ZSFG JOINT CONFERENCE COMMITTEE MEETING

February 27, 2024

MEDICAL STAFF Report

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ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on February 27, 2024
February 2024 MEC Meeting

SURGERY SERVICE REPORT: Joseph Cuschieri, MD, Service Chief

The Service's mission is to provide excellent surgical care to every individual with focus on clinical care, education, and research. The highlights of the report are as follows:

A. Faculty
   1. Number and Roles
      - Emergency General Surgery and Trauma- There are 6 core faculty members who do most of their clinical work at ZSFG, along with 7 additional faculty within UCSF.
      - Critical Services: General Surgery, Breast Surgery, Hepatobiliary Surgery, Cardiothoracic Surgery, and Colorectal Surgery – Each service has 1 faculty member except for Cardiothoracic Surgery that has 3 faculty members.
      - Others – Plastic Surgery has 6 faculty members, and Vascular Surgery has 2 faculty members.

      There is a diverse faculty with 46 members, encompassing all areas from instructor to full professor. However, there are only 18 faculty members for core clinical components, including plastic surgery, vascular surgery, and general surgery. There is a continued need for ongoing recruitment and growth within the division. Also, various clinical data are used in the reappointment process to ensure the following: (1) frequently updated medical records, (2) predominance of education, and (3) professional behavior at all times.
   2. Physician Leadership
      - ZSFG - Dr. Andre Campbell is the Director of Surgical Critical Care (SCC) Fellowship and Surgery Clerkship Site. Dr. Cuschieri is the Chief of Surgery and Trauma Medical Director. Other leaders were acknowledged.
      - UCSF - Dr. Campbell is the Vice Chair for DEI and Dr. Adnan Alseidi is the Vice Chair for Education. Other leaders were noted.
      - National Roles – Many physicians have leadership roles nationally, including Dr. Alseidi as Association of Surgical Education Past President and Fellowship Council President. Drs. Cuschieri and Rochelle Dicker are board members of American Association for the Surgery of Trauma; 2 board members from the same institution is unprecedented.
   3. Hospital Committee Participation – The faculty members are very active in various hospital committees.
   4. Honors and Awards – Several faculty members won many awards for the past years. Dr. Campbell was recently awarded by the Hearts Foundation. He also received a State and City Recognition for Service with recognition of Dr. Andre Campbell day on November 2nd. Moreover, Dr. Lucy Kornblith was a 2023 recipient of the UCSF Holly Smith Award.
   5. Research New Awards/Trials – Research funding is a major focus with total grant funding for ZSFG research of $12M+.

B. Service Structure/Education
   1. Residents – There are over 100 residents who rotate over the course of a year. Last year, there were 148 residents from Surgery, Anesthesia, Emergency Medicine, Podiatry, Oral Surgery, Urology, and more.
   2. Surgical Education – The Department provides a strong educational component with Surgery 110 (multi-site core surgery rotation by 3rd-year students) and Surgery 140 (sub-internship by 4th-year students from UCSF and other locations).
   3. Fellowship – The following are offered: ACS fellowship (2 fellows/year), SCC fellowship(2 fellows/year), Vascular fellowship, and Plastic Surgery fellowship.
   4. Conferences and Courses – Multiple educational components are provided on a regular basis. Advanced Surgical Exposure for Trauma, an American College of Surgery (ACS) cadaver course, was brought to UCSF over the past 2 years.

C. Scope of Clinical Services
   1. Clinical Services/Programs – The Core Specialty Care includes Trauma Surgery, Critical Care, Emergency General Surgery, Plastic Surgery, and Vascular Surgery. There is also the Wraparound Program (comprehensive care for patients following violent injury) to support the community. The Surgical Subspecialty Care includes "Elective" General Surgery, Breast, Hepatobiliary, Surgical Oncology, Thoracic, Colorectal. Lastly, diagnostic service is done at the Vascular Lab.
   2. ACS Committee of Trauma (COT) Re-verification – In July 2023, the Service underwent an ACS COT re-verification without any citation for critical deficiencies. Such was attributed to the dedicated work by a number of individuals.
   3. OR Performed Utilization – The Service is a very busy center from an operative standpoint with limited resources occasionally. Despite different numbers on acceptable overall utilization, the Service has chosen 80%. As an institution, the utilization stays above 80% which is unheard of for a county hospital that targets lower values (even 60%-70% utilization). General Surgery uses 91% of block time, limiting the flexibility of doing other cases because of time spent for elective surgery.
      - Volume of Service (December 2022 - December 2023) - The volume by service was extremely high with Orthopedics posting the highest volume and followed by General Surgery.
      - Department of Surgery OR Cases – From 2022 – 2023, there was steady growth in the number of cases. In 2020, there were about 1.3K cases for General/Trauma Surgery. In 2023 (without full December 2023 data), there were 1,682 cases; there were approximately 150 – 200 cases per month to be similar to, if not in excess, of previous year's volume. Other services such as Vascular Surgery and Plastic Surgery had similar scenarios.

- Block Hours - General Surgery uses in block hours mostly for elective cases, along with a fair amount of non-elective cases. Orthopedics uses more time during the daylight hours. For daytime out of block hours, General Surgery significantly spends more daytime out of block hours by expediting non-elective cases in comparison with other services. For after hours, General Surgery spends many hours operating mostly non-elective cases in the middle of the night, exceeding Orthopedics. For weekend utilization, most hours in the daytime are allocated to Orthopedics and followed by General Surgery. At nights, most hours are allocated to General Surgery and followed by Orthopedics.

D. Process Improvement – The Service continues to improve patient care for general, vascular, and plastic surgeries, along with trauma with the leadership of Dr. Sandhya Kumar and Dr. Cuschieri. The Service focuses on a number of True North categories and continues to work on ensuring provision of equity and quality of care that are regularly analyzed.
   1. Trauma Volume – The volume continued to increase. In 2023 (without full November – December 2023 data), there were about 3,259 patients (higher by about 100 patients in 2022 for the entire year). Many patients were seen as full activation and very few consults. There was also a large number of patients > 65 years with the trend continuing with increased volume. Also, most patients seen were critically ill.
   2. Trauma Quality Improvement Project (TQIP) Risk Adjusted Mortality – From a risk adjusted mortality, the Department of Surgery is an exceptional center — from Trauma Service to Neurosurgeons, Orthopedic surgeons, Medicine Service, nurses, respiratory therapists, pharmacists, and other involved staff. From pre-hospital to post-discharge care, the Service is exceptional with overall death rates and mortalities reduced by ≈19% . There is an opportunity for improvement of isolated hip structures of geriatric patient population.
   3. TQIP Risk Hospital Events – The biggest opportunities for improvement pertain to ventilator-associated pneumonia, pulmonary embolism, and catheter-associated UTI. Multiple work groups have been focusing on these areas. About a year ago, the work on pulmonary embolism rates led to reduction by nearly over 50%. Unfortunately, the rates increased in the last 6 months due to education and patients' refusal of chemoprophylaxis.
   4. Management of Orthopedic Injuries – Orthopedics has been remarkable in managing its trauma patients with actual metrics (e.g., time to first irrigation and debridement for patients with open tibia shaft structure) better than benchmarks.
   5. Management of Neurotrauma – Neurotrauma is an area of excellence for ZSFG with Dr. Geoffrey Manley's leadership. This is reflected in the optimized care of severe TBI patients relating to ED intubation, cerebral monitoring, and cerebral monitoring method. Moreover, craniotomy is done at an appropriate rate. The time for spinal decompression/stabilization for patients with spinal cord injury was exceptionally within 8 hours (vs national rate of 22 hours). Efforts continue on early tracheostomy for severe TBI patients with a current median of 11 days vs 18 days about two years ago.
   6. Transfusion in Hemorrhagic Shock – The work with the hematologists and blood bank has led to delivery of blood at a rapid and appropriate rate. The Service has done very well in giving 1:1:1 transfusions for nearly 80% of cases.
   7. Completed Appointments by Service – The Service is also busy with a great number of patients in the clinics, keeping elective practices going. With limited OR time, patients have to wait for surgery and occasionally for a prolonged duration.
   8. Third Next Available Appointment (TNAA) – With a surgeon's absence for 2 months, the TNAA went up to 62 days in July 2023. The Service's benchmark is < 21 days. With combined efforts by surgeons, TNAA is currently at 15 days.
   9. DOS Cholecystectomy – The wait time is still over a day with only 25% of patients done < 24 hours in 2023. Most patients wait for operations and stay longer at the hospital, aggravating high patient census. Patient volume continued to increase from 2021(125 cases) to 2023(192 cases).
   10. Colon SSI – There has been a reduction of surgery colon SSI rates. In FY 22-23, exemplary efforts led to overall SIR of 0.97. The rates for the emergency cases (i.e., colon perforations) can potentially be improved but unlikely to significantly decrease as patients already have infections when admitted.
   11. The Wraparound Project (WAP)– With expansion of the program over the last 1.5 years with Dr. Amanda Sammann's helm, the project serves both patients and members of the community, such as schools, to prevent violence particularly gun violence. The project is led by violence prevention professionals who themselves are survivors of past violence. The WAP enrollment for Sept - Nov 2023 was 70+ clients which in the past would be the total clients in a year.
   12. Interpersonal Violence Screening (IPV) Program – Patients have reported IPV(1 in 4 women and 1 in 10 men). With many patients inappropriately screened and returning to the same setting of injuries, there are efforts to improve the program.

E. Financial Report – In 2024, the projected profee payments will exceed $4M and the projected profee expenses at $4.3M.

F. Threats - These include limited space in ZRAB, distribution of faculty across ZSFG, satisfaction on leadership support, high burn out among faculty, after hours EMR, control over workload, and hours worked.

G. Summary
   1. Strengths – These include extraordinary and engaged faculty, along with dedication to surgical education.
   2. Opportunities for Improvement - These include limited evidence-based guidelines, service vs education balance, limited number of faculty, and the need to improve charge capture, documentation, and clarity around billing.
   3. Goals – These include developing a culture of collegiality and support, further empowering faculty, increasing collaborations across UCSF, recruiting nationally recognized leaders, core localization of offices, and further outreach/education.

Dr. Gabe Ortiz, along with other MEC members, praised the presentation, extensive analysis of the Service's strengths and opportunities, and the Service's collaboration with other departments.

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG February 27, 2024
FEBRUARY 2024 MEC Meetings

Service Chief Recommendation

- Department of Otolaryngology (OHNS) Service Chief Recommendation.....*for Approval*

Clinical Service Rules and Regulations

- Department of Surgery Rules & Regulations (attached).....*for Approval*

Credentials Committee

- Standardized Procedures – None
- Privileges List – None

University of California
San Francisco

UCSF

School of Medicine
Department of Ophthalmology

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February 15, 2024

San Francisco Health Commission

Re: Appointment of Dr. Megan Durr to Chief of Otolaryngology – Head and Neck Surgery, ZSFG

Dear Health Commissioners,

I write on behalf of the Search Committee for a new Chief of Otolaryngology – Head and Neck Surgery at Zuckerberg San Francisco General Hospital. The committee, comprised of leaders from both the San Francisco Department of Public Health and the University of California, San Francisco, conducted a competitive national search, and we are pleased to nominate Dr. Megan Durr for the position.

Dr. Durr graduated from the Johns Hopkins School of Medicine and completed her residency training at UCSF in 2013. Since that time, she has built a strong national reputation in academic OHNS through her peer-reviewed publications and presentations at national meetings. She has a particular interest in surgical quality and education and has been a leader in these domains both at Kaiser Permanente – Oakland and here at ZSFG, where she has served with distinction in the interim Chief role since 2022. We look forward to her continued contributions to our community in these and other areas.

Drs. Elena Fuentes-Afflick (Vice Dean, UCSF at ZSFG), Susan Ehrlich (CEO, ZSFG), and Andrew Murr (UCSF Chair of Otolaryngology – Head and Neck Surgery) have enthusiastically accepted the committee's recommendation and offered the position to Dr. Durr. The recommendation was also approved unanimously by the hospital's Medical Executive Committee on February 15, 2024. We are eager to welcome Dr. Durr to our leadership team at ZSFG. Thank you for your consideration.

Sincerely,

Jay M. Stewart

Jay M. Stewart, MD
Search committee chair

UCSF Department of Surgery

Division of Surgery, Zuckerberg San Francisco General

Joseph Cuschieri, MD
Professor of Surgery and Laboratory Medicine, UCSF
Chief of Surgery and Trauma Medical Director, ZSFG

February 2024

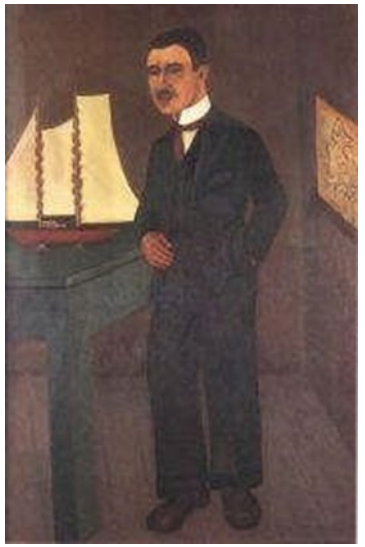
ZUCKERBERG SAN FRANCISCO GENERAL
Hospital and Trauma Center

UCSF Department of Surgery

Mission Statement

The surgical faculty at Zuckerberg San Francisco General are dedicated to providing exceptional clinical care to the citizens of San Francisco and the surrounding areas, regardless of their social or financial status.

Our purpose is to deliver an outstanding training environment to students and residents, to make significant advances in scientific knowledge and clinical practice through basic and clinical research, and to produce the next generation of leaders in surgery.



UCSF Department of Surgery

Strengths

UCSF Department of Surgery

Faculty Members

- Emergency General Surgery and Trauma
  - Marissa Boeck*
  - Tasce Bongiovanni*
  - Andre Campbell
  - Joseph Cuschieri
  - Rochelle Dicker*
  - Kent Garber*
  - Rachel Koch*
  - Lucy Kornblith
  - Robert Mackersie
  - Rebecca Plevin
  - Jennifer Reid
  - Amanda Samman
  - Ronald Tesoriero

UCSF Department of Surgery

Faculty Members

- General Surgery
  - Sandhya Kumar
- Breast Surgery
  - Jasmine Wong
- Hepatobiliary Surgery
  - Adnan Alseidi
- Cardiothoracic Surgery
  - Melissa Coleman
  - Art Hill
  - Amy Fiedler**
- Colorectal
  - Ed Kim

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Faculty Members

- Plastic Surgery
  - Scott Hansen
  - Alex Lin
  - Jason Pomerantz
  - Gloria Sue
  - Micheal Terry
  - David Young
- Vascular Surgery
  - Adam Oskowitz
  - Shant Vartanian

UCSF Department of Surgery

Faculty Members

Rank/Series	In-Residence	Clinical	Courtesy	Recall	Total	Rank%
Professor	2	4	15	1	22	
Associate	2	3	6		11	
Assistant	2	5	4		11	
Instructor		3	2		5	
Total	6	11	27	1	47	

Of primary surgical faculty 6 (35%) are In-Residence series, even between all levels

UCSF Department of Surgery

Clinical data used in the reappointment process

Core Competency	Proposed Metric	Thresholds	Data Source
Patient care	Attributable/ Preventable Mortality	Acceptable – Any 1A or < 2 1B Marginal – 1-2 1B Unacceptable >2 1B, and 1 C or 1D	Epic and M&M
	Complications & related errors	Marginal >1 class 3, any class 4 Unacceptable >1 class 4, any class 5 Uses classification scheme for errors (0-5)	M&M, trauma registry
	Unplanned readmissions	Marginal > 1 STD above mean % for faculty Unacceptable >2 STD above mean % for faculty	Epic and M&M
Medical/Clinical Knowledge	Board Certification/recertification	Meets/fails to meet.	Med Staff Office
	Attendance at Departmental Grand Rounds	Marginal <50% Unacceptable <25%	Department of Surgery Office
Practice-Based Learning and Improvement	Completion of required annual DPH training	Meets/fails to meet	Med Staff Office
	CME	Meets/fails to meet	ACS, surgeon provided
Interpersonal and Communication Skills	Resident Evaluations	Marginal > 1 STD above mean % for faculty Unacceptable >2 STD above mean % for faculty	Department of Surgery Education Office
	UOs about interpersonal and communication skills	Marginal 2-3 valid UOs RE: interpersonal and communication skills Unacceptable >3 valid UOs RE: interpersonal and communication skills	Review by Chief only
Professionalism	UOs about professionalism	Number with thresholds that would need to be developed	Review by Chief only
	Unexcused absences at assigned committee meetings	Marginal <50% Unacceptable <25%	Med Staff office
Systems based Practice	OP notes dictated and signed within 72 hours	NEED THRESHOLDS	Epic
	H&Ps signed within 3 days	<50% Marginal	Epic

Physician Leadership - ZSFG

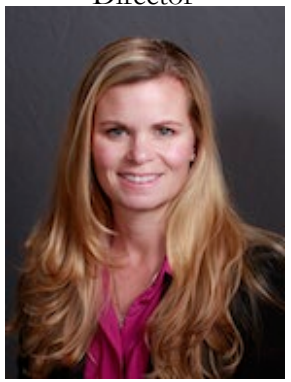
SCC Fellowship Director

Surgery Clerkship Site Director

Chief of Surgery, Trauma Medical Director

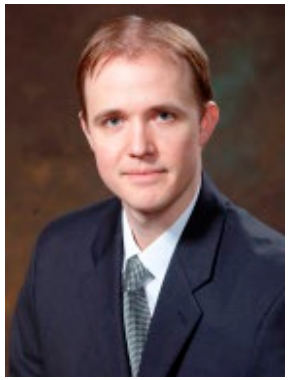
Medical Director OASIS Clinic

Physician Director for Quality Management



The Better Lab Executive Director,

Wrap Around Medical Director



Associate Medical Director Ambulatory Specialty Care

Medical Director Surgery Clinic

Director Gender Affirming Surgery

SICU Medical Director

Residency Site Director

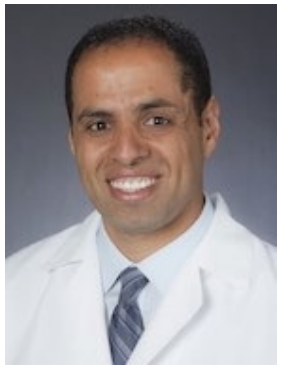
ACS Fellowship Director

Chief of Vascular Surgery

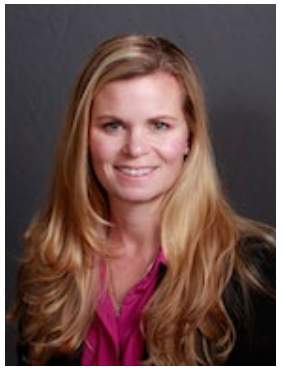
UCSF Department of Surgery

Physician Leadership - UCSF

Vice Chair for Diversity, Equity, and Inclusion



Vice Chair for Education



Chief Experience Officer

Co-Chair Muriel Steele Society

Director of Gender Equity

Chief of Surgery, ZSFG

Chief of Plastic Surgery, Program Director Plastic Surgery Residency Program

UCSF Department of Surgery

Hospital Committee Participation

- Multidisciplinary Trauma Peer Review Committee – Cuschieri (Chair), all trauma faculty
- Trauma PIPS – Cuschieri (Co-chair)
- Cancer – Alseidi (Chair)
- Transfusion – Kornblith
- PIPS – Kumar
- Risk Management – Kornblith
- OR – Cuschieri, Terry, Vartanian
- MEC – Cuschieri
- Disaster – Cuschieri
- Critical Care – Tesoriero, Cuschieri, Campbell
- GME – Tesoriero
- PEMT – Cuschieri
- Bylaws - Vartanian
- CPG Board – Cuschieri, Kornblith
- CPG Finance – Cuschieri
- CPG Comp – Kumar

Physician Leadership – National Roles

- Adnan Alseidi
  - Americas Hepato-Pancreato-Biliary Association Chair, Education and Training Committee
  - Association of Program Directors in Surgery (APDS)
    Member, APDS/ASE Medical Student Best Practices for General Surgery Residency Task Force
  - Society of American Gastrointestinal and Endoscopic Surgeons
    Member, Reimagining the Practice of Surgery (RPS)
  - Society of American Gastrointestinal and Endoscopic Surgeons
    Chair, Program Committee
  - Fellowship Council, 1st Vice President 1st Vice President
  - Fellowship council, Nominations Committee Member
  - Video Based Assessment, Society of American Gastrointestinal and Endoscopic Surgeons Member, Biliary Pathway leader
  - Communications Committee, Fellowship Council, Chair
  - Hepato-Pancreato-Biliary Association (IHPBA), Education and Training Committee
  - **Association of Surgical Education Past President**
  - **Fellowship Council President**

- Marissa Boeck
  - Eastern Association for the Surgery of Trauma Injury Control and Violence Prevention Committee
  - Association of Academic Global Surgery Research Committee
  - American College of Surgeons Resident and Associate Society Liaison Representative to International Relations Committee
  - American College of Surgeons Operation Giving Back Education Committee & Golbal Affairs Committee
  - Eastern Association for the Surgery of Trauma, Co-Chair Education Subcommittee of the Injury Control and Violence Prevention Committee

- Tasce Bongiovanni
  - ACS/AAST Geriatric Committee
  - ACS/AGS Surgical Liaison
  - Academy Health Perioperative IG Committee

UCSF Department of Surgery

Physician Leadership – National Roles

- Andre Campbell
  - American College of Surgeons Master Surgical Educators
  - Secretary-Treasurer American College of Surgeons Board of Governors
  - Past-President Society of Black Academic Surgeons
  - ACS COT Lead Reviewer
- Joseph Cuschieri
  - Society of Surgical Critical Care Program Directors, Mentorship Committee (Chair), Awards Committee (Chair)
  - American Association for the Surgery of Trauma
    - Critical Care Committee Chair
    - Manager at Large: Critical Care
    - Scholarship Committee
    - Program Committee
    - Membership Committee
  - American Association for the Surgery of Trauma: Career Mentor
  - NIH DSMB member
  - NIH Career Training Award Committee Member
  - ACS COT VRC Lead Reviewer
- Lucy Kornblith
  - Eastern Association for the Surgery of Trauma Research-Scholarship Committee
  - Association for Academic Surgery Publications Committee
  - Western Trauma Association Social Media Taskforce
  - Eastern Association for the Surgery of Trauma Practice Management Guideline Committee for the use of tranexamic acid in trauma
  - NIH Accelerating COVID-19 Therapeutic Interventions and Vaccines (ACTIV) IV (coagulation) Program Steering, Protocol Development, Mechanistic Studies, and Multi-platform RCT Publications Committees.
  - Association for Academic Surgery, Basic & Translational Science Committee
- Rebecca Plevin
  - EAST Injury Control and Violence Prevention Committee
  - American College of Surgeons Committee on Applicants, District 1
  - Society for Prevention Research Conference: Epidemiology & Etiology Abstract Theme Review Committee – Member
- Ronald Tesoriero
  - Western Trauma Association, Algorithm Committee

UCSF Department of Surgery

Honors/Awards

- Adnan Alseidi
  - The Haile T. Debas Academy for Medical Educators, Member
  - Kenneth Forde Excellence in Humanistic Clinical Care Award : Society of American Gastrointestinal and Endoscopic Surgeons
  - Honorary International Member of The Brazilian College of Surgeons for partnership in Hepato-Pancreato-Biliary (HPB) training in Latin America
- Marissa Boeck
  - UCSF Muriel Steele Society Influential Women in Surgery Honor Roll
- Tasce Bongiovanni
  - Excellence in Teaching Award from the UCSF's Haile T Debas Academy of Medical Educators
- Andre Campbell
  - Zuckerberg San Francisco General Hospital Commitment and Service Award
  - **State and City Recognition for Service with recognition of Dr. Andre Campbell Day on November 2nd**
- Joseph Cuschieri
  - Highlight paper AAOS 2023 Meeting
  - Best Basic Science Paper (February) Journal of Trauma and Acute Care Surgery
  - ACS Surgical Biology Club II Inductee
- Lucy Kornblith
  - Accelerated promotion to Associate Professor of Surgery In Residence for July 2023
  - Graduate of the 2022 UCSF CORO leadership program
  - Nominated into the Surgical Biology Club I
  - **UCSF Holly Smith Award 2023**
- Sandhya Kumar
  - Excellence in Teaching Award from the UCSF's Haile T Debas Academy of Medical Educators

UCSF Department of Surgery

Research New Awards/Trials

Total Grant Funding: $12,425,153.00

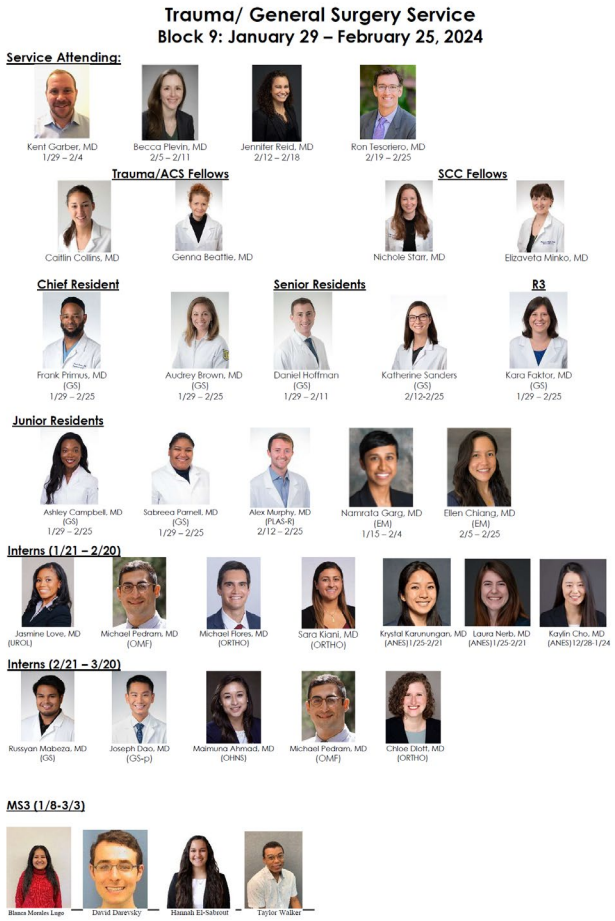
- Adnan Alseidi
  - Awarded CPG-SURF Grant ZSFG
- Marissa Boeck
  - USAID Development Innovation Ventures Stage 2 grant – Jan 2023 – Dec 2025 - co-investigator: “Evaluating the Impact of Flare’s Centralized Emergency Response System on Morbidity and Mortality of Trauma and Emergency Obstetrics Patients in Nairobi, Kenya”
  - Awarded CPG-SURF Grant ZSFG
  - Awarded the American Association for the Surgery of Trauma Junior Faculty Scholarship
  - Awarded Internal K21
- Tasce Bongiovanni
  - Awarded a K23 from the NIA
  - Awarded an AMFDP Leadership Grant from the Robert Wood Johnson Foundation
- Joseph Cuschieri
  - Site PI: MOBI 1 trial
  - Site PI: Restart anticoagulation trial
  - Site PI: CSL-Beirhing Kcentra trial
  - Site PI: TipToe trauma outcome trial
  - Co-Site PI LITES: Calcium and Vasopressin Following Trauma
- Lucy Kornblith
  - **Awarded NIH R35**
  - Awarded the Doris Duke Charitable Foundation’s Fund to Retain Clinical Scientists
  - Awarded the George H. A. Clowes, Jr., MD, FACS, Memorial Research Career Development Award
  - Awarded the ACTIV-4 Mechanistic Studies Grant
  - Site PI for LITES: Prehospital Analgesia Intervention (PAIN) Trial
  - Site PI for LITES: Calcium and Vasporessin following Trauma
- Sandhya Kumar
  - Awarded CPG-SURF Grant ZSFG
- Rebecca Plevin
  - CalVIP Grant for Gun Violence Prevention
- Amanda Sammann
  - CalVIP Grant for Gun Violence Prevention

