ZSFG JOINT CONFERENCE COMMITTEE MEETING

April 23, 2024

MEDICAL STAFF Report

Contents:

ZSFG CHIEF OF STAFF REPORT
Presented to the JCC-ZSFG on April 23, 2024
April 2024 MEC Meeting

ORTHOPAEDIC SURGERY SERVICE REPORT: Theodore Miclau, MD, Service Chief

The Service's mission is to mend the injured, inspire innovators, and empower leaders to restore lives through clinical care, education, research, and outreach. Its vision is to provide the best care possible with an interdisciplinary team in SF and to be recognized for improvements in the field nationally and internationally. The Orthopaedic Trauma Institute (OTI) recently celebrated its 15th year of providing service.

A. Scope of the Clinical Service

1. Service Scope of Practice: ZSFG - This includes orthopaedics, podiatry, rehabilitation, and orthotics and prosthetics (O&P). The Service manages all general orthopaedic problems with few cases referred out of ZSFG. The call coverage is provided entirely by the ZSFG's full-time staff who are all trauma fellowship trained surgeons. There are 17 weekly clinics, including subspecialty clinics in all orthopaedic subspecialties, podiatry, and O&P. Also, there are 5 elective OR blocks and 5 trauma rooms that run daily.
2. OTI's Clinical Scope - OTI provides additional surgical volume and financial support to UCSF Orthopaedic Institute/UCSF Parnassus Campus, Benioff Children's Hospital, LHH, and San Jose Medical Center.
3. Orthopaedic Surgery Clinical Service – There are 19 faculty members: 14 FT ortho faculty, 2 FT podiatry faculty, and 3 FT rehab faculty. Also, there is a variety of part-time faculty. It is divided into 2 services: 1 service on and other service off, 1 service in OR and other service in clinic. The residents are divided into 2 teams who rotate with the Service every year of residency. There are also Emergency Medicine residents, interns, and students.
    - Faculty
        - Full-Time Clinical Faculty – The Service has the largest number of trauma fellowship trained surgeons in the world who were trained in the US. It also has the largest number of dual fellowship (trauma and another area) trained surgeons in North America, leading to the highest level of service in subspecialties. There are surgeons with focus on hand/microvascular, physical medicine & rehabilitation, and podiatry.
        - Part-Time Faculty – There are 6 providers giving support in foot and ankle, pediatrics, podiatry, hand, and tumor. There is not enough volume for FT faculty on pediatrics and oncology.
    - Patient Care
        - Surgical Procedures – The Service's percentage of cases relative to total number of OR cases and minutes has been stable: ≈ 20% for OR cases and ≈30% to 33% for OR minutes.
        - Outpatient Orthopaedic Clinics – These clinics are the busiest surgical service with stable annual visits of 11k – 13k. The volume for FY 23/24 is at par to catch up with previous year's volume. There were decreased volumes during COVID, various moves, and electronic medical record changes.
        - Call Services - Primary and back-up call coverage by ZSFG-based staff is provided 24 hrs/365 days. For Ortho Hand and Ortho Spine, the call coverage of 24 hrs/365 days is divided with Plastics and Neurosurgery, respectively.
    - Podiatry Service – This service treats more diabetic feet than any other service in Northern California. Urgent and elective coverages, along with outpatient care M-F, are provided. The service also integrates functional limb service and O&P groups.
        - Patient Care: Outpatient Podiatry Clinics – The patient volume has increased with a new hire (regardless of an unapproved business plan) that addressed wait times. This is being done as a QA project.
        - Service Challenges – The challenges in 2020-2022 were addressed with a second podiatry provider, improved outpatient backlog from 3 months to 3 weeks, and returned fast-track room that improved OR access for elective surgery from 4 months to 4 weeks.
    - Physiatry
        - In-Patient Services – The following are provided: (1) consultation services – integrated with Trauma and Neurosurgery and provide support for accreditation, (2) screening services – encountered challenges with LHH issues, and (3) procedural services – include injections, EMGs, and Botox injections.
        - Clinics/Procedures – Services are provided in different areas throughout the hospital.
        - Service Challenges – The challenges in 2020-2022 were addressed with improved (but still limited) OR access from 6 months to 3 months and a recently approved ultrasound unit (expected in 2024).
    - O&P Service – This group has grown to 5 providers and 2 administrative assistants. Weekday and weekend coverages for inpatient, outpatient, and ED areas are provided. It also provides support to LHH and amputees. Outpatient and inpatient volume increased, resulting in increased billing but less satisfactory reimbursements.
    - Orthopaedic Surgery: Quality Measures
        - The following have been tracked: surgical site infections, fragility fracture initiatives, and OR wait times. The OR wait times continue to be challenging with the most recent metric check indicating a 16-month waitlist for a total joint procedure. Other quality measures (e.g., Specialty Care TNAA and eConsult turnaround time,

etc.) are improving. In reporting last year, the Service had a downturn due to various pressures, including the move to Pride Hall which caused difficulties; the situation is being stabilized and a goal for the year.
    - TQIP 2023 – The supporting services of Surgery and ED in addressing TQIP measures were acknowledged. In every single metric, the Service is at or better than other hospitals; the Service's management of hip fracture and femoral and tibial shaft is remarkably good.

B. Faculty
    1. Committee Participation – There are leadership positions in various committees at both UCSF and ZSFG.
    2. Leadership Positions – There are 2 subgroups/services (Blue and Gold) that are each led by a Service Chief. These align with the efforts to build leadership capacity with the Service getting bigger, along with giving opportunities for more people to manage growth and service. There are also medical directors for Clinic, Podiatry, Physiatry, and QA.
    3. Awards – A list of prestigious awards (some local but mostly international) received by faculty was presented. The Service continues to be represented and acknowledged nationally and internationally as a center for excellence.

C. Finances
    1. Ortho Payor Mix 23/24 – The payor mix is consistent with many surgical services that get trauma care. There are about 10%-15% of insured patients, but most patients have some form of coverage.
    2. Orthopaedic Surgery Income 22/23 – The $14M budget comes from the City Contract (40%), ZSFG collections (16%), and service to other locations (≈33%).
    3. Orthopaedic and Podiatry Service Work RVU Production – The work service production continues to increase with FY 2023/24 at par with RVU production in 2022/23 at the minimum. Also, the Ortho collections per RVU ratios have been stable through fiscal years (between $35 and $40).

D. Education
    1. Residency Rotation – For the last 5 years, the program has been highly ranked. The Department gives only 2 awards: UCSF Resident Teaching Award and UCSF Compassionate Physician Award. The Service has representation in 1 of the 2 awards almost every year.
    2. Weekly Conferences – There are daily meetings with a group review of all cases from ED. The Service also participates in other departments' teaching activities in an integrated way.
    3. Medical Student Training – Many medical students come to participate in various activities.
    4. 18th Annual International SF Orthopaedic Trauma Course – The privately-run conference recently concluded and is the largest one in the country. Typically, there are over 50 faculty. Also, the conference aligns with the Service's mission. Despite challenges, the conference is well attended and highly regarded.
    5. Surgical Training Center – There is a new training facility in Pride Hall. The full complement of courses are being obtained with some lost during the pandemic and move. There are about 100 courses a year which are provided at or near cost to the Service and other groups due to participation of industry groups. These include Junior Academy, international programs, and more. There are 7 other services that utilize the Center for external and internal courses.
    6. UCSF Orthopaedic Residency Core Surgical Curriculum - This is required by orthopaedic residencies and cycles through every 3 years. Each of the 8 specialties provides 2 or 3 core procedures performed only in cadavers.
    7. OTI Junior Academy – For over a decade now, the program has targeted high schools with less resources. Its goal is to spark interest among students on STEM activities, medicine, and healthcare. A list of participating schools and number of accepted students was presented. There are 42 alumni with an active role in the Academy, including 2 alumni running the program. Also, 55 of 59 alumni (2012 – 2019) either pursued or are pursuing a STEM degree.

E. Research
    1. Contracts and Grants (Direct Cost Only) – For orthopaedic departments in the country, the Service will be ranked in the top 15 in terms of funding. The busiest is the basic research laboratory with the Department ranked in top 5 for the last 5 years.
    2. Research Facilities- These include molecular biology and biomechanics laboratories, clinical research center, and a surgical training facility. The Clinical Research Center is one of the few clinical sites in the West Coast that belongs to the Major Extremity Trauma Research Consortium (METRC). METRC has a budget of > $150M for clinical research studies on orthopaedic trauma care both in the military and civilian populations.

F. Outreach – The Institute for Global Orthopaedics and Traumatology (IGOT) has been to or has been visited by many countries since 2009. Its mission is to build capacity in musculoskeletal care through global partnerships. A list of IGOT outstanding accomplishments in education, research, leadership, and development was presented. These include 90+ resident global electives, 80 international observers per year, > 35 active research projects, >20 publications, and more.

G. Service Goals – These include the following: (1) continue to adapt workflows for new spaces, (2) work on further integration with UCSF campus, and (3) address gaps in care, including wait times in several services such as arthroplasty, sports, and podiatry.

Dr. Gabe Ortiz and other MEC members acknowledged the Service's impressive activities and accomplishments with its expansion, international outreach, and great leadership. Other departments were extremely grateful for the collaboration and engagement by Dr. Miclau and the Service. *Approval requested for the Orthopedic Surgery service rules and regulations.*

ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG April 23, 2024
APRIL 2024 MEC Meetings

Clinical Service Rules and Regulations

- Orthopedic Surgery Rules & Regulations (summary of changes)
- Orthopedic Surgery Rules & Regulations (with tracked changes)
- Orthopedic Surgery Rules & Regulations (clean version)

Credentials Committee

- Standardized Procedures – None
- Privileges List – OBGYN

City and County of San Francisco

Department of Public Health

London Breed
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Gabriel Ortiz, MD, PhD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	*ZSFG Clinical Service Rules and Regulations*
Clinical Service:	*Orthopaedic Surgery*
Date of last approval:	*2021*
Summary of R&R updates:	*Any typographical errors were corrected; Orthopaedic was spelled out; workflow was updated to be consistent with the EMR and current service activities the presence of the fellow on the service was added to the educational section; resident responsibilities were updated according to their current workflow, particularly as it relates to the EMR; the Chief of Service responsibilities were updated consistent with the hospital bylaws, including articulation of the terms for maximum review (5 years).*
Update #1:	*Section V and VI: Reference to fellow was included in other sections; minor updates were made to the wording in residents' workflow, particularly as it relates to the EMR.*
Update #2:	*Section V and VI: Reference to fellow was included in other sections; minor updates were made to the wording in residents' workflow, particularly as it relates to the EMR.*
Update #3:	*Section VII: Minor updates were made to reflect current workflow in the consultation process in the Emergency Room.*
Update #4:	*Attachment C: Minor updates were made to the Clinical Service Chief responsibilities were made to be consistent with the ZSFG Hospital Bylaws, including the required performance review period.*

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

ORTHOPEDIC SURGERY CLINICAL SERVICE RULES AND REGULATIONS

~~2008~~~~2013~~~~2017~~~~21~~2024

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

ORTHOPEDIC SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

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

I. ORTHOPEDIC SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

As a member of the Orthopedic Surgery Service, the board-certified physiatrist is also the Medical Director of the Rehabilitation Service for ~~SFGH~~ZSFG. The service also has a fully equipped orthotics and prosthetics ~~wor~~ group~~kshop run by an experienced orthotist/prosthetist.~~with experts in prosthetics and orthotics.

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

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF ORTHOPEDIC SURGERY CLINICAL SERVICE

Currently the Clinical Service of Orthopedic Surgery at ~~San Francisco General Hospital~~Zuckerberg San Francisco General is staffed by ~~8~~ orthopedic surgeons with 50% or more time effort ~~(Drs. Coughlin, Kandemir, Matityahu, Miclau, McClellan, Pekmezci, Meinberg, and Morshed, Marmor,), two~~ trauma fellows (Clinical Instructors and Active ~~SFGH~~ZSFG Medical Staff Members), hand surgeons,~~ two full-time~~ podiatrists, ~~(Drs. Dr. Martin~~Dini, Werner~~), 2 full-time~~ physiatrists ~~(Drs. Pascual and Nagao)~~, and 1 part-time physiatrist ~~(Dr. Tran)~~. ~~Hand coverage is supplemented by~~one ~~full-time orthopaedic hand surgeon (Dr. Strauss) and~~ 42 ~~part-time~~volunteer ~~hand surgeons (Drs. Richards and, Cardon, and Green, Gordon).~~ Pediatric and oncology clinics are staffed by UCSF surgeons. ~~is staffed by 1 part-time staff member (Dr. Delgado).~~ There are several volunteer surgeons who assist in the clinics and OR~~s~~s in the above areas ~~(Drs. Jergesen, Rosenblatt, Glick, and Fong)~~. The attending physicians and podiatrists are responsible for

daily attending rounds on both services, assuring quality patient care, resident education, and dictation of attending notes on all patients every day. Ortho and ortho trauma call coverage are provided by the ~~Call coverage~~ is by the ~~8~~ 9 ortho trauma attendings, the hand call is split with the plastic surgery service and provided by the hand surgeons, and the spine call is split with the neurosurgery service and provided by the spine surgeons. ~~(with the exception of Dr. Rosenblatt, who covers approximately 1 call per month).~~

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

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

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles
Practitioner's performance profiles are determined and monitored in two fashions. Outpatient encounters are monitored by the hospital outpatient clinic services, and statistics are available ~~by ICD9 and~~ CPT codes. Inpatient services, including emergency room consultations, are monitored and counted according to different categories. Complications of all nature are also compiled on a monthly basis and are kept on file by the Service as well as in the Medical Staff Services Office.

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

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

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

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

The Orthopedic Surgery Clinical Service fall into the same staff categories which are described in Article III – *Categories of the Medical Staff* of the ~~SFGH~~ZSFG Bylaws, Rules and Regulations and accompanying manuals.

III. DELINEATION OF PRIVILEGES (Refer to Attachment A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

Proctoring requirements for physicians who perform surgery on the Orthopedic Surgery Clinical Service require that the Chief of Service, or designee, observe five (5) of the applicant's major surgical cases. Proctoring requirements for physicians who treat clinic outpatients require that the Chief of Service, or designee, observes the practitioner in three (3~~53~~) outpatient clinic settings, and retrospective reviews of the care provided to fifteen~~ve~~ (15) outpatients.

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

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

At the graduate level, the service is also the main teaching site for third-year UCSF medical students. It also offers rotations for UCSF fourth-year medical students. During the academic year, between 5-10 UCSF medical students and about 5-10 non-UCSF fourth-year medical students rotate through the service.

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

A. SUPERVISION

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

B. EDUCATIONAL ACTIVITIES

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

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

- interactive didactic sessions with faculty
- hands-on teaching in the operating room, clinic and rounds
- resident involvement in research projects.

