ZSFG CHIEF OF STAFF ACTION ITEMS
Presented to the JCC-ZSFG December 10, 2024
November 2024 MEC Meetings

Clinical Service Rules and Regulations

I. **Radiology**
- Radiology & Regulations (summary of changes)
- Radiology Rules & Regulations (with tracked changes)
- Radiology Rules & Regulations (clean version)
- Radiologic Technologist Position Overview

II. **Psychiatry**
- Psychiatry & Regulations (summary of changes)
- Psychiatry Rules & Regulations (with tracked changes)
- Psychiatry Rules & Regulations (clean version)

Credentials Committee

I. **Delineation of Privileges Lists, Standardized Procedures and Summary of Changes:**
- Interventional Radiology Standardized Procedures
- Medicine: Pulmonary & Critical Care Medicine Standardized Procedures

City and County of San Francisco

Department of Public Health

London Breed
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary P. Mercer, MD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	*ZSFG Clinical Service Rules and Regulations*
Clinical Service :	*Radiology*
Date of last approval:	*December 2022*
Summary of R&R updates:	*Updating title page, various spelling corrections, and revised number of radiology faculty*
Update #1:	*Updated date to 2024 on title page*
Update #2:	*Spelling correction - page 1*
Update #3:	*Increased number of faculty to 19 - Page 4*
Update #4:	*Spelling correction - page 4*
Update #5:	*Corrected the Org Chart to list 19 radiology faculty and 5 affiliated professionals in App C – Page 7*

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IMAGING CLINICAL SERVICE
RULES AND REGULATIONS
2024~~2~~

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IMAGING SERVICES CLINICAL SERVICE
RULES AND REGULATIONS
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I. IMAGING CLINICAL SERVICE: ORGANIZATION

A. PREAMBLE

Zuckerberg San Francisco General Hospital is a county hospital and one of the busiest hospitals in the San Francisco Bay Area. The Emergency Department is the designated trauma center for San Francisco. ZSFG also serves the Department of Public Health's neighborhood clinics and Laguna Honda Hospital patients.

B. SCOPE OF SERVICE

Zuckerberg San Francisco General is one of the four main teaching hospitals of the University of California, San Francisco. The University, through a contractual arrangement with the county, provides medical and medical support staff for the hospital.

The Imaging Services at ZSFG is one of busiest radiology departments in the county performing approximately 180,000 exams/year. The current department occupies 25,000 square feet in the main Department, with several satellite units. Current equipment includes two GE 64 slice CT Scanners, and two GE 1.5 T MRI scanners. Five Siemens,, and two Zonare (IR) Ultrasound Scanners. One portable CT scanner. One IR room integrating a C-Arm with a 16 slice CT Scanner. One biplane IR room for Neurological IR and stroke treatment. Three general radiography rooms, one fluoroscopy rooms, portable radiographic units, and dedicated chest and orthopedic room are in use. There are Three Hologic DMR Mammography rooms one which is Tomosynthesis. A digital network links CT, US, MRI, IR, General Radiology and Mammography to a digital network and we are fully PACS supported.

In our new Department located in Building 25, our services include in the Emergency Department: 2 CT scanners, two fixed imaging digital x-ray rooms and 4 Digital portable machines.

Our Interventional procedural area is located within the perioperative procedural area on the ground floor and includes the following: One room a single plane C-arm that is dedicated to Cardiology Interventional procedures, One Bi-plane neuro interventional room and one combination suite of CT and Single Plane C-arm. We also have support space for Technologist work area, Radiologist Reading room and supply storage. In planning we also have additional shell space for future expansion that is currently being developed. As this floor also maintains the operating rooms and procedural areas there are 3 Digital Portable x- ray units and 5 mobile c-arms

The new department also consists of an in-patient imaging suite on the basement level that contains the following: One CT scanner, one PET/CT scanner, 3 x ray rooms (digital) one which is fluoroscopy, One MRI and 3 ultrasound units. The area also has support space and infrastructures including reading rooms for all modalities in place to manage and maintain patient care, supplies and support staff.

C. The Imaging Services Department seeks to provide the highest quality diagnostic imaging services to the citizens of the City and County of San Francisco. We serve a broad range of patients and services, including the Emergency Department, Operating Room, Intensive Care units and other inpatient units, hospital and community-based primary care clinics, specialty clinics. The department provides a vital teaching function as part of the residency programs of the University of California, San Francisco, and is a teaching facility for student radiologic technologists from City College of San Francisco and student sonographers for Foothill College. Medical staff performs clinical research to improve patient care.

D. AVAILABLE SERVICES:

The following Radiology services are available 24-hours a day, 7 days a week* on a scheduled, drop-in or emergent basis. Services are provided to patients of all age groups and cultures, referred by an authorized care provider. Two percent of our patients are age 0-2 years, two percent are 3 –11, two and a half percent are 12-18, eighty percent are 18-64, and 14 percent are 65 and older.

Service	**Most Frequent Procedures**
Plain Film Radiography	Chest, abdomen, spine, Mammography
Fluoroscopy	Upper GI track, Lower GI track
Sonography	Obstetric, Abdomen, Pelvis
Computed Tomography (CT)	Brain, Abdomen, Pelvis
Magnetic Resonance Imaging (MRI)	Brain, Spine, MR Angiography
Interventional, Neuro-interventional, Vascular radiography	Dialysis Fistula maintenance, Central line placement, Percutaneous abscess drainage, stroke treatment

***Mammography** is routinely provided only on a scheduled basis, Monday through Friday

Medical services provided include medical pre- and post-procedural consultation, post-procedural observations, supervision and performance of procedures, moderate sedation, and interpretation of images. Nursing services provided include moderate sedation, patient monitoring, starting intravenous lines and injecting contrast media, general nursing care including patient education. Technical services include acquisition of images by certified and/or licensed staff, pre- and post-procedural patient education, and supervised, limited injection of contrast media. Other services provided are reception of patients and visitors, patient transportation and record/image management.

E. GOALS OF CARE

- Provide safe and efficient performance of procedure.
- Assure the highest level of diagnostic interpretation and therapeutic intervention;
- Provide prompt transmittal of results to clinicians;
- Archive images in a manner which assures prompt retrieval;
- Make recommendations for procuring cost-effective equipment that provides a high-quality of diagnostic information;
- Provide ongoing education that stresses the quality of patient care, medical and technical skill development, health and safety procedures and disaster preparedness.

F. MEMBERSHIP REQUIREMENTS

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

To ensure the highest possible level of patient care, faculty Radiologists will personally review the images and interpretation thereof for all procedures, which are dictated under his or her signature.

In accordance with HCFA Guidelines, all reports dictated under the signature of a faculty physician must contain a statement that he/she has personally reviewed the image and the interpretation thereof and either agrees with it or has edited the findings.

To facilitate this procedure, an "expression code" has been made available on the Radiology Information System and on the digital dictation system which reads as follows:

THE ELECTRONIC SIGNATURE ON THIS RADIOLOGIC REPORT INDICATES MY DIRECT INVOLVEMENT IN THE INTERPRETATION OF THE EXAMINATION AND/OR MY DIRECT SUPERVISION OF THE PROCEDURE AND AGREEMENT WITH THE REPORT.

This expression code will be used by residents when assigning standard (normal) reports to an interpretation or by the transcriber when a resident has dictated the report. It will always be the final statement, even if addenda are added after an initial approval.

G. ORGANIZATION OF IMAGING SERVICES CLINICAL SERVICE

1. ACADEMIC STAFF

Physician staffing consists of 19~~7~~ active radiologists, including the chief. In order to maintain subspecialty coverage, additional courtesy faculty from UCSF and the VA hospital cover periodically. There are six credentialed imaging fellows who serve as junior faculty and rotate through CT, ultrasound and MR and Chest during their one-year faculty appointment. Thirteen of the 42 UCSF radiology residents are rotated to Zuckerberg San Francisco General monthly. A management services agreement with the UCSF Department of Radiology provides administrative and fiscal management for university affairs.

2. ADMINISTRATIVE AND TECHNICAL STAFF

Hospital staff includes a director, 6 supervisors, 68 licensed technologists, 12 registered nurses, and 32 non-technical support staff. We have 4 NPs who assist with diagnostic exam protocoling and Interventional Radiology. The department's administrative cadre is lean, but efficient, highly skilled and motivated. The department has had a relationship with City College, San Francisco for more than 20 years, providing clinical experience for up to 12 student radiographers per year.

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3. ACCOUNTABILITY

The **Chief of Radiology** is responsible for the supervision of the medical care of patients within Radiology, determines the medical services available, ensures the integration of Radiology services with those of other clinical departments and with the hospital as a whole, and is responsible for the education and research functions of the medical staff. The Chief oversees the credentialing and quality assurance of the medical staff. The Chief reports to the Associate Dean, ZSFG and the Department Chair, UCSF Radiology.
(See **ATTACHMENT C** for Job Description)

The **Director of Radiology** is responsible for the administration and evaluation of the technical and support staff, provides the knowledge, skill and leadership to manage the department's resources, and coordinates the departments' services with other clinical departments. The Director reports to the Chief Operating Officer ZSFG.

All Radiology Technical staff will meet the qualifications as determined by the Medical Staff and approved by the Medical Executive Committee.

Qualifications:

1. Proof of possession of a current license issued by the State of California as a Certified Radiologic Technologist (CRT)
2. Proof of current registration with the American Registry of Radiologic Technologists (ARRT)
3. Possession of a valid Cardiopulmonary Resuscitation (CPR) Certificate issued by the American Heart Association

The attached Job descriptions have also been reviewed and approved by the San Francisco Department of Human Resources.

The Director and Chief jointly evaluate services and the status of capital equipment in the department and make recommendations to hospital administration, review radiation exposures of respective staffs in accordance with hospital policy. The Director~~, Chief and Radiology Charge nurse~~ and Chief of Raduilogy jointly review performance data and identify improvement opportunities.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

The following additional documentation items, as appropriate, are acceptable verified by hard copy or by explanation of the applicant with no further verification:

1. American Board Certification Status (if not certified)
2. BLS
3. ACLS
4. CPR
5. PALS
6. X-ray Operator/Supervisor's License
7. DEA certification

The Radiology Clinical Service at Zuckerberg San Francisco General Hospital encourages but does not require faculty or fellows to have CPR training or DEA certification.

B. REAPPOINTMENTS

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

1. Practitioners Performance Profiles
Profiling documentation: Review number of procedures of various types performed by physician since appointment/last reappointment. Data will be obtained through the Imaging Department's computer system. If data on number of procedures is not available for entire period since appointment/last reappointment, a representative period will be analyzed consisting of at least three months.

2. Modification of Clinical Service
Modification of the Imaging Clinical Service are reviewed and determined by the Chief of Imaging Services.

3. Staff Status Change
The process for Staff Status Change for members of the Imaging Services is in accordance with ZSFG Bylaws, Rules and Regulations.

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

C. AFFILIATED PROFESSIONAL STAFF

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

D. STAFF CATEGORIES

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Imaging Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V - *Clinical Privileges,* Rules and Regulations.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

Before any new staff radiologist can independently perform clinical services, he/she will be assigned to a proctor by the chief of the service. Any staff radiologist who already has privileges in areas requested by the new staff radiologist may be asked to be a proctor. The proctoring staff radiologist will review a minimum of 50 examinations or procedures that encompass every area in which privileges were requested by the new staff radiologist. If the new staff radiologist has requested a privilege that is not included in the proctoring radiologists' privileges, a second proctor may be assigned for evaluation of the specific privilege. The proctoring physician(s) will report his/her observations regarding the new radiologist and assess his/her ability to perform in all the areas that privileges were requested.

