxis, shortness of breath, aspiration, nasal congestion, and postnasal drip
   b. Precautions: may elicit gag reflex or trigger nosebleed
   c. Contraindications: patient history of croup, patient refusal following thorough explanation of the procedure, history of an allergy to the used preparatory medications (topical decongestant and 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. 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~~ Zuckerberg San Francisco General Hospital POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time-~~-~~out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a 3 part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of naso-pharyngeal anatomy text book 2. Observation of the proctor performing this procedure on at least 3 occasions 3. Practicing on models in the temporal bone lab
Proctoring Period: 1. Length of proctoring period is 1 month for an experienced NP and 3 months for an inexperienced NP. 2. The completion of the above 3--part training program 3. 3 successful demonstrations of nasopharyngoscopy on live patients for an experienced NP and 6 demonstrations for an inexperienced NP. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 4. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of nasopharyngoscopy and 1 chart review every 2 years.

Protocol # 5: Procedure: Rigid Nasal Endoscopy

A. DEFINITION

Rigid nasal endoscopy is the examination of a patient's sinonasal structures with the use of a rigid, lighted camera that is passed through the patient's nose. This is done ~~in order to~~to assess for masses of the nose or sinuses and structural abnormalities of the nose and sinuses that may contribute to the patient's symptoms such as a deviated septum, allergic rhinitis, sinusitis, nasal polyps, sources of nasal bleeding, or the presence of a foreign body.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or inpatient units.

2. Performance of procedure:
   a. Indications: nasal congestion/obstruction, sinusitis, previous nasal or sinus cancer/masses, recurrent nose bleeds, allergy symptoms and postnasal drip
   b. Precautions: may trigger nosebleed
   c. Contraindications: patient history of croup, patient refusal following thorough explanation of the procedure, history of an allergy to the used preparatory medications (topical decongestant and 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. Detailed physical exam head and neck.
   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~~ Zuckerberg San Francisco General Hospital POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

4. Follow-up
   As appropriate for procedure performed, pertaining to applicable treatment regimens and/or further diagnostic work-up

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:
1. The prior experience required for this involves a 3 part training program, elaborated in the next point.

2. The training program for this protocol includes the following:

a. Review of nasal and sinus anatomy text book b. Observation of the proctor performing this procedure on at least 3 occasions c. Practicing on models in the temporal bone lab
Proctoring Period: 1. Length of proctoring period is 1 month for an experienced provider and 3 months for an inexperienced provider. 2. Competency in performance of rigid nasal endoscopy includes: a. The completion of the above 3 part training program b. 3 successful demonstrations of rigid nasal endoscopy on live patients for an experienced provider and 6 for an inexperienced provider. c. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief d. The evaluator will be an Otolaryngology attending
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of rigid nasal endoscopy and 1 chart review every 2 years.

Protocol #6: Procedure: Chemical Nasal Cautery with Silver Nitrate

A. DEFINITION

Chemical nasal cautery is done on occasions of epistaxis or nasal bleeding that persists despite adequate external digital pressure. In treatment of epistaxis, the approach is systematic including: first, external digital pressure, second, chemical or electrical nasal cautery, third nasal packing, and lastly surgical intervention (Ho & Chan, 2008). Chemical nasal cautery is done with the use of silver nitrate sticks that can be applied to the observed points of excoriation or sources of nasal bleeding along the nasal mucosa. Visualization of these points or sources is aided with the use of rigid nasal endoscopy, a rigid, lighted probe that is passed through the patient's nose. This allows performance of this procedure without disturbing unaffected surrounding nasal mucosa.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or Inpatient units.

2. Performance of procedure:
   a. Indications: epistaxis that has not responded to external digital pressure and can be attributed to specific points/sources of bleeding along the nasal mucosa
   b. Precautions: use of silver nitrate has been associated with an uncomfortable burning sensation as well as septal perforation if over application is attempted
   c. Contraindications: if epistaxis is profuse and specific points/sources of bleeding cannot be identified, the source of bleeding is assessed to be located in the posterior part of nose, or the patient cannot tolerate either the silver nitrate application or rigid nasal endoscopy for whatever reason

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. Detailed physical exam of the head and neck.