Regular d~~Weekly d~~idactic sessions include~~are~~:

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

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

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

C. EDUCATIONAL GOALS

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

D. GUIDELINES

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

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

E. DUTIES OF RESIDENTS (Specific Responsibilities):

Also refer to House Staff Competencies Link on CHN Intranet Site

1. Patient Care Responsibilities

Orthopedic residents are expected to make patient rounds at least once a day. It is anticipated and expected that all residents on the service would make rounds in the early morning prior to going to the morning conferences. All patients should be seen, charts should be reviewed, orders written, dressings changed, consultations requested, and x-rays reviewed as necessary. The nurses should be advised of any problems or orders, which need to be carried out expeditiously. Rounds for problem patients should be made again at the end of the day, postoperative checks should be made on all patients and postoperative notes should be placed on the chart before the residents department for the evening. All postoperative x-rays should be reviewed and notations made in the chart of the appropriate findings. The status of the implants should be noted, or in the case of total hip arthroplasty, for instance, a notation should be made that the x-rays reveal that the hip implant is in satisfactory position and remains reduced. A neurological-vascular check should be a standard part of the postoperative evaluation and a notation should be made in the chart that this has been examined, evaluated and is normal or not. Any abnormalities should be reported to the staff physician immediately. A note must be written in the chart each day. The chief resident or designee should write an initial evaluation note after the junior resident's history and physical exam. All patients scheduled for operative

procedures must have a preoperative note, which includes the patient's diagnosis, alternatives of treatment and documents the patient's informed consent. ~~Patient Discharge Planning (PDP)~~Any necessary patient discharge documentation ~~forms are to~~should be completed the evening before the patient's anticipated discharge. All discharge summaries must be completed within 24 hours of the patient's discharge and preferably done the day the patient is discharged while the chart is still on the station.

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

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

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

7. **Conference Responsibilities**
   As an important part of the educational curriculum, conferences on specific topics are held daily, along with grand rounds each Wednesday at UCSF. ~~F and one Saturday morning per quarter for City-Wide Grand Rounds.~~ These conferences are planned months in advance and they have been carefully thought out by staff and senior residents as to the educational content as it relates to the overall educational curriculum. Residents are expected to attend these conferences and to come prepared

to discuss the subject matter and to provide a healthy exchange of ideas and questions that would maximize everyone's educational experience. Case presentations at the weekly orthopedic conference are essential for discussing and analyzing current treatment rationale. If the junior resident is presenting cases, he/she should discuss the presentation with the chief resident prior to the conference, review briefly the relevant literature and to have a working knowledge of the treatment, complications and results to be expected. The chief resident should have a more detailed knowledge of the material and problem, and be prepared to discuss more extensively the current concepts of the problem being presented along with its current accepted treatment and complications of treatment.

VII. ORTHOPEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. RESPONSIBILITY

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

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

To minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care, contributes to the efficient delivery of patient services.

B. REPORTING

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

C. CLINICAL INDICATORS

The following clinical indicators are among those closely followed:

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

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

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

E. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

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

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

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

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

X. MEETING REQUIREMENTS

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

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

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

XI. ADOPTION AND ADMENDMENT

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

XII. PATIENT INFORMATION

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

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

ATTACHMENT A– ORTHOPEDIC SURGERY PRIVILEGES

Privileges for Zuckerberg San Francisco General

Requested Approved

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

OrthoSurg ORTHOPAEDIC SURGERY 2010 (MEC 08/10)

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

28.00 GENERAL PRIVILEGES

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

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

Formatted ... [1]
Formatted ... [2]
Formatted ... [3]
Formatted: Indent: Left: 2.08", Space Before: 0.6 pt
Formatted: Font: 9 pt
Formatted: Indent: Left: 2.08"
Formatted: Font: 9 pt
Formatted ... [4]
Formatted ... [5]
Formatted ... [6]
Formatted ... [7]
Formatted ... [8]
Formatted ... [9]
Formatted ... [10]
Formatted ... [11]
Formatted ... [12]
Formatted ... [13]
Formatted ... [14]
Formatted ... [15]
Formatted ... [16]
Formatted ... [17]
Formatted ... [18]
Formatted ... [19]
Formatted ... [20]
Formatted ... [21]
Formatted ... [22]
Formatted ... [23]
Formatted ... [24]
Formatted ... [25]
Formatted ... [26]
Formatted ... [27]
Formatted ... [28]

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

Privileges for Zuckerberg San Francisco General

Requested Approved

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

28.05 OUTPATIENT PRIVILEGES

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

28.10 SPECIAL PRIVILEGES: SPINAL SURGERY

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

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

28.20 SPECIAL PRIVILEGES: HAND AND MICROVASCULAR SURGERY

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

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

28.30 GENERAL PODIATRIC PRIVILEGES

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

Formatted ... [29]
Formatted: Font: 8 pt
Formatted ... [30]
Formatted ... [31]
Formatted ... [32]
Formatted ... [33]
Formatted ... [34]
Formatted ... [35]
Formatted: Indent: Left: 2.08", Space Before: 0.6 pt
Formatted: Indent: Left: 2.08"
Formatted ... [36]
Formatted ... [37]
Formatted ... [38]
Formatted: Indent: Left: 2.08", Space Before: 0.6 pt
Formatted: Indent: Left: 2.08"
Formatted ... [39]
Formatted ... [40]
Formatted ... [41]
Formatted ... [42]
Formatted ... [43]
Formatted ... [44]
Formatted ... [45]
Formatted: Indent: Left: 2.08", Space Before: 0.6 pt
Formatted: Indent: Left: 2.08"
Formatted ... [46]
Formatted: Indent: Left: 0", Hanging: 2.3"
Formatted ... [47]
Formatted ... [48]
Formatted ... [49]
Formatted ... [50]
Formatted: Indent: Left: 2.08", Space Before: 0.6 pt
Formatted ... [51]
Formatted ... [52]
Formatted ... [53]
Formatted ... [54]

Privileges for Zuckerberg San Francisco General

Requested Approved

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

28.40 SURGICAL PODIATRIC PRIVILEGES

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

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

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

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

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

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

Formatted ... [55]
Formatted ... [56]
Formatted ... [57]
Formatted ... [58]
Formatted ... [59]
Formatted: Font: 9 pt
Formatted: Font: 9 pt
Formatted ... [60]
Formatted ... [61]
Formatted ... [62]
Formatted ... [63]
Formatted ... [64]
Formatted ... [65]
Formatted ... [66]
Formatted ... [67]
Formatted ... [68]
Formatted ... [69]
Formatted ... [70]
Formatted ... [71]
Formatted ... [72]
Formatted ... [73]
Formatted ... [74]
Formatted: Indent: Left: 2.08"
Formatted: Font: 9 pt
Formatted ... [75]
Formatted: Indent: Left: 2.08"
Formatted ... [76]
Formatted ... [77]
Formatted ... [78]
Formatted ... [79]

Privileges for Zuckerberg San Francisco General

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

Privileges for Zuckerberg San Francisco General

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

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

Privileges for Zuckerberg San Francisco General

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

I hereby request clinical privileges as indicated above.

_____

Applicant date

FOR DEPARTMENTAL USE:

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

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

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

APPROVED BY:

_____

Division Chief date

_____

Service Chief datec

PRINTED 6/24/2013

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

ATTACHMENT A – ORTHOPEDIC PRIVILEGE REQUEST FORM

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

Requested Approved

28 ORTHOPAEDIC SURGERY

28.00 GENERAL PRIVILEGES

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

28.10 DIAGNOSTIC RADIOLOGY: FLUOROSCOPY

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

28.20 PODIATRIC PRIVILEGES

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

28.21 Category I – Podiatric Surgery

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

28.22 Category II – Podiatric Surgery.

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

29.00 PHYSICAL MEDICINE & REHABILITATION

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

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

29.02 SPINAL INJECTION TECHNIQUES

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

29.03 CLINICAL NEUROPHYSIOLOGY

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

29.031 EMG

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

29.032 EVOKED POTENTIAL TESTING

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

~~Requested Approved~~

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

~~**30 ACUTE TRAUMA SURGERY**~~

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

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

~~**31 SPECIAL PRIVILEGES**~~

~~PATIENT MANAGEMENT INCLUDES THE AREAS SPECIFIED BELOW:~~

~~**31.1 Microsurgery** and replacement, replantation of limbs and parts, including adjacent and free-tissue transfer.~~
~~**PREREQUISITES:** Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microsurgery.~~
~~**PROCTORING:** Review of 5 cases if training is completed through an ACGME program and 10 cases if the individual completed training through a non-ACGME training program.~~
~~**REAPPOINTMENT**: Review of 2 cases.~~

~~**31.2 Complex Hand Surgery**, which includes comprehensive care from the wrist to the digits.~~
~~**PREREQUISITES:** Currently Board Admissible, Board Certified, or Re-Certified by The American Board of Orthopaedic Surgery or American Board of Plastic Surgery and has completed fellowship training in hand and microsurgery.~~
~~**PROCTORING:** Review of 5 cases if training is completed through an ACGME program and 10 cases if the individual completed training through a non-ACGME training program.~~
~~**REAPPOINTMENT**: Review of 2 cases.~~

~~**32 MODERATE SEDATION**~~

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

~~I hereby request clinical privileges as indicated above.~~

_____ _____
_____ _____
~~Applicant date~~

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

~~FOR DEPARTMENTAL USE:~~

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

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

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

~~APPROVED BY:~~

~~_____ _____~~
~~Division Chief date~~

~~_____ _____~~
~~Service Chief date~~

ATTACHMENT B– ORTHOPEDIC SURGERY POLICIES AND PROCEDURES

A. EMERGENCY ROOM COVERAGE

1. Respond IMMEDIATELY for ER consultation.
2. Confirm:
   a. that your name and contact information is~~beeper number are~~ listed correctly on the call schedule
   b. that your beeper is working.
3. The resident assigned to the ER on days should be available from 7:00 a.m. until 7:00 a.m. the following day, depending on their call assignment.~~.~~
4. The resident on call on holidays covers the ER during the day and night.
5. PATIENT TREATMENT REGISTER:
   a. All outpatients must be recorded on the electronic "Patient~~ Case~~ Log~~Treatment Register~~" ~~sheet~~ by the Orthopedic Emergency Room Resident.~~ Record name, MRB number, phone, address, diagnosis, treatment and clinic appointment date. Patients must have complete registry information placed on the registry information sheet.~~
   b. All admissions with orthopedic problems (whether admitted to Ortho or not) must also be recorded on the appropriate patient list.~~ specifying assigned SFGHZSFG ward and admitting service if other than Ortho.~~
   ~~c. The Ortho Service administrative staff and nurse practitioners will obtain the list each morning and use it for service records.~~
   c~~d~~. Acute conditions (fractures, dislocations, infections, etc.) shall not be given e-referral appointments.
6. EMERGENCY TREATMENT POLICIES:
   a. Consult immediately with Chief Resident regarding any potential surgical case.
   b. Unless the~~you are~~ junior resident on call is cert~~cert~~ain of diagnosis and treatment, consult Chief Resident prior to making disposition plans.
   c. The on-call junior resident should notify the Chief Resident immediately of all admissions to their service. The Chief Resident should notify the attending on call of all admissions to their service or cases scheduled.~~.~~
   d. R~~Save all your~~esidents should save all records, particularly the yellow copies of the consult forms (originals are to be left on the chart) to review the following morning in fracture rounds with the attending who was on-call. All consultations (ER & inpatient) must be reviewed by an attending prior to the on-call resident leaving the hospital post-call (no later than ~~noon~~ 11am the following day).
   e. When in doubt, the junior resident should not hesitate to ask the Chief Resident to personally see the patient and/or the imaging studies (e.g., compression fractures of spine, patients unable to walk or care for themselves safely in casts, potential compartment syndromes, "disposition problems" whose diagnoses are orthopedic, etc.).
   f. ER RECORDS: An ORTHO consult note must be written for each patient seen using the standard template form. The records should include medications given and procedures done for patients admitted to the hospital or sent home with follow-up instructions (including clinic follow-up). For admissions, the attending of record must review the consult and

see the patient within 24 hours of admission~~,~~ and complete an attending attestation form.

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

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

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

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

B. EMERGENCY ADMISSIONS

1. EMERGENCY ORTHOPEDIC ADMISSIONS

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

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

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

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

b. Complete ER admission ~~paperwork~~documentation, including admission orders and a complete history and physical examination.

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

2. ADMISSIONS TO OTHER SERVICES

There must be:

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

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

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

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

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

f. Children with orthopedic problems requiring hospitalization will be admitted to the Pediatric Ward (6A) under the primary care of the Pediatric Service who must be notified immediately about any admission (must see

in ER). Ortho interns may assist with the care of such patients, but need not do work-ups and ward care as these are provided by the Pediatric house staff.

C. NIGHT AND WEEKEND COVERAGE

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

D. VACATIONS

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

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

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

E. ORTHOPEDIC TEAM ROUNDS

1. Each chief resident will round with his/her team on all his or her patients daily, prior to ~~fracture~~ consult rounds (with the exception of Wednesdays when the

residents should attend Grand Rounds and the rounding is performed by the in-house residents on call, ~~the~~ inpatient service Nurse Practitioners,~~NPs,~~ and ~~with a~~~~the~~ fellow~~s~~). Patient visits~~This~~ must include an opportunity for the patient to discuss his/her care with team members. Patients should know their assigned team, the name of their chief resident, attending and at least one other M.D. on the team.

2. A patient's perception of his physician as "insensitive" or "unprofessional" is a frequent precursor of patient complaints and medicolegal issues. ~~a lawsuit! A~~always acknowledge the patient prior to examination or bedside discussion of his problems. Listen to the patient and take an interest in their personal life, concerns, and well-~~-~~being whenever ~~it is~~ possible.
3. Rounds must begin early enough so the ~~chief~~ residents can see and assess each patient.
4. WEEKENDS AND HOLIDAYS, the service the residents will be responsible to make rounds on patients from both teams, do necessary ward work, write notes and report problems to the team on duty. The residents will subsequently conduct rounds with the attending on call.
5. ATTENDING MULTIDISCIPLINARY WARD ROUNDS, followed by a review of all ~~inpatient~~ consults daily. ~~x-rays, will be held weekly by each team, Blue on Monday at 8:00 a.m. and Gold on Tuesday at 8:00 a.m.~~ Prior to these rounds, patients will have been seen on regular work rounds ~~and wounds prepared for examination.~~by the resident teams.

F. WARD PROCEDURES

1. MEDICAL RECORDS:
   a. A history and physical will be ~~written~~ documented for each patient on admission by the intern or junior housestaff who will ~~write~~ enter orders after consulting with a senior resident.
   b. There must be a resident note for each patient confirming pertinent history, physical examination, lab and x-ray findings, and given clearly recorded diagnoses and plans.
   c. Any procedure (case change, closed reduction, etc.) must be recorded in the patient's record along with physical finds, post-reduction x-rays, etc. and a note dictated on Provations as necessary.
   d. Progress notes by the residents should be ~~written~~ entered daily on each patient, and dated and signed legibly. ~~Electronic progress notes should be written by the fellow or an attending on the service daily.~~
   e. There should be an interval history/preoperative note written in the chart less than 24 hours before any elective procedure. ~~This should include but not~~ is not ~~limited to the patient diagnosis, surgical indications, significant laboratory values, significant co-morbidities, and planned procedure.~~

2. ORDERS
   a. All orders will be ~~written~~ entered completely~~, including time and date, and signed. All admission and postoperative orders **must be written** on the standing order forms.~~
   b. Verbal or phone orders must be countersigned within 24 hours.
   c. ~~Narcotics, anticoagulants and IV fluid orders will be carried out for up to 72 hours when they will stop automatically unless renewed.~~

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

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

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

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

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

3. DISCHARGE RECORDS

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

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

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

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

G. DISCHARGE PLANNING

1. P~~Anticipate your p~~atient's needs for discharge planning at the time of admission should be anticipated. If a patient is not certain to be discharged ambulatory and independent, consult the social worker and/or discharge ~~nurse coordinator~~planner as soon as possible.
2. Remember to allow for needed gait training or other physical therapy before planned time of discharge. ~~Schedule this in advance, not at the last minute.~~
3. Inform ~~your~~ patients as soon as possible about a planned discharge dates~~,~~ and keep ~~him~~ them informed of any changes.~~!~~
4. Visiting nurse services may permit discharge home where visiting PT may also be arranged.
5. Laguna Honda Hospital (county facility) has a limited number of acute rehabilitation beds (see below). ~~–~~They also have chronic care beds with a long waiting list.
6. Laguna Honda Hospital staff will screen all prospective patients for their rehabilitation ward before accepting them for admission. ~~–~~Patients must need rehabilitation services, must be willing and able to participate, and must have an appropriate plan for discharge from LHH.