Each staff radiologist will undergo peer review (proctoring and monitoring) by another staff radiologist once each year. Review material will consist of ten (10) cases chosen by the examining physician to include cases in the primary area of expertise of the radiologist being proctored as well as additional cases that may occasionally be the responsibility of the radiologist (i.e., on call). Both radiologists will dictate each case and the two reports compared by the Radiology Clinical Service QI Medical Director. Records will be kept and reported to the Radiology Clinical Service Department Chief, and the QI Medical Director (see proctoring form, Staff Physician Credentials Section). Both examiner and examinee will report significant

error to the Department QI Chief or QI Committee. Action to be taken may include consulting, remedial study, and/or clinical service in-service work, as appropriate.

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

A. All Imaging Clinical Service faculty are required to obtain ongoing ACCME accredited continuing medical education in the area of diagnostic radiology or nuclear medicine. The minimum standards required are those that the American Medical Association requires for the certificate award.

B. Imaging Services faculty that are full-time are allotted five weeks of meetings per year.

C. Documentation of continuing education is provided on an annual curriculum vita required by all faculty prior to the June performance appraisal performed by the Chief of Service.

VI. IMAGING SERVICES CLINICAL RESIDENT AND FELLOW TRAINING PROGRAM AND SUPERVISION

The Department of Imaging Services considers all physicians participating in ACGME approved training programs to be resident physicians. It is the policy of the department that no residents can provide clinical services without the direct supervision of an attending faculty physician. Non-ACGME are credentialed to render final interpretations but are usually supervised by an attending. The training program currently consists of 13 resident FTEs and 5.2 fellow FTEs.

All diagnostic imaging examinations performed by the Department of Imaging Services are interpreted and reported by one of the following procedures:

1. The examination is personally reviewed, interpreted and dictated by an attending faculty physician.

2. A resident physician performs a review contemporaneous with an attending physician and then dictates a preliminary report of the results. The report is then reviewed by the attending faculty physician who signs a statement in the medical record confirming that he or she has personally reviewed both the examination and the resident's preliminary report and either agrees with the resident's description of the attending physician’s interpretation as originally dictated or has edited the resident's report to reflect his or her opinion of the findings on the examination.

3. A resident physician performs a preliminary review of the examination and dictates a preliminary report of the results. The examination and the report are then reviewed by an attending faculty physician who signs a statement in the medical record confirming that he or she has personally reviewed both the examination and the resident's preliminary report and either agrees with the resident's interpretation as originally dictated or has edited the resident's findings.

   If the resident's preliminary interpretation has been transmitted for use in the treatment of the patient (either orally or in writing) prior to the attending faculty physician's review of the examination and

the attending physician significantly disagrees with the resident's findings after personally reviewing the examination, the attending physician notifies the referring physician of his/her own opinion in addition to editing the resident's findings in the medical record. Attending faculty physicians must make every effort to review the examination in a timely manner after the resident's preliminary interpretation.

In July 2022, an Emergency Radiology Service was instituted. This has resulted in improved on-call resident supervision, expedited attending readings of emergency after hours exams, and improved patient throughput in the ZSFG Emergency department.

All invasive imaging procedures and therapeutic interventions are performed by attending radiologists or residents with direct personal supervision of an attending faculty radiologist. Some invasive therapeutic interventions performed in the Radiology Department (such as thoracentesis) are also performed at the bedside by non-radiologists without the need for imaging guidance. Since only those patients with the most complex pathologic anatomy are referred for image-guided procedures, direct attending radiologist supervision is always required when radiology residents perform these procedures.

In accordance with HCFA regulations, for procedures performed by residents, the attending radiologist is in the procedure room directly supervising during the key portions of the procedure and in the immediate vicinity during the remainder of the procedure. To document the attending radiologist's involvement in the procedure he or she must sign a personal note on the radiology report describing his or her participation.

The list of Major and Minor procedures performed in the department are in Appendix B. For all major procedures, the key components are described.

VII. IMAGING SERVICES CLINICAL SERVICE CONSULTATION CRITERIA

A. The Imaging Service provides informal consultation on a daily basis to all CHN healthcare providers upon demand.

B. The Imaging Services does not provide formal consultation other than its written radiologic reports and discussions at clinical conferences such as Tumor Board, Radiology OB/GYN Conference, Radiology Neurology- Neurosurgery Conference, GI Medicine Surgery Conference, Radiology Gastroenterology General Surgery Conference, Pulmonary Medicine Conference, Pulmonary Medicine Surgery Imaging Services Conference, and occasional other conferences as needed.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

A. GOALS AND OBJECTIVES

The Department of Imaging Services has established a standing Performance Improvement (PI) committee that will meet monthly. This committee is responsible for identifying PI opportunities, determining metrics to measure the success of PI initiatives, and monitoring, evaluating, and reporting on

those initiatives to the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

B. CLINICAL INDICATORS

A faculty member meets monthly with residents to review quality assurance and patient safety issues. This information is compiled and presented to the Department of Imaging Services Performance Improvement Committee.

Regular faculty quality assurance and patient safety issues meetings occur in additional to annual peer-to-peer review to evaluate discrepancies.

The Department of Imaging Services audits critical results reporting bi-annually, and that information is compiled and presented to the Performance Improvement and Patient Safety (PIPS) Committee

C. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILE

Refer to Section III Proctoring and Monitoring above

D. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE OF IMAGING SERVICE MEMBERS

Refer to Section IV, Proctoring and Monitoring

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.

Imaging Clinical Services Department shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XI. ADOPTION AND AMENDMENT

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

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APPENDIX A – RADIOLOGY PRIVILEGE REQUEST FORM
PRIVILEGES FOR ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL

Rad RADIOLOGY AND NUCLEAR MEDICINE 2022
(02/2022 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.

CORE PRIVILEGES ___

36.10 GENERAL DIAGNOSTIC RADIOLOGY ___

36.10A PLAIN FILM INTERPRETATION ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 100 general diagnostic procedures in two years.

36.10B FLUOROSCOPIC PROCEDURES ___
Performance of fluoroscopic procedures, including contrast studies of the GI and GU tract.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology and a current fluoroscopy license.

PROCTORING: Double reading of 2 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 4 general fluoroscopy procedures in two years.

SPECIAL PRIVILEGES ___

36.20 COMPUTED TOMOGRAPHY ___
Interpretation of computed tomographic procedures of any or all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 100 computed tomography procedures in the past two (2) years

36.30 MAGNETIC RESONANCE IMAGING ___
Interpretation of magnetic resonance imaging procedures of any or all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 50 magnetic resonance imaging procedures in the past two years.

36.40 GENERAL SONOGRAPHY (EXCLUDES OBSTETRIC AND GYNECOLOGY) ___
Interpretation of non-OB/GYN ultrasound imaging procedures of any or all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: performance of at least 100 sonography procedures in the past two (2) years.

36.41 OBSTETRIC AND GYNECOLOGICAL SONOGRAPHY ___

36.41A Obstetric And Gynecological Sonography ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology; AND
1) formal obstetrical ultrasound training in Radiology Residency program; OR
2) 3 month's post residency experience to include:
a) 1 month: basic physics, technique, performance and interpretation
b) 2 months of practical experience with at least 200 examinations

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: performance of at least 100 sonography procedures in the past two (2) years.

36.41B Obstetric And Gynecological Sonography ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Obstetrics and Gynecology.
1) Completion of Maternal Fetal Medicine subspecialty training or Perinatal Genetics subspecialty training with a minimum of 6 months of training in ultrasound.
2) Joint appointment in the Department of Radiology.

PROCTORING: Total studies satisfactorily proctored: 500** abnormal studies satisfactorily proctored: 25** (**subspecialty training included.)

REAPPOINTMENT: performance of at least 100 sonography procedures in the past two (2) years.

36.50 ANGIOGRAPHY/VASCULAR INTERVENTIONAL PROCEDURES ___
Admission, work up, diagnosis, provision of endovascular and non endovascular care to patients of all adults presenting with illnesses, injuries and disorders who have or will undergo interventional radiologic procedures. Admission pertains only to patients undergoing elective procedures. Performance and interpretation of diagnostic and therapeutic vascular interventional procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology in Diagnostic Radiology and currently meets the training requirements for board eligibility by the American Board of Vascular and Interventional Radiology.

PROCTORING: Supervision of 3 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 25 angiography/vascular interventional procedures in the past two (2) years.

36.60 NON-VASCULAR INTERVENTIONAL PROCEDURES ___
Performance and interpretation of diagnostic and therapeutic non-vascular interventional procedures

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Supervision of 3 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 20 non-vascular interventional procedures in the past two (2) years.

36.65 IMAGE-GUIDED TUMOR ABLATION ___
Performance of radiofrequency, microwave, or cryoablation of solid organ, lung and soft tissue tumors.

PREREQUISITES: Currently Board Admissible or Board Certified by the American Board of Radiology and completion of an accredited Interventional Radiology Fellowship training program.

PROCTORING: Supervision of 2 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 2 procedures in the past two (2) years.

36.70 MAMMOGRAPHY ___
Performance and interpretation of diagnostic and interventional mammographic procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 240 mammography procedures in the last six months or at least 960 performed in the last two (2) years.

36.80 NUCLEAR MEDICINE BASIC PRIVILEGES ___
Performance and interpretation of diagnostic and therapeutic radionuclide procedures in any and all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Nuclear Medicine and must attain Board Certification in Nuclear Medicine within two (2) years of completion of residency.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 20 nuclear medicine procedures in the last 2 years.

36.90 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 Radiology 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

37.00 INVASIVE NEURORADIOLOGY ___
Performance and interpretation of diagnostic and therapeutic invasive neuroradiology procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology in Diagnostic Radiology and currently meets the training requirements for board eligibility by the American Board of Neuroradiology.

PROCTORING: Supervision of 3 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 20 invasive neuroradiology procedures in the past two (2) years.

37.10 CAROTID ARTERY STENTING ___
Performance and interpretation of therapeutic carotid artery stenting procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology in Diagnostic Radiology and Neuroradiology or Interventional Radiology, and performance of 25 carotid stenting procedures.

PROCTORING: Supervision of 1 procedure by a credentialed radiologist in the department.

REAPPOINTMENT: Performance of at least 2 carotid stenting procedures in the past two (2) years.

37.20 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

____ ____________________
CTSI Medical Director Date

37.30 EDUCATIONAL INTERPRETATION OF STUDIES ONLY ___
The physician shall interpret studies for teaching purposes for fellows, residents or medical students. The physician will have no involvement in the clinical care of patients.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Observation of 2 teaching sessions.

REAPPOINTMENT: Observation of 2 teaching sessions

I hereby request clinical privileges as indicated above.