UCSF Department of Surgery

Service Structure/Education

- Trauma/General Surgery
  - 1 ACS/SCC fellow, 1 R5, 2 R4s, 1 R3, 5 R2, 5-6 R1s
  - From multiple programs
- Plastic Surgery
  - 1 fellow, 1 R4/3, 2 R1s
  - From multiple programs
- Vascular Surgery
  - 1 fellow
- SICU
  - Other ZSFG services with General Surgery residents
  - Critical Care, Neurosurgery, Gastroenterology, Plastics

- Annually over 100 different residents rotate through these services



UCSF Department of Surgery

Surgical Education

- Surgery 110
  - Multi-site core surgery rotation
  - Eight 3rd year students per 8 week block @ ZSFG
  - Site director: Andre Campbell
- Surgery 140
  - Up to two 4th year students per month

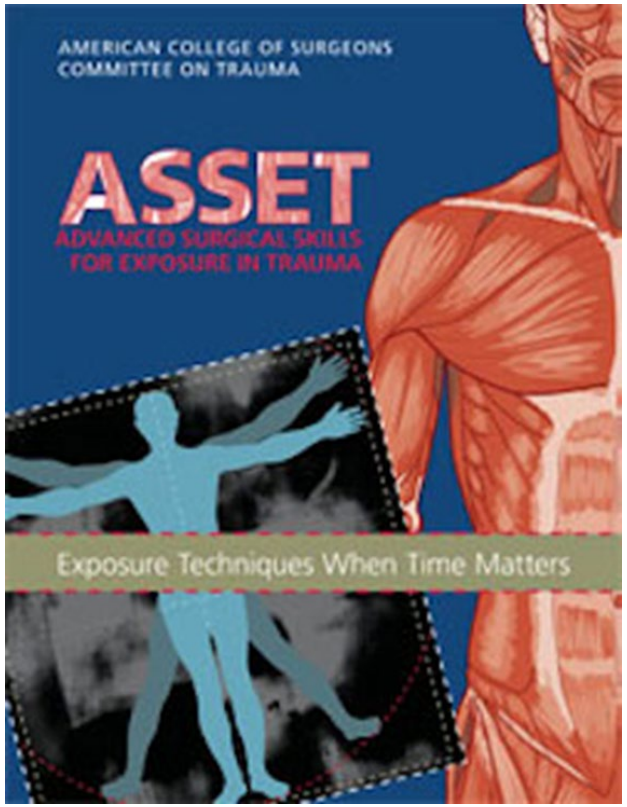
UCSF Department of Surgery

Surgical Education

- ACS fellowship
  - 2 fellows/year
  - Fellowship Director – Ron Tesoriero
- SCC fellowship
  - 2 fellows/year
  - Fellowship Director – Andre Campbell
- Vascular fellowship site
- Plastic Surgery fellowship

UCSF Department of Surgery

Surgical Education



- Conferences:
  - Daily morning report
  - Weekly morbidity and mortality conference
  - Monthly Trauma Video Review
  - Weekly Didactic Conference
  - Monthly WIPS
  - Monthly Surgical Journal Club
  - Monthly Surgical Critical Care Journal Club
- Courses:
  - **Advanced surgical exposure for trauma (ASSET)**
  - Advanced Trauma Life Support (ATLS)

UCSF Department of Surgery

Scope of Clinical Services

- Core Specialty Care
  - Trauma Surgery
  - Critical Care
  - Emergency General Surgery
  - Plastic Surgery
  - Vascular Surgery
- Community Support
  - Wraparound Program

- Surgical Subspecialty Care
  - “Elective” General Surgery
  - Breast
  - Hepatobiliary
  - Surgical Oncology
  - Thoracic
  - Colorectal
- Diagnostic Service
  - Vascular Lab

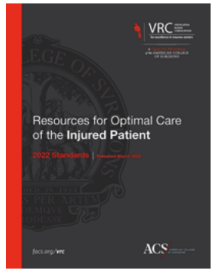
UCSF Department of Surgery

ACS COT Trauma Re-verification July 2023

THE COMMITTEE ON TRAUMA

VERIFIED TRAUMA CENTER

ACS COT releases new 2022 trauma center standards



UCSF Department of Surgery

Weakness

UCSF Department of Surgery

OR Performed Utilization

Data collected: Fri 1/12 12:17 PM

Utilization Filter: **All Blocks** | Performed Below Target | Performed At or Above Target

Performed Utilization Target (%)

82% ↘ Last Month
All Blocks

83% ↗ Last Three Months Combined
All Blocks

Block	Last Month ▼	Nov 2023	Oct 2023	Last Three Months Combined	Man Rel % Last Three Months Combined
Plastics	89%	71%	80%	79%	13%
General	86%	93%	92%	91%	7%
Gynecology	86%	86%	70%	81%	2%
Orthopedics	85%	87%	83%	85%	6%
Ophthalmology	84%	87%	88%	86%	5%
Urology	79%	84%	75%	79%	2%
ENT	72%	66%	75%	71%	9%
Oral Surgery	72%	75%	74%	74%	30%
Vascular	71%	73%	63%	69%	15%
Neurosurgery	43%	76%	91%	68%	13%
All Blocks	**82%**	**84%**	**82%**	**83%**	**8%**

UCSF Department of Surgery

OR Performed Utilization

Data collected: Fri 1/12 12:17 PM

Utilization Filter | **All Blocks** | Performed Below Target | Performed At or Above Target | Performed Utilization Target (%)

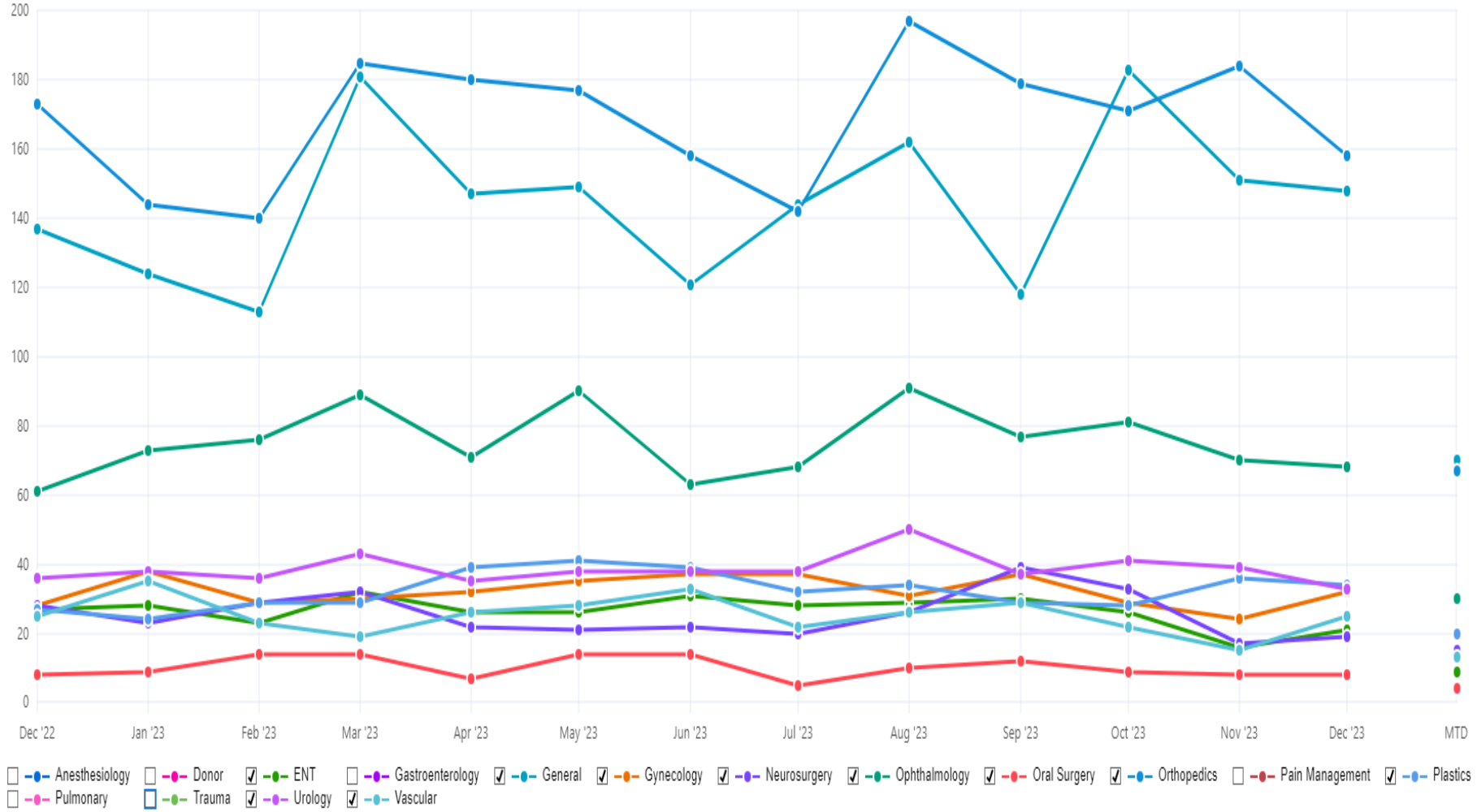
82% ↘ Last Month
All Blocks

83% ↗ Last Three Months Combined
All Blocks

Block	Last Month ▼	Nov 2023	Oct 2023	Last Three Months Combined	Man Rel % Last Three Months Combined
Plastics	89%	71%	80%	79%	13%
General	86%	93%	92%	91%	7%
Gynecology	86%	86%	70%	81%	2%
Orthopedics	85%	87%	83%	85%	6%
Ophthalmology	84%	87%	88%	86%	5%
Urology	79%	84%	75%	79%	2%
ENT	72%	66%	75%	71%	9%
Oral Surgery	72%	75%	74%	74%	30%
Vascular	71%	73%	63%	69%	15%
Neurosurgery	43%	76%	91%	68%	13%
All Blocks	**82%**	**84%**	**82%**	**83%**	**8%**

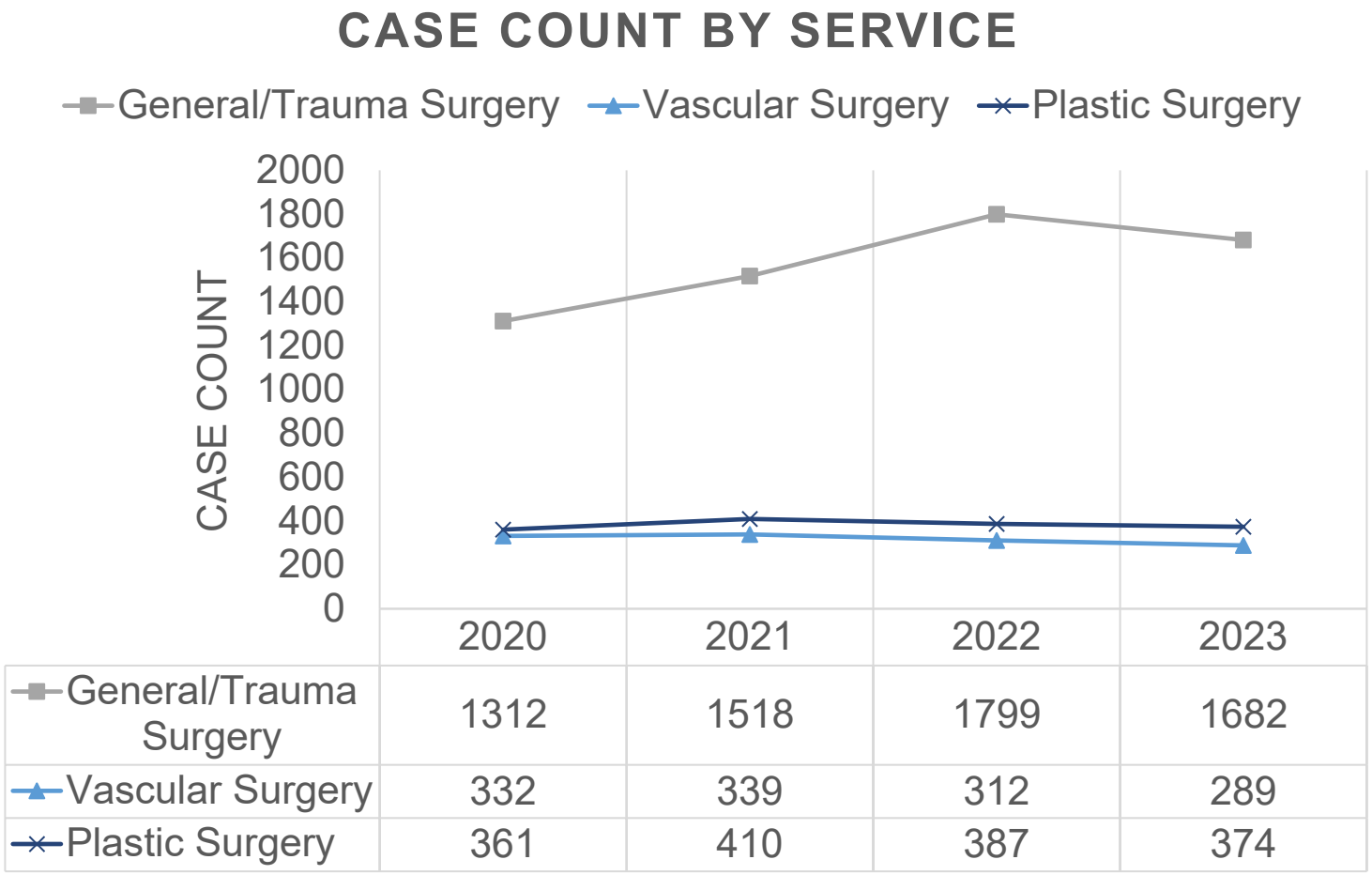
UCSF Department of Surgery

Volume by Service: December 2023



UCSF Department of Surgery

ZSGH| Department of Surgery OR Cases



	2020	2021	2022	2023
General/Trauma Surgery	1312	1518	1799	1682
Vascular Surgery	332	339	312	289
Plastic Surgery	361	410	387	374

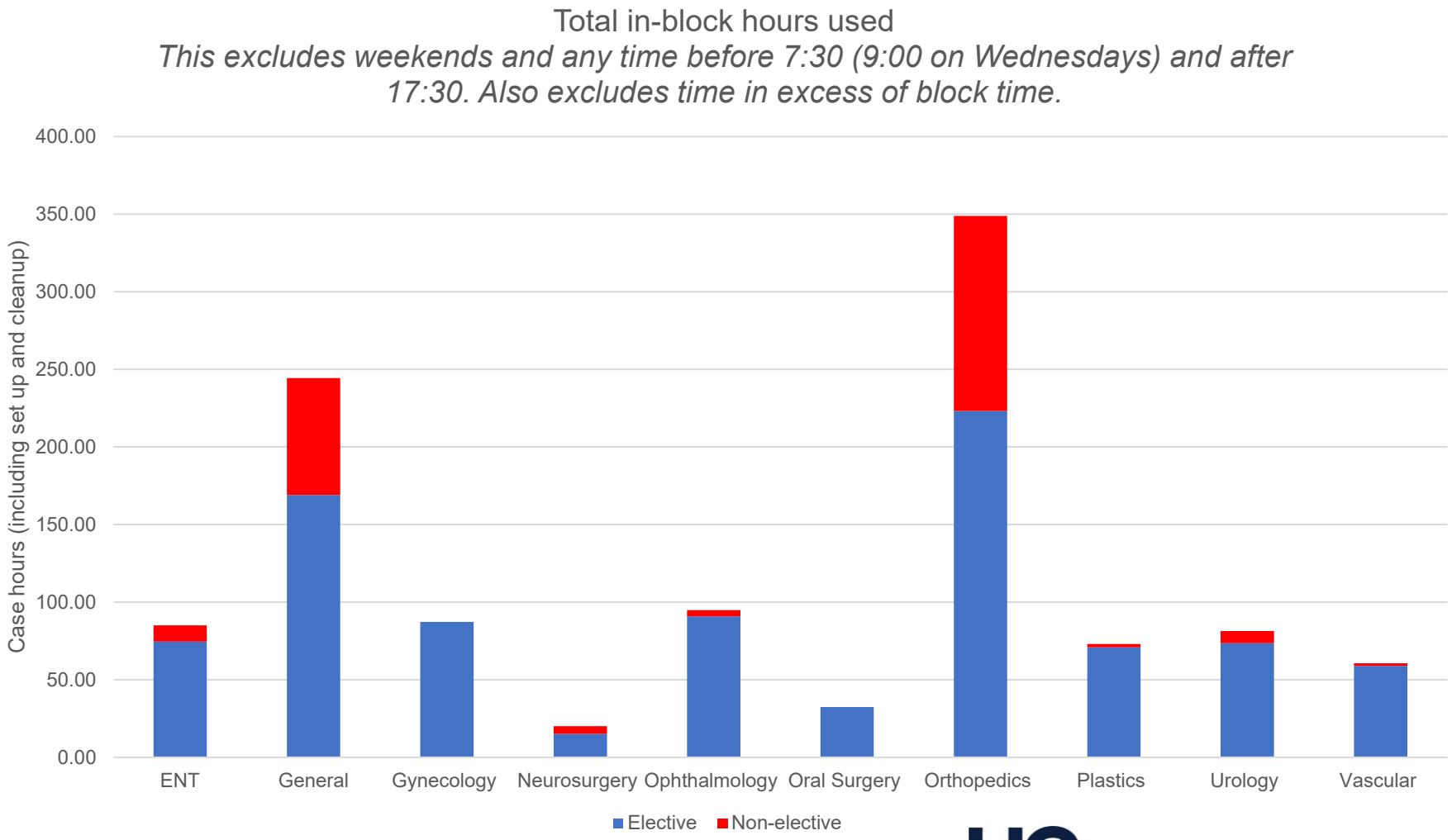
% Change year over year	2020-2021	2021-2022	2022-2023
General/Trauma Surgery	15.70%	18.51%	-6.50%
Vascular Surgery	2.11%	-7.96%	-7.37%
Plastic Surgery	13.57%	-5.61%	3.36%

Surgery Cases	2020	2021	2022	2023	Total
General/Trauma Surgery	1312	1518	1799	1682	6311
Vascular Surgery	332	339	312	289	1272
Plastic Surgery	361	410	387	374	1532

UCSF Department of Surgery

*Data updated to the beginning on December 2023

In Block Hours Used by Service



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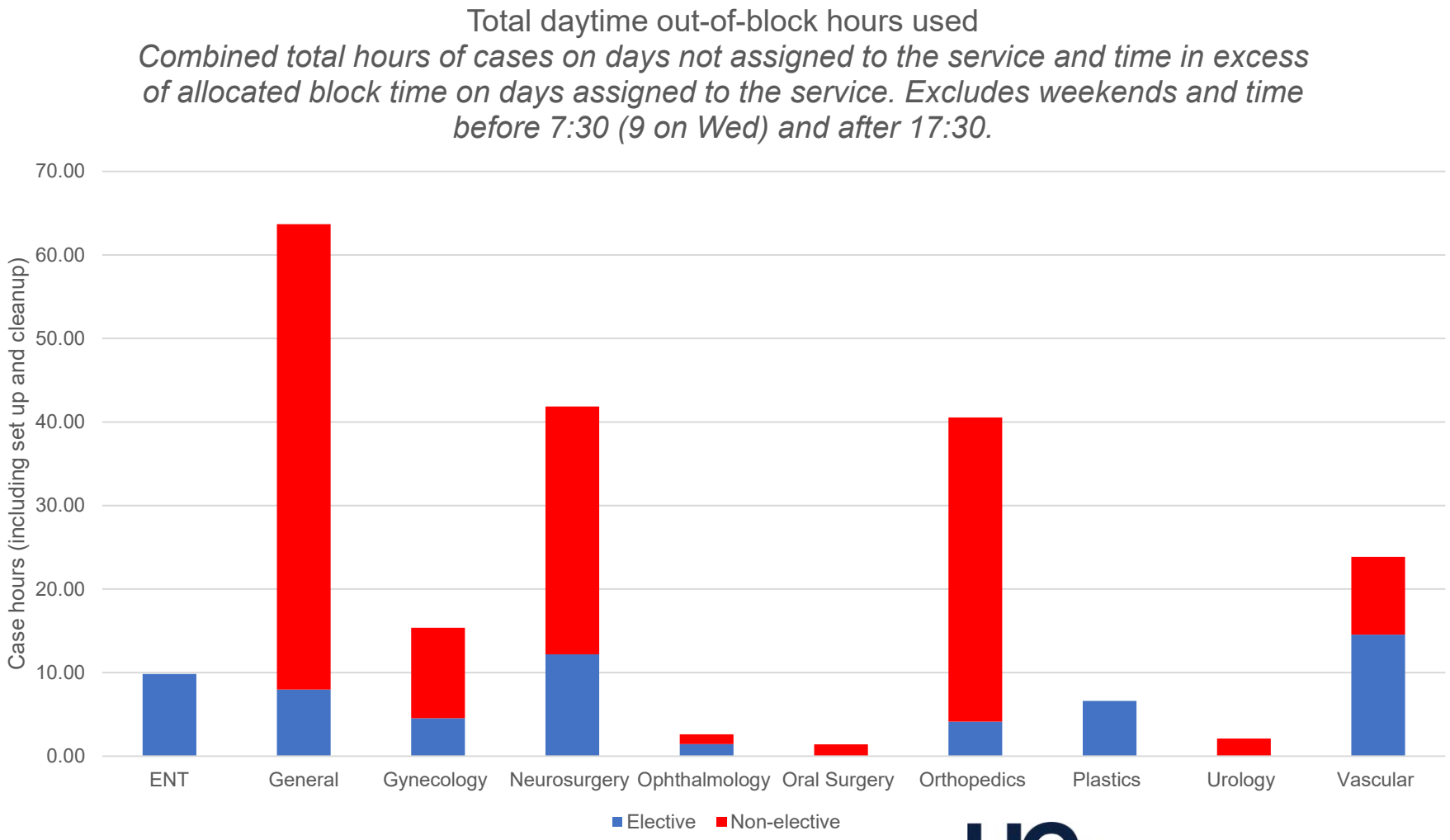
Daytime Out of Block Hours by Service



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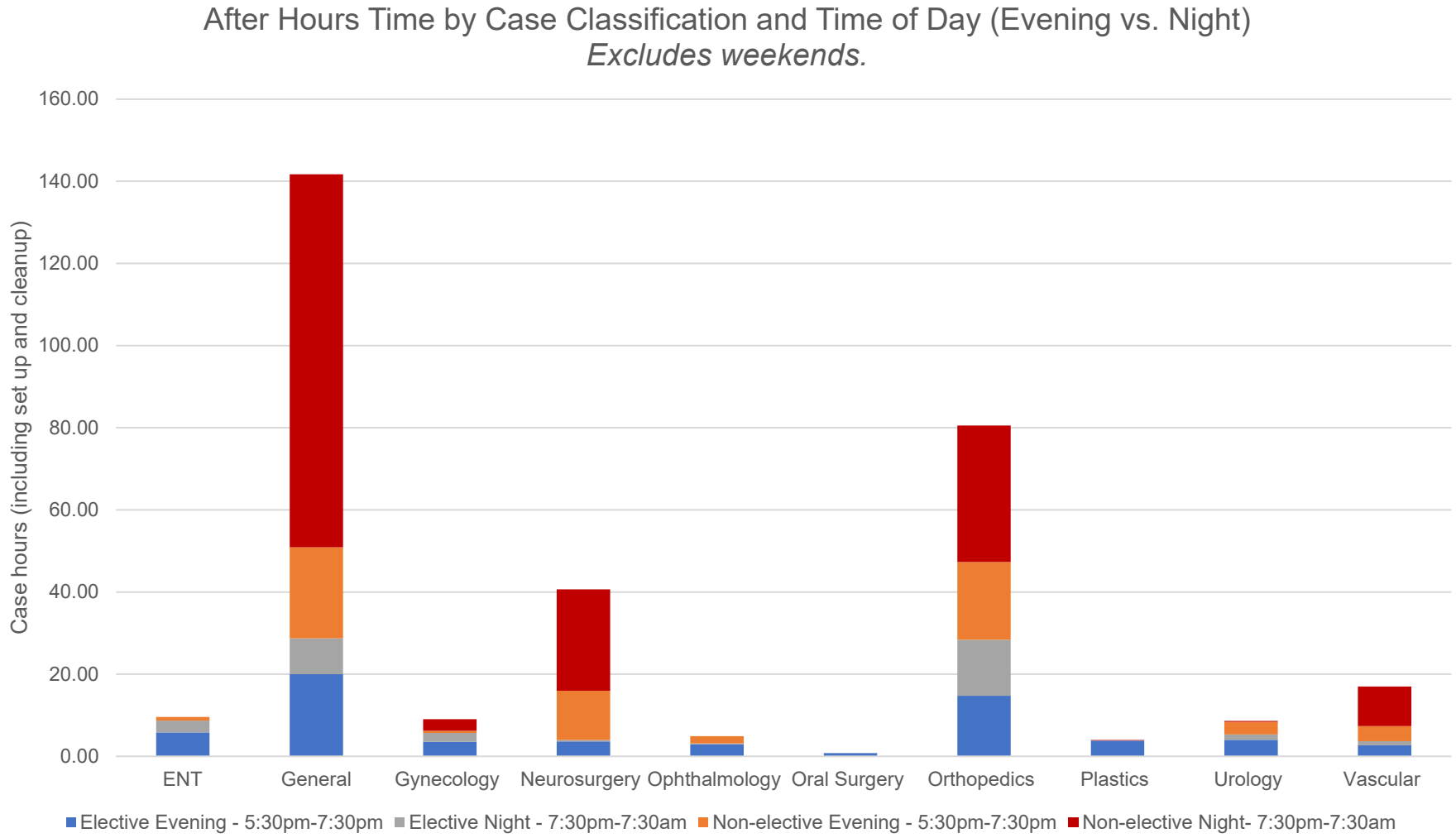
After Hours by Service and Case Classification