7. The social worker will arrange LHH rehabilitation evaluation for a patient upon request of the Orthopedic team.
8. The ~~SFGH~~ZSFG orthopedic Service has a weekly follow-up clinic at LHH every ~~at 1:00 p.m. on Tuesdays~~week ams alternating between the two services. One attending ~~and the appropriate junior resident~~ staffs these clinics.
9. I~~i~~f a patient is accepted for transfer to the LHH rehabilitation ward, a discharge summary must be dictated the day before transfer. I~~i~~t must include the following:
   a) Which team (Blue or Gold) will follow the patient.
   b) Explicit physical therapy and activity orders, including weight bearing status.
   c) Notation of any x-rays desired to be done prior to the first Tuesday LHH clinic in which the patient will be seen.

H. COMPLETION OF MEDICAL RECORDS

1. A dictated discharge summary ~~and a written discharge front sheet~~ should be completed before the patient is discharged.
2. Operative notes must be ~~dictated~~ entered within 24 hours of the surgical procedure and must be signed by the attending within 3 days. Any undictated or unsigned delinquent note ~~greater then 5 days~~ will result in suspension of surgical privileges.
3. Clinic visits should be seen with an attending when possible. ~~Clinic notes should be dictated as follows: non-licensed residents must see the patients with the attendings and dictate with the attendings name in the note; licensed residents should dictate under their name (with "Dr. Statistical" as attending if they do not see the patient with an attending and dictate in the attendings name if seen with an attending; and attendings should dictate their own name in the notes.~~ Medical students ~~are not allow to write notes~~notes do not substitute for resident and faculty notes. All clinic notes should be signed within a week. ~~Any unsigned note greater than 5 days after its dictation also will result in suspension of surgical privileges.~~
3. Hospital privileges may be suspended for any physician who fails to complete charts or **DICTATE** ~~operative reports~~notes within the designated time. ~~The undictated charts will be reviewed weekly and notes needing countersignature will be brought to the Department by Medical Records for signature.~~

I. INFECTION PREVENTION

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

J. PRESSURE SORES & CONTRACTURES

1. Immobilized patients may develop pressure sores, contractures, and other problems. Patients who cannot relive focal pressure by moving in bed, or who have insensible skin, are most at risk. For others, mobility aids will increase morale.
2. Unless sitting, trunk flexion, or loading of arms, is contraindicated, a ~~A~~n overhead frame and trapeze should routinely be provided.
3. Pressures sores typically develop on the sacrum, lateral buttocks and heels. Rolling the patient every two hours, maintaining dry clean sheets and use of additional padding (e.g., foam egg crate mattress pad) over the firm hospital mattress are standard. Additionally, a pillow placed longitudinally under the calf (not under the knee) with the heel hanging over the end will prevent heel pressure sores.
4. Patients in traction usually can be turned 30 degrees side-to-side, but if they cannot be turned enough to unload their sacrum, prompt use of ~~a Clinatron (or similar)~~an air bed before pressures develop is effective. Such beds are available after approval by the Plastic Surgery Service. If none are in the hospital, they can be rented and delivered immediately.

K. PLASTER

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

L. TRACTION SUPPLIES

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

M. ORTHOTICS AND PROSTHETICS

1. All over-the-counter inpatient equipment (i.e. braces, immobilizers, etc.) should be ordered through the Orthotics and Prosthetics service. Care must be taken to ensure that the brace is the right size and length to fit the patient.
2. Proper orders ~~or requisition forms~~ must be completed in the record.~~, including the patient's name, medical record number, diagnosis (including side of injury), and correct brace type.~~

N. SURGERY

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

O. PREOPERATIVE PREPARATION

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

The responsible resident will also perform the site markings, and confirm the paperwork is complete for all subsequent cases.

c. Residents will check with the attending pre-operatively to ensure that the surgical plan, including necessary instrumentation and positioning, is understood. The resident will go to the OR prior to induction to ensure that the proper instrumentation is available.

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

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

4. Attending-specific responsibilities:

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

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

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

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

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

3. Informed Consent

a. DISCLOSURE

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

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

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

b. WRITTEN CONSENT FORM
- AFTER disclosure
- Complete ALL spaces (including date and time)
- Signed by patient (or legally appointed conservator)
- Signature witnessed by another M.D. or ~~SFGH~~ZSFG employee
- Translator must sign
- Special rules for minors (see Hospital Policy Manual)

4. INCOMPETENT PATIENT
Check or family or legal guardian (conservator)
a. EMERGENCY: If delay or non-treatment post significant risk to life, limb or serious deterioration of the patient's condition, note this and patient's non-lucidity in the record as justification for proceeding.
b. NON-EMERGENCY:
1. Obtain probate court order (slow--call Risk Management, x5125 ~~or pager 997-9660,~~ to initiate).
2. Alternative: If treatment cannot reasonably be delayed, one member of the medical staff must document in the medical record:
a) nature of risk from delay of treatment, and
b) advantages of proposed procedure.

5. Preoperative evaluation and note which must include indications for surgery as well as a list of potential likely complications. ~~–~~This will be written by the resident or attending most involved with the procedure whenever possible.~~.~~

6. Appropriate Anesthesia consultations should be obtained early enough to permit optimal patient preparation and to prevent last minute cancellation by Anesthesia because of an "incompletely evaluated patient."

7. Early Anesthesia consultations are routine for patients with complicated medical problems, including those with cardio-respiratory, hepatic, renal, or diabetic problems, as well as Jehovah's Witnesses.

8. All elective patients scheduled through the clinic should be referred to the anesthesia pre-operative clinic.~~Preoperative medical evaluations can be obtained via the Medical Consult Service. For outpatients, they run a Preoperative Evaluation Clinic. Call x8492 to schedule appointment 2-4 weeks before anticipated date of surgery. However, if the patient already has a primary physician, that physician should do the evaluation.~~

9. Preoperative planning must consider requirements for equipment, especially implants.~~ Elective cases scheduled in the clinic must have the equipment required signed or~~ initialed by the attending surgeon.~~

10. The operating resident will review the patient, including x-rays, with the OR attending so that both may be involved in preoperative planning. The operating resident must know the anatomy, the surgical approach, the operative procedure, the indications and alternative methods of treatment.

11. Pre-operative notes should be written on inpatients the night prior to surgery.

12~~1~~. Routine lab studies~~s~~ (CBS, UA, EKG, LFT's, Lytes, Creatinine, clotting studies, etc.) should be ordered as indicated. Blood should usually be typed and held, or cross-matched if transfusion is anticipated. X-rays must pulled up~~be~~ in the OR before the case is begun.

13~~2~~. Essential instruments and implants must be selected and sterilized.~~ You must know where equipment is kept, as the night shift nurses are often unfamiliar with orthopedic equipment. Routine cases will be picked by OR nurse.~~

14~~3~~. Cast materials must be ready and outside the operating room until wound closure.

154. PREPARATION
   a. Shave (in OR) only when and where hair will impede closure. Clipping should be performed when possible.
   b. ~~If skin is intact, use iodophor~~Standard prep should be used (Prepadine, Betadine, Ioprep, etc.)~~ which can be painted directly on open wound~~. Skin must be completely dry if adhesive drape is to stick reliably.
   c. Drape according to standard sterile draping techniques.

15. PROTECTION FOR SURGEONS
   a. All surgeons must wear goggles, glasses, or face shield for every case.
   b. Double gloves must be worn for every case.
   c. For cases with significant blood loss, each surgeon must wear:
      1) Double shoe covers
      2) Knee high disposable boots
      3) Gowns with reinforced sleeves and front panel
      4) Extra sleeves
   d. The pulse lavage must be used with its splash shield. If none is available, the pulse lavage is not to be used. Irrigate with bulb syringe.
   e. Stackhouse surgical helmet systems are available for use on all high-risk cases. When scheduling cases, tell OR you want to use the Stackhouse system.
   b. When operating on high-risk patients, the members of the surgical team should consider the use of~~wear~~ Kevlar gloves.

176. Prophylactic antibiotics are used for all clean surgical procedures when implant materials used unless otherwise:~~:~~
   - 1 gram Kefzol IV with induction of anesthesia
   - 1 gram Kefzol IV in PAR

   Check for allergy and consult with chief resident if needed.

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

~~Grade III open fractures:~~
~~add gentamicin i.v. 1mg per kh q 8 urs if renal fuction is normal~~
~~If gross dirt contamination:~~
~~add penicillin 2,000,000 units q 6 hours~~

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

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

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

~~19.~~20. The patient must be site marked prior to surgery by a licensed practitioner who is capable of starting the case and will be present at the beginning of the case. ~~The attending must call in to the Operating Room by 7:15 the morning of the surgery.~~

~~20.~~21. All hair and street clothing must be covered. A self-laundered scrub cap can be used if covered up by a clean, disposable cap. Use hood, not cap alone to cover all hair if exposed (a~~.—A~~ sweatband helps with sweat).~~.~~

~~21.~~22. ~~If you leave OR in greens, wear a long gown closed in the front. A short white jacket does not prevent contamination of the front of your greens.~~ When in doubt, ~~change your~~ greens should be changed before beginning another case, particularly for ~~in~~ those cases that have been on contaminated or infected wounds or if the greens were worn outside of the operating room area. Greens should never leave

the hospital campus (can be worn between hospital and ~~B~~other campus buildings).~~uilding 9).~~

2~~1~~3. The operating resident for the next case should stay in the assigned operating room between cases to expedite room turnover. Patients in the pre-operative area should be checked by the surgical team for completion of paperwork, site marking, and desire to have additional questions answered prior to surgery in order to ensure no delay for the start of the next case. The surgical team in the OR in which the patient is expected to enter will be notified by the holding area staff for patients with incomplete requirements so that this can be dealt with in order to avoid delays in room turn-over.

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

~~23.~~24. Shoe covers must be worn in the OR at all times. If you leave the OR, remove your shoe covers and replace them upon return to the OR.

For general anesthesia, monitored anesthesia care (MAC), and local with sedation		
Age	**NO FOOD***	**CLEAR LIQUIDS ONLY****
Less than 6 months	4 hours before procedure	2 hours
7 months to age 12	After midnight	2 hours
Age 13 and adjust	After midnight	4 hours
Age	**NO FOOD***	**CLEAR LIQUIDS ONLY****
Any age	4 hours (recommended light meal only)	Ad lib

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

~~O.~~P. DICTATIONS

OPERATIVE REPORTS

1. Must be dictated within 24 hours ~~on the Provations system~~
2. All new fellows, residents, and interns who are unfamiliar with the system should be trained ~~within the first week of~~prior to their starting on the service.
3. At the time of surgery the surgical team should identify the resident responsible for the surgical dictation. ~~The surgical resident responsible for the dictation should be identified on the operative note.~~

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

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

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

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

~~**FORMAT:**~~

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

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

~~TO:~~	~~DIAL:~~
~~Listen~~	~~1~~
~~Dictate~~	~~2~~
~~Reverse (@15 w or~~	~~3~~

Formatted: Indent: Left: 0.5", Hanging: 1"
Formatted: Indent: Left: 0.5", Hanging: 1"
Formatted: Indent: Left: 0.5", Hanging: 1"
Formatted: Indent: Left: 0.5", Hanging: 1"
Formatted: Indent: Left: 0.5", Hanging: 1"

~~ds~~
~~)~~

~~Pause~~	~~4~~	**Formatted:** Indent: Left: 0.5", Hanging: 1"
~~Fast forward~~	~~7~~	**Formatted:** Indent: Left: 0.5", Hanging: 1"
~~Rewind to begin ing of report~~	~~6~~	**Formatted:** Indent: Left: 0.5", Hanging: 1"
~~End of report~~	~~5~~	**Formatted:** Indent: Left: 0.5", Hanging: 1"
~~Call operator~~	~~0 + 0~~	**Formatted:** Indent: Left: 0.5", Hanging: 1"
~~Insert*~~	~~0 + 6~~	**Formatted:** Indent: Left: 0.5", Hanging: 1"

Formatted: Indent: Left: 0.5", Hanging: 1"

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

~~4. After dictating the operative note, sign and dictate the blue sheet and place in box on 3B adjacent to resident boxes.~~ **Formatted:** Indent: Left: 0", First line: 0"

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

~~Do not sign any operative notes.~~

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

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

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

2. Only those orthopaedic practitioners with California fluoroscopy supervisors licenses may operate a fluoroscopy unit.
3. Prior to the use of fluoroscopy, the operator must announce that this equipment will be used and must ensure that those exposed to potential radiation are protected with shielding, including the operator, the patient, and ancillary personnel.

~~Q.~~R. CLINIC RULES

1. Arrive when the clinic starts.
2. ~~Records: Orthopedic Clinic Progress Record forms produce an automatic copy. Use ball-point pen. Provide all pertinent information. Are we mentioning anything here about dictating e-referrals, or new patients?~~All patient visits, including new patient visits, should be ~~dictated~~recorded on the hospital system. ~~according to the posted dictation instructions (initial consultation, final visits/discharge notes, and follow-up visits).~~

~~3. All Orthopedic Clinic records must remain there. If you must have it, a copy can be made by the~~through ~~the clinic. Ortho office secretary (3A36).~~

4. If x-rays or cast removal is planned for next visit, indicate it ~~on the Clinic Progress~~in the note so ~~Record so those nurses may~~ this can be arranged ~~this before you see the patient.~~at the beginning of the visit.
5. Most routine x-rays are done in the Ortho Clinic. Try to order these early.
6. Clinic has priority. Do not leave for ward work, etc., unless on call.
7. If you must leave for an emergency, tell chief resident and nurse that you are leaving and why.
8. Obtain written consent for appropriate procedures, such as hardware removal, etc.

~~P. CLINIC PAPERWORK~~

~~1. Registration slip: (billing slip goes to Hospital Accounting)~~
~~a. Dr.'s name and patient's diagnosis (essential)~~
~~b. Return visit date~~
~~2. Prescription slip:~~
~~a. One drug per form~~
~~b. Sign and print name, use UCSF ID number.~~
~~3. Others: Nurse will orient you.~~

~~R.~~S. ADMISSIONS FROM CLINIC

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

~~S.~~T. EMERGENCY ADMISSIONS

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

~~T.~~U. ELECTIVE (FUTURE) ADMISSIONS

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

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

~~3.~~ The patient should be evaluated by eligibility and may be appropriate for referral to the pre-operative clinic.~~Patient is then interviewed by eligibility worker.~~

~~4.~~3. ~~5. The patient should report to 1C1 immediately for pre-admit approval.~~be sent to the pre-operative clinic.