____ ____________________
Applicant Date

APPROVED BY

____ ____________________
Division Chief Date

____ ____________________
Service Chief Date

APPENDIX B-MAJOR AND MINOR PROCEDURES REQUIRING STAFF RADIOLOGIST SUPERVISION

	Major Procedures	Key Components	
19000	ASP BREAST CYST	Needle placement	Obtain specimen
19030	GALACTOGRAM	Needle placement	Injection of contrast
19102	PERC CORE BX BREAST	Needle placement	Obtain specimen
19103	PERC CORE BX BREAST ROT/VAC AS	Needle placement	Obtain specimen
19290	BREAST NEEDLE LOC	Needle placement	
19291	BREAST NEEDLE LOC EACH ADD'L	Needle placement	
19295	PLACE METAL CLIP IN BREAST BX	Needle placement	
20000	SOFT TISSUE ABS DRN SUPERFICIAL	Percutaneous entry	Catheter Placement
20205	MUSC BX DEEP	Needle placement	Obtain specimen
20206	SOFT TISSUE/MUSCLE BX	Needle placement	Obtain specimen
20220	SUPERFICIAL BONE BX	Needle placement	Obtain specimen
20225	DEEP BONE BX	Needle placement	Obtain specimen
20605	ASP/INJ SMALL JOINT	Needle placement	Obtain specimen
20610	ASP/INJ LARGE JOINT	Needle placement	Obtain specimen
21116	ASP/INJ SHOULDER JOINT	Needle placement	Obtain specimen
22521	PERC VERTEBOPLASTY UNI/BI THOR	Needle placement	Injection of cement
22521	PERC VERTEBOPLASTY UNI/BI LUMB	Needle placement	Injection of cement
22522	PERC VERTEBROPLASTY EACH ADD'L	Needle placement	Injection of cement
23350	SHOULDER ARTHROGRAM	Needle placement	Injection of contrast
24220	ARTHROGRAM ELBOW	Needle placement	Injection of contrast
25246	ARTHROGRAM WRIST	Needle placement	Injection of contrast
27093	HIP ARTHROGRAM	Needle placement	Injection of contrast
27096	SI JOINT ARTHROGRAM	Needle placement	Injection of contrast
27370	KNEE ARTHROGRAM	Needle placement	Injection of contrast
27648	ARTHROGRAM ANKLE	Needle placement	Injection of contrast
32000	THORACENTESIS	Needle placement	Obtain specimen
32002	THORACENTESIS(PNEUMOTHORAX)	Needle placement	Obtain specimen
32020	THORACOSTSTOMY	Percutaneous entry	Tube insertion
32201	PERC LUNG ABSCESS	Percutaneous entry	Catheter Placement
32400	NEEDLE BX PLEURA	Needle placement	Obtain specimen
32405	LUNG BX	Needle placement	Obtain specimen
35470	PTA TIBIOPERONEAL	Catheter Placement	Balloon Inflation
35471	PTA VISCERAL	Catheter Placement	Balloon Inflation
35472	PTA AORTA	Catheter Placement	Balloon Inflation
35473	PTA ILIAC	Catheter Placement	Balloon Inflation
35474	PTA FEM-POP	Catheter Placement	Balloon Inflation
35476	PTA VENOUS	Catheter Placement	Balloon Inflation
35491	ATHERECTOMY AORTA	Catheter Placement	Atherectomy
35492	ATHERECTOMY ILIAC	Catheter Placement	Atherectomy
35493	ATHERECTOMY FEM-POP	Catheter Placement	Atherectomy
35494	ATHERECTOMY BRACHIAL	Catheter Placement	Atherectomy
35495	ATHERECTOMY TIBIAL	Catheter Placement	Atherectomy
36005	EXT VENOGRAM	Catheter Placement	
36010	IVC/SVC	Catheter Placement	
36011	1ST ORDER VEIN	Catheter Placement	
36012	2ND ORDER VEIN	Catheter Placement	
36014	PULM ART CATH SELECT	Catheter Placement	

36015	PULM ART CATH SUBSELECT	Catheter Placement		
36140	DIRECT STICK ARTERY	Catheter Placement		
36145	DIALYSIS FISTULA CATH	Catheter Placement		
36160	TRANS LUMBAR	Catheter Placement		
36200	CATHETER AORTA	Catheter Placement		
36215	SELECTIVE 1ST ORDER HEAD	Catheter Placement		
36216	SELECTIVE 2ND ORDER HEAD	Catheter Placement		
36217	SELECTIVE 3RD ORDER HEAD	Catheter Placement		
36218	ADTNL 2ND OR 3RD ORD HEAD	Catheter Placement		
36245	1ST ORDER ABD/PELVIS/LEG	Catheter Placement		
36246	2ND ORDER ABD/PELVIS/LEG	Catheter Placement		
36247	3RD ORDER ABD/PELVIS/LEG	Catheter Placement		
36248	ADD'L 2ND OR 3RD	Catheter Placement		
36481	PORTAL VEIN CATH/ANY METHOD	Catheter Placement		
36489	PLACE CENTRAL LINE	Percutaneous entry	Catheter Placement	
36493	REPOSITION CENTRAL LINE	Percutaneous entry	Catheter Placement	
36500	VENOUS SAMPLE	Catheter Placement		
36533	IMPLANT VENOUS PORT	Percutaneous entry	Catheter Placement	
36534	REVISE VENOUS PORT	Percutaneous entry	Catheter Placement	
36870	DECLOT DIALYSIS FIST ANY METHOD	Percutaneous entry	Perform Declot	
37140	TIPS	Portal V catheterization	Stent Placement	Stent Dilation
37200	TRANS CATHETER BIOPSY	Catheter Placement	Needle placement	
37201	FIBRINOLYTIC INFUSION	Catheter Placement		
37202	OTHER RX INFUSION	Catheter Placement		
37203	FOREIGN BODY RETRIEVAL	Catheter Placement	Foreign body retrieval	
37204	EMBOLIZATION	Catheter Placement	Embolization	
37205	VASCULAR STENT INITIAL VESSEL	Catheter Placement	Stent Placement	
37206	STENT-EACH ADD'L VESSEL	Catheter Placement	Stent Placement	
37209	MANIPULATE UK CATH	Catheter Placement		
37620	IVC FILTER	Catheter Placement	Filter placement	
38200	SPLENOPORTOGRAM PUNCT	Needle placement	Injection of contrast	
38505	LYMPH NODE BX	Needle placement	Obtain specimen	
38790	LYMPHANGIOGRAM	Needle placement	Injection of contrast	
42400	BX SALIV GLAND	Needle placement	Obtain specimen	
42550	SIALOGRAM	Needle placement	Injection of contrast	
43456	DILATE ESOPHAGUS	Catheter Placement	Balloon Inflation	
43750	GASTROSTOMY	Percutaneous entry	Catheter Placement	
44300	TUBE ENEROSTOMY/CECOSTOMY	Percutaneous entry	Catheter Placement	
44901	PERC DRN APPENDIX ABSCESS	Percutaneous entry	Catheter Placement	
47000	LIVER BIOPSY	Needle placement	Obtain specimen	
47011	PERC DRAIN LIVER ABSCESS	Percutaneous entry	Catheter Placement	
47490	PERC CHOLECYSTOSTOMY	Percutaneous entry	Catheter Placement	
47500	PTC	Needle placement	Injection of contrast	
47510	PTBD EXTERNAL DRAIN	Percutaneous entry	Catheter Placement	
47511	PTBD INTERNAL OR STENT	Percutaneous entry	Catheter Placement	
47530	REVISE T-TUBE	Catheter Placement		
47555	DILATE BIL STRICT W/O STENT	Catheter Placement	Balloon Inflation	
47556	DILATE BIL STRICT W STENT	Catheter Placement	Balloon Inflation	Stent Placement
47630	STONE EX	Catheter Placement	Stone removal	

48000	PANCREATIC ABSCESS	Percutaneous entry	Catheter Placement
48102	PANCREATIC BIOPSY	Needle placement	Obtain specimen
48511	PERC DRAIN PSEUDOCYST	Percutaneous entry	Catheter Placement
49020	PERITONEAL ABSCESS	Percutaneous entry	Catheter Placement
49041	SUBPHRENIC ABSCESS	Percutaneous entry	Catheter Placement
49061	RETROPERITONEAL ABSCESS	Percutaneous entry	Catheter Placement
49080	PARACENTESIS	Needle placement	Obtain specimen
49180	BIOPSY ABD MASS	Needle placement	Obtain specimen
49420	INSERT PERITONEAL CATHTEMP	Percutaneous entry	Catheter Placement
49427	LEVEEN SHUNTOGRAM	Needle placement	Injection of contrast
50021	RENAL ABSCESS	Percutaneous entry	Catheter Placement
50390	ASP RENAL CYST OR PELVIS	Needle placement	Obtain specimen
50392	ANTEGRADE PYELO/NEPHROSTOMY	Percutaneous entry	Catheter Placement
50393	URETERAL STENT	Stent Placement	
50394	INJECTION FOR ANTEGRADE PYELOGRAM	Needle placement	Injection of contrast
50395	DIL NEPHROST TRACT	Catheter Placement	Balloon Inflation
50593	TUMOR ABLATION	Percutaneous entry	
51080	DRAIN PERIVESICLE ABSCESS	Percutaneous entry	Catheter Placement
51610	CATH BLADDER	Percutaneous entry	Catheter Placement
52007	BRUSH BX URETER OR RENAL PELVIS	Catheter Placement	Brush bx placement
54230	CORPORA CAVERNOSOGRAM	Needle placement	Injection of contrast
55700	PROSTATE BIOPSY	Needle placement	Obtain specimen
58340	US SONOHYSTEROGRAM	Percutaneous entry	Catheter Placement
58823	TRANS VAGINAL DRAIN	Catheter Placement	
60100	BX THRYOID	Needle placement	Obtain specimen
61050	CISTERNAL OR C1-2 PUNCTURE	Needle placement	Injection of contrast
61055	MYELOGR BY C1 PUNC	Needle placement	Injection of contrast
61070	PUNCTURE SHUNT OR RESERVOIR	Needle placement	Injection of contrast
61624	EMBO CNS	Catheter Placement	Injection of emb material
61626	EMBO NON CNS HEAD & NECK	Catheter Placement	Injection of emb material
62268	ASP SPINAL CORD CYST	Needle placement	Obtain specimen
62269	BX SPINAL CORD TUMOR	Needle placement	Obtain specimen
62270	SPINAL PUNCTURE LUMBAR FOR DX	Needle placement	Injection of contrast
62272	SPINAL PUNCTURE LUMBAR FOR RX	Needle placement	Injection of contrast
62273	INJECT EPIDURAL PATCH	Needle placement	Injection of blood
62284	CERVICAL MYELOGRAM	Needle placement	Injection of contrast
62284	THORACIC MYELOGRAM	Needle placement	Injection of contrast
62284	LUMBAR MYELOGRAM	Needle placement	Injection of contrast
62284	COMPLETE MYELOGRAM	Needle placement	Injection of contrast
62284	CERVICAL MYELOGRAM	Needle placement	Injection of contrast
62284	THORACIC MYELOGRAM	Needle placement	Injection of contrast
62284	LUMBAR MYELOGRAM	Needle placement	Injection of contrast
62284	COMPLETE MYELOGRAM	Needle placement	Injection of contrast
62290	DISCOGRAM LUMBAR	Needle placement	Injection of contrast
62291	DISCOGRAM CERVICAL	Needle placement	Injection of contrast
64795	BX NERVE	Needle placement	Obtain specimen
68850	DACROCYSTOGRAM	Needle placement	Injection of contrast

Minor Procedures

20500	SCLEROSE CYST
20501	FISTULA INJECTION
32005	PLEURODESIS
34808	ILIAC OCCLUS DEVICE W AAA REPA
36410	VENAPUNCTURE/PHYSICIAN SKILL
36470	INJ SCLEROSING SOL VEIN
36535	REMOVE VENOUS PORT
36550	DECLOT VASCULAR DEVICE
43760	GASTROSTOMY CHANGE
43761	NASO-JEJUNAL FEEDING TUBE
43761	FEEDING TUBE
44500	INTRODUCE LONG GI TUBE
47505	CHOLANGIO THRU EXISTING TUBE
47525	CHANGE PERC BIL DRAIN
49423	ABSCESS TUBE CHANGE
49424	ABSCESS TUBE CHECK
50398	CHANGE NEPHROSTOMY TUBE

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

APPENDIX C – CHIEF OF IMAGING CLINICAL SERVICES JOB DESCRIPTION

COMMUNITY HEALTH NETWORK OF SAN FRANCISCO
Zuckerberg San Francisco General Hospital Medical Center

Working Title: CHIEF, RADIOLOGY SERVICE

Position Summary:

The Chief of the Radiology Service directs and coordinates the Service's clinical, educational and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also ensures 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 the Radiology Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. A committee appointed by the Chief of Staff reviews the Chief not less than every five years. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associated 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 the Radiology Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

- Provides 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 Zuckerberg San Francisco General Hospital and the Department of Public Health.

- In collaboration with the Executive Administrator and other ZSFG leaders, develops and implements policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement; reviews and approves Service policies and procedures; identifies new clinical services that need to be implemented; and supports clinical services provided by the Department.