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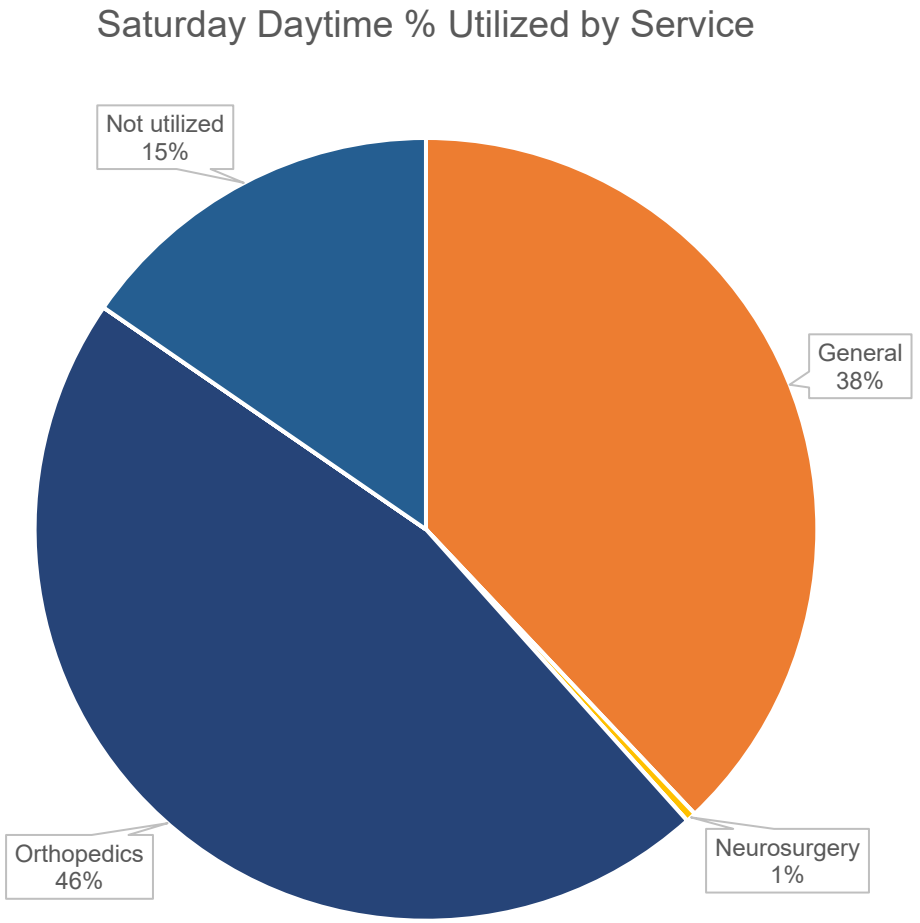
Saturday Daytime Utilization



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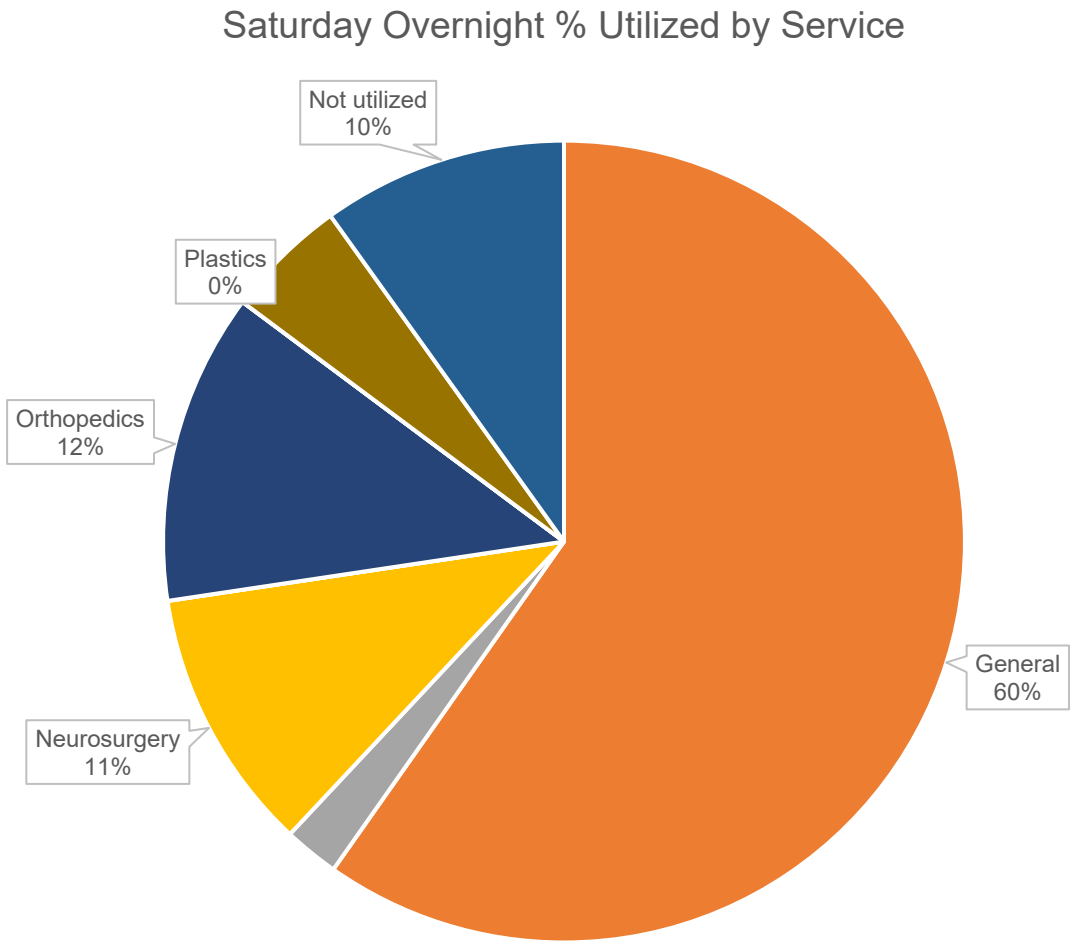
Saturday Overnight By Service



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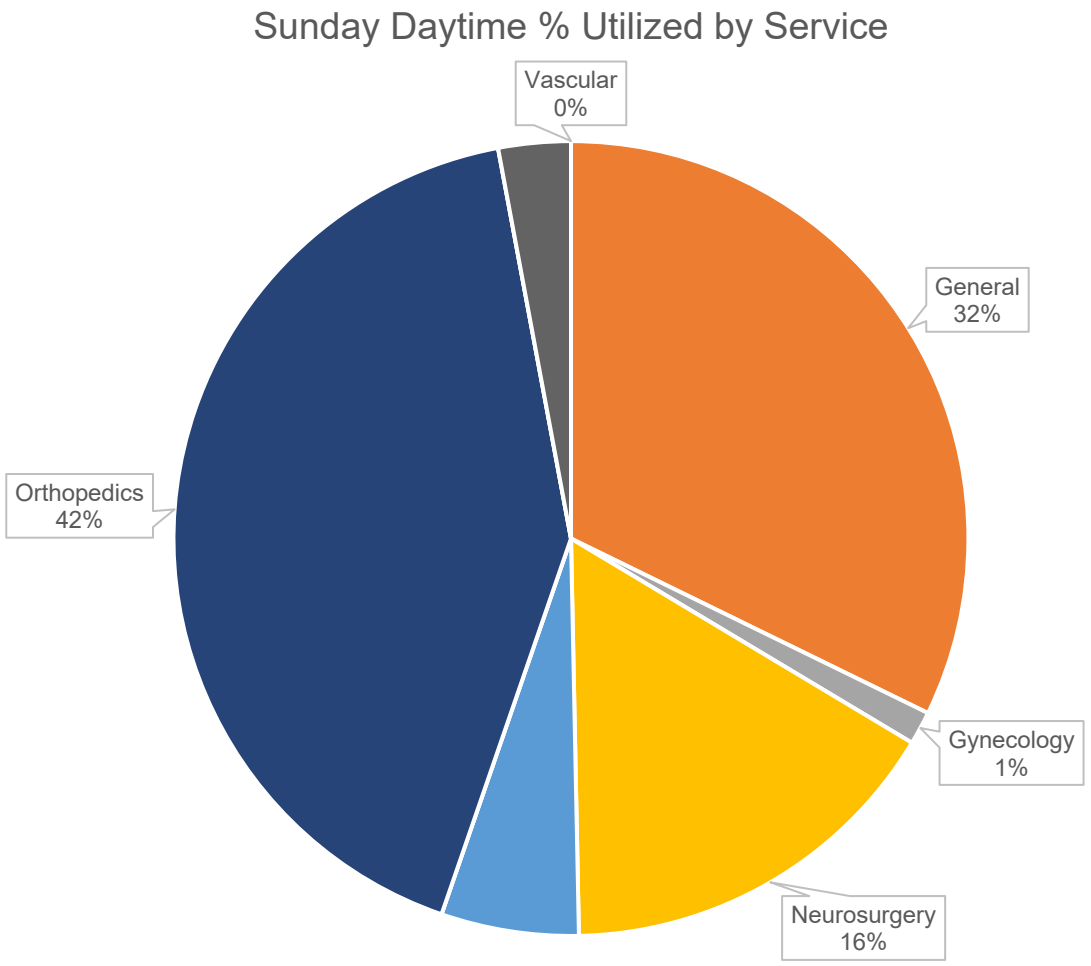
Sunday Daytime Utilization



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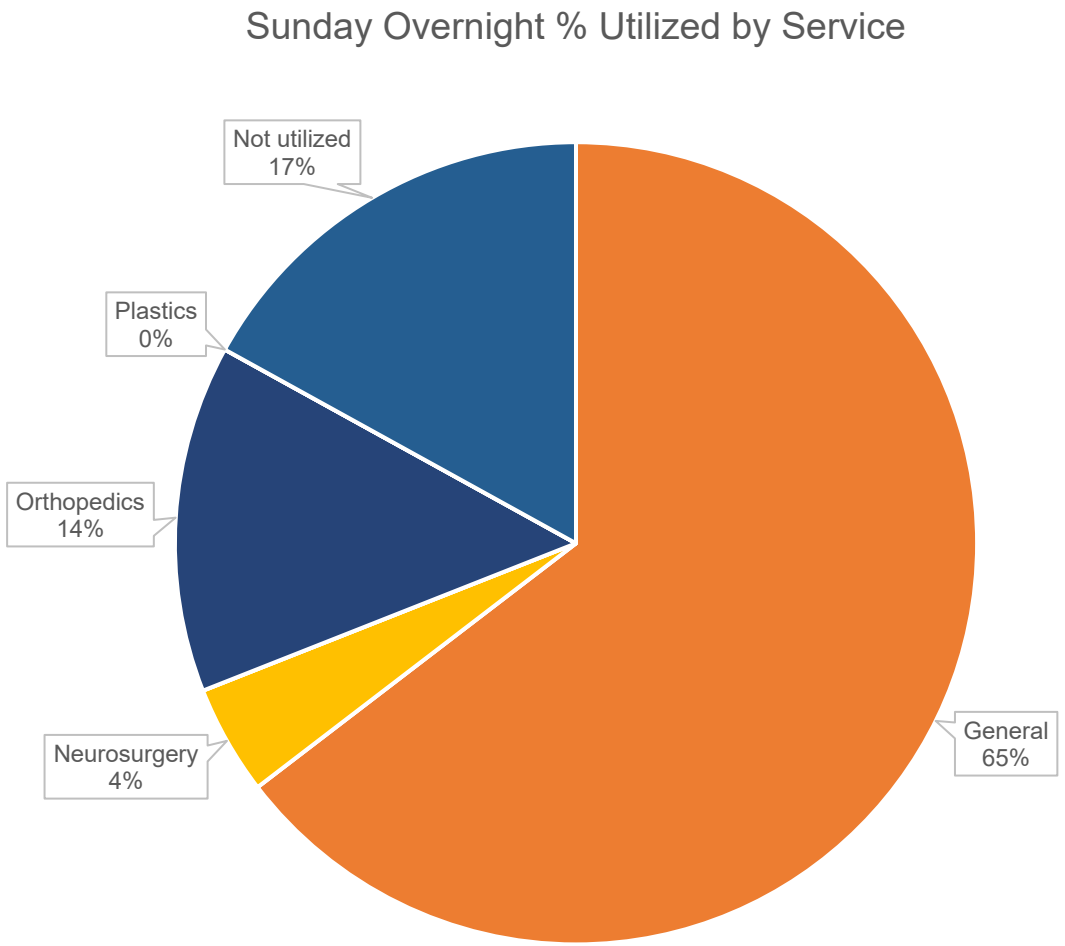
Sunday Overnight Utilization



UCSF Department of Surgery

Opportunities

UCSF Department of Surgery

Division of Surgery Process Improvement

- Physician Leadership:
  - Dr. Sandhya Kumar (General Surgery)
  - Dr. Joseph Cuschieri (Trauma and General Surgery)
- Data/Program manager:
  - Jeremy Ho (General Surgery)
  - Juliann Sussman(Trauma)
- Trauma Program Metrics
- Clinic Metrics
  - TNAA
- Operative Metrics
  - Elective (Inguinal hernia)
  - Urgent (Appendectomy, Cholecystectomy

UCSF University of California San Francisco

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

ZSFG Department of Surgery

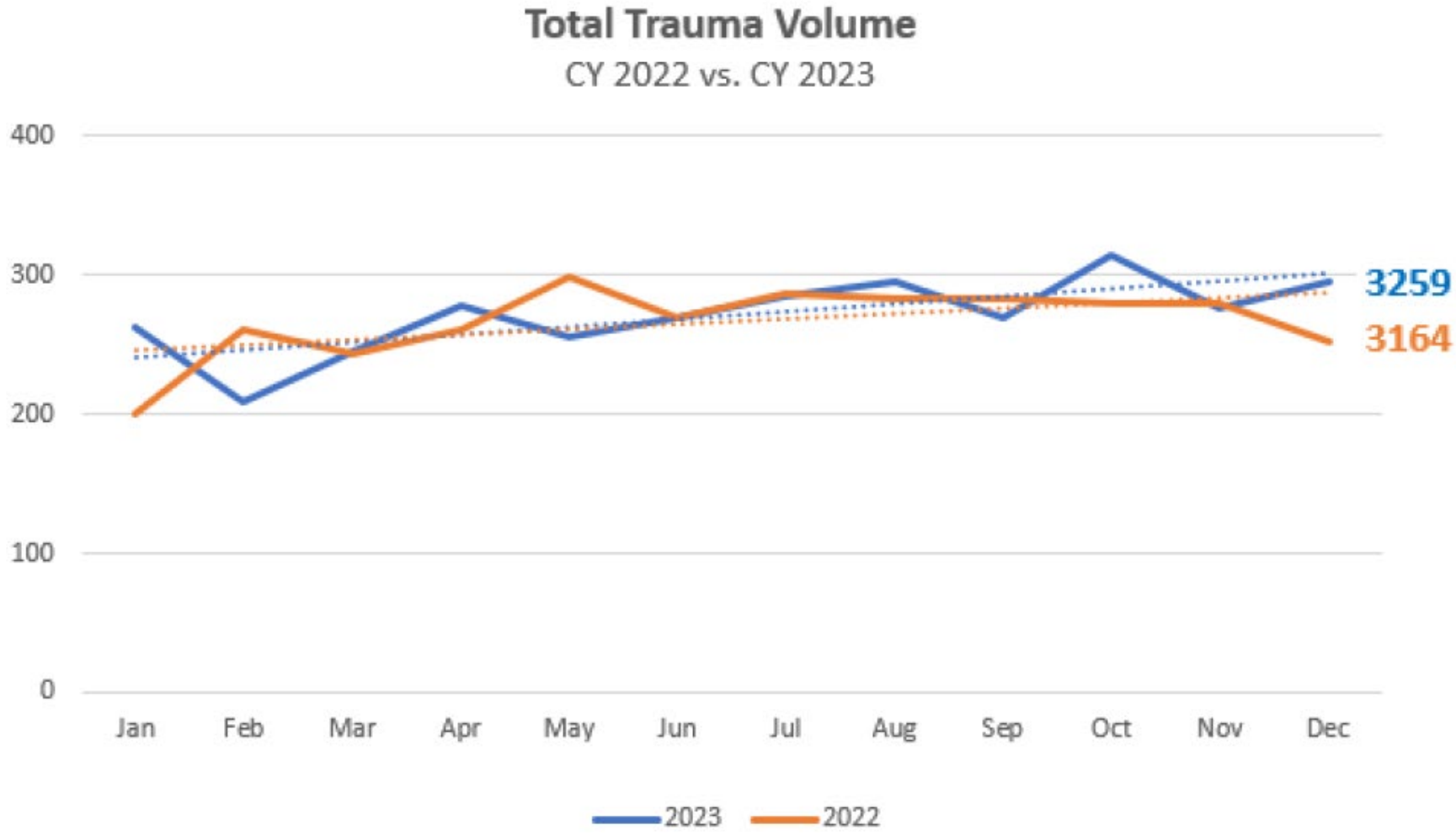
Clinical and Operational Report

UCSF Department of Surgery

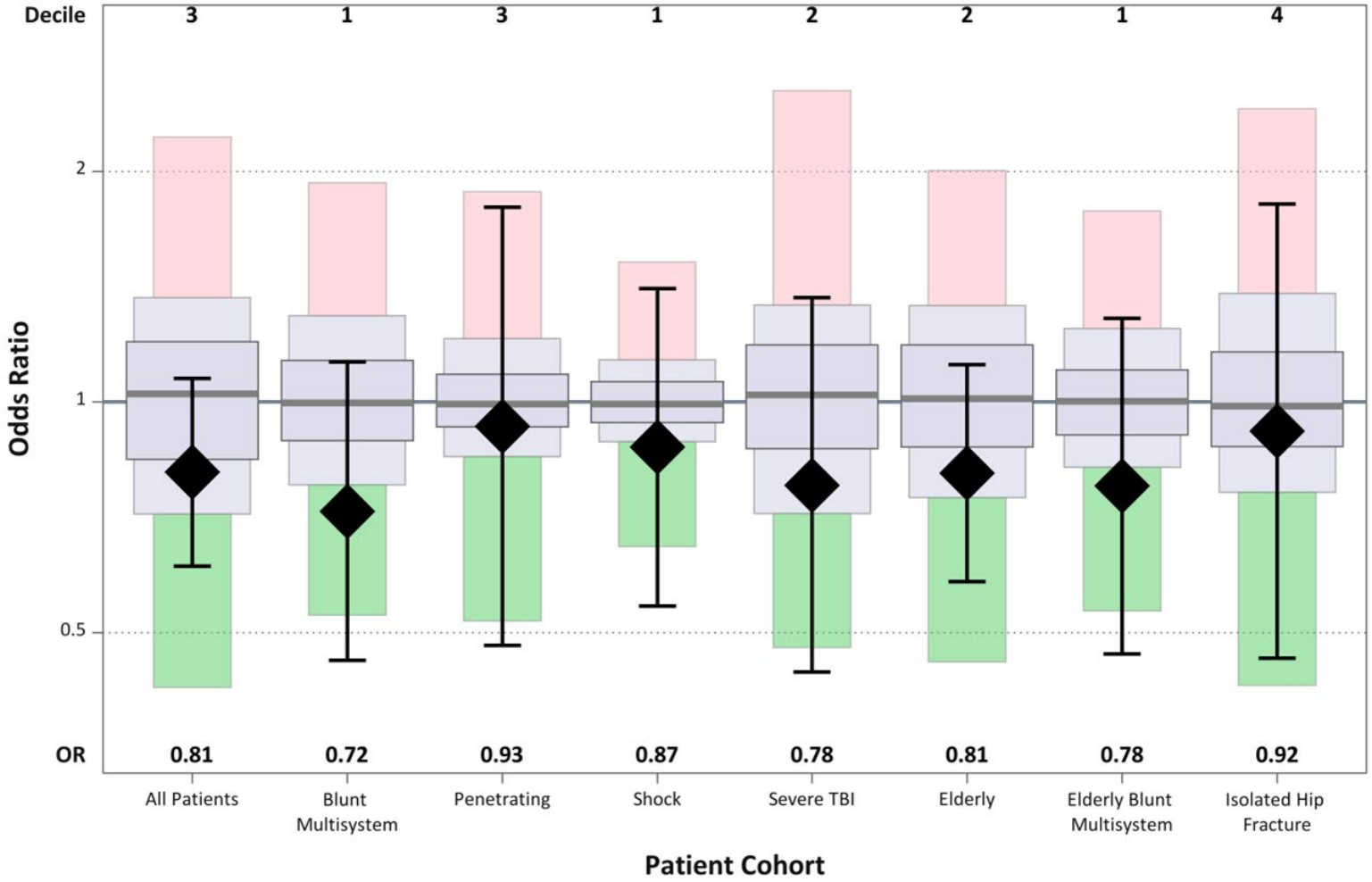
	True North Category	Measure Name	Owner	Measure Units	Baseline	CURRNT FYTD			PROPOSED 2022 PI Target
						Actual Performance; Color: On/Off Target	Desired Direction = (Up/Down)	2021 Target	
DRIVERS	Quality	Early Notification to ED of Critical (Shock) Trauma Patients – Trauma Attending arrival before (or within 1 minute of arrival of STA patient)	Cuschieri, J Peterson, S	%	64%	44%	Up	70%	70%
	Workforce Care and Development	TQIP Training/Annual Conference Participation for Trauma Program Staff	Peterson, S	#	1	5	Up	2	6
	Quality	Documentation of timely response of Trauma Attending to 900 TTA	Peterson, S	%	79%	83%	Up	80%	90%
	Equity	Implementation of the TQIP Palliative Care Bundle	Cuschieri, J	%	40%	65%	Up	70%	70%
	Equity	Implementation of IPV Screening	Bongiovanni, T	%	36%	52%	Up	60%	60%
	Patient Flow/ Safety/ Quality	Non-primary admission completion of tertiary survey within 24 hours	Cuschieri, J Sussman, J	% (completed)	86 %	88 %	UP	90%	90%
WATCH	Quality	Unanticipated mortality with opportunities for improvement (preventable death)	Cuschieri, J Sussman, J	#	0	0	Down	0	0
	Quality	Anticipated mortality with opportunities for improvement (possibly preventable death)	Cuschieri, J Sussman, J	#	4	1	Down	≤ 4	≤ 4

	DEC 22	2022 Total	JAN 23	FEB 23	MAR 23	APR 23	MAY 23	JUN 23	JUL 23	AUG 23	SEP 23	OCT 23	NOV 23*	DEC 23*	2023 Total*
All Patients	253	**3164**	263	209	246	278	255	269	285	296	270	315	278	295	**3259**
TTA Admitted	121	**1546**	111	95	111	124	105	134	117	130	119	141	118	111	**1416**
TTA ED D/C	86	**999**	87	64	67	88	87	69	99	106	84	99	85	94	**1029**
Non- TTA Admitted	46	**619**	65	50	68	66	63	66	69	60	67	75	75	90	**814**
DIRECT ADMIT	0	**0**	0	0	1	0	0	0	0	0	0	0	0	0	**1**
Activation Level															
Shock Trauma Alerts	10	**125**	11	7	6	8	14	13	16	13	9	15	5	4	**121**
900 Activations	66	**786**	74	37	49	63	56	65	64	79	38	92	57	51	**725**
911 Activations	141	**1757**	122	122	129	149	135	136	152	155	165	148	146	154	**1713**
Trauma Consult	10	**114**	15	6	13	14	12	5	9	6	7	11	4	0	**102**
Upgrade															
Upgrade: 911 to 900	11	**109**	7	6	3	8	2	6	11	10	7	13	14	8	**95**
Upgrade: NON to TTA	16	**292**	20	22	28	22	14	16	20	16	14	23	21	19	**235**
Age															
AGE > 65	82	**849**	77	57	80	70	70	77	76	69	68	79	82	105	**910**
AGE =< 14	3	**99**	5	4	5	8	11	9	11	15	10	6	4	3	**91**
Pediatric Admission by ED Dispo															
ICU	0	**11**	1	1	1	1	2	1	2	1	1	0	0	0	**11**
OR	1	**9**	0	1	0	1	0	0	1	0	1	0	0	1	**5**
TELEMETRY	0	**2**	0	0	0	0	0	0	0	0	0	0	0	0	**0**
FLOOR	1	**27**	1	0	1	3	3	4	3	5	5	3	2	1	**31**
Admitted Patient ISS Score															
ISS 1-9	82	**1042**	86	82	89	114	88	117	92	92	101	107	45	1	**1014**
ISS 10-15	37	**549**	51	33	47	38	35	39	52	44	43	51	19	0	**452**
ISS 16-24	23	**311**	16	21	19	21	24	26	23	26	18	25	8	1	**228**
ISS >= 25	18	**206**	16	7	16	12	17	17	17	26	23	16	3	3	**173**

**incomplete data*


Total Trauma Volume
CY 2022 vs. CY 2023
400
300
200
100
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
3259
3164
2023
2022

TQIP Risk Adjusted Mortality



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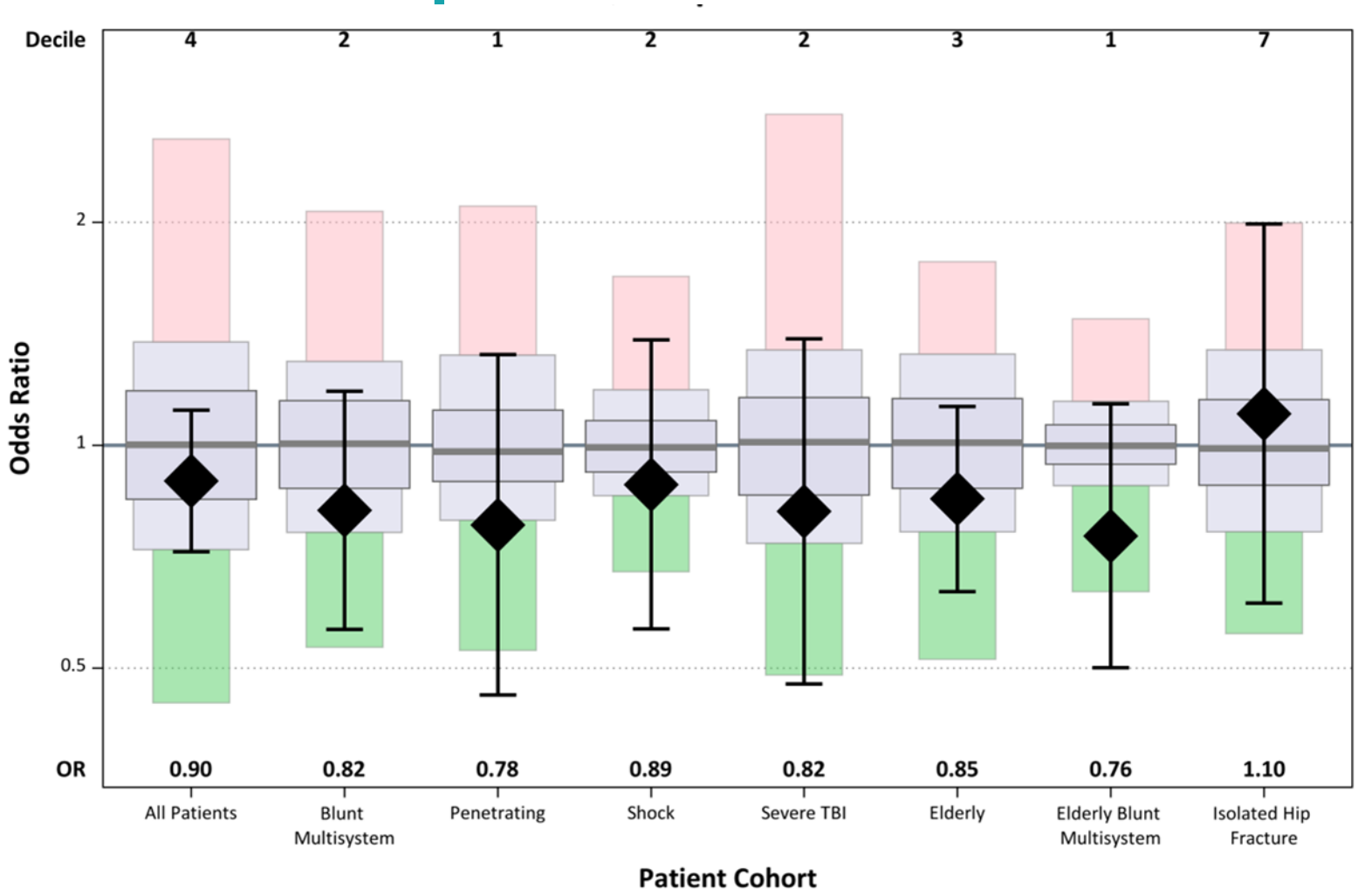
TQIP Risk Hospital Events and Death