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

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

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

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

~~1. TAR patients as soon as possible.~~
~~2.~~ M.D./R.N. should~~must~~ schedule with Surgi Center at least 3 days in advance~~advance~~.
~~2~~3. In general: Local anesthesia: Labs only if indicated. ~~–~~Need written H&P, disclosure and consent.

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

W. CLINIC DISCHARGE CRITERIA

1. The patient has a musculoskeletal condition that could be addressed with surgery, but after Orthopaedic Surgical Consultation, the patient is not a surgical candidate *or* the patient decides she/he does not want surgery.
2. The patient has a musculoskeletal condition that does not need or no longer requires further follow-up with an Orthopaedic Surgeon.
3. For patients who are discharged via this mechanism, a discharge note will be available in the LCR clearly explaining why the patient is currently not a good surgical candidate and when to reconsider referring the patient back for surgical evaluation. Additionally, recommendations will be made for appropriate non-surgical management.

~~V.~~X. INFECTIONS

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

~~W.~~Y. ORTHOPEDIC PEDIATRIC ADMISSIONS

1. The orthopedic intern and resident work up the ~~patient. Pediatric consultation is required on patients less than age 4 who are going to the OR.~~
2. ~~The orthopedic resident and intern will write the orders; progress notes and follows the patient daily.~~musculoskeletal exam of the patient.
2. Pediatric patients are admitted to the pediatric service with Orthopaedics providing the consultation.
3. Orthopaedic surgery service sees the patients daily, leaving a note on the patient and addressing any musculoskeletal issues.
4. Specific Service Responsibilities: Elective Surgeries, Emergency Admissions, Emergency Surgeries, and Transfers

Pediatics:

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

f. Communicate with PCP

Orthopedics:

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

Z. ORTHOPEDIC FAMILY INPATIENT SERVICE ADMISSIONS

1. Orthopaedic patients with acute medical issues while on the in-patient Orthopaedic ~~Ortho~~ Service will first be staffed by inpatient Medical Consult Service. For any straight-forward medical problems, the Medical Consult Service will continue to provide management help with Ortho serving as the primary care team of record. However, i~~I~~f deemed appropriate, there will be a very low threshold for transfer to the 3rd FIS team for any patients with complex medical needs.
2. Each morning, the FIS Hospitalist will receive any new overnight transfers from the overnight hospitalist or Medicine teams. ~~Later in the morning, the FIS Hospitalist will quickly round with the Ortho NPs and/or intern to set the plan of care for the Ortho-related problems for patients on the 3rd FIS team.~~
3. The FIS Hospitalist will be the primary caregiver with Orthopaedics serving as a close consulting service for patients on the Medicine inpatient service~~3rd FIS~~ team. Orthopaedic NPs ~~NPs~~ and interns will coordinate disposition plan and follow-up for any Ortho-related medical issues. Otherwise, the hospitalist will manage all other aspects of care and discharge.
4. For overnight and weekend issues, the overnight Medical Inpatient Service~~FIS~~ Overnight Hospitalist can be the first "go-to" person for any acute medical issues that arise on the Orthopaedic Service in-patients.

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

~~**PATIENTS WITH SPINE INJURIES**~~

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

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

ATTACHMENT C -- —CLINICAL SERVICE CHIEF OF ORTHOPEDIC SURGERY JOB Description

CLINICAL SERVICE CHIEF OF ORTHOPEDIC SURGERY SERVICE
JOB DESCRIPTION

~~March 19, 2002~~

Chief of Orthopedic Surgery Clinical Service

Position Summary:

The Chief of Orthopedic Surgery Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of ~~San Francisco General Hospital~~Zuckerberg San Francisco General (~~SFGH~~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 Orthopedic 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 five~~our~~ 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 ~~SFGH~~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 Orthopedic 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 Orthopedic Surgery Clinical Service include the following:

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

In collaboration with the Executive Administrator and other ~~SFGH~~ZSFG leaders, developing and implementing policies and procedures that support the provision of services by reviewing and approving the 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 ~~SFGH~~ZSFG leaders, participating in the operational processes that affect the Service by participating in the budgeting process, recommending the number of qualified and competent staff to provide care, evaluating space and equipment needs, selecting

outside sources for needed services, and supervising the selection, orientation, in-service education, and continuing education of all Service staff;

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

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

Page 19: [79] Formatted Miclau, Theodore 7/7/2013 6:50:00 PM

Font: Times New Roman, 10 pt

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

ORTHOPEDIC SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
2024

ORTHOPEDIC SURGERY CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

I. ORTHOPEDIC SURGERY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

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

As a member of the Orthopedic Surgery Service, the board-certified physiatrist is also the Medical Director of the Rehabilitation Service for ZSFG. The service also has a fully equipped orthotics and prosthetics group with experts in prosthetics and orthotics.

B. MEMBERSHIP REQUIREMENTS

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

C. ORGANIZATION OF ORTHOPEDIC SURGERY CLINICAL SERVICE

Currently the Clinical Service of Orthopedic Surgery at Zuckerberg San Francisco General is staffed by orthopedic surgeons with 50% or more time effort, trauma fellows (Clinical Instructors and Active ZSFG Medical Staff Members), hand surgeons, podiatrists, physiatrists, and 1 part-time physiatrist. Pediatric and oncology clinics are staffed by UCSF surgeons. There are several volunteer surgeons who assist in the clinics and ORs in the above areas. The attending physicians and podiatrists are responsible for daily attending rounds on both services, assuring quality patient care, resident education, and dictation of attending notes on all patients every day. Ortho and ortho trauma call coverage are provided by the is by the ortho trauma attendings, the hand call is split with the plastic surgery service and provided by the hand surgeons, and the spine call is split with the neurosurgery service and provided by the spine surgeons.

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

II. CREDENTIALING

A. NEW APPOINTMENTS

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

Criteria

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

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles

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

2. Modification of Clinical Service

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

3. Staff Status Change

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

4. Modification/Changes to Privileges

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

C. AFFILIATED PROFESSIONALS

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

D. STAFF CATEGORIES

The Orthopedic Surgery Clinical Service fall into the same staff categories which are described in Article III – *Categories of the Medical Staff* of the ZSFG Bylaws, Rules and Regulations and accompanying manuals.

III. DELINEATION OF PRIVILEGES (Refer to Attachment A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

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

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. MONITORING (PROCTORING) REQUIREMENTS

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

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

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

The Orthopedic Surgery Service at ZSFG offers high quality educational activities at the graduate and undergraduate levels. It is one of the main teaching sites for the UCSF orthopedic surgery residency program. The trauma group, also referred to as the Orthopaedic Trauma Institute that is housed at ZSFG, has two non-ACGME fellows that rotate through the site. The service is also an important teaching site for the Department of Emergency Medicine. Furthermore, residents from the Department of Family Medicine, Internal Medicine, and the Department of Pediatrics occasionally rotate through the orthopedic outpatient clinics.

At the graduate level, the service is also the main teaching site for third-year UCSF medical students. It also offers rotations for UCSF fourth-year medical students. During the academic year, between 5-10 UCSF medical students and about 5-10 non-UCSF fourth-year medical students rotate through the service.

VI. ORTHOPEDIC SURGERY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. SUPERVISION

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

B. EDUCATIONAL ACTIVITIES

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

Resident teaching at ZSFG occurs in three ways:

- interactive didactic sessions with faculty
- hands-on teaching in the operating room, clinic and rounds
- resident involvement in research projects.

Regular didactic sessions include:

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

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

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

C. EDUCATIONAL GOALS

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

D. GUIDELINES

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

It is stressed that the chief resident is ultimately responsible for the day-to-day care of patient management under the direction of the staff physicians. Should the first-year resident or the junior resident not be familiar with the plan of patient care or treatment protocols, it is the chief resident's responsibility to oversee these matters and to educate the junior resident as necessary. A smooth functioning, competent surgical team is dependent upon the chief resident's interest, organizational skills, efficiency, knowledge and ability to communicate. The surgical teams will be assisted thorough the work of the

nurse practitioners on the Orthopaedic Surgical Service. The orthopedic interns and residents are responsible for working closely with them to provide care to the patients on the service.

E. DUTIES OF RESIDENTS (Specific Responsibilities):

Also refer to House Staff Competencies Link on CHN Intranet Site

1. Patient Care Responsibilities

Orthopedic residents are expected to make patient rounds at least once a day. It is anticipated and expected that all residents on the service would make rounds in the early morning prior to going to the morning conferences. All patients should be seen, charts should be reviewed, orders written, dressings changed, consultations requested, and x-rays reviewed as necessary. The nurses should be advised of any problems or orders, which need to be carried out expeditiously. Rounds for problem patients should be made again at the end of the day, postoperative checks should be made on all patients and postoperative notes should be placed on the chart before the residents department for the evening. All postoperative x-rays should be reviewed and notations made in the chart of the appropriate findings. The status of the implants should be noted, or in the case of total hip arthroplasty, for instance, a notation should be made that the x-rays reveal that the hip implant is in satisfactory position and remains reduced. A neurological-vascular check should be a standard part of the postoperative evaluation and a notation should be made in the chart that this has been examined, evaluated and is normal or not. Any abnormalities should be reported to the staff physician immediately. A note must be written in the chart each day. The chief resident or designee should write an initial evaluation note after the junior resident's history and physical exam. All patients scheduled for operative procedures must have a preoperative note, which includes the patient's diagnosis, alternatives of treatment and documents the patient's informed consent. Any necessary patient discharge documentation should be completed the evening before the patient's anticipated discharge. All discharge summaries must be completed within 24 hours of the patient's discharge and preferably done the day the patient is discharged while the chart is still on the station.

5. Clinic Responsibilities

All residents are expected to be present on time for clinic sessions. Clinic staff will discuss with the resident how he wishes to run his or her particular clinic. In general, residents are expected to carry out thorough history and physical examinations directed toward the patient's orthopedic problem. The staff physician assigned to the clinic is available for consultation and instruction at all times while the clinic is operating. Residents will chart on the clinic patients they see and be in compliance with the standard billing practices.

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

6. Surgical Responsibilities

Residents assigned to specific operative cases are expected to check that the required paperwork, including history and physical (including interval history and physical) and consent, and that proper site marking has occurred. If the patient has questions

regarding the procedure and would like to confer with the attending staff, the resident will inform the attending staff member. The resident is expected to confer with the attending staff regarding details of the procedure, including specifics about the operation, appropriate implants, and positioning. The resident is expected to arrive in the operating suite promptly at the time the patient is brought into the room in order to assist the anesthesiologist as necessary and facilitate positioning of the patient, arranging x-rays, double checking instruments packs, time outs, etc. It is essential, that have a thorough knowledge of anatomy along with the procedure plan for the specific operation and a knowledge of alternative surgical techniques for the management of that specific problem. Orthopedic residents not well versed in the relevant literature or the anatomy of the exposure to be performed or the planned procedure are unlikely to be given active involvement in the surgical case and, at best, would have a compromised educational experience. The extent of a resident's involvement in a specific operative procedure is in a great part dependent not only on the resident's natural ability, surgical knowledge and skill, but also on their interest, desire, and preparation.

7. Conference Responsibilities

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

VII. ORTHOPEDIC SURGERY CLINICAL SERVICE CONSULTATION CRITERIA

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

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT, PATIENT SAFETY & UTILIZATION MANAGEMENT

A. RESPONSIBILITY

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

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

To minimize morbidity and mortality as well as to avoid unnecessary days of inpatient care, contributes to the efficient delivery of patient services.

B. REPORTING

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

C. CLINICAL INDICATORS

The following clinical indicators are among those closely followed:

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

D. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES

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

E. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

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

F. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1. Physicians/Affiliated Professionals

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

2. Housestaff

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

X. MEETING REQUIREMENTS

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

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

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

XI. ADOPTION AND ADMENDMENT

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

XII. PATIENT INFORMATION

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

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

ATTACHMENT A– ORTHOPEDIC SURGERY PRIVILEGES

Privileges for Zuckerberg San Francisco General

Requested Approved

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

OrthoSurg **ORTHOPAEDIC SURGERY 2010**
(MEC 08/10)
FOR ALL PRIVILEGES: All complication rates, including problem transfusions, deaths, unusual occurrence reports, patient complaints, and sentinel events, as well as Department quality indicators, will be monitored semiannually.

_____ _____ **28.00 GENERAL PRIVILEGES**
Core privileges directed at the treatment of disorders and injuries of the neck, back, thorax, pelvis, upper extremities, and lower extremities, include the following treatments (other than those outlined for supplemental privileges):
PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Orthopedic Surgery.
PROCTORING: 5 observed operative procedures and 15 retrospective reviews of operative procedures.
REAPPOINTMENT: 20 operative procedures in the previous two years.

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

Privileges for Zuckerberg San Francisco General

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

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

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

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

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

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

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

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

Privileges for Zuckerberg San Francisco General

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

Privileges for Zuckerberg San Francisco General

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

29.10 SPINAL INJECTION TECHNIQUES

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

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

29.20 SPINAL TECHNIQUES: SPECIAL PROCEDURES

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

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

Privileges for Zuckerberg San Francisco General

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

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

Privileges for Zuckerberg San Francisco General

Requested Approved

e

PRINTED 6/24/2013

ZUCKERBERG SAN FRANCISCO GENERALZUCKERBERG SAN FRANCISCO GENERALATTACHMENT B– ORTHOPEDIC SURGERY POLICIES AND PROCEDURES

A. EMERGENCY ROOM COVERAGE

1. Respond IMMEDIATELY for ER consultation.
2. Confirm:
   a. that your name and contact information is listed correctly on the call schedule
   b. that your beeper is working.
3. The resident assigned to the ER on days should be available from 7:00 a.m. until 7:00 a.m. the following day, depending on their call assignment.
4. The resident on call on holidays covers the ER during the day and night.
5. PATIENT TREATMENT REGISTER:
   a. All outpatients must be recorded on the electronic "Patient Log" by the Orthopedic Emergency Room Resident.
   b. All admissions with orthopedic problems (whether admitted to Ortho or not) must also be recorded on the appropriate patient list.
   c. Acute conditions (fractures, dislocations, infections, etc.) shall not be given e-referral appointments.
6. EMERGENCY TREATMENT POLICIES:
   a. Consult immediately with Chief Resident regarding any potential surgical case.
   b. Unless the junior resident on call is certain of diagnosis and treatment, consult Chief Resident prior to making disposition plans.
   c. The on-call junior resident should notify the Chief Resident immediately of all admissions to their service. The Chief Resident should notify the attending on call of all admissions to their service or cases scheduled.
   d. Residents should save all records, particularly the yellow copies of the consult forms (originals are to be left on the chart) to review the following morning in fracture rounds with the attending who was on-call. All consultations (ER & inpatient) must be reviewed by an attending prior to the on-call resident leaving the hospital post-call (no later than 11am the following day).
   e. When in doubt, the junior resident should not hesitate to ask the Chief Resident to personally see the patient and/or the imaging studies (e.g., compression fractures of spine, patients unable to walk or care for themselves safely in casts, potential compartment syndromes, "disposition problems" whose diagnoses are orthopedic, etc.).
   f. ER RECORDS: An ORTHO consult note must be written for each patient seen using the standard template form. The records should include medications given and procedures done for patients admitted to the hospital or sent home with follow-up instructions (including clinic follow-up). For admissions, the attending of record must review the consult and see the patient within 24 hours of admission and complete an attending attestation form.
   g. Orthopaedic Surgery residents are responsible for the consultations in the ER.
   h. Orthopedics & Neurosurgery should be called for consults according to the spine call schedule.