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

- Serves as a leader for the Department's quality/performance improvement, occupational 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.

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

Service Population: Patients, families and significant others of all age groups who are clients of Zuckerberg San Francisco General Hospital.

COMMUNITY HEALTH NETWORK OF SAN FRANCISCO
Zuckerberg San Francisco General Hospital Medical Center

Working Title: DIRECTOR, RADIOLOGY

Position Summary:

The Director, Radiology directs and coordinates Radiology's technical, nursing and support staff in keeping with the values, mission and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH); and integrates diagnostic imaging services into the hospital's care delivery plan.

Reporting Relationships:

- Reports directly to, and is evaluated by, the Associate Administrator, Specialty and Diagnostic Services
- Works collaboratively with the Chief, Radiology, and managers of other clinical services.

Position Qualifications:

- Current certification as a Radiologic Technologist with State of California (CRT), current registration with the American Registry of Radiologic Technologists (ARRT) with five years supervisory experience in Radiology; **OR**
- Master's degree in Hospital, Health, Public or Business Administration with four years supervisory experience in Radiology; **OR**
- Baccalaureate Degree with major course work in Health or Business Administration and six years supervisory experience in Radiology.

Major Responsibilities:

- Provides the necessary vision and leadership to effectively motivate and direct the Department of Radiology in developing and achieving goals and objectives that are congruous with the values, mission and strategic plan of Zuckerberg San Francisco General Hospital and the Department of Public Health.

- Develops, reviews, approves and implements policies and procedures that guide and support the provision of services.

- Responsible for the department's financial operations including budgets, contracts, and expenditures. In collaboration with the department's medical staff, recommends the procurement and evaluation of services, equipment, supplies and the identification of space and capital project needs to hospital administration.

- Develops staffing plans for non-medical staff to effectively provide the services identified by the Chief, Radiology and hospital Administration; Determines the qualifications and necessary competency requirements of staff; Selects and/or approves the selection of qualified staff; Develops orientation plans and provides for the orientation of staff; Identifies educational, training and developmental needs of staff and provides the necessary in-service and/or continuing education; Evaluates subordinate staff and reviews subordinate evaluation of staff.

- Serves as a leader for the Department's quality/performance improvement, occupational and patient safety programs; In collaboration with the medical staff, uses performance measurement tools to identify opportunities to improve services and staff/patient safety; participates in and/or provides for resources to appropriately analyze data pertinent to the improvement opportunity; implements recommendations.

Service Population: Patients, families and significant others of all age groups who are clients of Zuckerberg San Francisco General Hospital.

Zuckerberg San Francisco General Hospital
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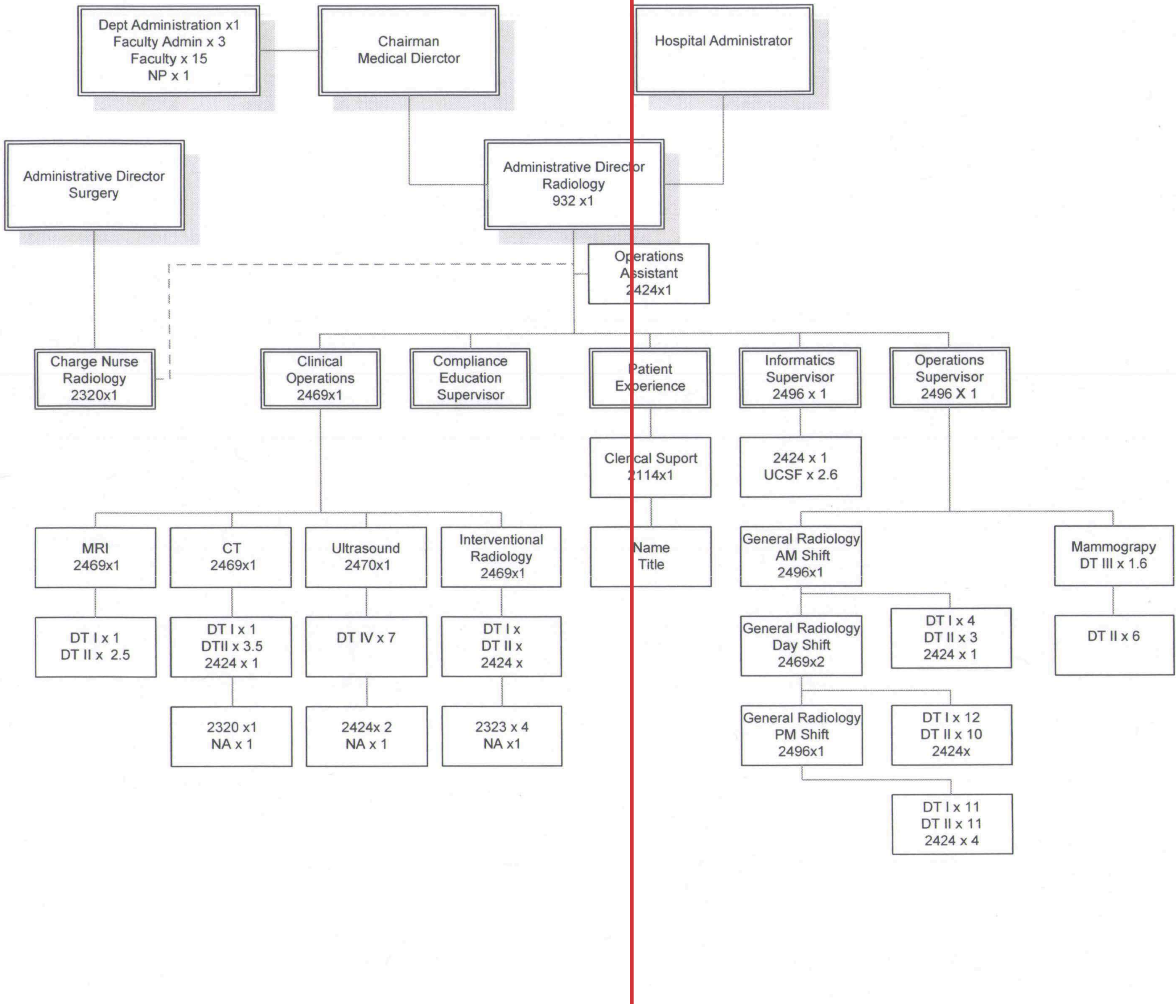

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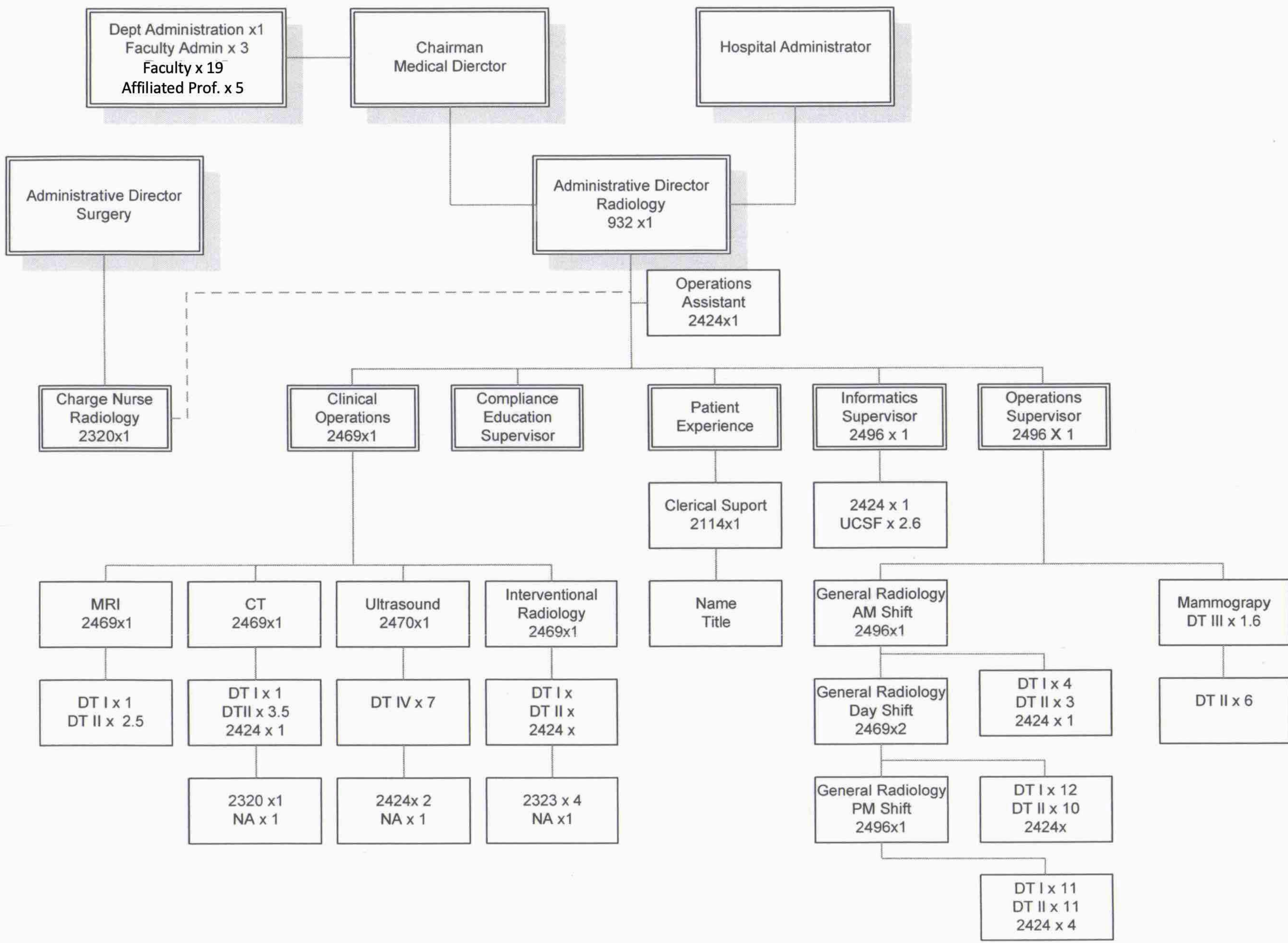

IMAGING CLINICAL SERVICE
RULES AND REGULATIONS
2024

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

IMAGING SERVICES CLINICAL SERVICE
RULES AND REGULATIONS
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I. IMAGING CLINICAL SERVICE: ORGANIZATION

A. PREAMBLE

Zuckerberg San Francisco General Hospital is a county hospital and one of the busiest hospitals in the San Francisco Bay Area. The Emergency Department is the designated trauma center for San Francisco. ZSFG also serves the Department of Public Health's neighborhood clinics and Laguna Honda Hospital patients.

B. SCOPE OF SERVICE

Zuckerberg San Francisco General is one of the four main teaching hospitals of the University of California, San Francisco. The University, through a contractual arrangement with the county, provides medical and medical support staff for the hospital.

The Imaging Services at ZSFG is one of busiest radiology departments in the county performing approximately 180,000 exams/year. The current department occupies 25,000 square feet in the main Department, with several satellite units. Current equipment includes two GE 64 slice CT Scanners, and two GE 1.5 T MRI scanners. Five Siemens and two Zonare (IR) Ultrasound Scanners. One portable CT scanner. One IR room integrating a C-Arm with a 16 slice CT Scanner. One biplane IR room for Neurological IR and stroke treatment. Three general radiography rooms, one fluoroscopy rooms, portable radiographic units, and dedicated chest and orthopedic room are in use. There are Three Hologic DMR Mammography rooms one which is Tomosynthesis. A digital network links CT, US, MRI, IR, General Radiology and Mammography to a digital network and we are fully PACS supported.

In our new Department located in Building 25, our services include in the Emergency Department: 2 CT scanners, two fixed imaging digital x-ray rooms and 4 Digital portable machines.