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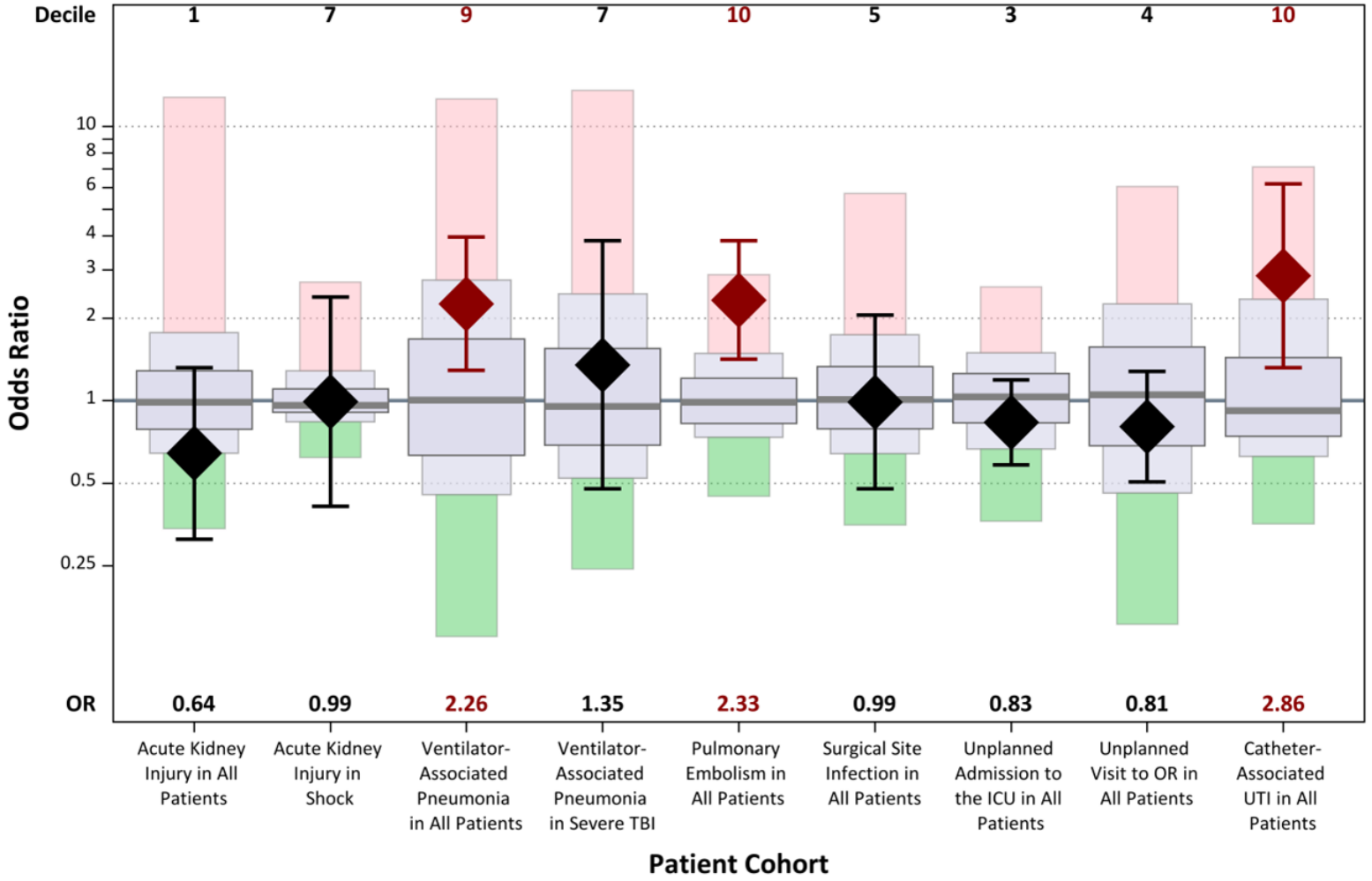
TQIP Risk Hospital Events



UCSF Department of Surgery

Management of Orthopedic Injuries

Table 18: Operative Irrigation and Debridement in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Irrigation and Debridement	Time to First Irrigation and Debridement (hours)	Irrigation and Debridement more than 24 Hours	Unknown Time to Irrigation and Debridement
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	7,657	7,272 (95.0)	7.7 (2.97-15.4)	611 (8.4)	18 (0.2)
Your Hospital	26	24 (92.3)	6.07 (2.06-12.14)	1 (4.2)	0 (0.0)

Table 19: Flap in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Flap	Time to Flap (days)	Flap after more than 7 Days	Unknown Time to Flap
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	7,657	358 (4.7)	8 (4-13)	186 (52.1)	1 (0.3)
Your Hospital	26	2 (7.7)	5.5 (1-10)	1 (50.0)	0 (0.0)

Table 20: Antibiotic Therapy in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Antibiotic Therapy	Time to Antibiotic Therapy (minutes)[1]	Time to Antibiotic Therapy more than 60 Minutes	Unknown Time to Antibiotic Therapy
Group	N	N (%)	Median (IQR)	N (%)[1]	N (%)
All Hospitals	7,639	7,531 (98.8)	22 (11-58)	1,645 (24.5)	107 (1.4)
Your Hospital	26	26 (100.0)	24 (17-34)	3 (11.5)	0 (0.0)

[1] Among patients receiving Antibiotic Therapy after Hospital/ED Arrival

UCSF Department of Surgery

Management of Neurotrauma

Table 26: ED Intubation for Severe TBI Patients

	Severe TBI[1]	Intubation in ED[2]	Time to ED Intubation (minutes)	Unknown Time to Intubation or ED Discharge
Group	N	N (%)	Median (IQR)	N (%)[3]
All Hospitals	26,615	11,697 (45.1)	8 (5-13)	676 (4.4)
Your Hospital	51	40 (81.6)	13 (12-18)	2 (4.8)

[1] Excluding patients directly admitted to the hospital
[2] Excluding patients with unknown intubation location
[3] Among Severe TBI patients who were intubated

Table 27: Cerebral Monitoring for Severe TBI Patients

	Severe TBI	Cerebral Monitoring	Time to Cerebral Monitoring (hours)[1]	Time to Cerebral Monitoring more than 4 hours	Unknown Time to Cerebral Monitoring
Group	N	N (%)	Median (IQR)	N (%)[1]	N (%)
All Hospitals	27,132	5,633 (20.8)	4.43 (2.4-10.62)	2,973 (53.3)	57 (1.0)
Your Hospital	51	16 (31.4)	5.1 (2.87-7.9)	9 (56.3)	0 (0.0)

[1] Among patients who received Cerebral Monitoring after Hospital/ED Arrival

Table 28: Cerebral Monitoring Method for Severe TBI Patients

	Cerebral Monitoring	External Ventricular Drain	Intraparenchymal Oxygen Monitor	Jugular Venous Bulb	Other Pressure Monitoring Device
Group	N	N (%)	N (%)	N (%)	N (%)
All Hospitals	5,633	2,916 (51.8)	358 (6.4)	37 (0.7)	3,353 (59.5)
Your Hospital	16	14 (87.5)	13 (81.3)	0 (0.0)	16 (100.0)

Note: Multiple methods are possible for an individual patient

UCSF Department of Surgery

Management of Neurotrauma

Table 29: Craniotomy for Severe TBI Patients

	Severe TBI	Craniotomy	Time to Craniotomy (hours)	Unknown Time to Craniotomy
Group	N	N (%)	Median (IQR)	N (%)
All Hospitals	27,219	5,242 (19.3)	2.43 (1.68-5.95)	17 (0.3)
Your Hospital	51	11 (21.6)	3.33 (1.57-14.62)	0 (0.0)

Table 30: Tracheostomy Management for Severe TBI Patients

	Severe TBI	Tracheostomy	Time to Tracheostomy (days)	Tracheostomy after more than 7 days	Unknown Time to Tracheostomy
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	27,219	4,581 (16.8)	10 (7-14)	3,188 (69.6)	0 (0.0)
Your Hospital	51	9 (17.6)	11 (7-15)	6 (66.7)	0 (0.0)

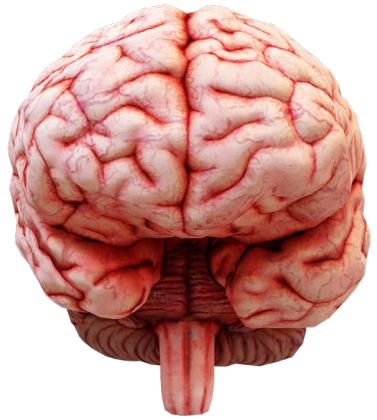


Table 31: Spinal Decompression/Stabilization for Patients with Spinal Cord Injury

	Spinal Cord Injury	Spinal Decompression/ Stabilization	Time to Spinal Decompression/ Stabilization (hours)	Time to Spinal Decompression/ Stabilization more than 24 hours	Unknown Time to Spinal Decompression/ Stabilization
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	13,993	9,546 (68.2)	22.07 (10.03-49.48)	4,447 (46.7)	17 (0.2)
Your Hospital	53	42 (79.2)	8.18 (5.47-19.72)	7 (16.7)	0 (0.0)

UCSF Department of Surgery

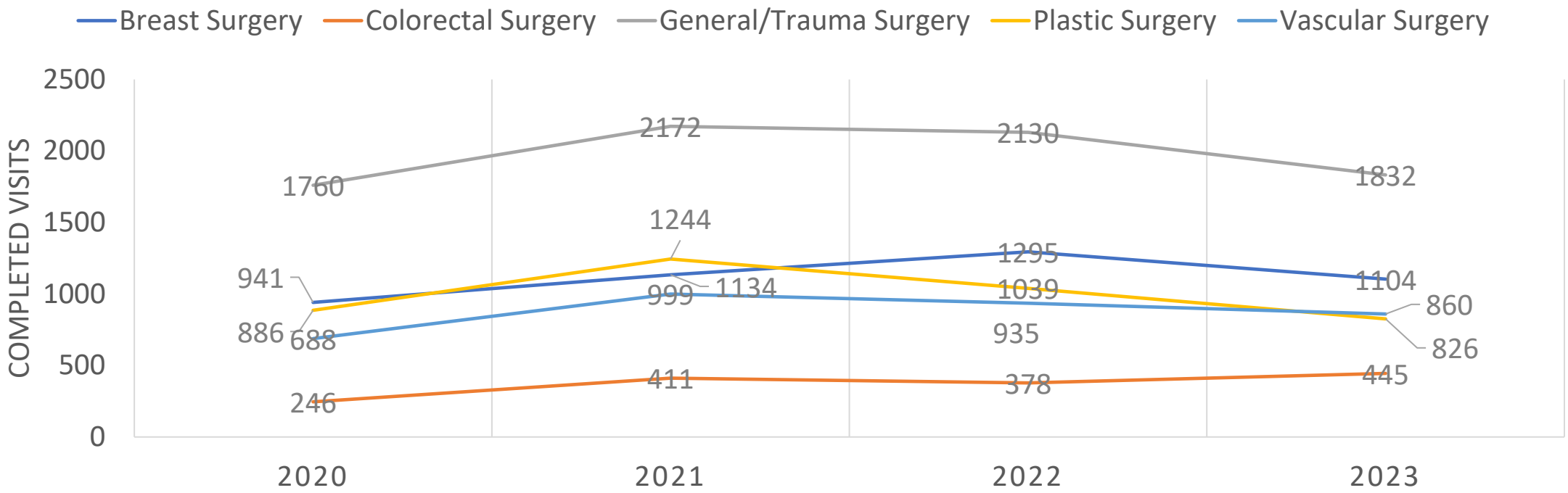
Transfusion in Hemorrhagic Shock

	Patients[1]	Plasma:PRBC Transfused Ratio between 1:1 and 1:2[2]	Patients with Unknown Plasma:PRBC Ratio
Group	N	N (%)	N (%)
All Hospitals	2,596	1,726 (66.7)	7 (0.3)
Your Hospital	14	11 (78.6)	0 (0.0)

[1] Hemorrhagic shock patients receiving more than 6 units of PRBCs and/or Whole Blood
[2] Whole Blood is treated as a 1:1 ratio of Plasma:PRBC and added to Plasma:PRBC volumes as described in the References

UCSF Department of Surgery

COMPLETED APPOINTMENTS BY SERVICE (YOY)



Completed Appointments	2020	2021	2022	2023	Total
Breast Surgery	941	1134	1295	1104	4474
Colorectal Surgery	246	411	378	445	1480
General/Trauma Surgery	1760	2172	2130	1832	7894
Plastic Surgery	886	1244	1039	826	3995
Vascular Surgery	688	999	935	860	3482

***Data updated to the end of October 2023**

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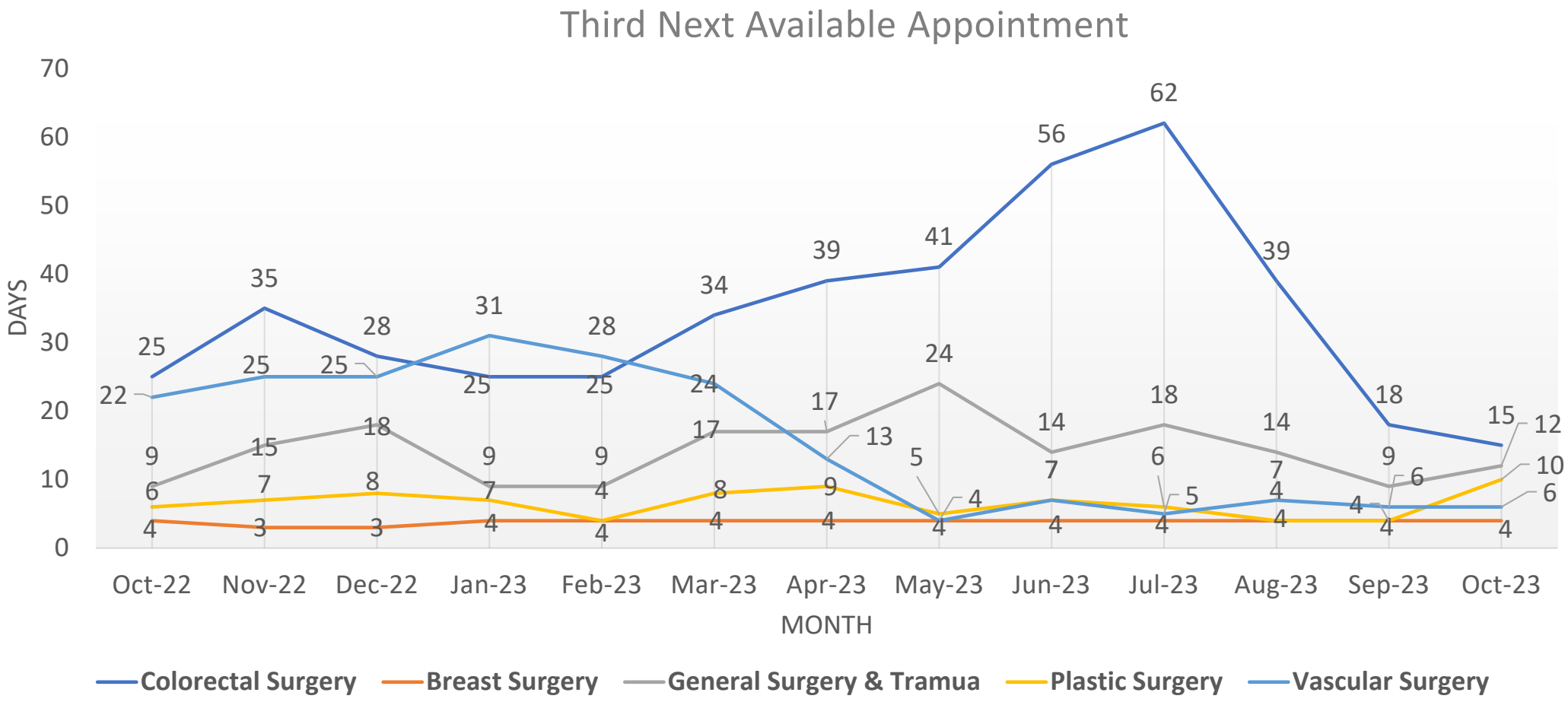
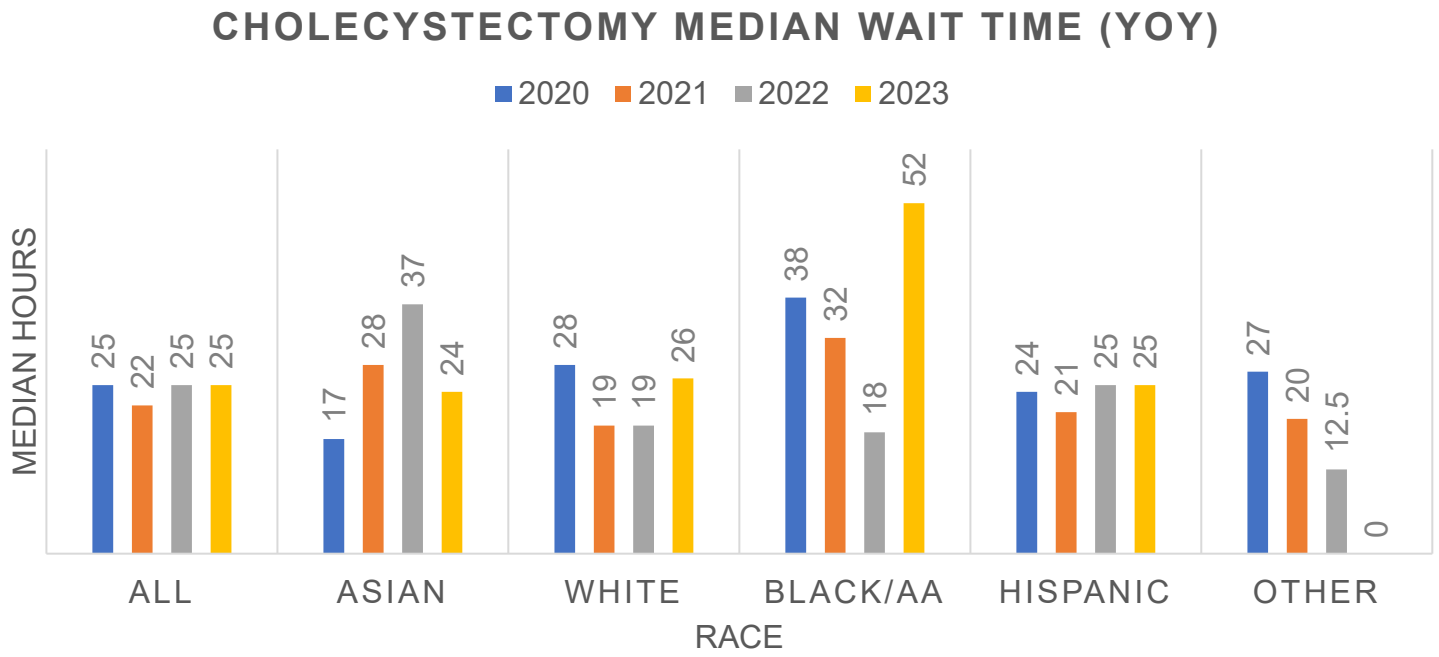


*Data updated to the end of October 2023

UCSF Department of Surgery

ZSGH| DOS Cholecystectomy

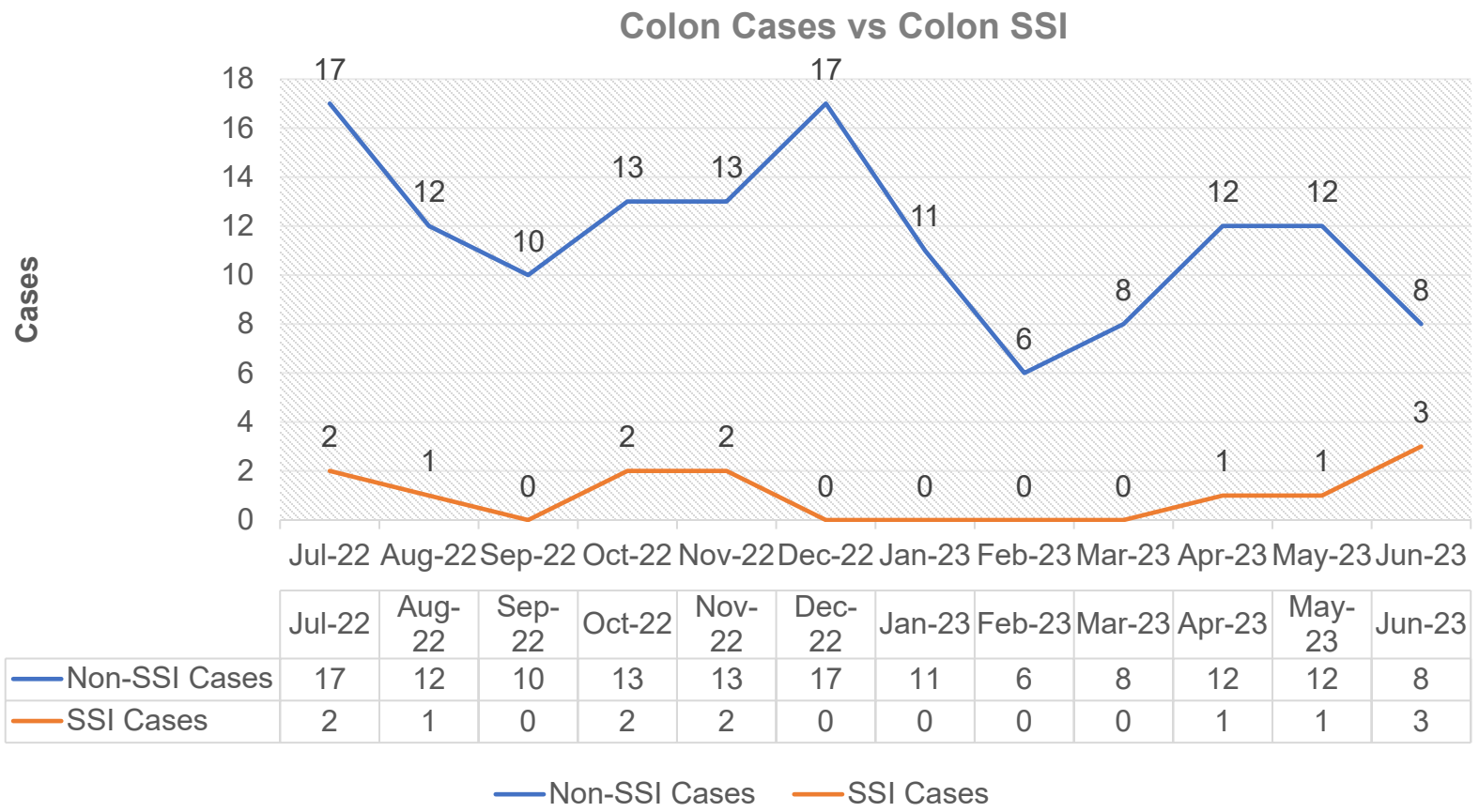


Year	% of patients with wait time <36 hrs	% of patients with wait time <24 hrs
2020	70%	49%
2021	73%	56%
2022	58%	49%
2023	63%	25%

Cholecystectomy cases	Total Cases	Gender		Race				
		Male	Female	Asian	White	Black/AA	Hispanic	Other
2021 Cases (n)	125	44	81	22	6	6	86	5
Median Wait time (hours)	22	23	21	28	19	32	21	20
2022 Cases (n)	138	47	91	13	12	6	102	5
Median Wait time (hours)	25	25	25	37	19	18	25	12.5
2023 Cases (n)	16	6	10	1	1	2	12	0
Median Wait time (hours)	25	41	24	24	26	52	25	0

UCSF Department of Surgery

ZSGH Department of Surgery Colon SSI



	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23
Non-SSI Cases	17	12	10	13	13	17	11	6	8	12	12	8
SSI Cases	2	1	0	2	2	0	0	0	0	1	1	3

All SSI Model	Total operations	# SSI	Predicted #	SIR
FY17-18	64	10	3.9	2.59
FY18-19	66	10	4.2	2.36
FY19-20	83	13	7.4	1.76
FY20-21	114	13	10.2	1.28
FY21-22	142	12	11.9	1.01
FY22-23	**151**	**12**	**12.3**	**0.97**

All SSI Model	ProcCount	SSI Count	Predicted #	SIR
FY22-23	151	12	12.3	0.97
Elective SIR	82	4	6.3	0.63
Emergent SIR	69	8	6	1.3
Trauma SIR	33	3	3.6	0.82
Non-trauma Emergent SIR	37	4	2.7	1.5

UCSF Department of Surgery

*Data updated through fiscal year 2022-2023


THE WRAPAROUND PROJECT
ZUCKERBERG SAN FRANCISCO GENERAL
HOSPITAL AND TRAUMA CENTER
63
SF
FDC

WAP Enrollment
September-November 2023

76 Clients Enrolled

Sex	Male	Female
%	90%	10%

Age Range	13-17	18-24	25-34	35-44	>45
%	3%	16%	36%	29%	16%

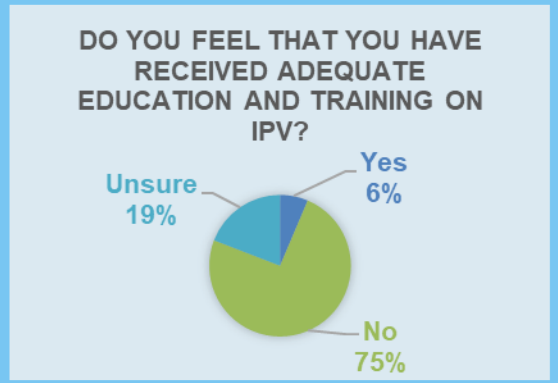
Race/ethnicity	Hispanic/Latinx	Black/African American	White	Middle Eastern	Pacific Islander	Asian	Declined/Unknown	Other
%	43%	32%	15%	4%	3%	1%	1%	1%