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

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

B. EMERGENCY ADMISSIONS

1. EMERGENCY ORTHOPEDIC ADMISSIONS
   a. Emergency admissions are assigned to the service on call for that day, with the following exceptions:
      1) Patients requiring emergency surgery will be cared for by the team performing the operation.
      2) Re-admissions for the same problem will return to their previous team.
      3) Patients seen from 6p to 7a will be reviewed by and admitted to the attending of the day (AOD), who will be covering the OR during the day, unless otherwise arranged.
   b. Complete ER admission documentation, including admission orders and a complete history and physical examination.
   c. Direct admissions/transfers from other hospitals are welcome and encouraged. They must be approved first by an attending who will arrange the transfer with the ZSFG eligibility/transfer coordinator (if inpatient to inpatient transfer) or the ED attending (if ED to ED transfer). Make note of patient diagnosis, reason for transfer, type of bed required (ICU, step-down, etc.) and optimal timing for surgery.

2. ADMISSIONS TO OTHER SERVICES
   There must be:
   a. A note in the medical record clearly defining the patient's orthopedic problems and treatment, provided or recommended.
   b. Clear indication of which orthopedic team is involved.
   c. Verbal communication with the responsible senior or chief resident of the admitting service to ensure proper communication and discussion of medical plans.
   d. Patient admissions and transfers should adhere to the general guidelines established between the various services (including trauma and medicine).
   e. While on another service, such "consult patients" will be followed at least daily by the appropriate orthopedic team, until the patient is stable for sign-off.
   f. Children with orthopedic problems requiring hospitalization will be admitted to the Pediatric Ward (6A) under the primary care of the Pediatric Service who must be notified immediately about any admission (must see in ER). Ortho interns may assist with the care of such patients, but need not do work-ups and ward care as these are provided by the Pediatric house staff.

C. NIGHT AND WEEKEND COVERAGE

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

D. VACATIONS

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

ZSFG

E. ORTHOPEDIC TEAM ROUNDS

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

patient and take an interest in their personal life, concerns, and well-being whenever possible.

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

F. WARD PROCEDURES

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

2. ORDERS
   a. All orders will be entered completely
   b. Verbal or phone orders must be countersigned within 24 hours.
   c. Provide adequate pain medication. Pre-medicate before a painful procedure. Do not hesitate to consult the pain management service.
   d. All medication orders must be renewed every 7 days.
   e. All orders must be re-established at the time of surgery and on inter-service transfer.
   f. X-rays and lab studies must be ordered in the record. Practitioners should not order unnecessary (routine) blood work or x-rays.
   g. All instructions for the cast technician or braces must be recorded in the record, just as any other order.

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

treatment undertaken and transfer arrangements. This conversation, including name, address and phone number of receiving orthopedist must be recorded in a progress note. A dictated summary and pertinent x-rays or their copies should accompany patients so transferred.

G. DISCHARGE PLANNING

1. Patient's needs for discharge planning at the time of admission should be anticipated. If a patient is not certain to be discharged ambulatory and independent, consult the social worker and/or discharge planner as soon as possible.
2. Remember to allow for needed gait training or other physical therapy before planned time of discharge.
3. Inform patients as soon as possible about a planned discharge dates and keep them informed of any changes.
4. Visiting nurse services may permit discharge home where visiting PT may also be arranged.
5. Laguna Honda Hospital (county facility) has a limited number of acute rehabilitation beds (see below). They also have chronic care beds with a long waiting list.
6. Laguna Honda Hospital staff will screen all prospective patients for their rehabilitation ward before accepting them for admission. Patients must need rehabilitation services, must be willing and able to participate, and must have an appropriate plan for discharge from LHH.
7. The social worker will arrange LHH rehabilitation evaluation for a patient upon request of the Orthopedic team.
8. The ZSFG orthopedic Service has a weekly follow-up clinic at LHH every week ams alternating between the two services. One attending staffs these clinics.
9. If a patient is accepted for transfer to the LHH rehabilitation ward, a discharge summary must be dictated the day before transfer. It must include the following:
    a) Which team (Blue or Gold) will follow the patient.
    b) Explicit physical therapy and activity orders, including weight bearing status.
    c) Notation of any x-rays desired to be done prior to the first Tuesday LHH clinic in which the patient will be seen.

H. COMPLETION OF MEDICAL RECORDS

1. A dictated discharge summary should be completed before the patient is discharged.
2. Operative notes must be entered within 24 hours of the surgical procedure and must be signed by the attending within 3 days. Any undictated or unsigned delinquent note will result in suspension of surgical privileges.
3. Clinic visits should be seen with an attending when possible. Medical students notes do not substitute for resident and faculty notes. All clinic notes should be signed within a week.
3. Hospital privileges may be suspended for any physician who fails to complete charts or **DICTATE** notes within the designated time.

I. INFECTION PREVENTION

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

J. PRESSURE SORES & CONTRACTURES

1. Immobilized patients may develop pressure sores, contractures, and other problems. Patients who cannot relive focal pressure by moving in bed, or who have insensible skin, are most at risk. For others, mobility aids will increase morale.
2. Unless sitting, trunk flexion, or loading of arms, is contraindicated, an overhead frame and trapeze should routinely be provided.
3. Pressures sores typically develop on the sacrum, lateral buttocks and heels. Rolling the patient every two hours, maintaining dry clean sheets and use of additional padding (e.g., foam egg crate mattress pad) over the firm hospital mattress are standard. Additionally, a pillow placed longitudinally under the calf (not under the knee) with the heel hanging over the end will prevent heel pressure sores.
4. Patients in traction usually can be turned 30 degrees side-to-side, but if they cannot be turned enough to unload their sacrum, prompt use of an air bed before pressures develop is effective. Such beds are available after approval by the Plastic Surgery Service. If none are in the hospital, they can be rented and delivered immediately.

K. PLASTER

1. Do not pull plastic covered pillows or any other plastic material next to setting plaster. If patient c/o burning, **REMOVE** case or splint immediately.
2. Circumferential casts, and even splints, can cause excessive pressure on a limb, especially a recently injured one with increasing swelling. Make sure that enough padding is applied to allow the case to be split without skin trauma.
3. Cast univalving or bivalving should be done the full-length of the case, dividing padding as well as plaster. The case must then be spread to loosen it.
4. Interns should check with the resident before opening a cast. Do not open a cast directly over a traumatic or operative wound.
5. Casts should generally be sawed open **OUTSIDE** the OR to minimize airborne dust.
6. Major cast work (spica, body jacket, etc.) should be planned and scheduled in accordance to with the Chief Resident and ortho technician the preceding day.
7. Inpatient cast work must not be done in the ER or the clinic. If prompt x-ray control or anesthesia is required, such plaster work is best done in the OR.
8. Cast technician duties: Collect treatment equipment, set up traction, apply overhead frames, apply routine casts and splints, assist with casts and cast braces.
9. Maintain reasonable cleanliness in the Cast Room.

10. Stamp and fill out cast room slips for all procedures done and equipment handed out (crutches, braces, etc.). Billing slips are required to obtain insurance payments for the hospital.
11. Plastic cast material is available in limited amounts for patients with appropriate indications.
12. Return all orthopedic equipment to the area from which it is borrowed. If something is missing or broken, inform the cast technician.

L. TRACTION SUPPLIES

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

M. ORTHOTICS AND PROSTHETICS

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

N. SURGERY

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

O. PREOPERATIVE PREPARATION

1. Consultation with attending is required before any patient is taken to surgery.
2. Scheduling (Emergency and Elective)
    a. All cases should be scheduled through the appropriate chief resident. The attendings should be informed when any case is scheduled under their name.
    b. Scheduling forms (ZSFG and Ortho) must be completed for all cases.
    c. Monday and Thursday are Gold OR days. Tuesday and Wednesday are Blue OR days. Friday is both an OR Gold and Blue day.
    d. Elective operating schedules must be entered prior to general release times for the ORs, or 72 hours prior to surgery for the elective room and 6:00 am the day of surgery for 8th Room Cases.
    e. Non-urgent cases "added on" after that time will be scheduled in sequence by the OR as space and personnel permit.
    f. Emergency cases must be scheduled in collaboration with the attending or service chief resident.
    g. The consent form must be obtained prior to booking and the booked case must match the booking form.
3. Resident-specific responsibilities:

a. Residents will perform pre-operative notes on night prior to surgery for inpatients.
b. A member of the resident team should be present at the 6:30am huddle in the OR. Residents will see all first cases prior to morning conference (6:45 a.m.) and verify that all required paperwork is complete and the patient is site marked. The site marking must be done by a provider that is licensed, and will be available for the time-out, and is capable of starting the procedure. The responsible resident will also perform the site markings, and confirm the paperwork is complete for all subsequent cases.
c. Residents will check with the attending pre-operatively to ensure that the surgical plan, including necessary instrumentation and positioning, is understood. The resident will go to the OR prior to induction to ensure that the proper instrumentation is available.
d. Chief resident will act as the contact person for the OR that day and identify themselves with the OR at the 6:35 am huddle on weekdays.
d. The Chief Resident for each team (Gold/Blue) will assign resident teams to each case and list the assigned residents on the weekly case list presented at the weekly conference. The cases listed will also have the responsible attendings for each elective case.

4. Attending-specific responsibilities:
   a. Attending surgeon should check the OR scheduling to ensure proper booking.
   b. Attending surgeon should check the room prior to induction to verify that the proper implants are available for elective cases. For emergency cases, the attending will provide verbal confirmation to the relevant teams.
   c. The OR Attending of the day (the on-call attending or his designee) will be available to cover any emergency or trauma cases in OR 8 and be available for board management or patient-related questions. The AOD will rounds at the 6:30 am huddle.
   d. Attending surgeons will see the patient pre-operatively and they or their designees will see the patient post-operatively if an inpatient (no later than POD #1). A member of the orthopaedic team who will be present for the start of the case will perform the site monitoring and complete the paperwork pre-operatively if it is not already done. The patient will not be placed in the room until the attending has seen the patient for elective cases. The attending will be available to go to the OR when paged by the circulator that the patient is in the room.
   e. The attending surgeon will discuss case of the patient with the patient's family post-operatively (if they are available).

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

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

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

b. WRITTEN CONSENT FORM
- AFTER disclosure
- Complete ALL spaces (including date and time)
- Signed by patient (or legally appointed conservator)
- Signature witnessed by another M.D. or ZSFG employee
- Translator must sign
- Special rules for minors (see Hospital Policy Manual)

4. INCOMPETENT PATIENT
Check or family or legal guardian (conservator)
   a. EMERGENCY: If delay or non-treatment post significant risk to life, limb or serious deterioration of the patient's condition, note this and patient's non-lucidity in the record as justification for proceeding.
   b. NON-EMERGENCY:
      1. Obtain probate court order (slow--call Risk Management, x5125 to initiate).
      2. Alternative: If treatment cannot reasonably be delayed, one member of the medical staff must document in the medical record:
         a) nature of risk from delay of treatment, and
         b) advantages of proposed procedure.
5. Preoperative evaluation and note which must include indications for surgery as well as a list of potential likely complications. This will be written by the resident or attending most involved with the procedure whenever possible.
6. Appropriate Anesthesia consultations should be obtained early enough to permit optimal patient preparation and to prevent last minute cancellation by Anesthesia because of an "incompletely evaluated patient."
7. Early Anesthesia consultations are routine for patients with complicated medical problems, including those with cardio-respiratory, hepatic, renal, or diabetic problems, as well as Jehovah's Witnesses.
8. All elective patients scheduled through the clinic should be referred to the anesthesia pre-operative clinic.
9. Preoperative planning must consider requirements for equipment, especially implants.
10. The operating resident will review the patient, including x-rays, with the OR attending so that both may be involved in preoperative planning. The operating resident must know the anatomy, the surgical approach, the operative procedure, the indications and alternative methods of treatment.
11. Pre-operative notes should be written on inpatients the night prior to surgery.
12. Routine lab studies (CBS, UA, EKG, LFT's, Lytes, Creatinine, clotting studies, etc.) should be ordered as indicated. Blood should usually be typed and held, or cross-matched if transfusion is anticipated. X-rays must pulled up in the OR before the case is begun.
13. Essential instruments and implants must be selected and sterilized.
14. Cast materials must be ready and outside the operating room until wound closure.
15. PREPARATION
   a. Shave (in OR) only when and where hair will impede closure. Clipping should be performed when possible.
   b. Standard prep should be used (Prepadine, Betadine, Ioprep, etc.). Skin must be completely dry if adhesive drape is to stick reliably.

c. Drape according to standard sterile draping techniques.

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

    Check for allergy and consult with chief resident if needed.
18. Antibiotics for open fractures should be started in the ED per protocol.
19. A member of the surgical team should be in the OR by 7:30 a.m. If a member of the surgical team is not in the room, the procedure cannot start.
20. The patient must be site marked prior to surgery by a licensed practitioner who is capable of starting the case and will be present at the beginning of the case.
21. All hair and street clothing must be covered. A self-laundered scrub cap can be used if covered up by a clean, disposable cap. Use hood, not cap alone to cover all hair if exposed (a sweatband helps with sweat).
22. When in doubt, greens should be changed before beginning another case, particularly for those cases that have been on contaminated or infected wounds or if the greens were worn outside of the operating room area. Greens should never leave the hospital campus (can be worn between hospital and other campus buildings).
23. The operating resident for the next case should stay in the assigned operating room between cases to expedite room turnover. Patients in the pre-operative area should be checked by the surgical team for completion of paperwork, site marking, and desire to have additional questions answered prior to surgery in order to ensure no delay for the start of the next case. The surgical team in the OR in which the patient is expected to enter will be notified by the holding area staff for patients with incomplete requirements so that this can be dealt with in order to avoid delays in room turn-over.
23. Masks should be changed between every case.
24. Shoe covers must be worn in the OR at all times. If you leave the OR, remove your shoe covers and replace them upon return to the OR.

For general anesthesia, monitored anesthesia care (MAC), and local with sedation		
Age	**NO FOOD***	**CLEAR LIQUIDS ONLY****
Less than 6 months	4 hours before procedure	2 hours
7 months to age 12	After midnight	2 hours
Age 13 and adjust	After midnight	4 hours
Age	**NO FOOD***	**CLEAR LIQUIDS ONLY****
Any age	4 hours (recommended light meal only)	Ad lib
* No food includes dairy products, infant formula, any unclear liquid, gum ** Clear liquids include water, filtered apply juice, cranberry juice, breast milk		

P. **DICTATIONS**

OPERATIVE REPORTS

1. Must be dictated within 24 hours
2. All new fellows, residents, and interns who are unfamiliar with the system should be trained prior to their starting on the service.
3. At the time of surgery the surgical team should identify the resident responsible for the surgical dictation.

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

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

Q. **X-RAYS AND FLUOROSCOPY POST OPERATIVE X-RAYS**

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

R. CLINIC RULES

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

S. ADMISSIONS FROM CLINIC

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

T. EMERGENCY ADMISSIONS

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

U. ELECTIVE (FUTURE) ADMISSIONS

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

V. COME –AND-GO SURGERY IN SURGICENTER

1. M.D./R.N. should schedule with Surgi Center at least 3 days in advance
2. In general: Local anesthesia: Labs only if indicated. Need written H&P, disclosure and consent. General anesthesia: Same work-up and documentation as for Come and Stay.