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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: 1. The prior experience required for this involves successful completion of the training program for rigid nasal endoscopy. 2. Ability to perform this procedure requires the following: a. Completion of the rigid nasal endoscopy training program (See Rigid Nasal Endoscopy by the Nurse Practitioner/Physicians Assistant) b. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. Length of proctoring period is 3 months for an experienced provider and 6 months for an inexperienced provider. 2. Competency in performance of chemical nasal cautery with silver nitrate includes: a. The completion of the above 3 requirements b. 3 successful demonstrations of chemical nasal cautery on live patients for an experienced provider and 6 for an inexperienced provider. c. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief d. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via one successful demonstration of chemical nasal cautery with silver nitrate every 2 years and 1 chart review.

Protocol #7: Procedure: Manual Cerumen Disimpaction under Ear Microscope

A. DEFINITION

Cerumen impaction "is defined as an accumulation of cerumen that causes symptoms, prevents a needed assessment of the ear canal/tympanic membrane or audiovestibular system, or both." (Roland et al., 2008). ~~Often times~~Often the patient with cerumen impaction has undergone several attempts of disimpaction by the primary care/referring provider, such as with cerumenolytic agents or irrigation. If these attempts prove unsuccessful, the patient is referred to Otolaryngology for disimpaction, or manual removal of the cerumen under a binocular ear microscope, which enhances visualization. This procedure is also done as a primary course of treatment if the patient cannot tolerate the use of cerumenolytic agents or irrigation, such as patients who have undergone previous ear surgery or have a history of a perforated tympanic membrane.

1. Location to be performed: Otolaryngology Outpatient Clinic, emergency department or inpatient unit

2. Performance of procedure:
   a. Indications: accumulation of cerumen that causes symptoms of otalgia, hearing loss, ear fullness, odor, discharge, or itching or that prevents a necessary evaluation of the ear canal or tympanic membrane
   b. Precautions: cerumen disimpaction can cause trauma to the external auditory canal and/or tympanic membrane, hearing loss, dizziness, bleeding, and/or infection
   c. Contraindications: patients that are unable to tolerate the procedure or unable to sit still during the procedure

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. Detailed physical exam of the head and neck.

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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves: 1. Observation of an attending performing this procedure on at least 3 occasions.
Proctoring Period: A. Length of proctoring period is until 3 successful observed demonstrations for an experienced provider and 6 for an inexperienced provider. B. Completion of the above specified period of observation and demonstration. C. The evaluator will be an Otolaryngology attending D. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief.
Reappointment Competency Documentation: A. Ongoing competency is established via one successful demonstration of manual cerumen disimpaction under ear microscope every 2 years in addition to 1 chart review.

Protocol #8: Procedure: Manual removal of a Foreign Body under Ear Microscope

A. DEFINITION

A foreign body in the ear is any object or structure that does not naturally occur in the ear or does not belong in the ear. Retention of these foreign bodies is associated with infection, hearing loss, otalgia, ear fullness, and discharge. The binocular ear microscope is used to enhance visualization and help make removal of these foreign bodies more successful (Schulze, S. L., Kerschner, J., and Beste, D., 2002).

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or inpatient unit.

2. Performance of procedure:
   a. Indications: visualized foreign body in the ear
   b. Precautions: removal of the foreign body can cause trauma to the external auditory canal and/or tympanic membrane, hearing loss, dizziness, bleeding, pain, and/or infection
   c. Contraindications: patients that are unable to tolerate the procedure or unable to sit still during the procedure

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. Detailed physical exam of the head and neck.
   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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves: 1. Observation of an attending performing this procedure on at least 3 occasions.
Proctoring Period: A. Length of proctoring period is until 3 successful observed demonstrations for an experienced provider and 6 for an inexperienced provider.

B. Completion of the above specified period of observation and demonstration. C. The evaluator will be an Otolaryngology attending. D. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief.
Reappointment Competency Documentation: A. Ongoing competency is established via one successful demonstration of manual removal of an ear foreign body under ear microscope every 2 years along with 1 chart review.

Protocol #9: Procedures: Debridement of nasal mucous or crusts with use of Rigid Endoscope following endoscopic sinus surgery

A. DEFINITION

Following functional endoscopic sinus surgery, a patient requires regular post operative appointments to debride or remove any secretions, clots, or crusts that may have formed. This is done under visual guidance with rigid nasal endoscopy, a rigid, lighted camera that is passed through the patient's nose. This is done in order to prevent infection, obstructions, and/or scar formation in the immediate post operative period (Lee, J. Y. and Byun, J. Y., 2008).

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or inpatient unit.