Our Interventional procedural area is located within the perioperative procedural area on the ground floor and includes the following: One room a single plane C-arm that is dedicated to Cardiology Interventional procedures, One Bi-plane neuro interventional room and one combination suite of CT and Single Plane C-arm. We also have support space for Technologist work area, Radiologist Reading room and supply storage. In planning we also have additional shell space for future expansion that is currently being developed. As this floor also maintains the operating rooms and procedural areas there are 3 Digital Portable x- ray units and 5 mobile c-arms

The new department also consists of an in-patient imaging suite on the basement level that contains the following: One CT scanner, one PET/CT scanner, 3 x ray rooms (digital) one which is fluoroscopy, One MRI and 3 ultrasound units. The area also has support space and infrastructures including reading rooms for all modalities in place to manage and maintain patient care, supplies and support staff.

C. The Imaging Services Department seeks to provide the highest quality diagnostic imaging services to the citizens of the City and County of San Francisco. We serve a broad range of patients and services, including the Emergency Department, Operating Room, Intensive Care units and other inpatient units, hospital and community-based primary care clinics, specialty clinics. The department provides a vital teaching function as part of the residency programs of the University of California, San Francisco, and is a teaching facility for student radiologic technologists from City College of San Francisco and student sonographers for Foothill College. Medical staff performs clinical research to improve patient care.

D. AVAILABLE SERVICES:

The following Radiology services are available 24-hours a day, 7 days a week* on a scheduled, drop-in or emergent basis. Services are provided to patients of all age groups and cultures, referred by an authorized care provider. Two percent of our patients are age 0-2 years, two percent are 3 –11, two and a half percent are 12-18, eighty percent are 18-64, and 14 percent are 65 and older.

Service	Most Frequent Procedures
Plain Film Radiography	Chest, abdomen, spine, Mammography
Fluoroscopy	Upper GI track, Lower GI track
Sonography	Obstetric, Abdomen, Pelvis
Computed Tomography (CT)	Brain, Abdomen, Pelvis
Magnetic Resonance Imaging (MRI)	Brain, Spine, MR Angiography
Interventional, Neuro-interventional, Vascular radiography	Dialysis Fistula maintenance, Central line placement, Percutaneous abscess drainage, stroke treatment

***Mammography** is routinely provided only on a scheduled basis, Monday through Friday

Medical services provided include medical pre- and post-procedural consultation, post-procedural observations, supervision and performance of procedures, moderate sedation, and interpretation of images. Nursing services provided include moderate sedation, patient monitoring, starting intravenous lines and injecting contrast media, general nursing care including patient education. Technical services include acquisition of images by certified and/or licensed staff, pre- and post-procedural patient education, and supervised, limited injection of contrast media. Other services provided are reception of patients and visitors, patient transportation and record/image management.

E. GOALS OF CARE

- Provide safe and efficient performance of procedure.
- Assure the highest level of diagnostic interpretation and therapeutic intervention;
- Provide prompt transmittal of results to clinicians;
- Archive images in a manner which assures prompt retrieval;
- Make recommendations for procuring cost-effective equipment that provides a high-quality of diagnostic information;
- Provide ongoing education that stresses the quality of patient care, medical and technical skill development, health and safety procedures and disaster preparedness.

F. MEMBERSHIP REQUIREMENTS

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

To ensure the highest possible level of patient care, faculty Radiologists will personally review the images and interpretation thereof for all procedures, which are dictated under his or her signature.

In accordance with HCFA Guidelines, all reports dictated under the signature of a faculty physician must contain a statement that he/she has personally reviewed the image and the interpretation thereof and either agrees with it or has edited the findings.

To facilitate this procedure, an "expression code" has been made available on the Radiology Information System and on the digital dictation system which reads as follows:

THE ELECTRONIC SIGNATURE ON THIS RADIOLOGIC REPORT INDICATES MY DIRECT INVOLVEMENT IN THE INTERPRETATION OF THE EXAMINATION AND/OR MY DIRECT SUPERVISION OF THE PROCEDURE AND AGREEMENT WITH THE REPORT.

This expression code will be used by residents when assigning standard (normal) reports to an interpretation or by the transcriber when a resident has dictated the report. It will always be the final statement, even if addenda are added after an initial approval.

G. ORGANIZATION OF IMAGING SERVICES CLINICAL SERVICE

1. ACADEMIC STAFF

Physician staffing consists of 19 active radiologists, including the chief. In order to maintain subspecialty coverage, additional courtesy faculty from UCSF and the VA hospital cover periodically. There are six credentialed imaging fellows who serve as junior faculty and rotate through CT, ultrasound and MR and Chest during their one-year faculty appointment. Thirteen of the 42 UCSF radiology residents are rotated to Zuckerberg San Francisco General monthly. A management services agreement with the UCSF Department of Radiology provides administrative and fiscal management for university affairs.

2. ADMINISTRATIVE AND TECHNICAL STAFF

Hospital staff includes a director, 6 supervisors, 68 licensed technologists, 12 registered nurses, and 32 non-technical support staff. We have 4 NPs who assist with diagnostic exam protocoling and Interventional Radiology. The department's administrative cadre is lean, but efficient, highly skilled and motivated. The department has had a relationship with City College, San Francisco for more than 20 years, providing clinical experience for up to 12 student radiographers per year.

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3. ACCOUNTABILITY

The **Chief of Radiology** is responsible for the supervision of the medical care of patients within Radiology, determines the medical services available, ensures the integration of Radiology services with those of other clinical departments and with the hospital as a whole, and is responsible for the education and research functions of the medical staff. The Chief oversees the credentialing and quality assurance of the medical staff. The Chief reports to the Associate Dean, ZSFG and the Department Chair, UCSF Radiology.
(See **ATTACHMENT C** for Job Description)

The **Director of Radiology** is responsible for the administration and evaluation of the technical and support staff, provides the knowledge, skill and leadership to manage the department's resources, and coordinates the departments' services with other clinical departments. The Director reports to the Chief Operating Officer ZSFG.

All Radiology Technical staff will meet the qualifications as determined by the Medical Staff and approved by the Medical Executive Committee.

Qualifications:

1. Proof of possession of a current license issued by the State of California as a Certified Radiologic Technologist (CRT)
2. Proof of current registration with the American Registry of Radiologic Technologists (ARRT)
3. Possession of a valid Cardiopulmonary Resuscitation (CPR) Certificate issued by the American Heart Association

The attached Job descriptions have also been reviewed and approved by the San Francisco Department of Human Resources.

The Director and Chief jointly evaluate services and the status of capital equipment in the department and make recommendations to hospital administration, review radiation exposures of respective staffs in accordance with hospital policy. The Director and Chief of Raduilogy jointly review performance data and identify improvement opportunities.

II. CREDENTIALING

A. NEW APPOINTMENTS

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

The following additional documentation items, as appropriate, are acceptable verified by hard copy or by explanation of the applicant with no further verification:

1. American Board Certification Status (if not certified)
2. BLS
3. ACLS
4. CPR
5. PALS
6. X-ray Operator/Supervisor's License
7. DEA certification

The Radiology Clinical Service at Zuckerberg San Francisco General Hospital encourages but does not require faculty or fellows to have CPR training or DEA certification.

B. REAPPOINTMENTS

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

1. **Practitioners Performance Profiles**
   Profiling documentation: Review number of procedures of various types performed by physician since appointment/last reappointment. Data will be obtained through the Imaging Department's computer system. If data on number of procedures is not available for entire period since appointment/last reappointment, a representative period will be analyzed consisting of at least three months.

2. **Modification of Clinical Service**
   Modification of the Imaging Clinical Service are reviewed and determined by the Chief of Imaging Services.

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

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

C. AFFILIATED PROFESSIONAL STAFF

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

D. STAFF CATEGORIES

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

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Imaging Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, Article V - *Clinical Privileges,* Rules and Regulations.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

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

D. TEMPORARY PRIVILEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

Before any new staff radiologist can independently perform clinical services, he/she will be assigned to a proctor by the chief of the service. Any staff radiologist who already has privileges in areas requested by the new staff radiologist may be asked to be a proctor. The proctoring staff radiologist will review a minimum of 50 examinations or procedures that encompass every area in which privileges were requested by the new staff radiologist. If the new staff radiologist has requested a privilege that is not included in the proctoring radiologists' privileges, a second proctor may be assigned for evaluation of the specific privilege. The proctoring physician(s) will report his/her observations regarding the new radiologist and assess his/her ability to perform in all the areas that privileges were requested.

Each staff radiologist will undergo peer review (proctoring and monitoring) by another staff radiologist once each year. Review material will consist of ten (10) cases chosen by the examining physician to include cases in the primary area of expertise of the radiologist being proctored as well as additional cases that may occasionally be the responsibility of the radiologist (i.e., on call). Both radiologists will dictate each case and the two reports compared by the Radiology Clinical Service QI Medical Director. Records will be kept and reported to the Radiology Clinical Service Department Chief, and the QI Medical Director (see proctoring form, Staff Physician Credentials Section). Both examiner and examinee will report significant

error to the Department QI Chief or QI Committee. Action to be taken may include consulting, remedial study, and/or clinical service in-service work, as appropriate.

B. ADDITIONAL PRIVILEGES

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

C. REMOVAL OF PRIVILEGES

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

V. EDUCATION

A. All Imaging Clinical Service faculty are required to obtain ongoing ACCME accredited continuing medical education in the area of diagnostic radiology or nuclear medicine. The minimum standards required are those that the American Medical Association requires for the certificate award.

B. Imaging Services faculty that are full-time are allotted five weeks of meetings per year.

C. Documentation of continuing education is provided on an annual curriculum vita required by all faculty prior to the June performance appraisal performed by the Chief of Service.

VI. IMAGING SERVICES CLINICAL RESIDENT AND FELLOW TRAINING PROGRAM AND SUPERVISION

The Department of Imaging Services considers all physicians participating in ACGME approved training programs to be resident physicians. It is the policy of the department that no residents can provide clinical services without the direct supervision of an attending faculty physician. Non-ACGME are credentialed to render final interpretations but are usually supervised by an attending. The training program currently consists of 13 resident FTEs and 5.2 fellow FTEs.

All diagnostic imaging examinations performed by the Department of Imaging Services are interpreted and reported by one of the following procedures:

1. The examination is personally reviewed, interpreted and dictated by an attending faculty physician.

2. A resident physician performs a review contemporaneous with an attending physician and then dictates a preliminary report of the results. The report is then reviewed by the attending faculty physician who signs a statement in the medical record confirming that he or she has personally reviewed both the examination and the resident's preliminary report and either agrees with the resident's description of the attending physician’s interpretation as originally dictated or has edited the resident's report to reflect his or her opinion of the findings on the examination.

3. A resident physician performs a preliminary review of the examination and dictates a preliminary report of the results. The examination and the report are then reviewed by an attending faculty physician who signs a statement in the medical record confirming that he or she has personally reviewed both the examination and the resident's preliminary report and either agrees with the resident's interpretation as originally dictated or has edited the resident's findings.

   If the resident's preliminary interpretation has been transmitted for use in the treatment of the patient (either orally or in writing) prior to the attending faculty physician's review of the examination and

the attending physician significantly disagrees with the resident's findings after personally reviewing the examination, the attending physician notifies the referring physician of his/her own opinion in addition to editing the resident's findings in the medical record. Attending faculty physicians must make every effort to review the examination in a timely manner after the resident's preliminary interpretation.

In July 2022, an Emergency Radiology Service was instituted. This has resulted in improved on-call resident supervision, expedited attending readings of emergency after hours exams, and improved patient throughput in the ZSFG Emergency department.

All invasive imaging procedures and therapeutic interventions are performed by attending radiologists or residents with direct personal supervision of an attending faculty radiologist. Some invasive therapeutic interventions performed in the Radiology Department (such as thoracentesis) are also performed at the bedside by non-radiologists without the need for imaging guidance. Since only those patients with the most complex pathologic anatomy are referred for image-guided procedures, direct attending radiologist supervision is always required when radiology residents perform these procedures.