W. CLINIC DISCHARGE CRITERIA

1. The patient has a musculoskeletal condition that could be addressed with surgery, but after Orthopaedic Surgical Consultation, the patient is not a surgical candidate *or* the patient decides she/he does not want surgery.
2. The patient has a musculoskeletal condition that does not need or no longer requires further follow-up with an Orthopaedic Surgeon.
3. For patients who are discharged via this mechanism, a discharge note will be available in the LCR clearly explaining why the patient is currently not a good surgical candidate and when to reconsider referring the patient back for surgical evaluation. Additionally, recommendations will be made for appropriate non-surgical management.

X. INFECTIONS

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

Y. ORTHOPEDIC PEDIATRIC ADMISSIONS

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

   *Pediatic*s:

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

   Orthopedics:

   a. Serve as the consulting service with an Orthopedic attending serving as the consultant attending
   b. Enter initial consultation note, including specific recommendations for:
      i. PT and level of activity
      ii. Additional nursing care needed for the specific type of injury (i.e neurovascular checks, etc.)
      iii. Specific orthopedic orders/requirements (i.e. limb elevation, icing, etc).
   c. Directly communicate the management plan and treatment recommendations to the pediatric service upon admission and on a daily basis, at a minimum
   d. Obtain consent, explain surgical procedures, and describe anticipated outcomes
   e. Be available to answer questions from the pediatrics service on a 24/7 basis and to answer the family's questions on a daily basis

f. Round and write daily notes in the medical record, including new orthopedic recommendations.
g. For elective cases, assure pre-op medical H&P has been performed prior to admission.
h. Collaborate with the discharge planning process, including appropriate discharge date, discharge management plans, and orthopedic clinic follow-up.

Z. ORTHOPEDIC FAMILY INPATIENT SERVICE ADMISSIONS

1. Orthopaedic patients with acute medical issues while on the in-patient Orthopaedic Service will first be staffed by inpatient Medical Consult Service. For any straight-forward medical problems, the Medical Consult Service will continue to provide management help with Ortho serving as the primary care team of record. However, if deemed appropriate, there will be a very low threshold for transfer to the 3rd FIS team for any patients with complex medical needs.
2. Each morning, the FIS Hospitalist will receive any new overnight transfers from the overnight hospitalist or Medicine teams.
3. The FIS Hospitalist will be the primary caregiver with Orthopaedics serving as a close consulting service for patients on the Medicine inpatient service team. Orthopaedic NPs and interns will coordinate disposition plan and follow-up for any Ortho-related medical issues. Otherwise, the hospitalist will manage all other aspects of care and discharge.
4. For overnight and weekend issues, the overnight Medical Inpatient Service Overnight Hospitalist can be the first "go-to" person for any acute medical issues that arise on the Orthopaedic Service in-patients.

ATTACHMENT C -- CLINICAL SERVICE CHIEF OF ORTHOPEDIC SURGERY JOB Description

CLINICAL SERVICE CHIEF OF ORTHOPEDIC SURGERY SERVICE JOB DESCRIPTION

Chief of Orthopedic Surgery Clinical Service

Position Summary:

The Chief of Orthopedic Surgery Clinical Service directs and coordinates the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General (ZSFG) and the Department of Public Health (DPH). The Chief also 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 Orthopedic 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 five years by a committee appointed by the Chief of Staff. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the 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 Orthopedic Surgery Clinical Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

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

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

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

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

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

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

Summary of changes to OB-Gyn Privileges as of December 11, 2023

24.03 INPATIENT OBSTETRICAL CARE

K. ~~Fetal scalp sampling*~~ remove this privilege

L. Tubal ~~ligation~~ sterilization, post-partum* remove word ligation and replace with sterilization

24.05 INPATIENT GYNECOLOGY AND GYNECOLOGIC SURGERY

BB. Non-hysteroscopic endometrial ablation techniques. ~~HTA, thermal balloon, Nova-Sure~~ Remove HTA, thermal balloon, Nova-Sure

24.22 LASER THERAPY

~~C. Laser conization of the cervix~~ Remove C. Laser conization of the cervix

Remove privilege, **24.23 HYSTEROSCOPIC STERILIZATION** which no longer exists.

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

Applicant: Please initial the privileges you are requesting in the Requested column.

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

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

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

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

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

_____ _____ **24.04 OUTPATIENT CLINIC: GYNECOLOGY**

Evaluate, diagnose, treat, and provide consultation, pre-and post-operative care necessary to correct or treat female patients of all ages presenting with injuries and disorders of the female reproductive system and the genitourinary system and nonsurgical disorders and injuries of the mammary glands. When inpatient gynecologic care privileges have been approved, procedures in this privilege group also can be performed in the hospital operating room.
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.
PROCTORING: Review of 5 medical records. Review of 3 medical records for UCSF-trained Fellows/Residents.
REAPPOINTMENT: 50 clinic visits in the previous 2 years

_____ _____ A. Preventive health visits: well women, family planning visits
_____ _____ B. Problem-oriented gynecologic visits
_____ _____ C. Microscopic diagnosis of urine and vaginal smears
_____ _____ D. Colposcopy
_____ _____ E. Vulvar, vaginal and cervical biopsy
_____ _____ F. Endometrial biopsy
_____ _____ G. Cervical or endometrial polypectomy
_____ _____ H. Insertion and removal of intrauterine contraceptive (IUC)
_____ _____ I. Insertion and removal of contraceptive implant
_____ _____ J. Pessary fitting
_____ _____ K. Trigger point injection
_____ _____ L. Cryosurgery (cervix, vulva, vagina)
_____ _____ M. Loop electrosurgical excision procedure (LEEP), cervix
_____ _____ N. Bartholin duct procedures (incision and drainage, marsupialization)
_____ _____ O. Dilation and curettage, suction curettage and manual uterine aspiration
_____ _____ P. Simple cystometry
_____ _____ Q. Paracervical and intracervical block
_____ _____ R. Insertion of cervical dilators
_____ _____ S. Anoscopy

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

Requested Approved

24.05 INPATIENT GYNECOLOGY AND GYNECOLOGIC SURGERY

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

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

Formatted: Strikethrough

Formatted: Highlight

attending obstetrician. See gynecologic surgery privileges (24.05) and gynecologic oncology privileges (24.41) for scope. Would be operating under their existing privileges for gynecologic surgery in cases that involved an obstetrics procedure; their involvement would be their expertise in gynecologic surgery.

Requested Approved

_____ _____ 24.06 EMERGENCY GYNECOLOGY AND GYNECOLOGIC SURGERY

Evaluate, diagnose, treat, and provide consultation, inpatient care and pre-and post-operative care necessary to correct or treat female patients of all ages presenting urgently or already hospitalized with injuries and disorders of the female reproductive system and the genitourinary system such as ectopic pregnancy, adnexal torsion, ruptured ovarian cyst, miscarriage, reproductive infections, uterine bleeding and trauma.
PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00
PROCTORING: 3 observed operative procedures including at least one laparoscopy.
REAPPOINTMENT: 15 procedures in the previous two years including at least 4 laparoscopies or laparotomies

_____ _____ A. Admission of patients with gynecologic issues
_____ _____ B. Care of admitted post-op and non-operative gyn patients
_____ _____ C. Surgical and non-surgical treatment of ectopic pregnancy and suspected ectopic pregnancy
_____ _____ D. Surgical and non-surgical treatment of miscarriage
_____ _____ E. Placement of intra-uterine balloon catheter to manage bleeding
_____ _____ F. Exam under anesthesia
_____ _____ G. Excision, I&D or surgical management of vulvar and vaginal lesions and abscesses
_____ _____ H. Dilatation and curettage, suction curettage, manual uterine aspiration; diagnostic or therapeutic
_____ _____ I. Exploratory laparotomy
_____ _____ J. Diagnostic laparoscopy, lysis of adhesions
_____ _____ K. Adnexal procedures (open or laparoscopic) such as: salpingectomy, salpingostomy, oophorectomy, ovarian detorsion, ovarian cystectomy, ovarian biopsy,salpingo-oophorectomy
_____ _____ L. Drainage or removal of pelvic abscess (vaginal, laparoscopic or open)
_____ _____ M. Repair of vaginal, vulvar or cervical lacerations and trauma
_____ _____ N. Myomectomy, abdominal or vaginal
_____ _____ O. Repair simple rent/tear of bowel or bladder
_____ _____ P. Paracentesis
_____ _____ Q. Wound management: skin debridement, wound dehiscence, wound closure
_____ _____ R. Cystoscopy
_____ _____ S.Emergent hysteroscopy

_____ _____ **24.10 WAIVED TESTING PRIVILEGES**

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges providers satisfy competency expectations for waived testing by The Joint Commission. PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology or General Surgery.
PROCTORING:By the Chief of the Laboratory Medicine Service or designee until successful

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

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

_____ _____ **24.20 SPECIAL PRIVILEGES**

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

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

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

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

Requested Approved

_____ _____ **~~24.23 HYSTEROSCOPIC STERILIZATION~~**
~~PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00.~~
~~TRAINING AND PROCTORING:~~
~~1. Providers must be trained in hysteroscopy and have current gynecologic endoscopy privileges in the ZSFG Department of Obstetrics and Gynecology~~

Formatted: Strikethrough
Formatted: Strikethrough, Highlight
Formatted: Highlight
Formatted: Strikethrough, Highlight
Formatted: Highlight

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

REAPPOINTMENT: 2 operative procedures in the previous two years

_____ _____ A. ESSURE tubal occlusion procedure

_____ _____ **24.24 UROGYNECOLOGY**

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

_____ _____ A. Urodynamics
_____ _____ B. Intravesical and intraurethral injections
_____ _____ C. Abdominal bladder neck suspension procedures
_____ _____ D. Vaginal bladder neck suspension procedures
_____ _____ E. Vaginal vault suspension procedures
_____ _____ F. Urethral procedures: dilation of urethral stricture
_____ _____ G. Colpocleisis

Requested Approved

_____ _____ **24.25 PROCEDURAL SEDATION**

Procedural sedation privilege is required for those who will work in Women's Options Center.

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

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

PROCTORING: Review of 5 cases. Review of 5 cases for UCSF-trained Fellows/Residents.

REAPPOINTMENT: Completion of the procedural sedation test as evidenced by a satisfactory score on the examination, and has completed at least one of the following:

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

_____ _____ **24.41 GYNECOLOGIC ONCOLOGY**

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

Current certification or active participation in the examination process leading to subspecialty certification in gynecologic oncology by the American Board of Obstetrics and Gynecology

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

REAPPOINTMENT: 15 operative procedures in the previous two years, at least 5 of which are performed at ZSFG

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

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

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

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

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

_____ _____ **24.42 MATERNAL-FETAL MEDICINE**

PREREQUISITES: Successful completion of an ACGME accredited postgraduate training program in Obstetrics and Gynecology. Current certification or active participation in the examination process leading to certification in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or a member of the Clinical Service prior to 10/17/00. Successful completion of postgraduate training program in Maternal and Fetal Medicine and current certification or active participation in the examination process leading to subspecialty certification in maternal and fetal medicine by the American Board of Obstetrics and Gynecology or having been given his privilege at ZSFG prior to 10/17/00

PROCTORING: Observed care of 3 patients. Observed care of 2 patients for UCSF-trained Fellows/Residents.

REAPPOINTMENT: Care of 20 patients in the previous 2 years

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

_____ _____ B. Genetic amniocentesis

_____ _____ C. Level 2 obstetrical ultrasound, including Doppler

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

_____ _____ **24.50 DUAL DEPARTMENT APPOINTMENT**

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

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

PREREQUISITES:

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

If a family planning fellowship has not been completed, clinical experience in the past 5 years of practice must include, at a minimum:

Insertion of contraceptive implants (5 procedures)
Insertion of intrauterine contraceptives (5 procedures)
First trimester abortion (through 14 weeks) (50 procedures)
Second trimester abortion (15 weeks and later) (50 procedures)
Basic obstetrical ultrasound as an adjunct to abortion (15 procedures)

PROCTORING:

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

REAPPOINTMENT (procedures in the past 2 years):

Insertion of contraceptive implants (2 procedures)
Insertion of intrauterine contraceptives (2 procedures)
First trimester abortion (through 14 weeks) (10 procedures)
Second trimester abortion (15 weeks and later) (10 procedures)

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

Basic obstetrical ultrasound as an adjunct to abortion (10 procedures)

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

_____ _____ **24.61 LICENSED CLINICAL PSYCHOLOGIST**

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

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

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

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

Applicant signature:_____ Date:

Department Chief signature:_____ Date: -

Formatted: Right: 0.55", Tab stops: 5.14", Left + 5.56", Left + 6.82", Left

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

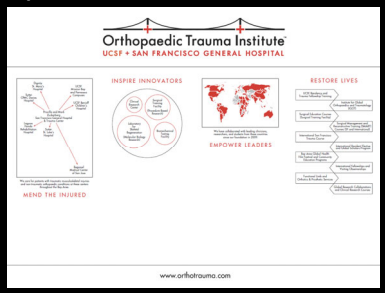
Zuckerberg San Francisco General
Orthopaedic Surgery
2022-2023

Orthopaedic Trauma Institute
UCSF + SAN FRANCISCO GENERAL HOSPITAL

1

Mission

To mend the injured, inspire innovators, and empower leaders to restore lives.



2

Vision

- To provide an interdisciplinary team of physicians, nurses and other health care professionals that deliver the highest level of care for its patients.
- To improve the outcomes and quality of life for patients in San Francisco and beyond, and to support education, research, and training efforts that improve the care of orthopaedic conditions.
- To be a nationally/internationally recognized center of excellence for orthopaedic trauma care.