UCSF Department of Surgery

Interpersonal Violence Screening Program

UNDERSTAND

Surveyed surgery residents to assess IPV related attitudes, beliefs, behaviors



Identified key knowledge gaps and barriers

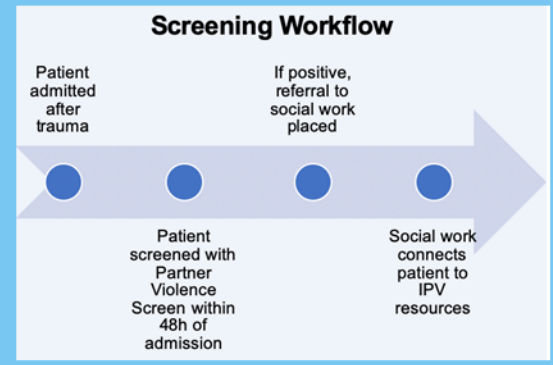
EDUCATE

Educated surgical residents via dedicated Zoom with IPV survivor and IPV social worker

Engaged Department of Surgery via short segment of Grand Rounds

DESIGN

Integrated best practices and expertise from trauma team, social work, IPV researchers



Analysis of screening and patient outcomes

UCSF Department of Surgery

Threats

UCSF Department of Surgery

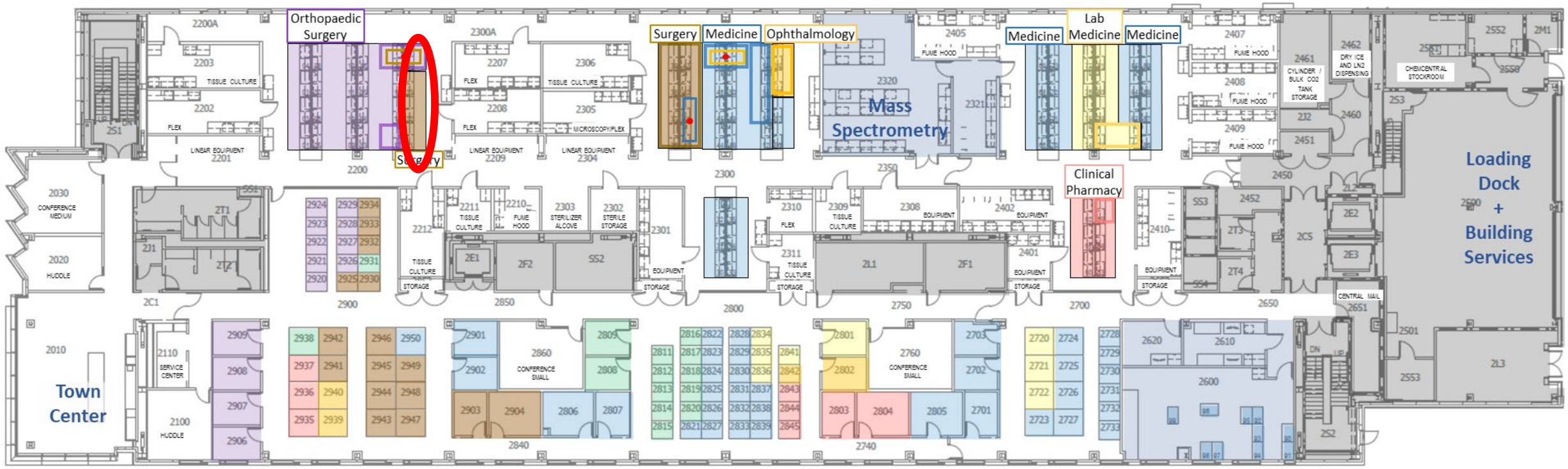
Limited Space in ZRAB

DEPARTMENT	2022 ALLOCATION	
	SPECIALTY & BENCH	WRITE-UP/ TOUCH-DOWN
Anesthesia and Perioperative Care	17	9
Laboratory Medicine	7	4
Medicine	93	46
NeuroSurgery	13	7
Ophthalmology	2	1
Orthopaedic Surgery	20	11
Pathology	7	4
School of Pharmacy	5	3
Surgery	5	3
Grand Total	**169**	**88**

UCSF Department of Surgery

Pride Hall Space Allocation

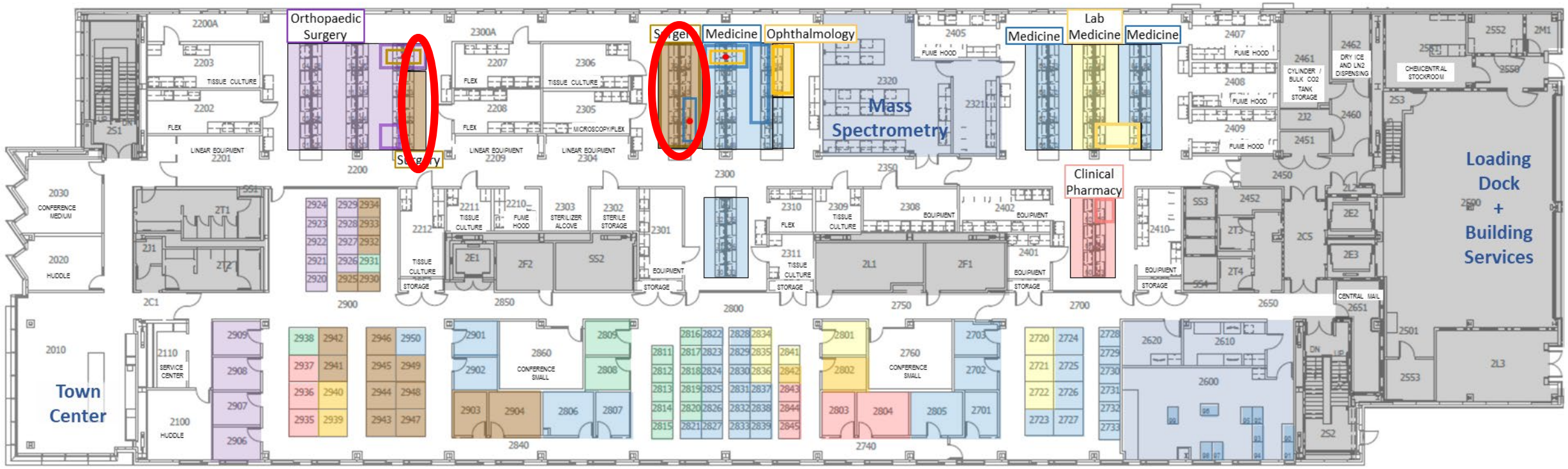
= *Building Services and Support* = *Reserved for future needs*