In accordance with HCFA regulations, for procedures performed by residents, the attending radiologist is in the procedure room directly supervising during the key portions of the procedure and in the immediate vicinity during the remainder of the procedure. To document the attending radiologist's involvement in the procedure he or she must sign a personal note on the radiology report describing his or her participation.

The list of Major and Minor procedures performed in the department are in Appendix B. For all major procedures, the key components are described.

VII. IMAGING SERVICES CLINICAL SERVICE CONSULTATION CRITERIA

A. The Imaging Service provides informal consultation on a daily basis to all CHN healthcare providers upon demand.

B. The Imaging Services does not provide formal consultation other than its written radiologic reports and discussions at clinical conferences such as Tumor Board, Radiology OB/GYN Conference, Radiology Neurology- Neurosurgery Conference, GI Medicine Surgery Conference, Radiology Gastroenterology General Surgery Conference, Pulmonary Medicine Conference, Pulmonary Medicine Surgery Imaging Services Conference, and occasional other conferences as needed.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

A. GOALS AND OBJECTIVES

The Department of Imaging Services has established a standing Performance Improvement (PI) committee that will meet monthly. This committee is responsible for identifying PI opportunities, determining metrics to measure the success of PI initiatives, and monitoring, evaluating, and reporting on

those initiatives to the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

B. CLINICAL INDICATORS

A faculty member meets monthly with residents to review quality assurance and patient safety issues. This information is compiled and presented to the Department of Imaging Services Performance Improvement Committee.

Regular faculty quality assurance and patient safety issues meetings occur in additional to annual peer-to-peer review to evaluate discrepancies.

The Department of Imaging Services audits critical results reporting bi-annually, and that information is compiled and presented to the Performance Improvement and Patient Safety (PIPS) Committee

C. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILE

Refer to Section III Proctoring and Monitoring above

D. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE OF IMAGING SERVICE MEMBERS

Refer to Section IV, Proctoring and Monitoring

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.

Imaging Clinical Services Department shall meet as frequently as necessary, but at least quarterly to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XI. ADOPTION AND AMENDMENT

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

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

APPENDIX A – RADIOLOGY PRIVILEGE REQUEST FORM
PRIVILEGES FOR ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL

Rad RADIOLOGY AND NUCLEAR MEDICINE 2022
(02/2022 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.

CORE PRIVILEGES ___

36.10 GENERAL DIAGNOSTIC RADIOLOGY ___

36.10A PLAIN FILM INTERPRETATION ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 100 general diagnostic procedures in two years.

36.10B FLUOROSCOPIC PROCEDURES ___
Performance of fluoroscopic procedures, including contrast studies of the GI and GU tract.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology and a current fluoroscopy license.

PROCTORING: Double reading of 2 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 4 general fluoroscopy procedures in two years.

SPECIAL PRIVILEGES ___

36.20 COMPUTED TOMOGRAPHY ___
Interpretation of computed tomographic procedures of any or all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 100 computed tomography procedures in the past two (2) years

36.30 MAGNETIC RESONANCE IMAGING ___
Interpretation of magnetic resonance imaging procedures of any or all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 50 magnetic resonance imaging procedures in the past two years.

36.40 GENERAL SONOGRAPHY (EXCLUDES OBSTETRIC AND GYNECOLOGY) ___
Interpretation of non-OB/GYN ultrasound imaging procedures of any or all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: performance of at least 100 sonography procedures in the past two (2) years.

36.41 OBSTETRIC AND GYNECOLOGICAL SONOGRAPHY ___

36.41A Obstetric And Gynecological Sonography ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology; AND
1) formal obstetrical ultrasound training in Radiology Residency program; OR
2) 3 month's post residency experience to include:
a) 1 month: basic physics, technique, performance and interpretation
b) 2 months of practical experience with at least 200 examinations

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department.
Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: performance of at least 100 sonography procedures in the past two (2) years.

36.41B Obstetric And Gynecological Sonography ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Obstetrics and Gynecology.
1) Completion of Maternal Fetal Medicine subspecialty training or Perinatal Genetics subspecialty training with a minimum of 6 months of training in ultrasound.
2) Joint appointment in the Department of Radiology.

PROCTORING: Total studies satisfactorily proctored: 500** abnormal studies satisfactorily proctored: 25** (**subspecialty training included.)

REAPPOINTMENT: performance of at least 100 sonography procedures in the past two (2) years.

36.50 ANGIOGRAPHY/VASCULAR INTERVENTIONAL PROCEDURES ___
Admission, work up, diagnosis, provision of endovascular and non endovascular care to patients of all adults presenting with illnesses, injuries and disorders who have or will undergo interventional radiologic procedures. Admission pertains only to patients undergoing elective procedures. Performance and interpretation of diagnostic and therapeutic vascular interventional procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology in Diagnostic Radiology and currently meets the training requirements for board eligibility by the American Board of Vascular and Interventional Radiology.

PROCTORING: Supervision of 3 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 25 angiography/vascular interventional procedures in the past two (2) years.

36.60 NON-VASCULAR INTERVENTIONAL PROCEDURES ___
Performance and interpretation of diagnostic and therapeutic non-vascular interventional procedures

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Supervision of 3 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 20 non-vascular interventional procedures in the past two (2) years.

36.65 IMAGE-GUIDED TUMOR ABLATION ___
Performance of radiofrequency, microwave, or cryoablation of solid organ, lung and soft tissue tumors.

PREREQUISITES: Currently Board Admissible or Board Certified by the American Board of Radiology and completion of an accredited Interventional Radiology Fellowship training program.

PROCTORING: Supervision of 2 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 2 procedures in the past two (2) years.

36.70 MAMMOGRAPHY ___
Performance and interpretation of diagnostic and interventional mammographic procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 240 mammography procedures in the last six months or at least 960 performed in the last two (2) years.

36.80 NUCLEAR MEDICINE BASIC PRIVILEGES ___
Performance and interpretation of diagnostic and therapeutic radionuclide procedures in any and all organ systems.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Nuclear Medicine and must attain Board Certification in Nuclear Medicine within two (2) years of completion of residency.

PROCTORING: Double reading of 3 studies by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 20 nuclear medicine procedures in the last 2 years.

36.90 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 Radiology 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

37.00 INVASIVE NEURORADIOLOGY ___
Performance and interpretation of diagnostic and therapeutic invasive neuroradiology procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology in Diagnostic Radiology and currently meets the training requirements for board eligibility by the American Board of Neuroradiology.

PROCTORING: Supervision of 3 procedures by a credentialed radiologist in the department. Trainees of the graduates of the UCSF Radiology Training Program hired onto the faculty require supervision of a single procedure.

REAPPOINTMENT: Performance of at least 20 invasive neuroradiology procedures in the past two (2) years.

37.10 CAROTID ARTERY STENTING ___
Performance and interpretation of therapeutic carotid artery stenting procedures.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology in Diagnostic Radiology and Neuroradiology or Interventional Radiology, and performance of 25 carotid stenting procedures.

PROCTORING: Supervision of 1 procedure by a credentialed radiologist in the department.

REAPPOINTMENT: Performance of at least 2 carotid stenting procedures in the past two (2) years.

37.20 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

______________________________ __________________
CTSI Medical Director Date

37.30 EDUCATIONAL INTERPRETATION OF STUDIES ONLY ___
The physician shall interpret studies for teaching purposes for fellows, residents or medical students. The physician will have no involvement in the clinical care of patients.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Radiology.

PROCTORING: Observation of 2 teaching sessions.

REAPPOINTMENT: Observation of 2 teaching sessions

I hereby request clinical privileges as indicated above.

______________________________ __________________
Applicant Date

APPROVED BY

______________________________ __________________
Division Chief Date

______________________________ __________________
Service Chief Date

APPENDIX B-MAJOR AND MINOR PROCEDURES REQUIRING STAFF RADIOLOGIST SUPERVISION

	Major Procedures	Key Components	
19000	ASP BREAST CYST	Needle placement	Obtain specimen
19030	GALACTOGRAM	Needle placement	Injection of contrast
19102	PERC CORE BX BREAST	Needle placement	Obtain specimen
19103	PERC CORE BX BREAST ROT/VAC AS	Needle placement	Obtain specimen
19290	BREAST NEEDLE LOC	Needle placement	
19291	BREAST NEEDLE LOC EACH ADD'L	Needle placement	
19295	PLACE METAL CLIP IN BREAST BX	Needle placement	
20000	SOFT TISSUE ABS DRN SUPERFICIAL	Percutaneous entry	Catheter Placement
20205	MUSC BX DEEP	Needle placement	Obtain specimen
20206	SOFT TISSUE/MUSCLE BX	Needle placement	Obtain specimen
20220	SUPERFICIAL BONE BX	Needle placement	Obtain specimen
20225	DEEP BONE BX	Needle placement	Obtain specimen
20605	ASP/INJ SMALL JOINT	Needle placement	Obtain specimen
20610	ASP/INJ LARGE JOINT	Needle placement	Obtain specimen
21116	ASP/INJ SHOULDER JOINT	Needle placement	Obtain specimen
22521	PERC VERTEBOPLASTY UNI/BI THOR	Needle placement	Injection of cement
22521	PERC VERTEBOPLASTY UNI/BI LUMB	Needle placement	Injection of cement
22522	PERC VERTEBROPLASTY EACH ADD'L	Needle placement	Injection of cement
23350	SHOULDER ARTHROGRAM	Needle placement	Injection of contrast
24220	ARTHROGRAM ELBOW	Needle placement	Injection of contrast
25246	ARTHROGRAM WRIST	Needle placement	Injection of contrast
27093	HIP ARTHROGRAM	Needle placement	Injection of contrast
27096	SI JOINT ARTHROGRAM	Needle placement	Injection of contrast
27370	KNEE ARTHROGRAM	Needle placement	Injection of contrast
27648	ARTHROGRAM ANKLE	Needle placement	Injection of contrast
32000	THORACENTESIS	Needle placement	Obtain specimen
32002	THORACENTESIS(PNEUMOTHORAX)	Needle placement	Obtain specimen
32020	THORACOSTSTOMY	Percutaneous entry	Tube insertion
32201	PERC LUNG ABSCESS	Percutaneous entry	Catheter Placement
32400	NEEDLE BX PLEURA	Needle placement	Obtain specimen
32405	LUNG BX	Needle placement	Obtain specimen
35470	PTA TIBIOPERONEAL	Catheter Placement	Balloon Inflation
35471	PTA VISCERAL	Catheter Placement	Balloon Inflation
35472	PTA AORTA	Catheter Placement	Balloon Inflation
35473	PTA ILIAC	Catheter Placement	Balloon Inflation
35474	PTA FEM-POP	Catheter Placement	Balloon Inflation
35476	PTA VENOUS	Catheter Placement	Balloon Inflation
35491	ATHERECTOMY AORTA	Catheter Placement	Atherectomy
35492	ATHERECTOMY ILIAC	Catheter Placement	Atherectomy
35493	ATHERECTOMY FEM-POP	Catheter Placement	Atherectomy
35494	ATHERECTOMY BRACHIAL	Catheter Placement	Atherectomy
35495	ATHERECTOMY TIBIAL	Catheter Placement	Atherectomy
36005	EXT VENOGRAM	Catheter Placement	
36010	IVC/SVC	Catheter Placement	
36011	1ST ORDER VEIN	Catheter Placement	
36012	2ND ORDER VEIN	Catheter Placement	
36014	PULM ART CATH SELECT	Catheter Placement	