3

Orthopaedic Trauma Institute (Founded 2/19/09)

- **Clinical:**
  - Orthopaedic Subspecialties (Trauma)
  - Physical Medicine and Rehabilitation
  - Podiatry
  - Orthotics and Prosthetics
- **Education:**
  - Student, Resident and Fellow Training
  - Orthopaedic Trauma Course
  - Surgical Training Facility
- **Research:**
  - Laboratory for Skeletal Regeneration
  - Biomechanical Testing Facility
  - Clinical Research Center
  - Procedure Based Research
- **Outreach**

4

Clinical

5

Service Scope of Practice: ZSFG

- Includes orthopaedics, podiatry, rehabilitation, and orthotics and prosthetics
- Service manages all general orthopaedic problems; few cases referred out of ZSFG
- Call coverage provided entirely by ZSFG – full-time staff
- 17 weekly clinics total, including sub-specialty clinics in sports medicine, foot and ankle, hand, pediatrics, spine, podiatry, diabetic foot, and rehabilitation
- 5 elective OR blocks + 5 trauma room blocks weekly

6

The OTI's Clinical Scope 2022-23

Provides additional surgical volume and financial support:

- UCSF Orthopaedic Institute / UCSF Parnassus Campus (UCSF) - 2010
  - Outpatient visits / Inpatient referrals / Consultations / Surgery (Trauma Chief: S. Morshed)
- Benioff Children's Hospital
  - Pediatric orthopaedic trauma back-up coverage
- San Jose Medical Center (Stand-alone) - 2013
  - 24/7 Trauma Coverage (Medical Director: A. Matityahu)
  - Encounters / Consultations (250 +/month total)
  - Surgery (approx. 45 cases/month)
- Laguna Honda Hospital (SF Dept. of Public Health)
  - Orthopaedics, Hand, and Podiatry Clinics
  - Orthotics and Prosthetics; Rehabilitation (Medical Director: L. Pascual)
  - Inpatient follow-up visits / Consultations

7

Orthopaedic Surgery Clinical Service 22/23

- Attendings
  - 14 Full-time ortho faculty
  - 2 Full-time podiatry faculty
  - 3 Full-time rehabilitation faculty
- 2 Fellows (2 Trauma)
- Residents
  - 2 Teams (each with a PGY-5, PGY-4, PGY-3, PGY-2)
  - Emergency Medicine resident
  - Interns: 3 (GS, Ortho)
- Students

8

Full-time Clinical Faculty (2022-23)

Physician	Specialty
Comtock, Curt	*Trauma*
Ding, Anthony	*Trauma, Hand/Microvascular*
El Naga, Ashraf	*Trauma, Spine*
Elsevier, Hannah	*Trauma*
Gendelberg, David	*Trauma, Spine*
Kandemir, Utku	*Trauma, Sports*
Marmor, Meir	*Trauma, Arthroplasty*
Matityahu, Amir	*Trauma*
Miclau, Theodore	*Trauma, Trauma,* Basic Research
Morshed, Saam	*Trauma,* Clinical Research
Shearer, David	*Trauma, Foot and Ankle*
Tangtiphaiboontana, Jennifer	*Trauma, Sports*
Toogood, Paul	*Trauma, Arthroplasty/Reconstruction*
Xu, Mark	*Trauma, Spine*
Lee, Nicolas	*Hand/Microvascular*
Santiesteban, Lauren	*Hand/Microvascular*
Del Rosario, Karina	Physical Medicine & Rehabilitation
Nagao, Masato	Physical Medicine & Rehabilitation
Pascual, Lisa	Physical Medicine & Rehabilitation
Mostovoy, Amelia	Podiatry
Parks, Charles	Podiatry

9

Part-Time Faculty (2022-2023)

Physician	Part-time
Coughlin, Rick (foot and ankle)	2 days/week
Delgado, Eliana (pediatrics)	1 day/week
Dini, Monara (podiatry)	1 day/week
Hewitson, Joseph (podiatry)	½ day/week
Schroeder, Nikki (hand)	½ Week
Wustrack, Rosie (tumor)	1 day/month

10

Patient Care: Surgical Procedures

	2023/24	2022/23	2021/22	2020/21	2019/20
Cases					
Ortho/Podiatry/Physiatry	1669	2,497	2,135	2,356	2,273
Total OR Cases	9078	15,691	10,343	7,941	~7,851
% Ortho/Ttl OR Cases	18%	16%	21%	30%	29%
Minutes					
Ortho/Podiatry/Physiatry	210,890	320,838	312,221	434,707	416,948
Total OR Mins	675,316	959,493	933,898	1,387,211	1,246,151
% Ortho/Total OR Mins	31%	33%	33%	31%	33%

11

Patient Care: Outpatient Orthopaedic Clinics

Outpatient	FY 23/24	FY 22/23	FY21/22	FY20/21	FY19/20
Clinic Encounters					
Hand**	2,410	3,942	3,962	3,505	3,408
Arthroplasty**	938	1,439	1,566	1,786	1,620
Pediatrics	222	408	450	349	359
Physiatry**	410	611	655	618	528
Spine	712	933	892	716	669
Sports	1242	2432	2,573	2,268	2,061
Surgery	529	844	N/A	N/A	N/A
Total	6,463	**13,910**	**11,101**	**10,291**	**9,691**

12

Call Services

Call Service	Description	Availability
Ortho Trauma / General	Call and back-up call coverage provided by ZSFG-based staff	24hrs/7days/52 wks
Ortho Hand	Call coverage shared 50-50 with plastics	24hrs/7days/26 wks
Ortho Spine	Call coverage shared 50-50 with neurosurgery	24hrs/7days/26 wks

13

Podiatry Service

Consultation Services
- ED, Inpatient, Outpatient

Outpatient Care
- 3M Clinics: M-F
- Foot orthotics
- Functional Limb Service support

Surgical
- Urgent and elective coverage

Teaching
- Samuel Merritt College (Students)
- VA (Residents)

14

Patient Care: Outpatient Podiatry Clinics

Outpatient	FY 23/24	FY 22/23	FY 21/22	FY 20/21	FY19/20
Clinic Encounters					
Podiatry	2,613	3,301	3,365	3,093	3,389

15

Podiatry Service Challenges (2020-22)

- Single podiatry provider
- Outpatient backlog from pandemic (3 month wait)
- Reduction of ORs resulted in loss of OR time causing inpatient urgent care delays to OR and increasing elective case backlogs (4 month wait)

16

Podiatry Service Challenges (2020-22)

- Single podiatry provider
- Outpatient backlog from pandemic (3 month wait)
- Reduction of ORs resulted in loss of OR time causing inpatient urgent care delays to OR and increasing elective case backlogs (4 month wait)

- Second podiatry provider
- Improved outpatient backlog (3 week wait)
- Returned fast-track room improving OR access for elective surgery (4 weeks)

17

Physiatry: In-Patient Services

Consultation Services
- Treat all rehabilitation –related diagnoses
- Consult for SCI injured patients as indicated by the SCI guidelines
- Facilitate pre-prosthetic training for amputees
- Provide recommendations re: Acute or SNF level rehabilitation
- Participate in Functional Limb Service care coordination
- Interdisciplinary Rounds: Trauma and Neurosurgery

Screening Services
- Provide pre-admission screening services for patients referred to Laguna Honda for Acute or SNF level rehabilitation

Procedural Services
- Pain injections (OR)
- EMGs (inpatient, outpatient)
- Botox injections

18

Physiatry: Clinics/Procedures

Clinic	Scheduled Visits
3M Physiatry/MSK/Spine	18 visits/week
3M Spine Clinic (Physiatry)	8-12 visits/week
4J Spine Health	9 visits /week
EMG	13 visits/week
	309 studies performed
Functional Limb Service	6-8 visits/week
Consult Visits	313
MSK Procedures (OR)	298

19

Physiatry Service Challenges (2020-22)

- Ongoing limited OR availability for physiatric MSK procedures continues to impact patient access (6 month wait)
- Lack of an ultrasound unit for use on 3M to perform targeted MSK injections and to facilitate dynamic evaluation of tendon and joint pathologies

20

Physiatry Service Challenges (2020-22)

- Ongoing limited OR availability for physiatric MSK procedures continues to impact patient access (6 month wait)
- Lack of an ultrasound unit for use on 3M to perform targeted MSK injections and to facilitate dynamic evaluation of tendon and joint pathologies

- Improved, but still limited OR access (3 month wait)
- Ultrasound unit was recently approved for purchase (possibly to arrive 2024)

21

ZSFG Orthotics and Prosthetics Service

- Staff: 1 resident, 4 clinicians and 2 administrative personnel
- Regular coverage: 8am to 5pm
  Weekend on-call coverage: 8am to 5pm
- Clinic support: Bldg. 9
  Inpatient: All floors, Emergency department, OR,
  Outpatient: 3M (and Functional Limb Service) 4A, Pediatrics, 1M
- Laguna Honda Hospital
- Monthly support group meetings for amputees (Wellness Center), assistance with Peer Visitor Program for amputees
- Regular in-services and in-house training to other healthcare providers

22

Orthotics and Prosthetics Service Volumes

	2022-2023	2021-2022	% Increase
Volume of Outpatients seen	3958	3652	8%
Volume of Outpatients fit	2614	2284	14%
Total Charges Billed	5,338,702.54	5,103,142.43	5%
Total Payments Received	1,030,558.35	1,039,084.74	-1%
Volume of Inpatient Consults	1110	1175	-5%

23

Orthopaedic Surgery: Quality Measures PIPS (2022-23)

	True North Category	Measure Name	Owner	Measure Units	Baseline CYTD (2021)	CURRENT CYTD (2022)			PROPOSED PI PLAN	
						Actual Performance; Color = Target	Desired Direction = (Up/Down)	12M Target	Driver/ Watch	New 12M Target
DRIVERS	Quality/Safety	Total Joint Surgical Site Infections: - (superficial or deep)	M. Marmor	%	0% (0/83) THR 1% (1/93) TKR	0% (0/68) THR 0% (0/79) TKR	Down	0%/0%	Driver	0%/0%
	Quality/Safety	Fragility Fracture Initiative	T. Miclau M. Marmor A. Asturias	% Orders during Inpt. Stay	0% (not measured)	58% (CY 2022)	Up	50%	Driver	>50%
	Equity/Safety	OR Wait Times for Arthroplasty	P. Toogood M. Marmor T. Miclau	Months Patients	9-12 months 164 patients	10-12 months (as of 4/7/23) 171 patients on list (as of 4/7/23)	Down	4.5months 90 patients	Driver	4.5months 90 patients

24

Orthopaedic Surgery: Quality Measures PIPS (2022-23)

	True North Category	Measure Name	Owner	Measure Units	Baseline CYTD (2021)	CURRENT CYTD (2022)			PROPOSED PI PLAN	
						Actual Performance: Color Target	Desired Direction = (Up/Down)	12M Target	Drive/ Watch	New 12M Target
WATCH	Care Experience	Specialty Care: TNAA	T. Miclau	# of Clinics TNAA < 21 days	7 of 8 < 21 days	7 of 8: Arthroplasty	Up	7	Watch	7
	Care Experience	Specialty Care: eConsult Turnaround Time <5 Days	N. Lee	% <5 days	--	>90%	Up	90%	Watch	90%
	Care Experience	Periop: Block Utilization %	T. Miclau	%	>90%	>80%	Up	>80%	Watch	>80%
	Safety	Preventable Mortality	P. Toogood	# non-1A Deaths	0	0	Down	0	Watch	0
	Developing People	Resident Work Hour Violations	T. Miclau	Events	14	4	Down	0	Watch	0
	Developing People	Faculty Burn Out Rates (Provider Survey)	T. Miclau	% Reporting Burnout	27% (2nd Lowest among ZSFG)	17% (Lowest among ZSFG)	Down	0%	Watch	0%

25

Orthopaedic Surgery: Quality Measures TQIP (2023)

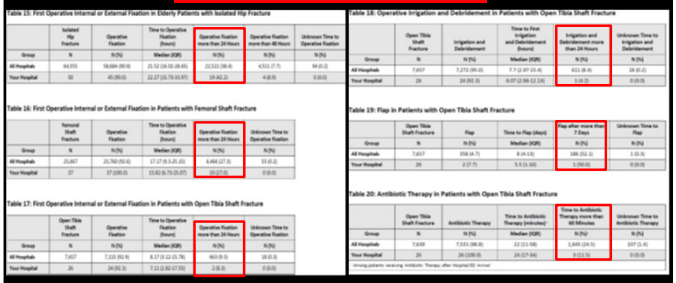


Table 15: First Operative Internal or External Fixation in Elderly Patients with Isolated Hip Fracture

	Isolated Hip Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Operative Fixation more than 48 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)	N (%)
All Hospitals	64,555	58,684 (90.9)	21.52 (16.02-28.65)	22,522 (38.4)	4,511 (7.7)	94 (0.2)
Your Hospital	30	45 (90.0)	22.27 (15.73-33.97)	19 (42.2)	4 (8.9)	0 (0.0)

Table 16: First Operative Internal or External Fixation in Patients with Femoral Shaft Fracture

	Femoral Shaft Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	25,667	23,760 (92.6)	17.17 (9.3-25.15)	6,466 (27.3)	55 (0.2)
Your Hospital	37	37 (100.0)	15.82 (6.73-25.07)	10 (27.0)	0 (0.0)

Table 17: First Operative Internal or External Fixation in Patients with Open Tibia Shaft Fracture

	Open Tibia Shaft Fracture	Operative Fixation	Time to Operative Fixation (hours)	Operative Fixation more than 24 Hours	Unknown Time to Operative Fixation
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	7,657	7,115 (92.9)	8.17 (3.12-15.78)	663 (9.3)	18 (0.3)
Your Hospital	25	24 (92.3)	7.11 (2.82-17.55)	2 (8.3)	0 (0.0)

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	25	24 (92.3)	6.07 (2.98-12.14)	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	558 (4.7)	8 (4-13)	180 (32.1)	1 (0.2)
Your Hospital	25	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)	Time to Antibiotic Therapy more than 60 Minutes	Unknown Time to Antibiotic Therapy
Group	N	N (%)	Median (IQR)	N (%)	N (%)
All Hospitals	7,639	7,541 (98.8)	22 (11-58)	1,845 (24.5)	107 (1.4)
Your Hospital	25	24 (100.0)	24 (17-34)	3 (12.5)	0 (0.0)

Among patients receiving Antibiotic Therapy after Hospital ED Arrival

26

Faculty Committee Participation (ZSFG Campus)

Physician	Committees
Marcucio, Ralph	UCSF Research and Animal Subcommittee
Miclau, Theodore	ZSFG Risk Management, Medical Executive, OR/Block Committee, PEMT, CPG Board
Toogood, Paul	UCSF Graduate Medical Education, Trauma Multidisciplinary
Nagao, Masato	Pain Management
Pascual, Lisa	TPOPP (Trauma Program Operational Process Performance Improvement)
Parks, Charles	Functional Limb Service, Radiation Safety, CPG Compliance

27

Faculty Leadership Positions

Positions	Functions
Chief (Unit) – Miclau	Oversee Clinical Services and Dept. Personnel, Administration and Finances
Executive Leadership Committee Orthopaedic Trauma Institute (Miclau/Morshed/Matityahu/Meinberg/Kandemir)	Integrate/Coordinate Clinical and Academic Operations at all sites
Service Chiefs (Blue/Gold) – Marmor/Kandemir	Oversee Service Care Issues, review resident performance
Med Director (Clinic) – Lee	Oversee Outpatient Services
Med Director (Podiatry) – Parks	Oversee Podiatric Services, Clinical Evaluation/Credentialing of DPH Podiatrists, Co-Director of Limb Salvage Service
Med Director (Physiatry) – Pascual	Oversee PM&R Clinical Service, Organize Intraservice Collaborations, Medical Director, Trauma Service Rehabilitation (required for Level 1 Centers)
Med Director (Quality Assurance) – Marmor	Oversee Dept. QA (M&M), Trauma Liason, Clinical Practice Guidelines

28

OTI Faculty Awards

Ralph Marcucio, PhD	NIH Natl Inst Institute of Arthritis and Musculoskeletal and Skin2022 David Bixler Award $2.8M
Ralph Marcucio,PhD	Osteosynthesis & Trauma Care Foundation
Ralph Marcucio, PhD	Henry Gray Scientific Achievement Award from American Association for Anatomy
Theodore Miclau, MD	Transformative Award (Inaugural); Orthopaedic Research Society (Fellow(; International Combined Orthopaedic Research Society (Fellow); International Orthopaedic Trauma Association (Fellow)
Saam Morshed, MD, PhD; Theodore Miclau, MD	Kappa Delta Award, American Academy of Orthopaedic Surgeons/Orthopaedic Research Society