2. Performance of procedure:
   a. Indications: history of recent endoscopic sinus surgery
   b. Precautions: may trigger nosebleed
   c. Contraindications: patient intolerance of procedure or refusal following thorough explanation of the procedure

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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

1. The prior experience required for this involves a 3 part training program, elaborated in the next point.

2. The training program for this protocol includes the following:
   a. Review of nasal and sinus anatomy text-book
   b. Observation of the proctor performing this procedure on at least 3 occasions
   c. Practicing on models in the temporal bone lab

Proctoring Period: 1. Length of proctoring period is until 3 successful observed demonstrations for an experienced provider and 6 for an inexperienced provider. 2. The completion of the above ~~3 part~~3-part training program 3. 3 successful demonstrations of post operative sinonasal debridement on live patients for an experienced provider and 6 for an inexperienced provider. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 5. The evaluator will be an attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via one successful demonstration of post operative sinonasal debridement every two years along with 1 chart review.

Protocol #10: Procedure: Nasal Biopsy Obtained under Guidance of Rigid Nasal Endoscopy

A. DEFINITION

As part of the diagnostic work up of a unilateral nasal mass, biopsy should be considered. This can be done in the office setting under visual guidance with rigid nasal endoscopy, a rigid, lighted camera that is passed through the patient's nose.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or inpatient unit.

2. Performance of procedure:
   a. Indications: physical exam revealing a nasal mass suspicious for malignancy
   b. Precautions: may trigger nosebleed
   c. Contraindications: vascular appearing masses either on exam or imaging consistent with an angiomatous tumor or nasal masses in the adolescent patient highly suspected for a juvenile nasopharyngeal angiofibroma (Tami, T. A., 2002)

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 ZSFG~~H~~ 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. Biopsy tissue is sent to pathology
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:

1. The prior experience required for this involves a ~~3 part~~3-part training program, elaborated in the next point.

2. The training program for this protocol includes the following:
   a. Review of nasal and sinus anatomy ~~text book~~textbook

b. Observation of the proctor performing this procedure on at least 3 occasions c. Practicing on models in the temporal bone lab
Proctoring Period: 1. Length of proctoring period is until 3 successful observed demonstrations for an experienced provider and 6 for an inexperienced provider. 2. The completion of the above ~~3 part~~3-part training program 3. 3 successful demonstrations of nasal biopsy on live patients for an experienced provider and 6 for an inexperienced provider. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 5. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of nasal biopsy every 2 years and 1 chart review.

Protocol #11: Procedure: Punch Biopsy, Incisional Biopsy or Excisional Biopsy less than 5mm

A. DEFINITION

As part of the diagnostic work up of an oral lesion, biopsy should be considered. This can be done in the office setting. After the procedure is discussed with the patient and the patient is consented, lidocaine with epinephrine is injected in and around the intended biopsy location. After the area is thoroughly anesthetized, the biopsy is obtained with either a punch method or with superficial use of a scalpel. Bleeding is then controlled with silver nitrate cauterization and suturing to the site.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or inpatient unit.

2. Performance of procedure:
   a. Indications: physical exam revealing an oral lesion suspicious for malignancy
   b. Precautions: may trigger bleeding
   c. Contraindications: highly vascular appearing masses, patient inability to cooperate, or patient refusal

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

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:
1. The prior experience required for this involves a ~~3 part~~3-part training program, elaborated in the next point.

2. The training program for this protocol includes the following:

a. Review of head and neck anatomy ~~text book~~textbook b. Observation of the proctor performing this procedure on at least 3 occasions c. Practicing on pig parts during a chief resident run workshop
Proctoring Period: 1. Length of proctoring period is until 3 successful observed demonstrations for an experienced provider and 6 for an inexperienced provider. 2. The completion of the above ~~3 part~~3-part training program 3. 3 successful demonstrations of oral biopsy on live patients for an experienced provider and 6 for an inexperienced provider. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 5. The evaluator will be an Otolaryngology attending
Reappointment Competency Documentation: 1. Ongoing competency is established via one successful demonstration of oral biopsy every 2 years and 1 chart review.