36015	PULM ART CATH SUBSELECT	Catheter Placement		
36140	DIRECT STICK ARTERY	Catheter Placement		
36145	DIALYSIS FISTULA CATH	Catheter Placement		
36160	TRANS LUMBAR	Catheter Placement		
36200	CATHETER AORTA	Catheter Placement		
36215	SELECTIVE 1ST ORDER HEAD	Catheter Placement		
36216	SELECTIVE 2ND ORDER HEAD	Catheter Placement		
36217	SELECTIVE 3RD ORDER HEAD	Catheter Placement		
36218	ADTNL 2ND OR 3RD ORD HEAD	Catheter Placement		
36245	1ST ORDER ABD/PELVIS/LEG	Catheter Placement		
36246	2ND ORDER ABD/PELVIS/LEG	Catheter Placement		
36247	3RD ORDER ABD/PELVIS/LEG	Catheter Placement		
36248	ADD'L 2ND OR 3RD	Catheter Placement		
36481	PORTAL VEIN CATH/ANY METHOD	Catheter Placement		
36489	PLACE CENTRAL LINE	Percutaneous entry	Catheter Placement	
36493	REPOSITION CENTRAL LINE	Percutaneous entry	Catheter Placement	
36500	VENOUS SAMPLE	Catheter Placement		
36533	IMPLANT VENOUS PORT	Percutaneous entry	Catheter Placement	
36534	REVISE VENOUS PORT	Percutaneous entry	Catheter Placement	
36870	DECLOT DIALYSIS FIST ANY METHOD	Percutaneous entry	Perform Declot	
37140	TIPS	Portal V catheterization	Stent Placement	Stent Dilation
37200	TRANS CATHETER BIOPSY	Catheter Placement	Needle placement	
37201	FIBRINOLYTIC INFUSION	Catheter Placement		
37202	OTHER RX INFUSION	Catheter Placement		
37203	FOREIGN BODY RETRIEVAL	Catheter Placement	Foreign body retrieval	
37204	EMBOLIZATION	Catheter Placement	Embolization	
37205	VASCULAR STENT INITIAL VESSEL	Catheter Placement	Stent Placement	
37206	STENT-EACH ADD'L VESSEL	Catheter Placement	Stent Placement	
37209	MANIPULATE UK CATH	Catheter Placement		
37620	IVC FILTER	Catheter Placement	Filter placement	
38200	SPLENOPORTOGRAM PUNCT	Needle placement	Injection of contrast	
38505	LYMPH NODE BX	Needle placement	Obtain specimen	
38790	LYMPHANGIOGRAM	Needle placement	Injection of contrast	
42400	BX SALIV GLAND	Needle placement	Obtain specimen	
42550	SIALOGRAM	Needle placement	Injection of contrast	
43456	DILATE ESOPHAGUS	Catheter Placement	Balloon Inflation	
43750	GASTROSTOMY	Percutaneous entry	Catheter Placement	
44300	TUBE ENEROSTOMY/CECOSTOMY	Percutaneous entry	Catheter Placement	
44901	PERC DRN APPENDIX ABSCESS	Percutaneous entry	Catheter Placement	
47000	LIVER BIOPSY	Needle placement	Obtain specimen	
47011	PERC DRAIN LIVER ABSCESS	Percutaneous entry	Catheter Placement	
47490	PERC CHOLECYSTOSTOMY	Percutaneous entry	Catheter Placement	
47500	PTC	Needle placement	Injection of contrast	
47510	PTBD EXTERNAL DRAIN	Percutaneous entry	Catheter Placement	
47511	PTBD INTERNAL OR STENT	Percutaneous entry	Catheter Placement	
47530	REVISE T-TUBE	Catheter Placement		
47555	DILATE BIL STRICT W/O STENT	Catheter Placement	Balloon Inflation	
47556	DILATE BIL STRICT W STENT	Catheter Placement	Balloon Inflation	Stent Placement
47630	STONE EX	Catheter Placement	Stone removal	

48000	PANCREATIC ABSCESS	Percutaneous entry	Catheter Placement
48102	PANCREATIC BIOPSY	Needle placement	Obtain specimen
48511	PERC DRAIN PSEUDOCYST	Percutaneous entry	Catheter Placement
49020	PERITONEAL ABSCESS	Percutaneous entry	Catheter Placement
49041	SUBPHRENIC ABSCESS	Percutaneous entry	Catheter Placement
49061	RETROPERITONEAL ABSCESS	Percutaneous entry	Catheter Placement
49080	PARACENTESIS	Needle placement	Obtain specimen
49180	BIOPSY ABD MASS	Needle placement	Obtain specimen
49420	INSERT PERITONEAL CATHTEMP	Percutaneous entry	Catheter Placement
49427	LEVEEN SHUNTOGRAM	Needle placement	Injection of contrast
50021	RENAL ABSCESS	Percutaneous entry	Catheter Placement
50390	ASP RENAL CYST OR PELVIS	Needle placement	Obtain specimen
50392	ANTEGRADE PYELO/NEPHROSTOMY	Percutaneous entry	Catheter Placement
50393	URETERAL STENT	Stent Placement	
50394	INJECTION FOR ANTEGRADE PYELOGRAM	Needle placement	Injection of contrast
50395	DIL NEPHROST TRACT	Catheter Placement	Balloon Inflation
50593	TUMOR ABLATION	Percutaneous entry	
51080	DRAIN PERIVESICLE ABSCESS	Percutaneous entry	Catheter Placement
51610	CATH BLADDER	Percutaneous entry	Catheter Placement
52007	BRUSH BX URETER OR RENAL PELVIS	Catheter Placement	Brush bx placement
54230	CORPORA CAVERNOSOGRAM	Needle placement	Injection of contrast
55700	PROSTATE BIOPSY	Needle placement	Obtain specimen
58340	US SONOHYSTEROGRAM	Percutaneous entry	Catheter Placement
58823	TRANS VAGINAL DRAIN	Catheter Placement	
60100	BX THRYOID	Needle placement	Obtain specimen
61050	CISTERNAL OR C1-2 PUNCTURE	Needle placement	Injection of contrast
61055	MYELOGR BY C1 PUNC	Needle placement	Injection of contrast
61070	PUNCTURE SHUNT OR RESERVOIR	Needle placement	Injection of contrast
61624	EMBO CNS	Catheter Placement	Injection of emb material
61626	EMBO NON CNS HEAD & NECK	Catheter Placement	Injection of emb material
62268	ASP SPINAL CORD CYST	Needle placement	Obtain specimen
62269	BX SPINAL CORD TUMOR	Needle placement	Obtain specimen
62270	SPINAL PUNCTURE LUMBAR FOR DX	Needle placement	Injection of contrast
62272	SPINAL PUNCTURE LUMBAR FOR RX	Needle placement	Injection of contrast
62273	INJECT EPIDURAL PATCH	Needle placement	Injection of blood
62284	CERVICAL MYELOGRAM	Needle placement	Injection of contrast
62284	THORACIC MYELOGRAM	Needle placement	Injection of contrast
62284	LUMBAR MYELOGRAM	Needle placement	Injection of contrast
62284	COMPLETE MYELOGRAM	Needle placement	Injection of contrast
62284	CERVICAL MYELOGRAM	Needle placement	Injection of contrast
62284	THORACIC MYELOGRAM	Needle placement	Injection of contrast
62284	LUMBAR MYELOGRAM	Needle placement	Injection of contrast
62284	COMPLETE MYELOGRAM	Needle placement	Injection of contrast
62290	DISCOGRAM LUMBAR	Needle placement	Injection of contrast
62291	DISCOGRAM CERVICAL	Needle placement	Injection of contrast
64795	BX NERVE	Needle placement	Obtain specimen
68850	DACROCYSTOGRAM	Needle placement	Injection of contrast

Minor Procedures

20500	SCLEROSE CYST
20501	FISTULA INJECTION
32005	PLEURODESIS
34808	ILIAC OCCLUS DEVICE W AAA REPA
36410	VENAPUNCTURE/PHYSICIAN SKILL
36470	INJ SCLEROSING SOL VEIN
36535	REMOVE VENOUS PORT
36550	DECLOT VASCULAR DEVICE
43760	GASTROSTOMY CHANGE
43761	NASO-JEJUNAL FEEDING TUBE
43761	FEEDING TUBE
44500	INTRODUCE LONG GI TUBE
47505	CHOLANGIO THRU EXISTING TUBE
47525	CHANGE PERC BIL DRAIN
49423	ABSCESS TUBE CHANGE
49424	ABSCESS TUBE CHECK
50398	CHANGE NEPHROSTOMY TUBE

APPENDIX C – CHIEF OF IMAGING CLINICAL SERVICES JOB DESCRIPTION

COMMUNITY HEALTH NETWORK OF SAN FRANCISCO
Zuckerberg San Francisco General Hospital Medical Center

Working Title: CHIEF, RADIOLOGY SERVICE

Position Summary:

The Chief of the Radiology Service directs and coordinates the Service's clinical, educational and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH). The Chief also ensures 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 the Radiology Service reports directly to the Associate Dean and the University of California, San Francisco (UCSF) Department Chair. A committee appointed by the Chief of Staff reviews the Chief not less than every five years. Reappointment of the Chief occurs upon recommendation by the Chief of Staff, in consultation with the Associated 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 the Radiology Service is board certified, has a University faculty appointment, and is a member of the Active Medical Staff at ZSFG.

Major Responsibilities:

- Provides 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 Zuckerberg San Francisco General Hospital and the Department of Public Health.

- In collaboration with the Executive Administrator and other ZSFG leaders, develops and implements policies and procedures that support the provision of services by reviewing and approving the Service's scope of service statement; reviews and approves Service policies and procedures; identifies new clinical services that need to be implemented; and supports clinical services provided by the Department.

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

- Serves as a leader for the Department's quality/performance improvement, occupational 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.

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

Service Population: Patients, families and significant others of all age groups who are clients of Zuckerberg San Francisco General Hospital.

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110

COMMUNITY HEALTH NETWORK OF SAN FRANCISCO
Zuckerberg San Francisco General Hospital Medical Center

Working Title: DIRECTOR, RADIOLOGY

Position Summary:

The Director, Radiology directs and coordinates Radiology's technical, nursing and support staff in keeping with the values, mission and strategic plan of Zuckerberg San Francisco General Hospital (ZSFG) and the Department of Public Health (DPH); and integrates diagnostic imaging services into the hospital's care delivery plan.

Reporting Relationships:

- Reports directly to, and is evaluated by, the Associate Administrator, Specialty and Diagnostic Services
- Works collaboratively with the Chief, Radiology, and managers of other clinical services.

Position Qualifications:

- Current certification as a Radiologic Technologist with State of California (CRT), current registration with the American Registry of Radiologic Technologists (ARRT) with five years supervisory experience in Radiology; **OR**
- Master's degree in Hospital, Health, Public or Business Administration with four years supervisory experience in Radiology; **OR**
- Baccalaureate Degree with major course work in Health or Business Administration and six years supervisory experience in Radiology.

Major Responsibilities:

- Provides the necessary vision and leadership to effectively motivate and direct the Department of Radiology in developing and achieving goals and objectives that are congruous with the values, mission and strategic plan of Zuckerberg San Francisco General Hospital and the Department of Public Health.

- Develops, reviews, approves and implements policies and procedures that guide and support the provision of services.