UCSF Department of Surgery

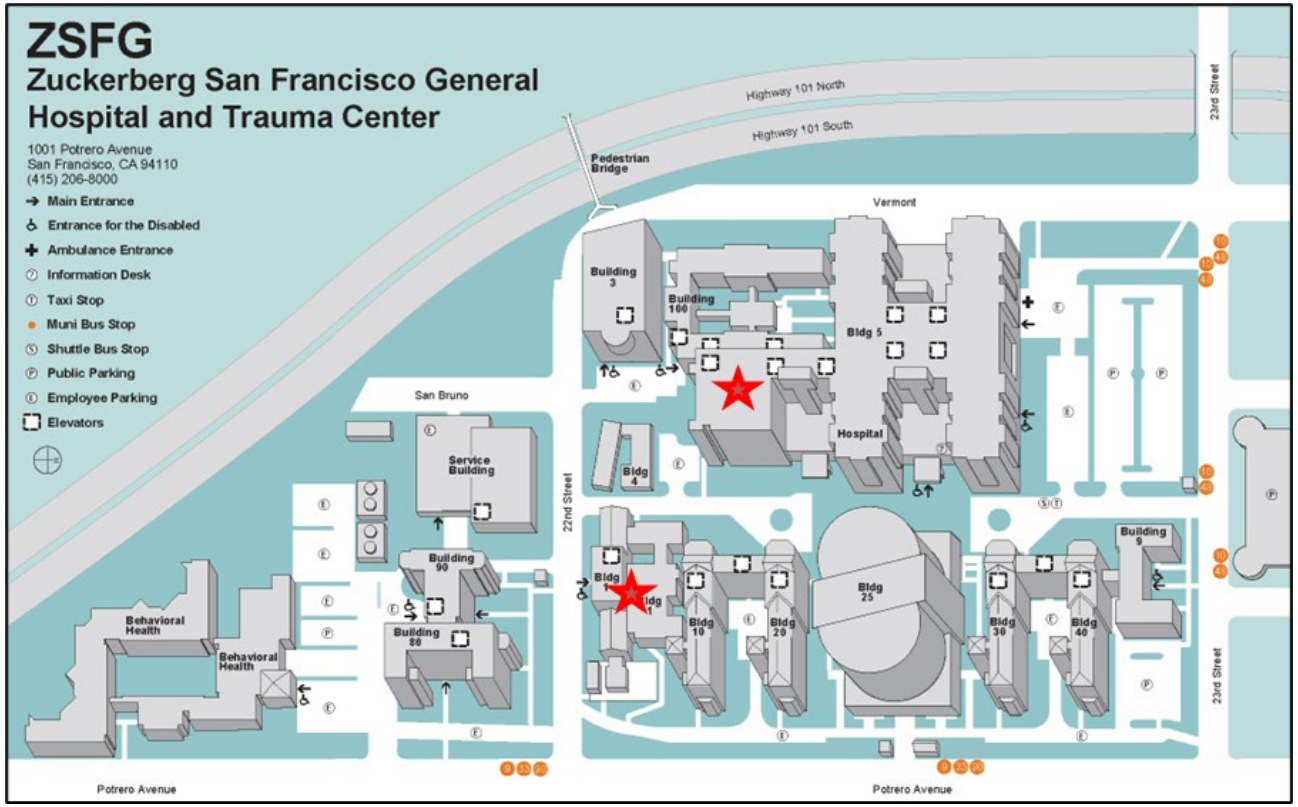
Pride Hall Space Allocation

= *Building Services and Support* = *Reserved for future needs*



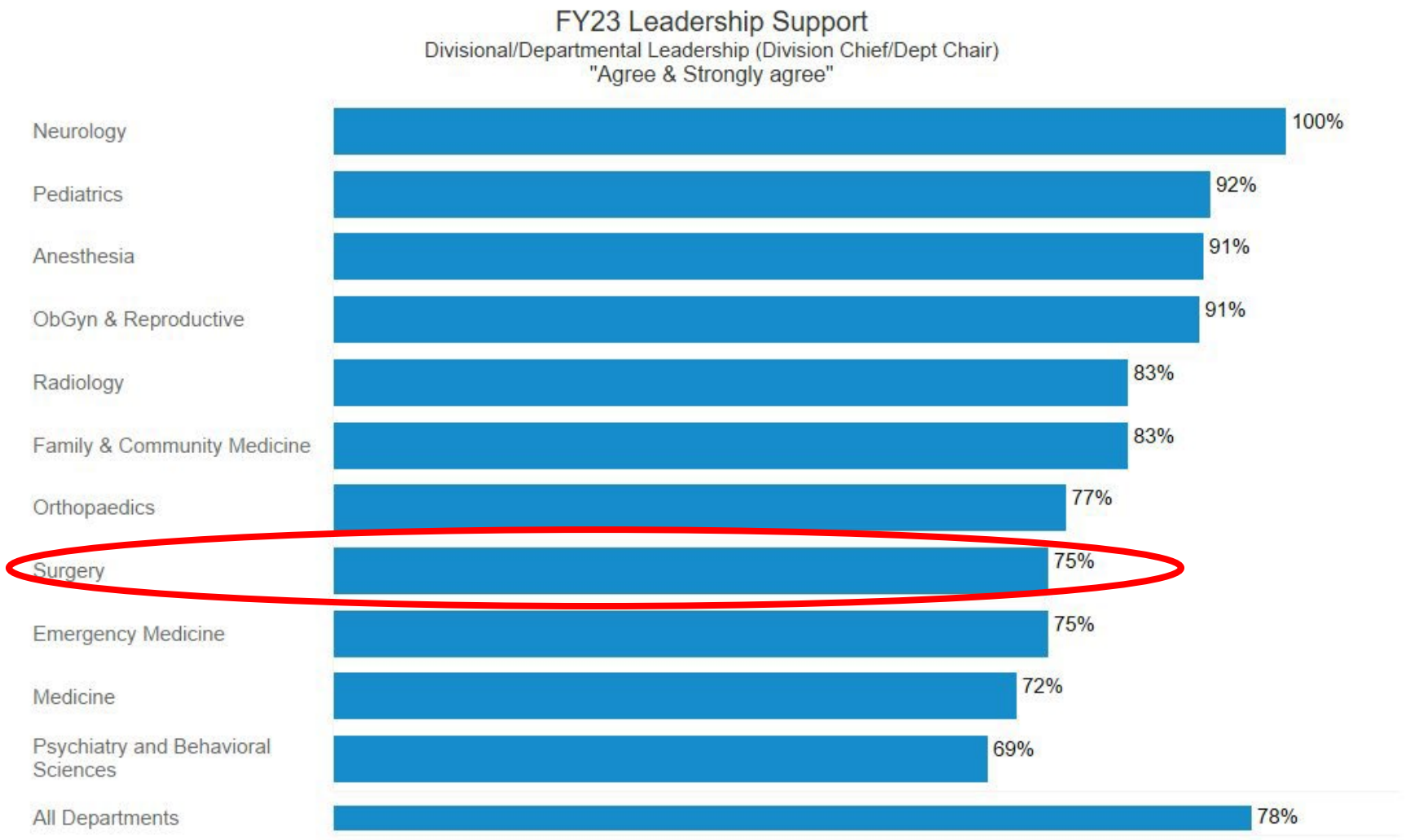
UCSF Department of Surgery

Office Location and Community Culture



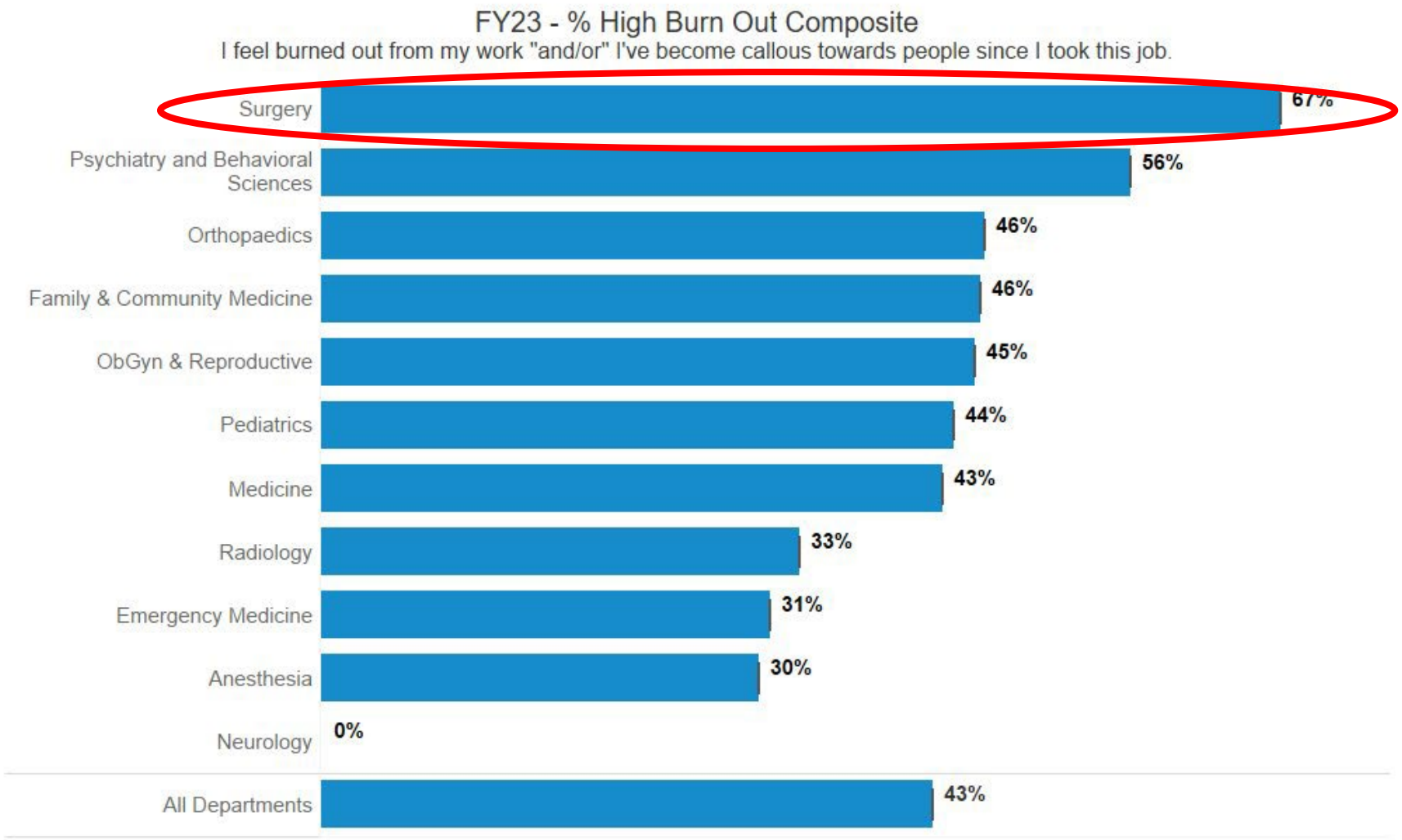
UCSF Department of Surgery

UCSF ZSFG



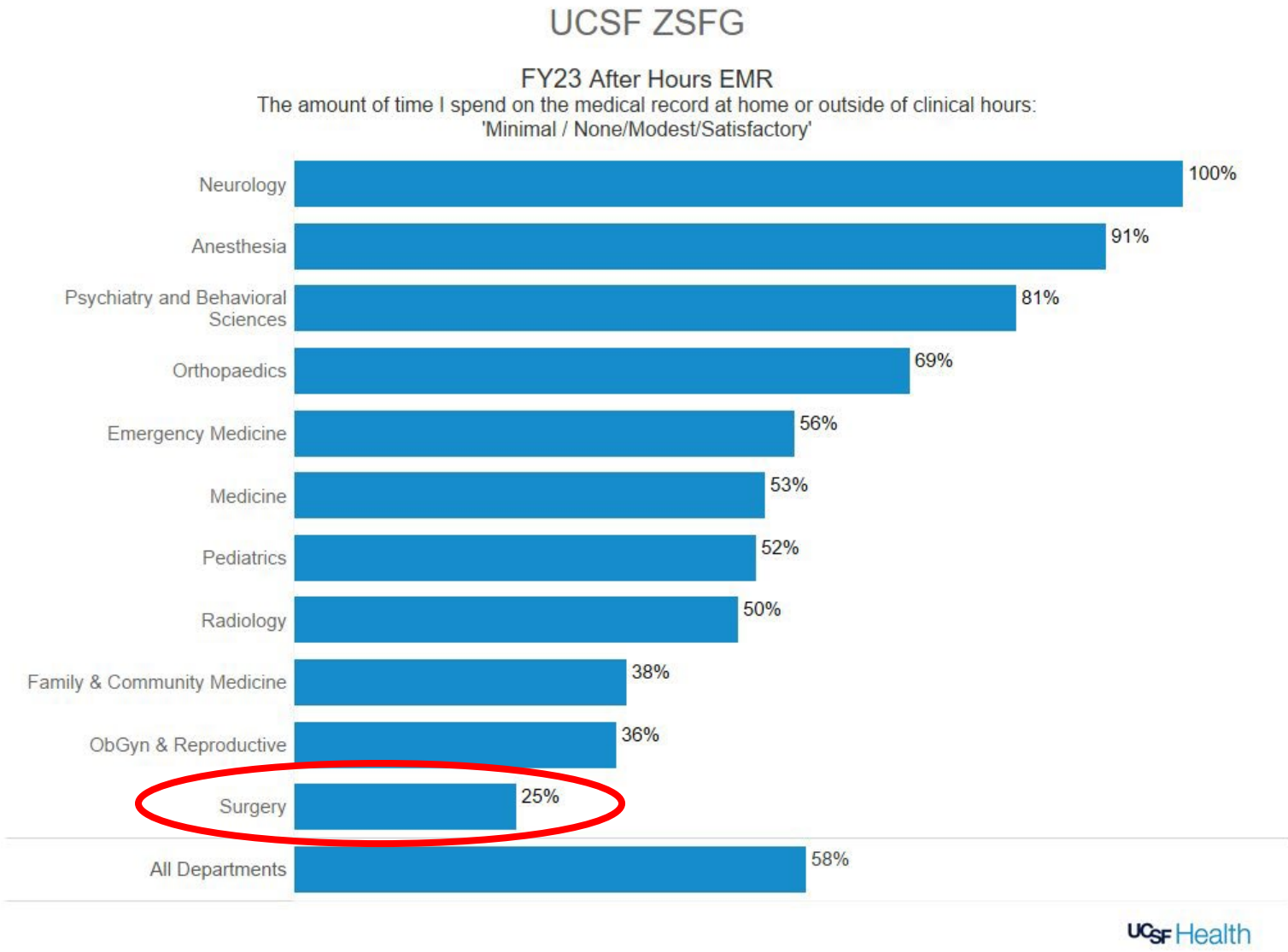
UCSF Department of Surgery

UCSF ZSFG



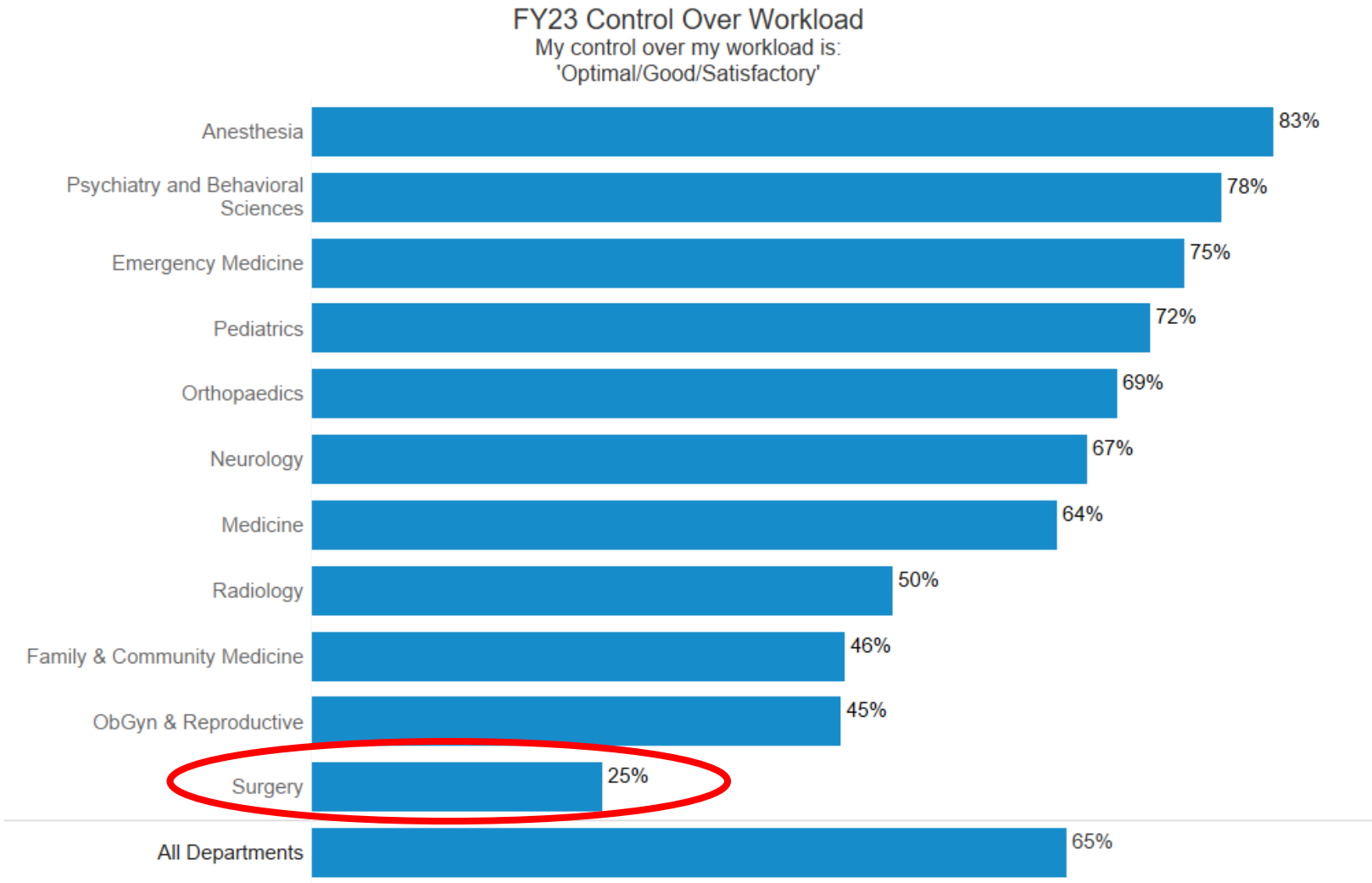
UCSF Department of Surgery

ZSFG



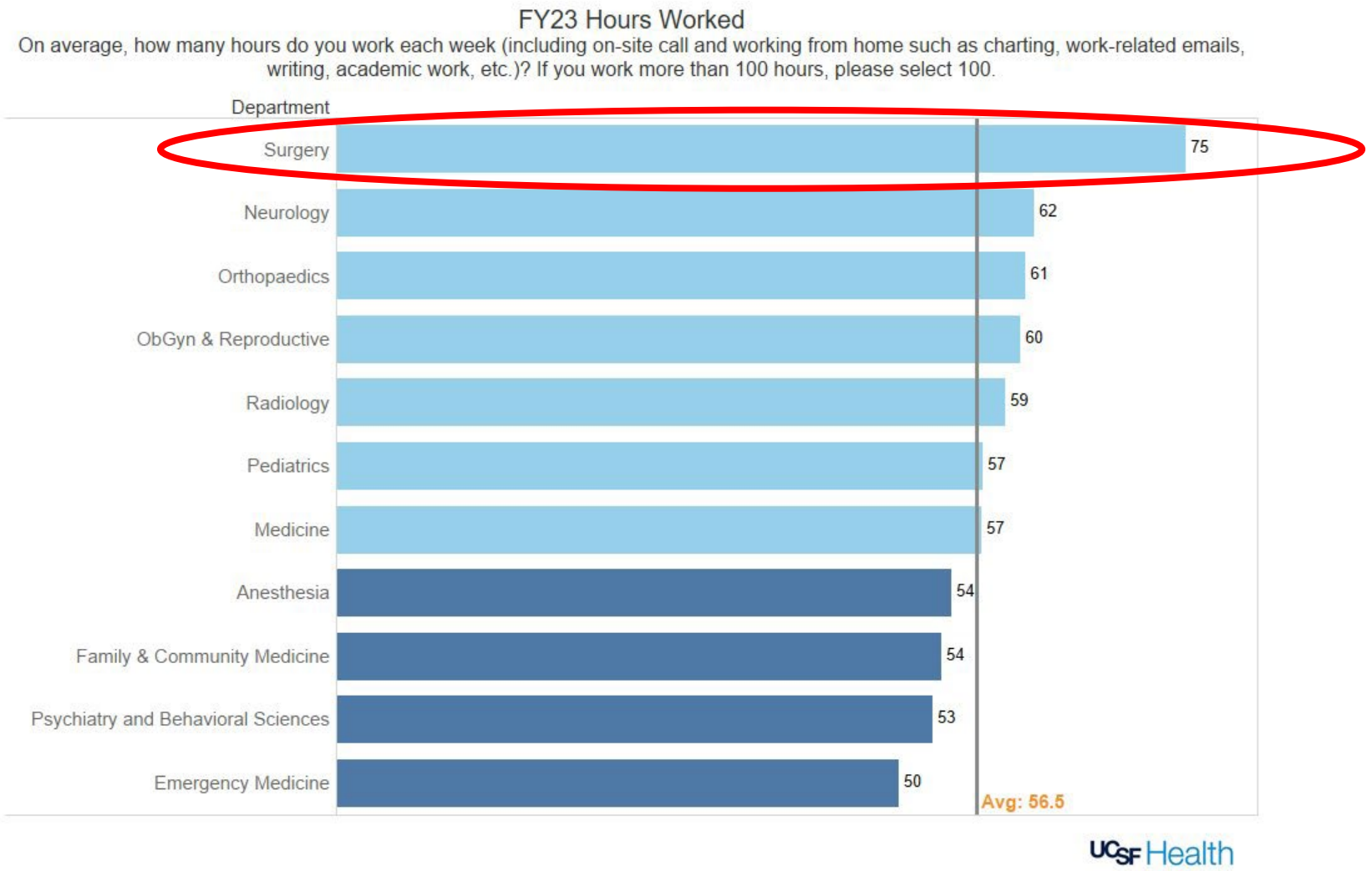
UCSF Department of Surgery

UCSF ZSFG



UCSF Department of Surgery

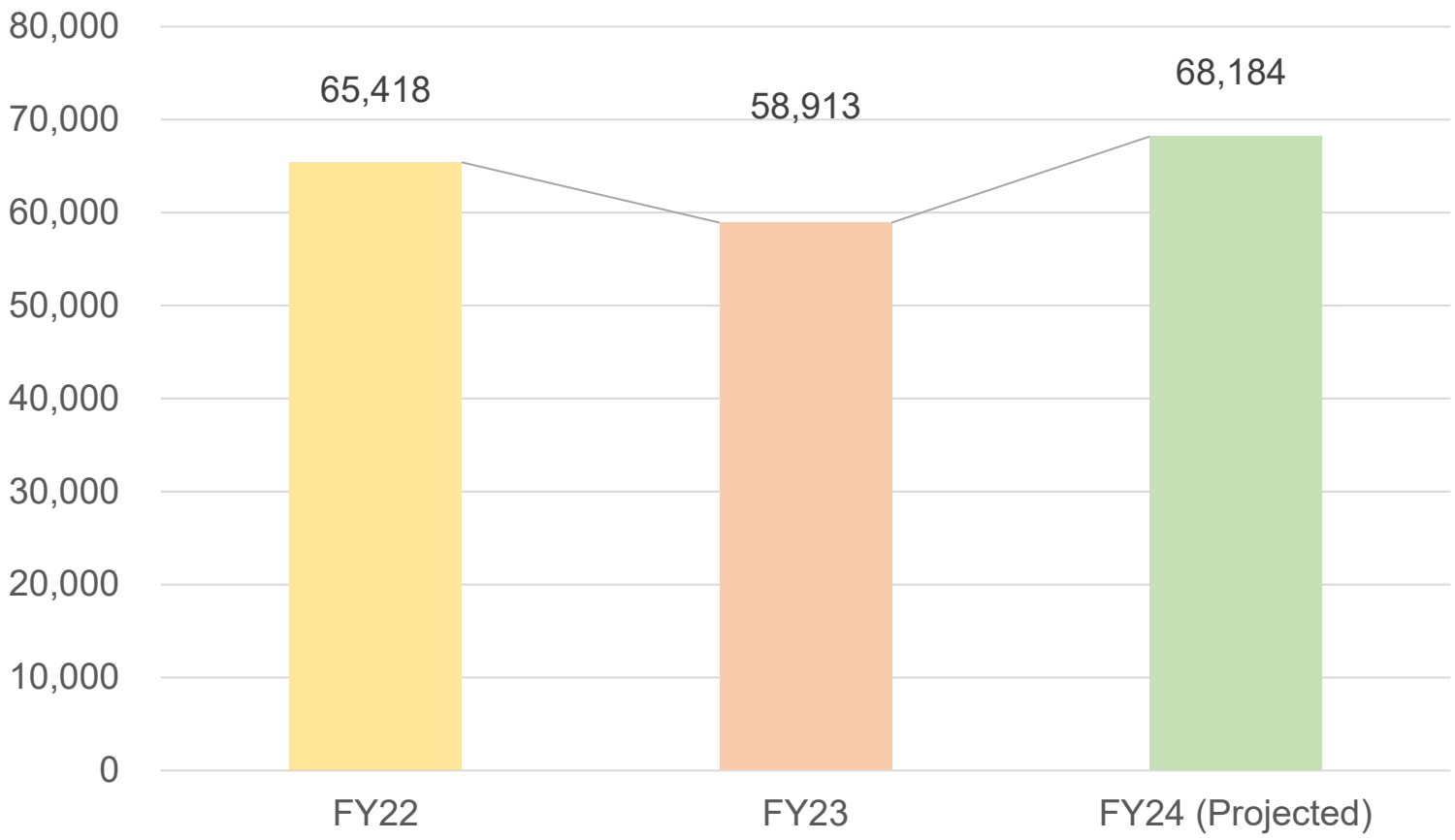
UCSF ZSFG



UCSF Health

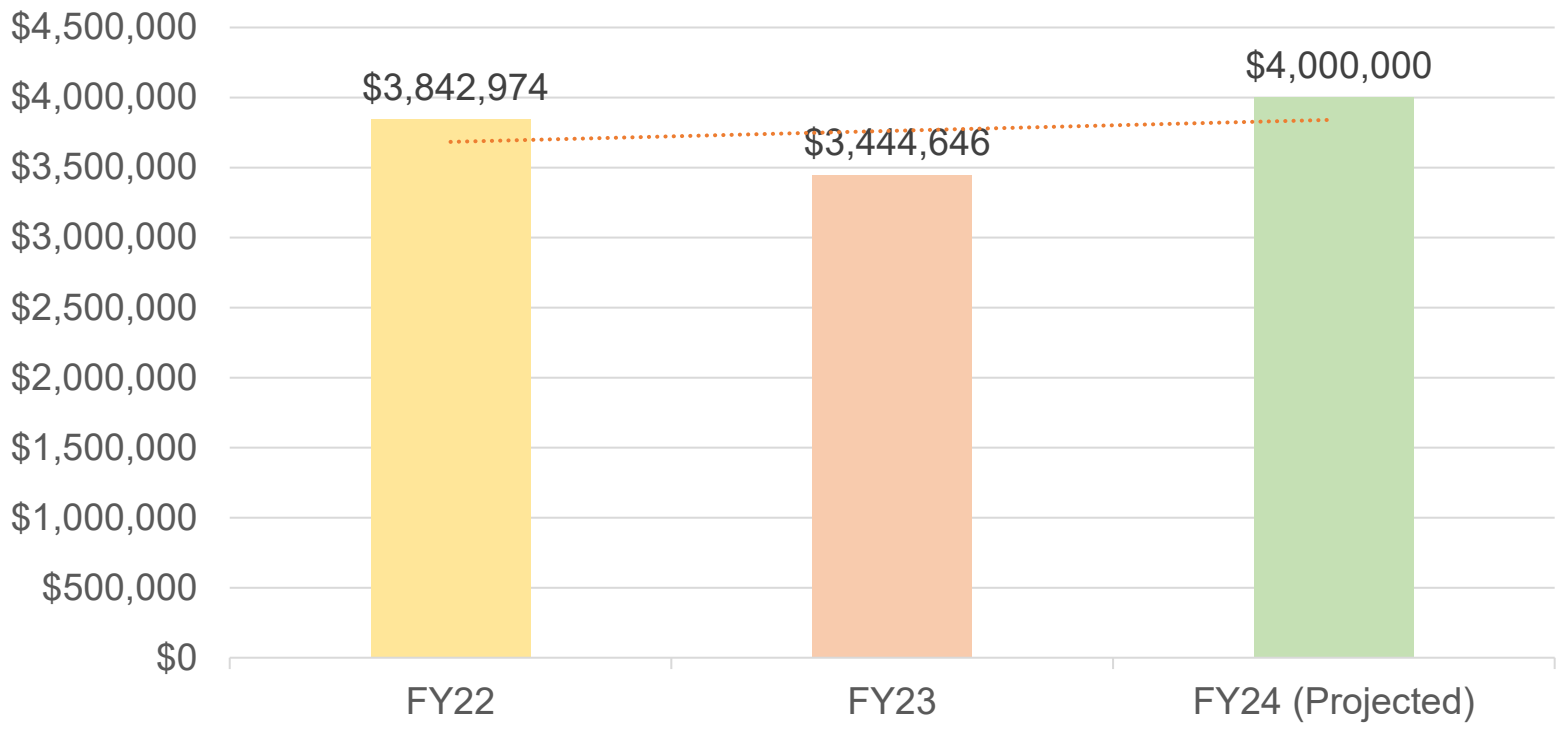
UCSF Department of Surgery

ZSFG Department of Surgery wRVU



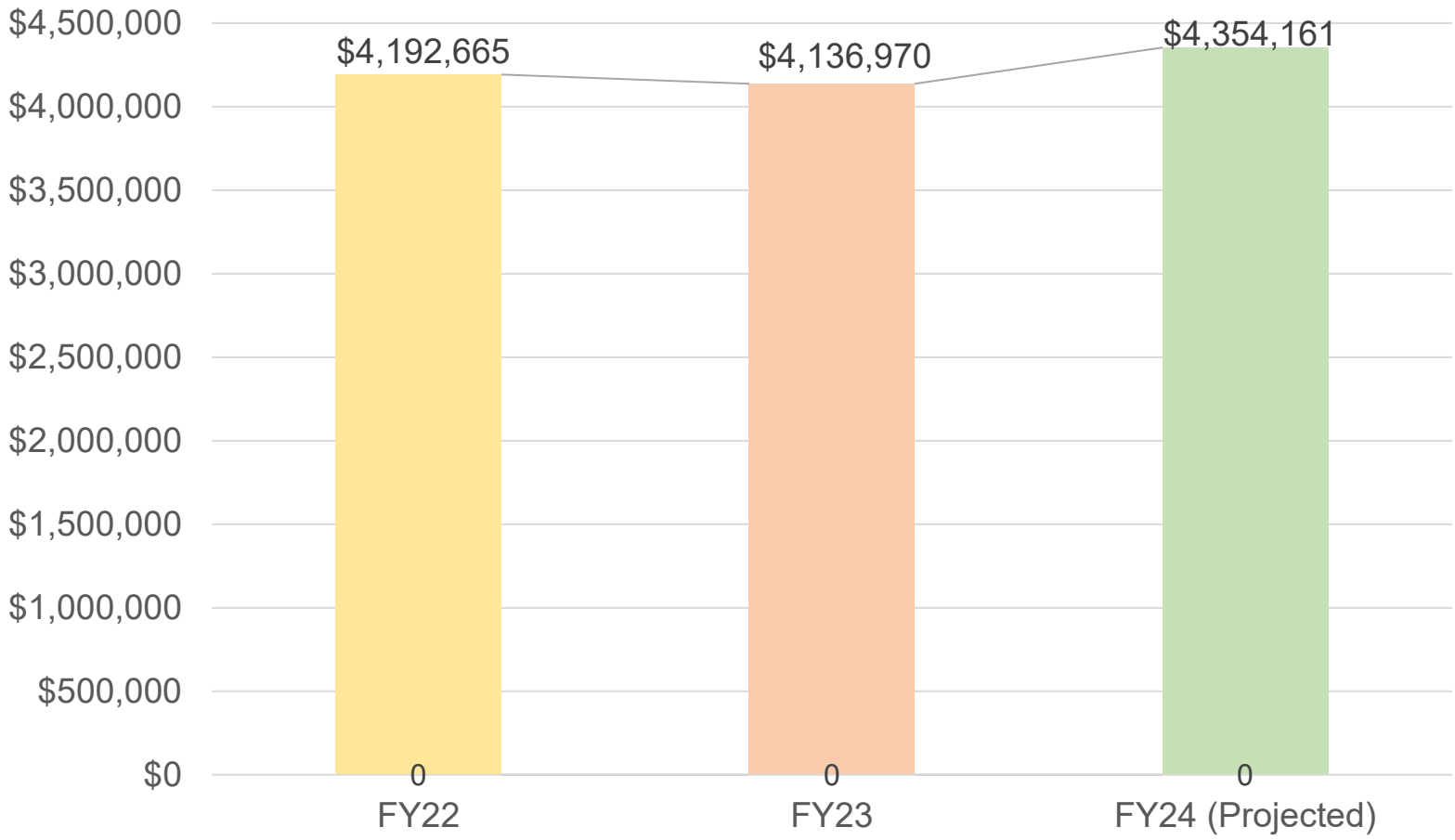
UCSF Department of Surgery

ZSFG Department of Surgery Payments



UCSF Department of Surgery

ZSFG Department of Surgery Profee Expenses



UCSF Department of Surgery

Summary

UCSF Department of Surgery

Divisional Summary

- **Strengths**
  - Nationally recognized extraordinary faculty providing exceptional patient care with excellent outcomes.
  - Dedication to surgical education with two primary fellowships in surgical critical care and acute care surgery.
  - Bright, motivated, resilient and engaged junior faculty with multiple funding opportunities and career trajectories

- **Opportunities for improvement**
  - Limited evidence-based practice guidelines
  - Service vs education balance
  - Limited number of faculty and risk of burnout
  - Improve charge capture, documentation, and clarity around billing

UCSF Department of Surgery

Divisional Summary

- Goals
  - Develop culture of collegiality and support
  - Strive to empower further impower faculty, and provide multi-disciplinary mentorship for clinical, administrative and research
  - Establish and develop collaborations in evidence-based practices across divisions and departments
  - Develop research collaborations to advance the science and care of septic and critically ill patients combining basic science, translational, implementational, and global health expertise within USCF, but in particular those centered at ZSFG.
  - Recruit national recognized leaders in clinical care and basic science, with current search for TMD.
  - Geographic colocalization of faculty offices
  - Development of further outreach and education

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 :	*Surgery*
Date of last approval:	
Summary of R&R updates:	
Update #1:	*Minor grammatical changes*
Update #2:	*Addition of Stop the Bleed and ASSET courses as part of the TMD responsibility to conduct*
Update #3:	
Update #4:	
Update #5:	

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS

~~2022~~2024

Updated January 2018

SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
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I. SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

1. The Surgery Service consists of the following surgical specialties: elective general surgery; emergency general surgery; trauma, plastic surgery, vascular surgery, thoracic surgery, colorectal surgery, minimally invasive surgery, surgical oncology -and surgical critical care.

2. The Trauma and General Surgery Service will care for all patients admitted to the hospital for acute traumatic problems, and all patients admitted through the Emergency Medicine Service for acute or emergent non-traumatic surgical problems for the surgical specialties listed above.

3. The Trauma and General Surgery Service will also consist of all patients who present through the Surgical Clinic with non-urgent surgical problems including those admitted for any of the surgical subspecialties listed above (excluding plastic surgery).

4. The Plastic Surgery Service will care for all patients who need reconstructive surgery, both emergently and electively.

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION AND STAFFING OF THE SURGERY CLINICAL SERVICE

1. The Organization of Surgery Clinical Services Officers is as follows: (Note: See also attached Organizational Chart)*

Chief of Service

Chief of Plastic Surgery
Trauma Medical Director
Associate Trauma Medical Director
Surgical Director of the Surgical Intensive Care Unit
Chief of Vascular Surgery
Chief of Thoracic Surgery

Medical Director of the Soft Tissue Infection Clinic (OASIS)
Director of Surgery Clinic

A. Chief of Service
1) Appointment and Review

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

2) Responsibilities
The Chief of Service is responsible for the overall direction of the clinical, teaching and research activities for the Surgery Service including:
(a) Review and recommendation of all new appointments, request for privileges and reappointments.
(b) Appointment of the other officers of the Surgery Service and service on committees.
(c) Financial affairs of the Surgery Service.
(d) Attendance at the Medical Executive Committee, the Dean's Meetings and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.
(e) Disciplinary actions as necessary, as set forth in these rules and regulations in the Bylaws and Rules and Regulations of the Medical Staff.

2. Attending Physician Clinical Responsibilities

A. Overall direction of clinical care is the responsibility of the attending staff of the Surgery Service. ~~In order to~~To ~~discharge~~ perform that responsibility, close supervision of house-staff and Nurse Practitioners and active participation in the care of each patient on the in-patient service or those seen in the outpatient setting is required.

B. Specific Duties

1) Trauma /General Surgery Service Attending:
Core surgery faculty members are assigned each week to be the attending of record for the service. The service attending makes rounds with the resident team, writes daily progress notes in EPIC, responds to major trauma activations in the emergency department, and sees all emergent and non-emergency consults from other services as needed. The Service Attending also oversees all operations performed on consult and service patients (emergent and non-emergent) during the daytime weekday shift. The service attending will be immediately available during their daytime shift unless specific arrangements are made for a back-up surgeon to cover. Any purely elective surgery will not be scheduled by the Service attending unless specific cross coverage arrangements are made in advance. Clinic responsibilities for the service attending are minimized.

2) In addition to the Trauma/General Surgery Weekly Service Attending, there is an on-call attending for trauma/emergency surgery that is immediately available to

cover the night call (generally 6 PM to 7 AM). This on-call surgeon responds to major trauma activations during their shift and conducts or supervises all trauma and emergency general surgery operations during that time. A back-up trauma/general surgeon is also assigned for each shift (day and night) and is promptly available should the on-call surgeon request assistance.

3) All attending surgeons that are assigned clinic time are expected to be present for the evaluation of new and follow-up patients scheduled into their elective clinic. Patients in need of surgery will be evaluated by the attending surgeon and consent obtained by the surgeon prior to formal scheduling in the operating room. The surgeon of record will perform or directly supervise the conduct of all elective surgical procedures in the operating room.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the Medical Staff of ZSFG through the Surgery Clinical Service will be in accordance with ZSFG~~H~~ Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the Medical Staff of ZSFG through the Surgery Clinical Service will be in accordance with ZSFG Bylaws, Rules and Regulations as well as these Clinical Service Rules and Regulations. Reappointment to the staff is dependent on continuing demonstration of competence.

C. ONGOING PROFESSIONAL PERFORMANCE EVALUATION (OPPE)

The quality assurance information specific to Surgery Service Practitioners will be maintained by the Chief of Surgery and/or their designee and will be used to monitor and report on ongoing professional performance evaluations (Surgery OPPE, Appendix F) and in the data summary sheets provided by the Service Chief at the time of reappointment or re-credentialing.

The process for Staff Status Change for members of the Surgery Services will be in accordance with ZSFG Bylaws, Rules and Regulations, and accompanying manuals.

D. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of the Affiliated Professionals through the Surgery Clinical Service will be in accordance with ZSFG Bylaws,

Rules and Regulations, as well as with these Clinical Service Rules and Regulations (see Attachment A).

E. STAFF CATEGORIES

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

III. DELINEATION OF CLINICAL PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

The Surgery Clinical Service Privilege Request Form shall be reviewed annually at the time of reappointment to the medical staff.

C. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

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

Privileges to practice on the Surgery 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, SURGERY SERVICE, ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL, ATTACHMENT A.**

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

Individuals' privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, at the time as judged necessary by the Chief of Service.

Note: Completion of medical records including dictation of operative notes within two weeks of the date of operation is a medical staff requirement and individuals who are consistently delinquent may have their privileges suspended.

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

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

IV. PROCTORING AND MONITORING REQUIREMENTS

A. REQUIREMENTS

Proctoring requirements for the Surgery Clinical Service shall be the responsibility of the Chief of the Service.
All requirements and details of proctoring will be delineated in the document.

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Surgery Clinical Service shall be in accordance with ZSFG Bylaws, Rules and Regulations, as well as these Clinical Service Rules and Regulations.

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION OF MEDICAL STAFF

The Surgery Clinical Services offers weekly educational activities/teaching conferences as follows:

ZSFG Trauma Service Morning Report	Monday-Friday 0630-0730
UCSF Surgery Grand Rounds	Wednesday 0700-0900
ZSFG Surgery Mortality and Morbidity Conference	Every 1st and 3rd Tuesday 1700-1800*
Trauma Multidisciplinary Peer Review (faculty only)*	Monthly - every 4th Wednesday 3-5pm
ZSFG~~H~~ Surgical Case Conferences/ Grand Rounds	Every 4th Tuesday 1700-1800*
GI Radiology Conference	Monday1200-1300
Trauma Video Resuscitation Conference	2nd Tuesday 1700-1600
Tumor Board	Thursday 0800-090

Note: Attendance at 50% of ZSFG Surgery Grand Rounds /Case Conference is an expectation for all full-time surgery faculty. Persistent non-compliance may be reported to the medical staff office as part of OPPE.
*>50% attendance at TMPR is a privileging requirement for core trauma panel members, failure of this requirement will require suspension of trauma privileges.

VI. SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

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

1. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF THE HOUSE STAFF (Refer to CHN Website for Housestaff Competencies link.)

A. The Trauma and General Surgery Service and the Plastic Surgery Services will be overseen by a Chief Resident and/or Surgical Critical Care Fellow in each respective discipline. The Chief Resident in collaboration with senior residents will supervise the junior house staff in all aspects of patient care including the admission history and physical exams, ordering of laboratory and radiologic investigations, house staff rounds on all hospitalized patients, and house staff patient evaluation in the outpatient clinics. All residents are under the supervision of the attending surgeon assigned to the Trauma and General Surgery Service or Plastic Surgery Service, or to the attending surgeons working in the outpatient surgical clinic area. In addition, all residents are directly supervised for all critical portions of the procedure by the attending surgeons in the operating room except for minor procedures such as incision and drainage of abscesses, and consistent with the ACGME rules of indirect supervision.

B. All surgical residents are assigned specific duties appropriate to their level of training and expertise. These duties are outlined in detail in Attachment C.4. The surgical curriculum for house staff at the University of California, San Francisco is designed to ensure that the basic fund of knowledge and technical skill for the performance of these duties are taught to the residents under the direct supervision of the faculty. Specific house staff competencies are detailed in Appendix B.

2. RESIDENT EVALUATION PROCESS

The surgical attending staff meet regularly to perform individual evaluation of the residents and interns assigned to the surgical service at ZSFG. This evaluation includes all the components considered essential for progression to the next level training, including professionalism, technical abilities, communication skills, and system-based and practice-based learning. These evaluations are provided on-line and made available to the UCSF Surgical Residency Director (or Director from a surgical or medical sub-specialty as appropriate) as well as to the residents themselves for their own self-evaluation. Each resident is given an exit interview by a surgery attending prior to leaving the rotation.

A. Mortality and Morbidity Conference includes discussion of all deaths and important complications with an emphasis on identification of opportunities for changes to systems of care or clinical practice that will improve care. This will be tracked within the either the Surgical or Trauma QI Program dependent on the service line of the complication.

3. ABILITY TO WRITE PATIENT CARE ORDERS

House staff members may write patient care orders, except as specified by ZSFG policy (for example: DNR or Chemotherapy Agents). The supervising attending surgeon has ultimate responsibility for orders written by the surgical house staff on the patients under their supervision.

VII. SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

Non-emergent, non-urgent surgical consultations are requested through eReferral, by submitting a consultation request form, or by telephone request tendered through a member of the surgical faculty, Fellow, or senior resident. Emergency consultations are requested through contact of the on-call attending, service attending, or on-call senior resident. Emergency consultations are staffed by the either the service or on-call attending surgeon. A record of such consultations will be provided by either the senior resident staff or directly by the attending.

VIII. DISCIPLINARY ACTION

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

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

A. GOALS AND OBJECTIVES

The Chief of Service, or designee, will be responsible for ensuring solutions to surgical performance improvement, and patient safety. As necessary, assistance will be invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization (eg: Executive Committee; OR Committee, Risk Management etc) to:

1. Ensure appropriate care and safety of all patients receiving care in the department. It is understood that this care is provided chiefly in the emergency room, the operating room, the ICU, the surgical wards, and the surgical clinics.

2. Maximize the safety of patients receiving surgical care.

3. Minimize morbidity and mortality of surgical patients and to avoid unnecessary days of inpatient care.

4. Improve efficiency in delivery of service.

B. RESPONSIBILITY

1. The Chief of Surgery has overall responsibility for the conduct of the Surgical Performance, Improvement and Patient Safety (PIPS) program. The Chief of Surgery may delegate portions of this responsibility to the Trauma Medical Director, , or the Director of the OASIS Outpatient Clinic.

C. REPORTING

Performance improvement/patient safety and utilization management activity records will be maintained by the clinical service. Minutes will be sent to the Medical Staff Services Department.

D. CLINICAL INDICATORS

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

F. MONITORING & EVALUATION OF APPRORIATENESS OF PATIENT CARE SERVICES

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

G. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

Refer to Surgical Performance, Improvement and Patient Safety Plan – Attachment C.4.

H. MEDICAL RECORDS

The members of the Surgery Service are committed to the maintenance of complete, accurate and timely medical records. These requirements are set forth in the ZSFG Bylaws and Rules and Regulations which define the minimum standards for Medical Record completion.

1. Operative Records
   Dictated operative reports are required for all major and minor operative procedures performed in the operating suite, whether inpatient or outpatient. Operations or procedures performed in the surgical or OASIS clinics will generally be capable of being performed under local anesthesia and minor in extent. A dictated operative note will not be required for these procedures, but they must be documented in the medical chart by an operative procedure note.

   Dictated operative reports should, contain the following elements (minimum):
   a. Pre-operative diagnosis
   b. Post-operative diagnosis
   c. Operative procedure(s) performed
   d. Surgeon(s)
   e. Narrative description of the operation
   f. Major findings
   g. Complications
   h. Estimated blood loss
   i. Specimens

2. Discharge Summaries
   Dictated discharge summaries will be completed on all patients hospitalized for more than 48 hours, and for those trauma patients surviving less than 48 hours. Patients hospitalized less than 48 hours may have a handwritten or dictated discharge summary at the discretion of the treating resident or attending physician. Dictated discharge summaries will contain a succinct description of the reasons for hospitalization, the course of treatment, complications of treatment, condition on discharge, and plans for post-hospitalization care.

   As noted above, consistently delinquent operative or medical records may result in temporary or permanent loss of privileges as outlined in the Medical Staff Bylaws.

I. INFORMED CONSENT

1. All decisions for operative treatment should involve the active participation of the patient or their surrogate~~,~~ and should be made after appropriate discussions of the details of the procedure and expectations

for the procedure, and attendant alternatives, risks, benefits, and complications.

2. Documentation of "Informed Consent" on medical staff approved forms is required for the following:
    a. All surgical procedures performed in the operating room, procedure rooms, ICU or wards.
    b. All procedures performed in the clinic unless specifically included on the list of procedures that do not require consent.
    c. All procedures involving laser therapy.
3. Documentation of patient consent will be provided by a properly signed and completed ZSFG Operative Consent Form.
4. The operating surgeon will also provide a Preoperative Note in the progress notes section of the patient chart (typically on pre- and post-operative note form). This note should include~~d~~ elements outlined in I.1. above.