29

Finances

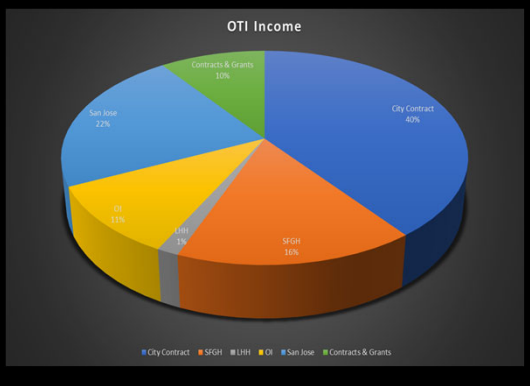
30

SFGH Ortho Payor Mix 23/24

Payor	Payer Mix -Percent Charges	Payer Mix -Percent Payments
Guarantor	2.15%	3.07%
Medicare	25.84%	21.04%
Medi-Cal	15.29%	5.84%
Insurance	12.56%	31.67%
3rd Party	4.49%	2.38%
Managed Care	37.91%	31.55%
NB/MIA	4.8%	4.74%
Cal Pending	-3.04%	-0.28%

31

Orthopaedic Surgery: Income 2022-23

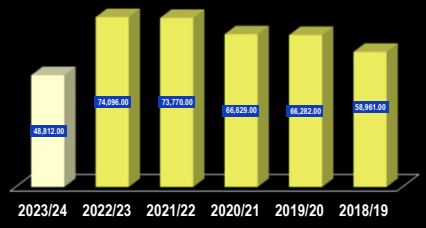


32

Orthopaedic and Podiatry Service Work RVU Production

33

Orthopaedics and Podiatry Service Total RVU Production



34

Ortho Collections (per RVU/Ratio)

- 23/24: $39.27(24.10%)
- 22/23: $35.50 (21.85%)
- 21/22: $37.59 (23.10%)
- 20/21: $40.76 (25.18%)
- 19/20: $41.47 (25.29%)
- 18/19: $43.66 (25.78%)

35

SFGH Ortho Payor Mix 22/23

Payor	Payor Mix - Percent Charges	Payor Mix - Percent Payments
Guarantor	-0.23%	2.63%
Medicare	30.40%	20.85%
Medi-Cal	12.65%	6.71%
Insurance	13.63%	22.39%
3rd Party	2.48%	3.77%
Managed Care	36.11%	38.69%
NB/MIA	4.31%	4.97%
Cal Pending	0.65%	-0.02%

36

Podiatry Collections (per RVU/Ratio)

- 22/23: $31.86 (31.86%)
- 21/22: $34.60 (21.59%)
- 20/21: $34.10 (20.48%)
- 19/20: $31.99 (20.63%)
- 18/19: $25.26 (19.51%)
- 17/18: $23.55 (18.25%)

37

Education

38

SFGH/OTI Orthopaedic Surgery: Resident Rotation

- UCSF Residency program: "top 10" choice
- SFGH rotation: rated as housestaff favorite
- Medical student clerkship ratings: high (3rd and 4th year rotations); medical student casting course based at SFGH
- All anatomy sessions now run at SFGH

UCSF Resident Teaching Award: Nicole Schroeder, MD (2018); Paul Toogood (2020)
UCSF Compassionate Physician Award: Paul Toogood, MD (2017); David Shearer (2019), Ashraf El Naga (2022)
Kaiser Teaching Award: Paul Toogood (2020)

39

Department of Orthopaedic Surgery: Weekly Conferences

- Daily: Consult/trauma case on-call rounds
- Twice weekly: Interdisciplinary rounds, Blue (Mon)/Gold (Tues)
- Monday: Pre- and Post-operative indications conference (Blue)
- Tuesday: Pre- and Post-operative indications conference (Gold)
- Wednesday: UCSF Grand rounds/Basic science
- Thursday: Trauma conference – Blue; M&M (1x/8 weeks)
- Friday: Trauma conference – Gold; M&M (1x/8 weeks)

40

Medical Student Teaching

- Students receive orthopaedic teaching at SFGH/UCSF in:
  - Lecture-demonstration work, casting seminar
  - Orthopaedic lectures, case presentations, and outpatient clinic assignments
  - Instruction in methods of evaluation of patients with musculoskeletal disorders
  - Examination and treatment of patients
  - Assistance in surgery and in use of treatment modalities (hands-on training)

41

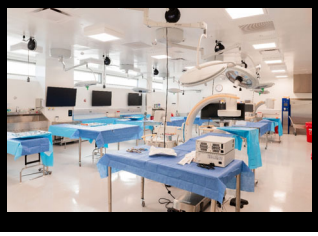
18th Annual Int'l San Francisco Orthopaedic Trauma Course

- National/International faculty (53)
- > 215 Attendees (21 of 50 States; 10 countries)
- Pre-course Case Review
- Nursing Course

42

Education: Surgical Training Center

- 2018-19: 131 courses
- 2019-20: 112 courses
- 2020-21: 100 courses
- 2021-22: 103 courses
- 2022-23: 97 courses



- 2018-19: 65 Resident Courses
- 2019-20: 42 Resident Courses
- 2020-21: 47 Resident Courses
- 2021-22: 51 Resident Courses
- 2022-23: 59 Resident Courses

43

Education: Surgical Training Center Academic Courses

UCSF Ortho
- Auto Elbow Replantation

UCSF/ZSFG OHNS
- Microvascular surgery training (anastomosis)
- Sialendoscopy
- Resident T-Bone
- FESS Surgery
- Facial Recon

UCSF/ZSFG Anesthesia
UCSF/ZSFG Emergency Medicine
UCSF/ZSFG O+P
UCSF Pain Management
UCSF/ZSFG Plastic Surgery
UCSF/ZSFG Urology

FACS- American College of Surgeons

ZSFG/OTI Education
- OTI Jr. Academy
  - Modules: Job Shadowing, Public Health, Biomech Engineering, Case Study, Surgical Training, Prof Dev, Journal Club
- IGOT – SMART Summit Course
- Resident Anatomy
- Interns skill lab
- Core Surgical Curriculum
- Med School Ortho Rotations
- Advanced Fellowship Procedure Training

44

UCSF Orthopaedic Residency Core Surgical Curriculum

Trauma:
- ORIF-midshaft and proximal humerus, ORIF BBF
- IM Nail Tibia and antegrade/retrograde Femur, Fasciotomies
- ORIF tibial plateau and supercondylar femur fracture

Spine:
- Anterior/Posterior Cervical Approach with anterior plating
- Anterior thoracolumbar approach with Cage
- Minimally invasive approaches, Laminectory, Posterior TL approach, Pedicle instrumentation

Sports:
- Knee scope with meniscal debridement or repair, ACL Reconstruction
- Shoulder scope with SAD and Cuff Repair, and stabilization techniques

Foot & Ankle:
- Posterior tibial tendon reconstruction, Tripple Fusion, Bunion reconstruction
- Lisfranc's ORIF, Calc ORIF, and Talus ORIF

Arthroplasty
- THA anterolateral and posterior, hip arthrocentesis, all hip approaches (anterior/ anterolat/ direct lateral/ posterolat); and extensile exposure as time permits (extended troch osteotomy
- TKA, knee arthrocentesis

Hand:
- Carpal Tunnel Release, anterior and posterior approach to the wrist, ORIF DRF
- Trigger Finger Release, Tendon Repair, with approaches, Metacarpal Pinning
- Terrible Triad, elbow ligament repair, Olecranon fx repair, radial head fx repair/replace

Pediatrics:
- Supercondylar humerus fracture CRPP and ORIF, Monteggia Fx ORIF
- Casting, Flexible femoral Nailing, Club feet manipulation and casting
- Smith Pete approach (ped hip infection), SCFE assessment and pin

Oncology
- Femoral resections and Reconstruction
- Retrograde and Antegrade humeral nails

45

OTI Junior Academy: Students Impacted

17 Bay Area High Schools Across 5 Unified school districts have participated in Junior Academy

- Galileo Academy of Science and Technology *SFUSD*
- Raul Wallenberg Traditional *SFUSD*
- Philip and Sala Burton Academic School *SFUSD*
- June Jordan *SFUSD*
- Urban School of San Francisco *SFUSD*
- John O'Connell
- Redwood *TUSD*
- Castilleja School
- Arroyo *SLZUSD*
- De Anza *WCCUSD*
- Richmond *WCCUSD*
- Middle College *WCCUSD*
- Pinole Valley *WCCUSD*
- Hercules *WCCUSD*
- Greenwood *WCCUSD*
- Dougherty Valley *SRVUSD*
- *Los Altos MVLAUHSD*

2012 – 2020 131 Student have been accepted into Junior Academy

- **2012: 20 Students**
- **2013: 12 Students**
- **2015: 12 Students**
- **2016: 12 Students**
- **2017: 15 Students**
- **2018: 15 Students**
- **2019: 15 Students**
- **2020: 30 Students**
- **2021: 14 Students**
- **2022: 13 Students**

46

OTI Junior Academy
Where are our Students now?

42 Alumni have an active role in Junior Academy
- Manage and Produce Curriculum
- Mentor current students
- Coordinate modules for summer
- Organize application/interview process for incoming students
- Guest speaker about their Junior Academy and college experience

Staff filled positions by Alumni
- Director
- Senior Program Coordinator
- Module Lead
- Post Summer mentor
- Guest Speaker
- High School Senior Alumni Reflection

55 of 59 Alumni pursed/pursing a STEM Degree (2012 – 2019)

Allied health personel
- 4 Registered Nurses
- 1 Nurse Practitioner
- 1 Combat Medic (US Army)
- 1 Operations Analyst
- 1 Athletic Trainer
- 1 Education Specialist
- 1 Quality Engineer

Post undergraduate degrees
- 2 Residents (Anesthesiology , Pediatric)
- 2 Physician Assistant
- 4 Medical Student
- 1 Pharmacology Student
- 1 Dental Student

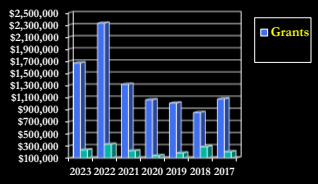
Undergraduate degrees
- 12 Nursing
- 11 Pre-Med
- 4 Medical Device Research
- 4 Social Workers
- 2 Physical Therapy
- 1 Environmental Sciences
- 4 Non-Stem

47

Research

48

Contracts and Grants (Direct Cost Only)



	2023	2022	2021	2020	2019	2018	2017
Grants	1,670,464	2,327,825	1,316,219	1,060,316	1,006,923	851,600	1,074,654
Contracts	233,788	325,408	218,772	138,979	181,060	284,629	202,203

49

SFGH Orthopaedic Research Facilities

- Laboratory for Skeletal Regeneration (Molecular Biology)
- Biomechanical Testing Facility (Biomechanics)
- Clinical Research Center
- Surgical Training Facility (Procedure Based Research)

50

Laboratory for Skeletal Regeneration

- Musculoskeletal injury and repair; Craniofacial development
- 7 PIs (Director: Ralph Marcucio, PhD; other PIs: Ted Miclau, MD, Nathan Young, PhD, Kazuhito Morioka, MD, Suzanne Tabbaa, PhD, Chelsea Bahney, PhD)
- Funded Grants:
  - NIH: 5 R01s; C-Doctor
  - Foundations: CIHR; AO; NSF (2 CDMI); Osteosynthesis & Trauma Care Foundation Grant

51

OTI Biomedical Engineering Lab

Focus Areas

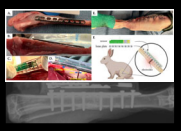
- Biomechanical evaluation of fracture fixation strategies
- Wearables & computer vision to monitor patients post-op
- Data science initiative - clinical datasets

Lab PIs

- Safa Herfat, PhD, Technical Director
- Meir Marmor, MD, Clinical Director

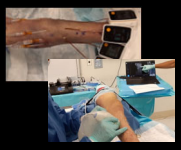
Innovation Projects

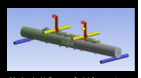
- Development of a Handheld Ultrasound-Based System to Assist in Clinical Diagnosis of Acute Compartment Syndrome (DOD - USA Med Research ACQ Activity)
- Development of a Smart Fracture Fixation Implant to Wirelessly Monitor Fracture Healing (NSF Grant)
- Diagnosing Muscle Ischemia in the Setting of Acute Compartment Syndrome Using Computer Vision (VA)



Recent Publication (Sensors 2022): Wireless Measurements Using Electrical Impedance Spectroscopy to Monitor Fracture Healing

Mechanical comparison of augmentation techniques for locking plate fixation of proximal humerus fractures





Mechanical influence of mini-fragment plates humeral shaft fracture fixation (FEA)

52

Clinical Research Center

- Director: Saam Morshed, MD, PhD
- Research: Regional/National/International
- Funded UCSF/SFGH/RMC investigators: Ted Miclau; Saam Morshed; Meir Marmor; Amir Matityahu; David Shearer, Karina Del Rosario, Monara Dini
- 12 Orthopaedic Trauma-related clinical trials projects (funded)
- Funding organizations:
  - DOD, NIH (R01, K Award)
  - Industry

METRC Collaborators

- Core Center for Major extremity Trauma Research Consortium (METRC), Department of Defense Grant (>$150M budget; clinical research studies)

53

Outreach

54

OTI Educational and Research Partners' Countries

Since 2009

55

Institute for Global Orthopaedics and Traumatology (IGOT)

IGOT
Institute for Global Orthopaedics and Traumatology

MISSION: TO BUILD CAPACITY IN MUSCULOSKELETAL CARE THROUGH GLOBAL PARTNERSHIPS

56

IGOT Activities

Education
- SMART Courses (San Francisco, Tanzania, Mexico, Cuba)
- Webinars
- Online Learning Portal
- Surgical Approach Videos
- Resident Global Elective
- Observership and Global Scholar Program

Research
- IGOT Research Fellowship (supported by the McClellan Research Fund)
- Global Research Initiative (collaboration and publications on high-quality musculoskeletal disease studies with orthopaedic surgeons from LMICs)
- ACTUAR (Asociación de Cirujanos Traumatólogos de las Americas)

Leadership
- COACT (Consortium of Orthopaedic Academic Traumatologists)
- Leadership Development Modules
- Advisory Board

Outreach
- International Orthopaedic Trauma Association (IOTA)
- New IGOT Branding and Fundraising Efforts

UCSF Global Resident Elective in Dar es Salaam, Tanzania; April 2023

Tanzanian surgeons observing at the OTI in San Francisco; November 2023

SMART Course in Richland, WA; October 2023

IGOT Research Fellow, Baba Adejuyigbe, helping with research projects in Tanzania

57

IGOT Accomplishments

Education
- Delivered 10 webinars since 2020
- Executed 27th SMART Course (SF, Tanzania, Mexico, Cuba)
- 90+ Resident Global Electives (3 active international sites)
- 80+ International Observers from 30 countries since 2010

Research
- 35 active research projects in 6 countries
- 2 clinical trials and 1 randomized controlled trial
- Partnerships with countries across Sub-Saharan Africa and Latin America
- In 2023 : 20+ publications

Leadership
- Asociación de Cirujanos Traumatólogos en las Americas (ACTUAR)
- Consortium of Orthopaedic Traumatologists (COACT)

Development
- Individual charitable giving: $50k (FY 23-24)
- Wyss Foundation grant: $378k directs (FY 23-24)

58

Program Development

59

Service Goals: 2024-2025

- Continue to adapt workflows for new spaces
- Work on further integration with UCSF campus
- Address gaps in care, including wait times in several services (arthroplasty, sports, podiatry)

60


Thank You
Orthopaedic Trauma Institute
UCSF + SAN FRANCISCO GENERAL HOSPITAL