Protocol #12: Procedure: Tracheostomy Tube Change

A. DEFINITION

This procedure takes place when a tracheostomy needs to be changed. This may be because the tube is no longer functioning, it has been in place for a long period of time that warrants routine changing of the tube, it has been determined that the patient is safe to undergo weaning and or eventual decannulation, or ~~in order to~~to enable speech.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department Inpatient Unit

2. Performance of procedure:
   a. Indications: agreement by an otolaryngology attending, at least a five day post-operative stoma maturity level, ventilation independence, patient ability to control their secretions, a good cough reflex, and reasonable mental status (All the criteria listed must be met before this procedure is considered.)
   b. Precautions: may elicit cough, suction should be available at bedside, the tracheostomy site should be inspected for signs/symptoms of infection and/or granulation tissue
   c. Contraindications: patient poor mental status, less than five days post-operative, poor cough, ventilation dependent, acute respiratory infection, or poor oxygen saturation

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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites:
1. The prior experience required for this involves a period of both observation and demonstration.

2. The training program for this protocol includes the following: a. Review of head and neck anatomy ~~text book~~textbook b. Observation of the proctor performing this procedure on at least 3 ~~occasion~~occasions.
Proctoring Period: 1. Length of proctoring period is 3 successful observed demonstrations for an experienced provider and 6 for an inexperienced provider. 2. The completion of the above training 3. 3 successful demonstrations of tracheotomy tube changes on live patients for an experienced provider and 6 for an inexperienced provider. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 5. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via one successful demonstration of tracheostomy tube change every 2 years and 1 chart review.

Protocol #13: Procedure: Myringotomy with and without tube placement

A. DEFINITION

"Myringotomy" is making an incision in the ear drum to drain fluid and treat Eustachian tube dysfunction. A tube can be placed to keep the incision open so that the middle ear fluid can continue to drain out into the ear canal, and so that medication can be placed into the middle ear in the form of ear drops.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department or inpatient units.

2. Performance of procedure:
   a. Indications: otitis media, chronic ear effusion, Eustachian tube dysfunction
   b. Precautions: bleeding, infection, chronic perforation
   c. Contraindications: if fluid in ear is cerebrospinal fluid

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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a ~~3 part~~3-part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of ear anatomy ~~text book~~textbook 2. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. Length of proctoring period is 1 month for an experienced NP and 3 months for an inexperienced NP. 2. The completion of the above ~~3 part~~3-part training program 3. 3 successful demonstrations of myringotomy with or without tube placement on live patients for an experienced NP and 6 demonstrations for an inexperienced NP.

4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 3. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of myringotomy with or without tube placement and 1 chart review every 2 years.

Protocol #14: Procedure: Inferior turbinate coblation

A. DEFINITION

The inferior turbinate is a structure in the nose that warms, humidifies, and filters the air that we breathe in. The inferior turbinate can become enlarged, frequently due to allergies. Coblation is radiofrequency ablation that is used to decrease the size of the turbinate so that the nasal airway becomes ~~larger~~larger, and patients experience improvement in their nasal breathing.

1. Location to be performed: Outpatient Otolaryngology Clinic.

2. Performance of procedure:
   a. Indications: rhinitis (nasal obstruction, nasal congestion, nasal drainage)
   b. Precautions: bleeding, infection, scarring
   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. 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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a ~~3 part~~3-part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of nasal anatomy ~~text book~~textbook 2. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. Length of proctoring period is 1 month for an experienced NP and 3 months for an inexperienced NP. 2. The completion of the above ~~3 part~~3-part training program 3. 3 successful demonstrations of turbinate coblation on live patients for an experienced NP and 6 demonstrations for an inexperienced NP. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 3. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of turbinate coblation and 1 chart review every 2 years.

Protocol #15: Procedure: Diagnostic ultrasound of the neck

A. DEFINITION
In office ultrasound offers radiologic evaluation of head and neck structures in real time and helps with treatment planning.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department, inpatient setting.

2. Performance of procedure:
   a. Indications: neck masses, thyroid exam, lymph node exam, salivary gland exam
   b. Precautions: operator dependent
   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. 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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.

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

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a ~~3 part~~3-part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of neck anatomy ~~text book~~textbook 2. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. Length of proctoring period is 1 month for an experienced NP and 3 months for an inexperienced NP. 2. The completion of the above ~~3 part~~3-part training program 3. 3 successful demonstrations of ultrasound technique on live patients for an experienced NP and 6 demonstrations for an inexperienced NP. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 3. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of ultrasound technique and 1 chart review every 2 years.

Protocol #~~15~~16: Procedure: Ultrasound-guided needle placement

A. DEFINITION
Ultrasound can be used to guide needle placement for biopsy of lesions in the head and neck or drainage of fluid collections in the head and ~~neck~~neck

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department, inpatient setting.