X. MEETING REQUIREMENTS

A. MEETING CRITERIA

In accordance with ZSFG Medical Staff Bylaws, a~~A~~ll Active members of the ZSFG medical staff 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. This information will be located in the provider files.

Clinical Services (faculty) meetings are conducted at least twice monthly for the purpose of discussing clinical service needs, financial monitoring, educational and research agendas and other business as appropriate.

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

B. COMMITTEES

Members of the Department of Surgery either Chair or participate in the following ZSFG committees

1. Multidisciplinary Trauma Peer Review Committee (TMD serves as Chair)
2. Hospital PIPS
3. Risk management
4. MEC (Chief and Trauma Director are ex officio members)
5. Disaster
6. Operating Room (Chief is ex officio member & co-chair)
7. Transfusion
8. Critical Care
9. PEMT
10. CPG

11. Credentials
12. Cancer
13. Others as needed

XI. ADDITIONAL CLINICAL SERVICE SPECIFIC INFORMATION

A. OPERATIONAL

All house staff will receive, and are required to review, the online orientation module, “Surgical Resident Orientation to the Operating Room" (see Attachment C.5). All new faculty members will be oriented by the Chief of Surgery and have meetings scheduled to meet other key physician and nursing colleagues to assist in orientation to the hospital. The Chief of Surgery will be responsible for ensuring that 24-hour a day, 365 day-a-year attending and resident surgeon coverage is available for the hospital.

B. SCHEDULES

Full time faculty must submit their requests for time off to the Chief of Surgery at least two months ahead of time. Full time faculty must note on their schedule request reasons for days off (i.e. personal, reason for work-related business.)

All approved schedule requests will be kept on file with the scheduling administrative assistant. She/he will coordinate with the 3M and ISIS clinics and the OR regarding out of office faculty schedule blocking. Absence from clinic and release of OR time will not be accommodated (except in case of an emergency or illness) if the notification is shorter than 6 weeks in advance.

Once the trauma/service calendars are completed, it is up to the individual attending surgeon to find coverage should they wish to trade dates. In the event of an illness, the back-up surgeon will be call to provide in-house coverage until the schedule can be rearranged.

C. CLINICAL

The evaluation and documentation of patients admitted to the hospital are discussed in section IX D and IX E.

D. RISK MANAGEMENT

The Chief of Service will ensure that hospital policies regarding leaving against medical advice, restraints, informed consent, DNR, universal precautions, and the use of interpreters are followed by members of the Surgery Service.

XII. ADOPTION AND AMENDMENT

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

Surgery Privileges

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

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

Surg SURGERY 2010

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

_____ _____ **38.00 CORE PRIVILEGES/GENERAL SURGERY**

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

Preoperative, operative and post-operative care of patients Surgery of the alimentary tract, abdomen, breast, skin and soft tissues, and endocrine system. Privilege includes care of general surgical and trauma patients in the Intensive Care Unit, non-surgical or surgical management in the surgical clinic or emergency department, and comprehensive management of enteral and parenteral nutrition. Surgical procedures are:

_____ _____ 38.01 ABDOMEN, PERITONEUM
- _____ _____ A. Insertion Peritoneal Dialysis Catheter
- _____ _____ B. Open or Laparoscopic Exploratory Laparotomy
- _____ _____ C. Open Drainage Abdominal Abscess
- _____ _____ D. Open Repair of Inguinal, Femoral, and Ventral Hernia
- _____ _____ E. Laparoscopic Repair of Inguinal, Femoral, and Ventral Hernia
- _____ _____ F. Repair Miscellaneous Hernias

_____ _____ 38.02 ESOPHAGUS
- _____ _____ A. Laparoscopic Anti-Reflux Procedure
- _____ _____ B. Open Anti-Reflux Procedure or Repair of Paraesophageal Hernia

_____ _____ 38.03 LIVER, BILIARY TRACT, PANCREAS
- _____ _____ A. Open or Laparoscopic Cholecystectomy With or Without Cholangiography
- _____ _____ B. Cholecystostomy
- _____ _____ C. Open Common Bile Duct Exploration, Repair Acute Common Bile Duct Injury
- _____ _____ D. Choledochoscopy
- _____ _____ E. Choledochoenteric Anastomosis
- _____ _____ F. Operation for Gallbladder Cancer (when found incidentally)
- _____ _____ G. Hepatic Biopsy, Wedge Resection of Liver, Drainage Liver Abscess
- _____ _____ H. Distal Pancreatectomy or Pancreatic Debridement for Necrosis
- _____ _____ I. Intraoperative Pancreatic Ultrasound
- _____ _____ J. Drainage Pancreatic Pseudocyst

_____ _____ 38.04 STOMACH and INTESTINES
- _____ _____ A. Percutaneous Endoscopic Gastrostomy
- _____ _____ B. Partial/Total Gastrectomy
- _____ _____ C. Truncal Vagotomy and Drainage, Repair Duodenal Perforation, Open Gastrostomy
- _____ _____ D. Open or Laparoscopic Appendectomy

Privileges for Zuckerberg San Francisco General Hospital

Requested	Approved	
_____	_____	E. Open Partial Colectomy, Colostomy, Colostomy Closure
_____	_____	F. Subtotal Colectomy with Ileorectal Anastomosis/Ileostomy
_____	_____	G. Laparoscopic Partial Colectomy
_____	_____	H. Hemorrhoidectomy, Lateral Internal Sphincterotomy, Banding for Internal Hemorrhoids
_____	_____	I. Drainage Anorectal Abscess, Pilonidal Cystectomy, anal Fistulotomy/Seton Placement
_____	_____	38.05 ENDOCRINE SYSTEM
_____	_____	A. Partial or Total Thyroidectomy and Parathyroidectomy
_____	_____	B. Open Adrenalectomy
_____	_____	38.06 ENDOSCOPY
_____	_____	A. Esophagogastroduodenoscopy
_____	_____	B. Proctoscopy
_____	_____	C. Colonoscopy with or without Biopsy/Polypectomy
_____	_____	38.07 HEMIC and LYMPHATIC SYSTEMS
_____	_____	A. Open splenectomy
_____	_____	B. Lymph-Node Biopsy or Excision
_____	_____	C. Bone marrow Biopsy and Aspiration
_____	_____	38.08 SKIN and SOFT TISSUES
_____	_____	A. Excisional/Incisional Resection and/or Repair of Lesions of Skin and Subcutaneous Tissues.
_____	_____	B. Excision, Biopsy, Incision of Soft Tissue Lesion of Muscular or Fascial Areas
_____	_____	C. Incision, Drainage, Debridement for Soft Tissue Infections
_____	_____	D. Wide Local Excision Melanoma
_____	_____	E. Split-thickness and Full-thickness Skin Grafts
_____	_____	F. Burn Debridement
_____	_____	G. Repair of Wounds and Complex Lacerations and Traumatic Injuries
_____	_____	H. Repair Tendons
_____	_____	I. Digital Nerve Block
_____	_____	J. Fasciotomy
_____	_____	K. Placement of Negative Pressure Dressing Devices
_____	_____	38.09 CARDIOVASCULAR SYSTEM
_____	_____	A. Venous Insufficiency and Operation for Varicose Veins
_____	_____	B. Sclerotherapy, Peripheral Vein
_____	_____	C. Insertion of Vena Caval Filter
_____	_____	D. Percutaneous Vascular Access
_____	_____	E. Creation or Rrevision of Arteriovenous Graft/Fistula
_____	_____	F. Embolectomy/Thrombectomy Artery
_____	_____	G. Major Extremity Amputations (above or below knee, foot, transmetatarsal, toe)
_____	_____	38.10 THORAX
_____	_____	A. Chest Tube Placement
_____	_____	B. Exploratory Thoracotomy, Pericardial Window for Diagnosis/Drainage
_____	_____	38.11 TRACHEA and BRONCHI
_____	_____	A. Tracheostomy and Cricothyroidotomy
_____	_____	**38.20 SPECIAL PRIVILEGES**

Privileges for Zuckerberg San Francisco General Hospital

Requested	Approved	
_____	_____	38.21 COMPLEX UPPER ABDOMINAL SURGERY PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or American Board of Cardiothoracic Surgery, or a member of the Clinical Service prior to 10/17/00 PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures. REAPPOINTMENT: 10 operative procedures in the previous 2 years. Preoperative, operative and post-operative care of patients with complex benign or malignant conditions of the esophagus, liver, and pancreas:
_____	_____	A. Total esophagectomy, esophagogastrectomy
_____	_____	B. Open Heller myotomy, Collis gastroplasty, resection of perforated esophagus
_____	_____	C. Cricopharyngeal myotomy with excision Zenker's diverticulum
_____	_____	D. Laparoscopic repair of paraesophageal hernia or Heller myotomy
_____	_____	E. Open liver segmentectomy/lobectomy
_____	_____	F. Laparoscopic liver segmentectomy/lobectomy
_____	_____	G. Portal-systemic shunt
_____	_____	H. Operation for gallbladder or bile duct cancer (planned)
_____	_____	I. Excision choledochal cyst
_____	_____	J. Pancreaticoduodenectomy, ampulary resection, or total pancreatectomy
_____	_____	K. , Frey procedure, Beger procedure
_____	_____	38.22 COMPREHENSIVE CARE OF BREAST DISEASE PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures. REAPPOINTMENT: 20 operative procedures in the previous 2 years. Preoperative, operative and post-operative care of patients with complex benign or malignant conditions (excluding soft tissue infections) of the breast:
_____	_____	A. Aspiration of breast cyst
_____	_____	B. Duct excision
_____	_____	C. Breast biopsy with or without needle localization
_____	_____	D. Lumpectomy, partial, simple mastectomy, modified radical, radical mastectomy
_____	_____	E. Sentinel lymph node biopsy, axillary lymph node dissection
_____	_____	F. Stereotactic breast biopsy
_____	_____	38.23 COMPLEX COLO-RECTAL SURGERY PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or American Board of Colorectal Surgery, or a member of the Clinical Service prior to 10/17/00. PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures. REAPPOINTMENT: 10 operative procedures in the previous 2 years. Preoperative, operative and post-operative care of patients with complex benign or malignant conditions of the colon and rectum:
_____	_____	A. Total proctocolectomy, ileoanal pull-through, ileal-pouch procedures

Requested	Approved		
_____	_____		B. Repair complex anorectal fistulae
_____	_____		C. Excision of anal cancer, transanal resection for tumor
_____	_____		D. Perineal operation for rectal prolapse
_____	_____		E. Stapled hemorrhoidectomy
_____	_____		F. Open or laparoscopic transabdominal operation for rectal prolapse
_____	_____		G. Abdominoperineal resection
_____	_____		H. Pelvic exenteration for rectal cancer
_____	_____	38.24	COMPLEX VASCULAR SURGERY
			PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or Board Certification or eligibility in Vascular Surgery, or a member of the Clinical Service prior to 10/17/00.
			PROCTORING: 2 observed operative procedures and 10 retrospective reviews of operative procedures.
			REAPPOINTMENT: 10 operative procedures in the previous 2 years.
			Preoperative, operative and post-operative care of patients with complicated vascular disease:
_____	_____		A. Aorto-iliac, ilio-femoral, aorto-femoral bypass
_____	_____		B. Femoral-femoral, femoral-popliteal, axillo-femoral bypass
_____	_____		C. Profunda endarterectomy, other endarterectomy
_____	_____		D. Infrapopliteal bypass, composite leg bypass graft, revise/re-do lower extremity bypass
_____	_____		E. Thoracic outlet decompression, vertebral artery operation, arm bypass, or endarterectomy
_____	_____		F. Celiac/SMA/renal endarterectomy/bypass
_____	_____		G. Elective repair aorto/iliac/femoral/popiteal aneurysm
_____	_____		H. Repair thoracoabdominal aortic aneurysm
_____	_____		I. Carotid endarterectomy, reoperative carotid surgery, excise carotid body tumor
_____	_____		J. Angioscopy
_____	_____		K. Balloon angioplasty, transcatheter stent
_____	_____		L. Endovascular repair other aneurysm, other endovascular graft
_____	_____		M. Endovascular thrombolysis
_____	_____		N. Pseudoaneurysm repair/injection
_____	_____		O. Excise infected vascular graft, repair graft-enteric fistula
_____	_____		P. Sympathectomy
_____	_____		Q. Venous embolectomy/thrombectomy, venous reconstruction
_____	_____		R. Repair arteriovenous malformation
_____	_____	38.25	COMPREHENSIVE PEDIATRIC SURGERY
			PREREQUISITES: Currently Board Certified, or Re-Certified by the American Board of Pediatric Surgery, or a member of the Clinical Service prior to 10/17/00.
			PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures
_____	_____		A. Excision of retroperitoneal or pelvic tumor, including Wilms' tumor and neuroblastoma
_____	_____		B. Repair of complex chest and abdominal wall defect
_____	_____		C. Repair omphalocele or gastroschisis
_____	_____		D. Repair of esophageal atresia, stenosis or tracheo-esophageal fistula
_____	_____		E. Definitive surgery for Hirschsprung's Disease
_____	_____		F. Operation for rectal duplication
_____	_____		G. Repair of imperforate anus, including secondary operations

Privileges for Zuckerberg **San Francisco General Hospital**

Requested	Approved	
_____	_____	H. Operative reduction intussusception
_____	_____	I. Pyloromyotomy
_____	_____	J. Correction of congenital vaginal/penile anomalies, exploration and management of intersex
_____	_____	K. Excision cystic hygroma, lymphangioma, hemangioma
_____	_____	L. Excision of hemangiomas and lymphangiomas
_____	_____	M. Repair of pectus excavatum, pectus carinatum and other thoracic deformities
_____	_____	N. Excision intrathoracic tumor, cyst or other lesion, including mediastinum
_____	_____	O. Segmental pulmonary resection, lobectomy, pneumonectomy
_____	_____	P. Repair exstrophy of cloaca or vesicointestinal fissure, repair of cloacal anomaly
_____	_____	Q. Nephrectomy, partial or complete for trauma or benign and malignant cyst or tumor
_____	_____	R. Repair hypospadias or epispadias, meatotomy
_____	_____	S. Nissen fundoplication
_____	_____	38.26 SURGICAL CRITICAL CARE

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery in Surgical Critical Care, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Review of 10 cases
REAPPOINTMENT: Provision of surgical critical care to a minimum of 20 patients and at least 10 hours of critical care – related CME in the previous 2 years

Critical care of patients hospitalized in Intensive Care Units, including (but not limited to) comprehensive management of mechanical ventilation, nutrition, cardiovascular support, diagnosis and management of infections, management of shock, critical care of neurologic and neurosurgical patients, critical care of burn patients. Performance of invasive critical care procedures:

_____	_____	A. pulmonary artery catheter placement
_____	_____	B. Endotracheal intubation, airway management
_____	_____	C. Thoracentesis, paracentesis
_____	_____	D. Patient controlled analgesia and epidural analgesia
_____	_____	
_____	_____	
_____	_____	E. Cardiac pacing (external and transvenous), defibrillation and cardioversion.
_____	_____	38.27 PLASTIC SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures
REAPPOINTMENT: 40 operative procedures in the previous two years

Functional and aesthetic management of congenital acquired and traumatic defects of the face, neck, body, and extremities, excluding microsurgery and replantation of limbs and parts

_____	_____	A. Incision and Drainage of abscess
_____	_____	B. Flexor/extensor tendon repair, tenolysis, drainage of tendon sheath
_____	_____	C. Local skin/ muscle rotational flap, skin tissue rearrangement
_____	_____	D. Repair nailbed injury
_____	_____	E. Release a-1 pulley, pulley reconstruction

Privileges for Zuckerberg **San Francisco General Hospital**

Requested	Approved		
_____	_____	F.	Fasciotomy
_____	_____	G.	Separation of digit syndactyly, excision of supranumery digit
_____	_____	H.	Carpal/cubital tunnel release
_____	_____	I.	Completion amputation of digit
_____	_____	J.	ORIF/CRPP radius, ulnar, carpal, metacarpal, phalangeal fractures
_____	_____	K.	Removal of foreign body
_____	_____	L.	Placement of tissue expander
_____	_____	M.	Breast reconstruction with TRAM, free perforator flap
_____	_____	N.	Breast capsulotomy/capsulectomy
_____	_____	O.	Breast ~~reconstuction~~reconstruction with saline implant, removal saline implants
_____	_____	P.	Nipple ~~reconstuction~~reconstruction
_____	_____	Q.	ORIF mandibulomaxillary/ZMC/nasal/nasoethmoid/orbital floor fracture
_____	_____	R.	Full thickness (FTSG) or split thickness skin graft (STSG)
_____	_____	S.	Abdominal wall reconstruction, components separation, mesh placement
_____	_____	T.	Debridement, skin and subcutaneous tissue, muscle and bone
_____	_____	U.	Placement of negative pressure dressing devices
_____	_____	38.28	MICROSURGERY AND REPLANTATION OF LIMBS AND PARTS

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery, or Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery with successful completion of a Fellowship in Microsurgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 2 observed operative procedures and 5 retrospective review of operative procedures
REAPPOINTMENT: 5 operative procedures in the previous two years

_____	_____	A.	Use of operating microscope, repair blood vessel/ nerve, digit replantation
_____	_____	B.	Free myo/skin flap microvascular ~~anastamosis~~anastomosis
_____	_____	38.29	LASER SURGERY

PREREQUISITES: Currently Board Admissible, Board ~~Certified~~Certified, or Re-Certified by the

American Board of Surgery, or a member of the Clinical Service prior to 10/17/00.
Appropriate training, viewing of the laser safety video prepared by the ~~SFGH~~ 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 ~~SFGH~~ ZSFG Laser Safety Committee and documentation of eye exam within the previous 6 months

_____	_____	A.	Removal of congenital and acquired lesions (tattoos, hemangiomas, pigmented lesions)
_____	_____	38.30	LAPAROSCOPIC GENERAL SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified or Re-certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Demonstration of competence in Laparoscopic Surgery and completion of a surgical residency/fellowship that incorporates structured experience in laparoscopic surgery. For those without formal training during residency or fellowship in laparoscopic procedures, the minimum requirements are: observation of a minimum of five (5) cases and successful completion of twenty-five (25) cases.
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 5 operative procedures in the previous two years

Privileges for San Francisco General Hospital

Requested	Approved	
_____	_____	A. Laparoscopic repair of paraesophageal hernia or Heller myotomy
_____	_____	B. Laparoscopic liver segmentectomy/lobectomy
_____	_____	C. Laparoscopic procedures for morbid obesity
_____	_____	D. Laparoscopic or lap-assisted colectomy
_____	_____	E. Laparoscopic assisted ~~pancreatectomy~~pancreatectomy
_____	_____	F. Laparoscopic splenectomy
_____	_____	G. Laparoscopic adrenalectomy
		H. Other advanced laparoscopic procedures NOS
_____	_____	38.31 BRONCHOSCOPY AND FOREIGN BODY REMOVAL PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Surgery or American Board of Thoracic Surgery, or a member of the Clinical Service prior to 10/17/00. PROCTORING: 1 observed operative procedure REAPPOINTMENT: 2 cases in the previous two years
_____	_____	38.32 ACUTE TRAUMA CARE PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Current ATLS certification (provider). Availability, clinical performance and continuing medical education consistent with current standards for general surgeons at Level One Trauma Centers specified by the California Code of Regulations (Title 22) and the American College of Surgeons. PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures REAPPOINTMENT: 5 operative procedures in the previous two years. 32 hours of trauma-related CME in previous 2 years. On-call trauma coverage for the initial resuscitation and comprehensive management of the acutely injured patient. Includes acute operative management of thoracic and vascular injuries, and initial surgical critical care of the trauma patient:
_____	_____	A. Repair/resection for renal, ureteral, or bladder trauma
_____	_____	B. Placement of intracranial pressure monitor
_____	_____	C. Reduction and stabilization of maxillofacial fracture
_____	_____	D. Repair of tendon or nerve
_____	_____	E. Open reduction/ debridement of open/closed fracture, closed reduction of fracture

Requested Approved

_____ _____ 38.33 PERCUTANEOUS DILITATIONAL TRACHEOSTOMY WITH BRONCHOSCOPIC ASSISTANCE
Privilege shall be performed either in the Operating Room or in the ICU. All procedures will be performed with bronchoscopic guidance.
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. Documentation of two successfully performed procedures supervised by an experienced practitioner or documentation of two previous successful procedures during residency or fellowship.
PROCTORING: 1 observed operative procedure
REAPPOINTMENT: 1 operative procedure in the previous two years

_____ _____ 38.34 SURGICAL ULTRASOUND
Examination for the detection of peritoneal or pericardial fluid
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery. Successful completion of a basic ultrasound course approved by the American College of Surgeons and successful completion of the advanced module for trauma and acute care imaging course.
PROCTORING: Interpretation of 25 exams
REAPPOINTMENT: Interpretation of 25 ultrasounds and 3-hours of Category I CME in ultrasonography in the previous two years

_____ _____ 38.35 MODERATE SEDATION
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00. The physician must possess the appropriate residency or clinical experience (read Hospital Policy 19.8 SEDATION) and have completed the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department
PROCTORING: Review of 5 cases
REAPPOINTMENT: Review of 5 cases or completion of the educational module and post test as evidenced by a satisfactory score on the examination, and a signed the Physician Attestation Form submitted it to the Medical Staff Services Department

_____ _____ 38.36 NON-TRAUMA THORACIC SURGERY
PREREQUISITES: Currently Board ~~Admissable~~Admissible, Board Certified, or Re-Certified by the

American Board of Cardiothoracic Surgery, or currently Board ~~Admissable~~Admissible, Board Certified, or Recertified by the American Board of Surgery, or a member of the Clinical Service prior to 10/17/00, or successful completion of a structured experience in thoracic surgery including the successful completion of twenty-five (25) cases.
PROCTORING: 2 operative cases
REAPPOINTMENT: 2 operative cases in the previous two years

_____ _____ A. Pulmonary lobectomy, pneumonectomy, wedge lung resection
_____ _____ B. Pleurodesis, open drainage of empyema
_____ _____ C. Excision mediastinal tumor
_____ _____ D. Transthoracic repair diaphragmatic hernia
_____ _____ E. Repair aortic arch injury, dissection, or thoracic aortic aneurysm or dissection
_____ _____ F. Pericardiectomy
_____ _____ G. ORIF rib fractures

Requested Approved

38.37 THORACOSCOPIC SURGERY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery or American Board of Cardiothoracic Surgery, or a member of the clinical service prior to 10/17/00, or completion of a surgical residency/fellowship that incorporates a structured experience in thoracoscopic surgery. Competence should be documented by instructors. For those without formal training during residency or fellowship in thoracoscopic procedures, the minimum requirements are observation of three thoracoscopic surgical procedures performed by a surgeon experienced in the performance of such procedures; and either training in thoracoscopic surgery by a surgeon experienced in thoracoscopic surgery with proctored assistance by a surgeon experienced in either thoracoscopic procedures or laparoscopic techniques, or completion of a University sponsored or academic society (Joint Committee) recognized didactic course with clinical and hands-on laboratory practice in three animals
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 1 operative procedure in the previous two years

A. Thoracoscopy with or without biopsy
B. Thoracoscopic pleurodesis, evacuation hematoma or empyema
C. Thoracoscopic Heller myotomy

38.38 CARDIOPULMONARY BYPASS
PREREQUISITES: Currently Board Eligible, Board Certified, or Re-Certified by the American Board of Cardiothoracic Surgery, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 2 operative procedures in the previous two years

38.39 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Surgery and current X-Ray/Fluoroscopy Certificate, or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Presentation of valid California Fluoroscopy certificate;
REAPPOINTMENT: Presentation of valid California Fluoroscopy certificate

38.40 COMPLEX CRANIOFACIAL SURGERY
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery
PROCTORING: 2 observed operative procedures
REAPPOINTMENT: 2 cases in the previous two years

A. Closed reduction and Mandibulomaxillary (MMF) fixation of mandible fracture
B. Open reduction and internal fixation of mandible fracture
C. Open reduction and internal fixation of zygoma fracture
D. Open reduction and internal fixation of orbital floor fracture
E. Open reduction and internal fixation of orbital wall fracture
F. Open reduction and internal fixation of zygomaticomaxillary (ZMC) complex fracture
G. Open reduction and internal fixation of noso-orbital ethmoid fracture
H. Open reduction and internal fixation of Le Fort I fracture
I. Open reduction and ~~intenal~~internal fixation of Le Fort II fracture
J. Open reduction and internal fixation of Le Fort III fracture
K. Cleft lip repair
L. Cleft palate repair
M. Resection of arteriovenous malformation
N. ~~Comlex~~Complex tissue rearrangement, scalp

Requested Approved

38.45 COMPLEX HAND SURGERY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Plastic and Reconstructive Surgery, or the American Board of Surgery with successful completion of a fellowship in Hand Surgery

PROCTORING: 1 observed operative procedures

REAPPOINTMENT: 2 cases in the previous two years

_____ A. Incision/drainage abscess, finger or hand
_____ B. Palmar fasciotomy Dupuytren's contracture
_____ C. Palmar fasciectomy Dupuytren's contrature
_____ D. Closed capsulotomy
_____ E. Open capsulotomy
_____ F. Exicsion Bone cysts
_____ G. Excision bone tumors
_____ H. Bone Grafts, hands or fingers
_____ I. Arthrodeisis, hand or finger joints
_____ J. Tenolysis
_____ K. Tenorrhaphy
_____ L. Tendon Transfer
_____ M. Free Tendon graft, from arm or leg
_____ N. Arthroplasty with implant
_____ O. Ligament repair or reconstruction
_____ P. Reconstruction Hand Deformities
_____ Q. Amputation, finger, hand or forearm
_____ R. Fractures/dislocations
_____ S. Carpal tunnel release
_____ T. Nerve tranpositions
_____ U. Nerve repair, primary
_____ V. Nerve repair, ~~scondary~~secondary with nerve graft
_____ W. Removal of foreign bodies
_____ X. Replantation of fingers and/or hand
_____ Y. Wrist arthoscopy
_____ Z. Carpal bone fractures
_____ A1. Wrist Fractures

38.55 WAIVED TESTING

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

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

Privileges for Zuckerberg San Francisco General Hospital

Requested Approved

I hereby request clinical privileges as indicated above.

_____ _____
Applicant date

FOR DEPARTMENTAL USE:

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

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

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

APPROVED BY:

_____ _____
Division Chief date

_____ _____
Service Chief date

Appendix A. OR Block Time

MONDAY:

~~3.5~~4.0 OR's available –, Plastic Surgery (Terry), General Surgery, Vascular (1st and 3rd Mondays), Emergency General Surgery

TUESDAY:

2.5 OR's available Breast Surgery (Wong), Surgical Oncology (Alseidi), ~~(~~~~)~~ ~~Plastic Surgery (Terry)

WEDNESDAY:

2.5 OR available Surgery (Tesoriero, Sammann), Plastic Surgery (~~Rahgozar~~Soo), Emergency General Surgery

THURSDAY:

3.5 OR's available – Surgery (Mackersie, Campbell, Cuschieri, Plevin), Plastic Surgery (Young, Hansen, Terry)

FRIDAY:

1.5 OR's available – Vascular (Vartanian, Oskowitz), Emergency General Surgery

APPENDIX B: SURGERY HOUSE STAFF COMPETENCIES

Refer to CHN Intranet site, House Staff Competencies link.

APPENDIX C – ADDITIONAL CLINICAL SERVICE SPECIFIC ATTACHMENTS

1. **ATTACHMENT C1: AFFILIATED PROFESSIONALS**
2. **ATTACHMENT C2: SURGERY CLINICAL SERVICE PROCTORING PLAN**
3. **ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN**
4. **ATTACHMENT C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL**
5. **ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY**
~~5.~~
6. **ATTACHMENT D: JOB DESCRIPTIONS**

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APPENDIX C ATTACHMENT C1: AFFILIATED PROFESSIONALS

(TRAUMA NURSE PRACTITIONER BINDER KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX C: ATTACHMENT C2 - SURGERY CLINICAL SERVICE PROCTORING PLAN

SURGERY CLINCIAL SERVICE
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL PROCTORING PLAN

I. REQUIREMENTS

A Proctoring will be required who request surgical privileges within the Surgery Clinical Service at Zuckerberg San Francisco General Hospital. The proctoring which is carried out will be specific to the area in which privileges are requested.

C Applicants for surgical privileges at ZSFG who are accredited on the active staff at UCSF campus hospitals and UCSF affiliated hospitals (SFVAMC, CPC, Kaiser SF), have faculty appointments in the UCSF Department of Surgery, and perform the majority of their surgery at a UCSF campus hospital or UCSF affiliated hospital will be assumed to have been adequately proctored and will not be required to have direct observation on their cases in the operating room. Unless the Chief of Surgery determines that there is a reason for intraoperative proctoring.

D Proctoring will consist of these activities:

1. Intraoperative Observation
   Direct intraoperative observation of applicants will be carried out by one of the assigned proctors for a sufficient number of cases in each category of privileges to assure competence in the technical and operative aspects of surgery.

2. Complication Review
   All deaths and complications occurring in patients treated by the applicant during the provisional year of staff appointment will be tabulated, and the conclusions of the surgery D&C conference regarding the specific complication will be reviewed.

E. The proctor appointed for the applicant and the Chief of Surgery will meet periodically to review the above areas, and determine when to discontinue monitoring in areas D.1. and D.2., based on the number of cases and competence demonstrated. At any point in the proctoring process, if the proctor and the Chief of Surgery feel that the applicant is not qualified in a specific area, they may revoke provisional privileges in that area and shall notify the applicant and the Credentials Committee in writing of this action.

F Anyone performing general surgery can be placed under observation at any time when it is deemed indicated by (1) the Chief of Service, (2) the Credentials Committee, (3) the Medical Executive Committee, or (4) the Operating Room Committee. The duration of observation shall be at the discretion of the Chief of Service, and a report shall be made at the end of this time to the requesting committee.

II. APPOINTMENT AND RESPONSIBILITITES OF PROCTORS

A. Any member of the Department of Surgery, who is a member of the Active Staff, or member of the Courtesy Staff with a UCSF faculty appointment, may be appointed as a proctor. The proctor must be experienced in the areas being evaluated, but need not have the same Board Certification or subspecialty certification as the applicant.

B. One or more proctors will be appointed by the Chief of Surgery for each applicant. The Chief of Surgery may participate as a proctor or may independently evaluate any aspect of patient care performed by the applicant.

C. The applicant will notify one of the proctors of all cases scheduled during the proctoring period, so that they may arrange to be present during surgery, until the requirements of Section I, D.1. above, have been satisfied. The applicant may schedule surgery at his or her discretion and it will be the responsibility of the proctor to attend if he wishes.

D. A proctoring form for each operative observation will be completed by the proctor and submitted to and maintained by the Chief of Surgery. These will be kept in the applicant's clinical service credentials file and will be confidential as legally defined within hospital surgical Performance, Improvement and Patient Safety process.

APPENDIX C: ATTACHMENT C3: SURGERY CLINICAL SERVICES PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

APPENDIX C: ATTACHMENT C5: OUTPATIENT CLINICAL EXPECTATIONS FOR FACULTY

1. **The Faculty clinic absentee** window is set at 6 weeks. In the event that the physician will not be available after the 6 week window has passed for a non-emergent reason:

    a. When a faculty absentee form is filled out, the clinic staff is responsible for informing the faculty member and the Department Assigned Administrative Assistant of receipt of the absentee date/time via email.
    b. The Attending has to directly inform the clinic nursing director, and the chief of surgery in writing including the reason for missing clinic. A specific reason (academic, out of town, site visit commitment) must be given.
        i. Action plan as understood by clinic staff will be communicated back to faculty member and Department Assigned Administrative Assistant via email to include
            1. Date of expected absence
            2. Plan for alternative coverage/rescheduling
        ii. Faculty must make every attempt at obtaining coverage – either from another attending assigned to that clinic or by having another attending cover the patient load, OR
        iii. As an alternative, patients can be rescheduled to one of the two back flow clinics on Monday or Thursday PM for the following week. This will be first come first serve.
2. **Faculty timeliness**:
    a. Service expectations are that the patients are roomed and ready to be seen by 9 AM/1 PM so that clinic can start immediately. The service expects the attending to be on time for clinic and if not the clinic will call the attending by 9:15 or 1:15. If no response from the attending they are to call the Chief of Service or designee.
3. **Attending surgeons will be automatically excused from clinic when they are covering the service or are assigned to the ICU.** This includes the ICU service at UCSF Moffit ,VAMC and UCSF Mission Bay
    a. Faculty who need to see patients should use Monday afternoon overflow clinic time during the following week.
4. **Clinic Room Assignment:**
    a. NP's will use the room in the back of the clinic to complete H&P's.
    b. MEA's have been proposed to help staff the rooms and will be assigned to specific rooms to help with patient throughput.
    c.
5. **H&P's:** If the day of surgery is within 30 days of the last clinic visit, an interim H&P update is completed by the surgical attending or resident in the pre-operative area. In the event that surgery is > 30 days from the last clinic visit, a full H&P is to be completed by a member of the surgical team.
6. **Block time in the OR:**
    a. OR blocks may only be released by the attending assigned to that block. This should be done as soon as the attending knows she/he will be unavailable (on service; out of town etc). In general, these blocks should be released two months ahead of time. Once the OR time has been released, the clinic OR calendar will clearly state that the time has been released. Once released it cannot be reclaimed.
        i. Other attendings may not schedule surgeries on a block day that is not theirs unless it has been released.
        ii. See appendix A for OR block schedule.

~~b.~~ .

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7. **Scheduling templates:**
    a. Each Faculty will be assigned a template designed by attending with an expectation that they will see between 5-10 new patients per week in general surgery and a similar number of followups. However, some attendings are only part-time and may see fewer patients.
8. **Additional Scheduling Notes:**
    a. Patients who fail to show up for their H&P's two weeks prior to surgery will be cancelled from the scheduled surgery. The clinic staff will immediately communicate with the faculty member about this cancellation so that another patient on the "blue list" can be placed in this slot. If that faculty member is not able to be reached, that slot will be opened up for inpatient overflow or other elective cases.

SURGERY CLINICAL SERVICE

PERFORMANCE, IMPROVEMENT AND PATIENT SAFETY PLAN

I. ORGANIZATION

The Surgery Clinical Service at Zuckerberg San Francisco General Hospital, under the umbrella of the hospital-wide Surgical Performance, Improvement and Patient Safety Committee, operates a quality management program within the Surgery Clinical Service with multiple facets. These activities, to be described below, are carried out under the direction of the Chief of Surgery. They, in turn, report to the ZSFG Surgical Performance, Improvement and Patient Safety Management Committee.

II. PURPOSE

The overall purpose of the Surgical Performance, Improvement and Patient Safety Committee is to (1) continuously monitor feedback and (2) ultimately improve the quality of patient care delivered by the Surgery Clinical Service. Monitoring exists for both surgical and resident staff, in addition to system monitoring for the Trauma Service. The intent of this monitoring is to identify and correct specific individual and system problems.

III. SCOPE

The services, which are included within this program, are the Trauma (which include General Surgery, Thoracic Surgery and Vascular Surgery), and Plastic Surgery Services. Oversight of the Plastic Surgery Surgical Performance, Improvement and Patient Safety program is delegated to the Chief of the Division of Plastic Surgery. Oversight of the other service is by the Chief of Surgery. Orthopedics, Neurosurgery, Urology, Otolaryngology (ENT), and Ophthalmology are not included within the Surgery Clinical Service and are responsible for the independent operation of their programs.

IV. IDENTIFICATION OF PROBLEMS

Three general methods are used to identify and correct problems that occur within a busy teaching hospital environment. These are as follows:

A. Routine Surveillance

The activities grouped under this heading are carried out as continuous activities for monitoring and ensuring the quality of care, and providing optimal teaching to students and residents.

1. Daily Attending Ward Rounds

   Ward rounds are made by surgical attendings with senior or chief residents on every service and every patient is seen and evaluated daily. Diagnostic and treatment plans, and clinical course are reviewed. A daily progress note is generated by each attending on every patient and filed in the electronic medical record.

2. Daily Trauma Nurse Clinical Rounds

   An experienced Emergency/Trauma Nurse (most often the Trauma Program Coordinator or Trauma Case Manager) rounds daily with the Trauma Service Residents and collects data concurrently regarding diagnosis and treatment of trauma patients. Specific patient complications, as well as system problems (E.g., missed triage, delay in trauma team activation, etc.) are

tabulated and reported back to the Trauma Director. Patient complications are also reported by the resident staff at a weekly Service meeting. Data collected by the Trauma Program Coordinator is entered into the computerized Trauma Registry and analyzed for discrepancies in predicted vs. observed outcome as described below.

3. Surgical Mortality and Morbidity Conference
   This conference is held biweekly and all available Surgery Clinical Service attendings and residents attend. Weekly statistics are reviewed and all deaths and complications are reported and discussed. All deaths and complications are then entered in the computerized departmental registry and are categorized as preventable, possibly preventable, non-preventable, or systems problem according to responsible attending and resident for later compilation and analysis. In addition, complications or deaths are assigned a Severity Index (SI) rating on a 5 point scale as follows:
   SI-1: minor inconvenience. (Examples: superficial surgical site infection, pneumonia, UTI, uncomplicated missed injury)
   SI-2: moderate severity, slight prolongation hospital stay. (Examples: DVT requiring Coumadin, deep SSI requiring percutaneous drainage, iatrogenic pneumothorax)
   SI-3: complication associated with prolonged stay, need for readmission or additional procedures or interventions. (Examples: wound dehiscence, respiratory arrest, pulmonary embolus, post-operative bleeding requiring reoperation.)
   SI-4: Complication requiring major intervention, associated with prolonged morbidity or inconvenience. (Examples: Enteroatmospheric fistula, reoperation requiring ostomy, multiple additional procedures or admissions)
   SI-5: Long term or permanent morbidity, disability, or death.(Examples: Death, major amputation, permanent brain injury).

4. Monitoring of Incomplete Charts and Undictated Operative Notes
   All surgical charts of discharged patients from the preceding week are prepared by Medical Records weekly and are reviewed by the Surgery Clinical Service residents and attendings. All incomplete entries, unsigned medical student notes or orders, or absent discharge summaries are completed.

   An independent system is used for completion of operative notes. The Medical Records Department notified the Chief of Surgery weekly with a written list of all incomplete operative notes. The Chief of Surgery directly contacts the responsible individual to ensure timely completion of the dictation.

B. Exception Reporting
The second method of identification of problems is via the reporting or unusual or unexpected occurrences. These problems are then individually investigated and evaluated and are referred to the Chief of Service or Trauma Director/Trauma QA Committee for resolution.

1. Unusual Occurrence Report
   Incident reports are completed by the nursing staff according to a set of defined indicators (e.g., drug reaction, patient complaint, unexpected return to the operating room, post-operative bleeding, etc) and these are channeled to the Chief of Surgery when any surgical patient or surgical staff is involved with the incident. These are individually investigated and either resolved or referred to the most appropriate body for resolution.

2. Interdepartmental Incidents
   System problems arising on surgical units between Services, etc. not requiring specific Unusual Occurrence Reports, are reported back to the Trauma Program Coordinator by faculty, residents, or nursing/ancillary personnel. This reporting system is in addition to routine surveillance made by the Trauma Program Coordinator as described previously. Specific problems are then forwarded to either the Chief of Surgery or the Trauma Director/Trauma PIPS Committee for discussion/resolution.

C. Use of Clinical Indicators
With the advent of the clinical registry of all surgical patients, it has become possible to greatly expand the scope of this activity and identify attending-specific information related to patient outcomes. This activity is steadily evolving as more information is accumulated in the registry. The following are indicators currently in place.

1. Surgical Site Infections (General and Plastic Surgery)
   Overall wound infection rates are monitored by the Infection Control Committee and reported to the Chief of Surgery. These are attending specifics and may be discussed at the weekly Morbidity and Mortality Conference.

2. Attending Specific Compilation of Deaths and Complications (General Surgery)
   Aggregate compilation of deaths and complications on a quarterly basis for each attending surgeon are complied and reviewed by the departmental staff quarterly, in order to allow inter-attending comparison of rates.

3. Trauma Attending Presence at 900 Trauma Activations
   Expectation of ACS Trauma Center Verification is that a surgical attending will respond to highest level trauma activations within 15 minutes of the patient's arrival in the ED, monitored by the Trauma Medical Director as part of trauma PIPS process.

4. Unexplained Return to the Operating Room
   Information reported at M&M conference will be compiled to determine surgeon specific rates.

V. PROBLEM RESOLUTION

Resolution of problems identified by the above mechanisms occurs on multiple levels, as seems most appropriate to the individual circumstances. The principal methods are the following:

A. Individual Discussion
Minor problems related to individual behavior, administrative problems, and interpersonal or communication problems are best dealt with on an individual level. This is done by the Attending Surgeon on a given service in the process of daily contact and patient surveillance described above. Unusual problems are brought to the attention of the Chief of Surgery, who discusses the problem(s) with the individual(s) involved, when they are in the Surgery Clinical Service. Similar problems involving nursing personnel are dealt with by the Trauma Nurse Coordinator either through the Head Nurse of the Unit involved, or the individual nurse.

B. Group Discussion/Education –Surgery M&M Conference
The most common mechanism for evaluating and correcting problems in a teaching environment is through the constant education of the trainees involved in the process. This is accomplished as a significant part of the weekly Mortality and Morbidity Conference, in which the problems are identified, and then discussed in detail as to methods of avoidance or prevention. Expected standards of care, standards of monitoring, priority setting, methods of assessment, etc., are communicated to all levels of resident staffs.

C. Trauma Surgical Performance, Improvement and Patient Safety Committee
This conference is attended by representatives from all clinical services involved in the care of the trauma patient, as well as from nursing, and interdepartmental issues, policy changes, pre-hospital care issues, and more global institutional issues are addressed at this committee. The primary function of the Trauma PIPS Committee is to formulate and implement policy in response to system problems that arise and are identified by the methods described above. The clinical indicators specific to trauma patients are also reported back to this Committee. Trauma PIPS meeting is conducted by the Trauma Director who also sits on the Hospital Trauma PIPS Committee as a surgical representative.

APPENDIX C4: SURGERY CLINICAL SERVICES HOUSESTAFF MANUAL

(KEPT IN TRAUMA COORDINATOR'S OFFICE)

APPENDIX D: JOB DESCRIPTIONS

CHIEF OF SURGERY CLINICAL SERVICE JOB DESCRIPTION

Chief of Surgery Clinical Service

Position Summary:

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

Position Qualifications:

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

Major Responsibilities:

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

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

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

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

Serving as a leader for the Service's performance improvement and patient safety programs by setting performance improvement priorities, determining the qualifications and competencies of

service personnel who are or are not licensed independent practitioners, and maintaining appropriate quality control programs.

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

TRAUMA PROGRAM MEDICAL DIRECTOR

General Description:

The trauma medical director is a general surgeon, appointed by the Hospital through the Executive Administrator, to lead the multidisciplinary activities of the Trauma Program. The role of the TMD will be to work with service Chiefs and hospital administration in order to organize, manage, and develop the Trauma Program, and to seek to improve the Trauma Center in terms of quality, volume, scope of services, and cost-effectiveness of trauma care.

Qualifications:

- Current ABMS board certification in General Surgery.
- Fellow in good standing of the American College of Surgeons (ACS).
- Member in good standing of active medical staff, ZSFG.
- Advanced competency and special interest in trauma care and surgical critical care.
- Active involvement in clinical trauma care and surgical critical care.
- Active involvement in regional or national trauma education.
- Active involvement/participation in regional & national trauma organizations.
- Active involvement and demonstrated proficiency in trauma-related research.
- Demonstrated leadership skills & established history of positive collegial relationships with professional and ancillary staff in an acute care environment.
- Minimum of three years prior experience in an established designated trauma center or system.
- Demonstrated leadership in peer-review committee functions for 'sentinel' or 'critical' case review.
- Demonstrated commitment to the underlying principles of Trauma Performance Improvement, Trauma Program requirements by the ACS Committee on Trauma and Title 22, and the process of trauma program verification and designation.

Appointment, reappointment, review, termination

- Appointed by the ZSFG Executive Administrator, in collaboration with the Chief of Surgery.
- Requires approval of Department Chair .
- Requires approval of the majority of the MEC Chiefs of Services.
- Term of appointment three years.
- TMD performance review conducted every three years by the MEC. More often at the direction of the ZSFG Executive Administrator.
- The TMD may be removed by the Chief of Surgery, the Department Chair, or the ZSFG Executive Administrator in conjunction with a majority of MEC Chiefs of Service.

Responsibilities:

1) General Administrative Responsibilities and reporting relationships

- Directs the multidisciplinary functions of the trauma program.
- Provides the medical liaison between trauma team members and hospital administration.
- Responsible for ensuring that the quality of trauma patient care provided at ZSFG is commensurate with the institution's designation as a Level 1 center and as the sole provider of trauma services to the City & County of San Francisco.

- Takes action to correct deficiencies in coverage, response, or competence in the provision of trauma care by members of the trauma panel and trauma team.
- Regularly provides reports on Trauma Program performance to the MEC, including topics and issues related to policy, operations, staffing, quality improvement, and compliance with the Trauma Performance Agreement.
- Helps develop institutional policies, procedures and protocols, as needed, to improve the quality and cost-effectiveness of trauma care.
- Acts to further develop and promote the ZSFG trauma program as a regional resource.
- Acts as the principal clinical supervisor for the Trauma Program Nurse Practitioners.
- Reports directly to the ZSFG Executive Administrator.
- Collaborates with other Hospital Administrators, Chief of Staff, and Chiefs of Service.
- Monitors compliance with trauma performance agreement.
- Participates in CHN strategic planning.

2) Performance Improvement (PI) program

- Ensures that appropriate peer review is conducted for all types of adverse or potentially adverse event.
- Chairs Multidisciplinary Peer Review Committee.
- Helps develop clinical practice guidelines.
- Monitors as needed and makes recommendations regarding trauma-related hospital privileges and credentials for members of the trauma team.
- Monitors, as needed, facility standards to ensure that they are commensurate with Level 1 Center function.
- Reports matters of critical importance related to trauma patient care, as needed, directly to other administrative agencies or officers within the Department of Public Health or related CCSF agencies (e.g. SFPD, SFFD).

3) Trauma Center designation & verification

- Interacts with SF EMSA in reviewing Trauma Center performance consistent with the requirements in Title 22.
- Works with SF EMSA in revising, as needed, the CCSF Trauma Plan.
- Directs planning and preparation for ACS-COT Trauma Center site surveys and any additional site surveys that the local EMSA may require.

4) Trauma Registry

- Maintains control / oversight of Trauma Registry in conjunction w/ hospital administration.
- Responsible for overseeing timely updates of same.
- Establishes guidelines for use of ZSFG Trauma Registry data outside the Trauma Program.
- Reviews and approves written requests for registry data use by individuals or departments.

5) Credentialing / privileges

- Reviews, as needed, the performance and qualifications of Trauma Surgeons & members of the trauma team providing trauma care at ZSFG.
- Adds/removes trauma surgeons from trauma panel, subject to the approval by TEC.
- Acts to restrict or suspend trauma-related privileges, as necessary and for just cause, in conjunction with the TEC, for any member of the trauma team.

- Recommends and/or approves recommendation, as indicated, for trauma privileges for members of the trauma team.

6) Pre-hospital care
- Involved in review/development of pre-hospital policies, practices, and procedures.
- Meets regularly w/ EMSA director, paramedic medical director & paramedics, as needed for purposes of: 1) City disaster planning, 2) Trauma triage, 3) Title 22 compliance, 4) Trauma system performance improvement, 5) Pre-hospital performance improvement.

7) Prevention
- Identifies a member of the trauma team or trauma panel who acts to coordinate injury prevention at ZSFG.
- Monitors and acts to promote/enhance injury prevention activities at ZSFG.
- Acts as a liaison and/or consultant for the Dept. of Public Health for purposes of organizing and promoting injury prevention programs and activities.

8) Patient & Community relations (outreach)
- Helps support & develop trauma patient/family satisfaction projects.
- Develops strategic relationships with referring hospitals & physicians for purposes of improving trauma care and facilitating any requested transfers.
- Supports and helps to provide provider educational offerings within the region.
- Participates in regional trauma audit committees as needed.
- Helps to develop and provide trauma consulting services, as needed, to surrounding communities.

9) Trauma Education / training / research
- Actively supports and participates trauma-related research and educational programs including those for medical students, residency programs, and post-graduate education.
- Participates in regional trauma audit committees as needed.
- Is actively involved in ATLS, Stop the Bleed and ASSET -courses.

10) Participation at regional & national level (per ACS)
- Participates in local, regional, and national trauma-related activities and organizations.
- Participates in the trauma activities of the American College of Surgeons Committee on Trauma.

11) Managerial / Financial
- Works with trauma business mgr. & senior administrator to effect improvement in LOS, cost effectiveness as needed
- Implements policy/practice changes to help improve cost effectiveness.
- Ensures establishment of appropriate call schedules for all specialties.
- Assists TP manager in developing/meeting budgetary goals.

INTENSIVE CARE UNIT MEDICAL DIRECTORS
ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER
JOB DESCRIPTION

The Medical Directors are physician leaders in critical care responsible for coordinating clinical care, clinical operations, and education and training in alignment with Zuckerberg San Francisco General Hospital's mission, vision, values and goals. The unit Medical Directors report to the ZSFG Critical Care Medical Director (CCMD) and work closely with the mangers of nursing and other allied healthcare professions to implement strategies for optimizing patient care and operational efficiency.

MISSION STATEMENT

The Medical Directors are committed leaders in continuous clinical innovation, quality improvement, and excellence in medical education.

QUALIFICATIONS

Board-certified in a relevant specialty as well as Critical Care Medicine
Credentialed ZSFG physician or eligible for such credentialing
Excited and inspired by the opportunity to make changes and improve systems
Strong commitment to the mission statement and responsibilities of the position
Outstanding professional credibility and personal integrity
Exceptional clinical skills
Demonstrated ability for teamwork and collaborative problem-solving using an analytical and systematic approach
Excellent verbal and written communication skills
Ability to provide leadership to physicians and other health care professionals

DUTIES AND RESPONSIBILITIES

XIII. Reporting Relationships

- Although the Medical Directors are full-time UCSF faculty members with an appointment within an academic department, in this position they report directly to the ZSFG Critical Care Medical Director
- The Medical Directors work in close partnership with the other ICU Medical Directors and the ZSFG Critical Care Medical Director
- The Medical Directors work collaboratively with the ICU faculty and inter-disciplinary ICU care team

Performance Improvement and Patient Safety

- Develop and implement clinical protocols and quality improvement projects
- Review potential ICU-wide projects in the Critical Care Directors meetings
- Monitor the performance of the various protocols and analyze the results for further improvement
- Review relevant clinical quality data and performance measures and share findings to the ZSFG Critical Care Medical Director monthly
- Review and address major adverse events, near-misses, and patient safety vulnerabilities and coordinate Morbidity & Mortality Conferences

Clinical Operations

- Ensure adequate critical care physician staffing of intensive care units
- Coordinate call schedules for ICU faculty, fellows, and residents
- Assist the ZSFG Critical Care Medicine Director in optimizing patient flow in all ICU beds, coordinating with the Emergency Department, inpatient units, Operating Room, and Post-Anesthesia Care Unit
- Assist ZSFG Critical Care Medical Director in standardization and analysis of compliance in documentation, billing practices, and financial analysis of ICU operations
- Work with ICU nursing and hospital leadership to assure compliance with all regulatory requirements

Leadership and Communication

- Meet monthly with the ICU nurse manager and other healthcare professional leaders in the ICU to ensure close collaboration, coordination, and clear communication
- Meet monthly with the ZSFG Critical Care Medical Director and other ICU Medical Directors to standardize and coordinate care among all critical care units
- Participate in scheduled unit-specific ICU faculty meetings
- Participate in quarterly combined ICU faculty meetings
- Attend Quarterly ICU multi-disciplinary Grand Rounds
- Host and coordinate one ICU multi-disciplinary Grand Rounds per academic year
- Co-lead annual ICU faculty retreat
- Initiate and lead recurring multi-disciplinary Quality Improvement reviews in partnership with other services (ED, Trauma Surgery, Anesthesia, Family Medicine, Medicine, Otolaryngology, etc.)

Supervision of ICU Faculty

- Review clinical and teaching performance of individual Attendings and provide regular feedback, including compliance with protocols, promptness on rounds, and completion of teaching evaluations
- Ensure participation in quality improvement initiatives and adherence to standardized practices
- Set expectations and ensure Attending adherence to professional behavior standards at all times
- Ensure satisfactory Attending participation at various ICU faculty meetings and Grand Rounds

Medical Education (as applicable to the individual units)

- Resident and Fellow scheduling
- Serve as Medical Student Clerkship Director
- Coordinate Resident and Student evaluations
- Coordinate Journal Club, didactic teaching sessions, and other educational activities

Some duties above may be delegated with the understanding that the Medical Director is responsible for ensuring all tasks are completed.

Committees

All Medical Directors serve on a minimum of two Medical Staff committees, assigned upon mutual agreement with the ZSFG Critical Care Medical Director, including, but not limited to:

- Critical Care Committee
- Procedural Sedation Subcommittee of Pharmacy & Therapeutics Committee
- Trauma Peer Review Committee
- Performance Improvement and Patient Safety Committee
- Donor Committee
- Code Blue Committee
- Ethics Committee

Time Commitment

The Medical Director positions are 0.2 FTE commitment for each for the Medical and Surgical ICUs. When there are Co-Directors, duties are divided evenly and the expected effort is 0.1 FTE each. Division of responsibility is negotiated between the Co-Directors with the ZSFG Critical Care Medical Director and specific duties are clearly delineated.

Term of Appointment

The term of appointment as ICU Medical Director is one year subject to annual renewal based on satisfactory performance of the physician in this role and the needs of ZSFG. There is an initial evaluation after the first 6 months of appointment and annually thereafter. Review is performed jointly by the ZSFG Critical Care Medical Director and Chief Medical Officer. Consideration of non-renewal of appointment will be discussed in advance with the faculty member's Service Chief.