2. Performance of procedure:
   a. Indications: biopsy or head and neck masses, drainage of fluid collection in the head and neck
   b. Precautions: bleeding, infection, pain
   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. 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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a ~~3 part~~3-part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of head and neck anatomy ~~text book~~textbook 2. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. Length of proctoring period is 1 month for an experienced NP and 3 months for an inexperienced NP. 2. The completion of the above ~~3 part~~3-part training program 3. 3 successful demonstrations of Us-guided fine needle aspiration on live patients for an experienced NP and 6 demonstrations for an inexperienced NP. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief

3. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of US-guided fine needle aspiration and 1 chart review every 2 years.

~~Protocol #16: Procedure: Botox injection~~

~~A. DEFINITION~~

~~Botulinum toxin prevents the release of the neurotransmitter acetylcholine from axon endings at the neuromuscular junction and create paralysis. Botox can be used for various diseases in the head and neck.~~

~~1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department, inpatient setting.~~

~~2. Performance of procedure:~~

~~a. Indications: sialorrhea, temporomandibular joint disorder, headache~~

~~b. Precautions: bleeding, infection, pain, facial palsy~~

~~c. Contraindications: neuromuscular disorders, allergy to any constituents in the botulinum toxin product, unrealistic expectations~~

~~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. Diagnostic tests for purposes of disease identification.~~
~~d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.~~
~~e. Referral to physician, specialty clinics, and supportive services, as needed.~~

~~2. Patient conditions requiring Attending Consultation~~

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

~~3. Education~~

~~Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.~~

~~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 as appropriate.~~

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a 3 part3-part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of head and neck anatomy text booktextbook 2. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. Length of proctoring period is 1 month for an experienced NP and 3 months for an inexperienced NP. 2. The completion of the above 3 part3-part training program 3. 3 successful demonstrations of Botox injection on live patients for an experienced NP and 6 demonstrations for an inexperienced NP. 4. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 3. The evaluator will be an Otolaryngology attending.
Reappointment Competency Documentation: 1. Ongoing competency is established via 1 successful demonstration of Botox injection and 1 chart review every 2 years.

Protocol #17: Procedure: Botox injection for temporomandibular joint disorder

A. DEFINITION

Botulinum toxin prevents the release of the neurotransmitter acetylcholine from axon endings at the neuromuscular junction and create paralysis. Botox can be used for various diseases in the head and neck.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department, inpatient setting.

2. Performance of procedure:
   a. Indications: temporomandibular joint disorder
   b. Precautions: bleeding, infection, pain, facial palsy
   c. Contraindications: neuromuscular disorders, allergy to any constituents in the botulinum toxin product, unrealistic expectations

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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education

Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a 3-part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of head and neck anatomy textbook 2. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. The completion of the above 3-part training program 2. 6 successful demonstrations of Botox injection on live patients under supervision 3. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 4. The evaluator will be an Otolaryngology attending
Reappointment Competency Documentation: 1. Ongoing competency is established via an average of 3 successful demonstrations of Botox injection per year and 1 chart review every 2 years.

Protocol #18: Procedure: Botox injection for sialorrhea

A. DEFINITION

Botulinum toxin prevents the release of the neurotransmitter acetylcholine from axon endings at the neuromuscular junction and create paralysis. Botox can be used for various diseases in the head and neck.

1. Location to be performed: Outpatient Otolaryngology Clinic, emergency department, inpatient setting.

2. Performance of procedure:
   a. Indications: sialorrhea
   b. Precautions: bleeding, infection, pain, facial palsy
   c. Contraindications: neuromuscular disorders, allergy to any constituents in the botulinum toxin product, unrealistic expectations

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 Zuckerberg San Francisco General Hospital~~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. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions pertaining to applicable treatment regimens and/or further diagnostic work-up.

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 as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: A. The prior experience required for this involves a 3-part training program, elaborated in the next point. B. The training program for this protocol includes the following: 1. Review of head and neck anatomy textbook 2. Observation of the proctor performing this procedure on at least 3 occasions
Proctoring Period: 1. The completion of the above 3-part training program 2. 3 successful demonstrations of Botox injection on live patients 3. Submission of a letter of competency to the Credentialing Committee by the Clinical Service Chief 4. The evaluator will be an Otolaryngology attending
Reappointment Competency Documentation: 1. Ongoing competency is established via an average of 3 successful demonstrations of Botox injection per year and 1 chart review every 2 years.