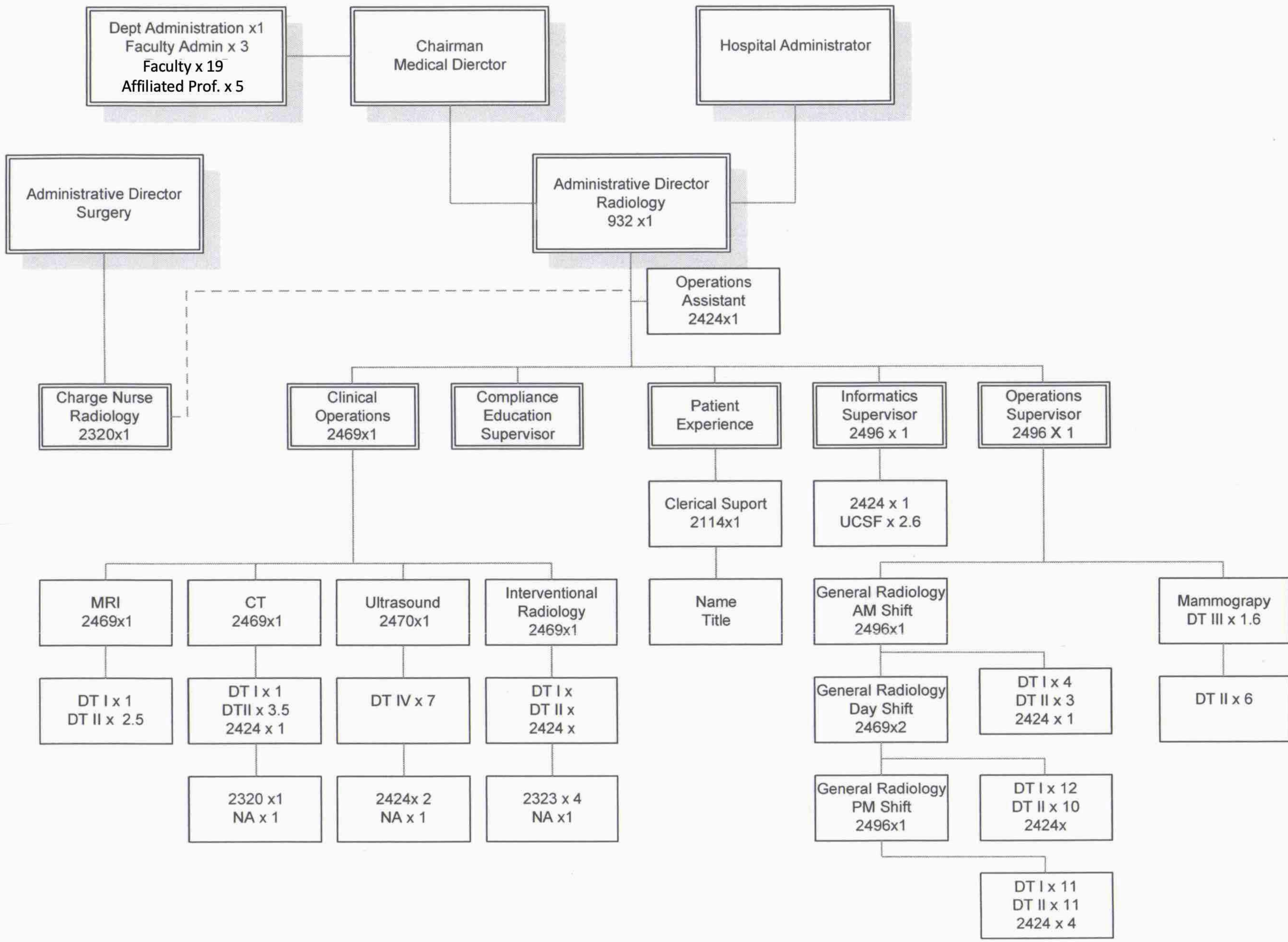
- Responsible for the department's financial operations including budgets, contracts, and expenditures. In collaboration with the department's medical staff, recommends the procurement and evaluation of services, equipment, supplies and the identification of space and capital project needs to hospital administration.

- Develops staffing plans for non-medical staff to effectively provide the services identified by the Chief, Radiology and hospital Administration; Determines the qualifications and necessary competency requirements of staff; Selects and/or approves the selection of qualified staff; Develops orientation plans and provides for the orientation of staff; Identifies educational, training and developmental needs of staff and provides the necessary in-service and/or continuing education; Evaluates subordinate staff and reviews subordinate evaluation of staff.

- Serves as a leader for the Department's quality/performance improvement, occupational and patient safety programs; In collaboration with the medical staff, uses performance measurement tools to identify opportunities to improve services and staff/patient safety; participates in and/or provides for resources to appropriately analyze data pertinent to the improvement opportunity; implements recommendations.

Service Population: Patients, families and significant others of all age groups who are clients of Zuckerberg San Francisco General Hospital.

Zuckerberg San Francisco General Hospital
1001 Potrero Avenue
San Francisco, CA 94110



Radiologic Technologist I, II &III,

Position Overview

The Radiologic Technologist I, II, and III positions are responsible for performing diagnostic imaging procedures in a safe and efficient manner while providing compassionate care to patients. They use specialized equipment to capture high-quality images that assist physicians in diagnosing and treating medical conditions. Radiologic Technologists ensure proper patient positioning, apply radiation safety principles, and document procedures in compliance with regulatory and departmental standards. They assess patient conditions, assist physicians during procedures, and provide support with venipuncture and contrast media administration. Additionally, they maintain imaging equipment, clean procedure rooms, and participate in quality improvement efforts. The duties for each level are cumulative, meaning that technologists at higher levels may perform tasks from preceding levels, depending on departmental needs. As technologists progress to Levels II and III, they gain expertise in one or more advanced imaging modalities, such as CT, MRI, or mammography, and may train student technologists in diagnostic imaging techniques. Throughout all levels, technologists work collaboratively with patients, physicians, and staff to ensure high-quality care and safety.

Medical Executive Committee (MEC)
Summary of Changes

Document Name:	*ZSFG Clinical Service Rules and Regulations*
Clinical Service :	Psychiatry
Date of last approval:	2022
Summary of R&R updates:	
Update #1:	Update to OPPE criteria: 1. Attributable/preventable mortality 2. Adverse drug reporting events 3. NP/PA - Appropriateness of clinical decision-making 4. Completion of annual training modules 5. Maintenance of State Licensing CME requirements 6. SAFE reports about interpersonal and communication skills 7. Patients' complaints 8. SAFE reports about provider professional behavior 9. Flu vaccine policy compliance 10. Percent closed Epic clinical notes within 3 days 11. Complaints from non-ZSFG DPH clinicians/staff
Update #2:	Additions to Psychiatry Department Executive Committee: Director, Division of Integrated Behavioral Health ZSFG Chief Integrative Officer

PSYCHIATRY CLINICAL SERVICE
RULES AND REGULATIONS
2022

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

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RULES AND REGULATIONS
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I. PSYCHIATRY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The mission of the Psychiatry Clinical Service is to provide the highest quality care to individuals with a variety of mental disorders and psychosocial problems, especially those from ethnic and minority groups, who largely depend on the public sector. In support of this mission and to further the academic collaboration between the City and the University, the Psychiatry Clinical Service is committed to providing training, research and evaluation, and direct patient care that will enhance the treatment of consumers of our services. Scope of Service Statements for specific units/services are maintained in the ZSFG Psychiatry Clinical Service Policy and Procedures Manual, Section 5.1B.

B. MEMBERSHIP REQUIREMENTS

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

CPR Certification is required for Affiliated Professionals.

C. ORGANIZATION OF PSYCHIATRY CLINICAL SERVICE

1. **The Officers of the Psychiatry Clinical Service are:**
   a. Chief of Service
   b. Deputy Chief
   c. Director of Administration

2. **Chief of Service (refer to APPENDIX G for additional information)**
   a. Appointment and review of the Chief of Service will occur by the process specified in the ZSFG Medical Staff Bylaws.

   b. Responsibilities

      1) Overall direction of the clinical, teaching, and research activities for the service.
      2) Review and recommendation of all new appointments, requests for privileges and reappointments.
      3) Overall direction of the Performance Improvement/Patient Safety and CQI activities for the Service.
      4) Appointment of the remaining officers of the service and of service committee members.
      5) Financial affairs of the service.
      6) Attendance at the Medical Executive Committee, the Chiefs of Service meetings and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.
      7) Disciplinary actions as necessary, as set forth in these Rules and Regulations and in the Bylaws and Rules and Regulations of the Medical Staff.

3. **Deputy Chief:**
   a. Responsibilities: Assists the Chief of Service with the above.

4. **Director of Administration:**

   a. Responsibilities: Provides overall direction for the budget of the department, human resources, and overall operations of the Service.

5. **Attending Responsibilities (Psychiatrists, Psychologists):**
   Overall direction of clinical care is the responsibility of the supervising attending clinical staff of the Psychiatry Clinical Service. Specific attending job descriptions are maintained in the ZSFG Psychiatry Clinical Service Job Description Manual, (Refer to Appendix C).

II. CREDENTIALING

A. CREDENTIALING OF MEDICAL STAFF AND AFFILIATED PROFESSIONAL STAFF (refer to APPENDIX B)

B. NEW APPOINTMENTS

The process of application for membership to the Medical Staff or Affiliated Professional Staff of ZSFG through the Psychiatry Clinical Service is in accordance with ZSFG Medical Staff Bylaws and the Rules and Regulations.

C. REAPPOINTMENTS

The process of reappointment to the Medical Staff or Affiliated Professional Staff of ZSFG through the Psychiatry Clinical Service is in accordance with ZSFG Bylaws and the Rules and Regulations.

D. PRACTITIONER PERFORMANCE PROFILES

It is the policy of the Psychiatry Clinical Service to certify clinical competence of all medical staff and affiliated professionals, including newly appointed staff members. Information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Psychiatry Clinical Service, who then makes appropriate recommendations to continue or revise the status of the staff member. For subsequent reappointment to the medical staff or affiliated professional staff, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who makes appropriate recommendations to reappoint or revise the status of the staff member. All materials gathered for evaluation purposes are kept in confidential files in the Psychiatry Clinical Service. Details are outlined in the Psychiatry Clinical Service Credentialing of Medical and Affiliated Professional Staff Policy and Procedure 5.1A (Refer to Appendix B).

E. MODIFICATION OF CLINICAL SERVICE PRIVILEGES

Periodic re-determination of clinical service privileges and the increase in, or curtailment of same, shall be based upon direct observation of care provided, review of records of patients treated in the hospital, review of the records of the Medical Staff which document the evaluation of the member's provision of professional care. Clinical privileges will also be reviewed in the event of a change in job duties/responsibilities to determine that appropriate privileges are assigned. This process for modification of clinical service is in accordance with the ZSFG Bylaws and the Rules and Regulations.

F. STAFF STATUS CHANGE
The process for Staff Status Change for members of the Psychiatry Clinical Service is in accordance with ZSFG Bylaws and the Rules and Regulations.

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

H. STAFF CATEGORIES
The Psychiatry Clinical Service staff fall into the same staff categories which are described in the ZSFG Bylaws and the Rules and Regulations, as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES (refer to APPENDIX A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Psychiatry Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

Psychiatry Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Psychiatry Clinical Service or his/her designee.

1. Privileges to practice in the Psychiatry Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice. The specifics of the process are set forth in the Bylaws and the Rules and Regulations of the ZSFG Medical Staff. Privileges, which will be assigned, are described in detail in the Privileges Request Form for Privileges in Psychiatry Service (Refer to Appendix A).

2. Privileges are delineated by consensus of the Active members of the clinical service, and are approved by the Chief of Service or his/her designee, subject to the approval of the Credentials Committee of the medical staff.

3. Individual privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, at the time as judged necessary by the Chief of Service, or at any time recommended by 2/3s of the clinical service's Active staff.

D. TEMPORARY PRIVLEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

It is the policy of the Psychiatry Clinical Service, ZSFG, to certify that clinical competence of all medical/affiliated professionals, during the first two years of the initial appointment. Upon completion of the two years, information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who then makes appropriate recommendation to continue or revise the status of the staff member. For subsequent reappointment to the medical/affiliated professionals, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who makes appropriate recommendations to reappoint or revise the status of the staff member. All materials gathered for evaluation purposes are kept in confidential files in the Psychiatry Clinical Service. Details are outlined in the Psychiatry Clinical Service Credentialing of Medical Professional Staff Policy and Procedure 5.1A (Refer to Appendix B)

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Psychiatry Clinical Service shall be in accordance with ZSFG Medical Staff Bylaws and the Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Psychiatry Clinical Service shall be in accordance with ZSFG Medical Staff Bylaws and the Rules and Regulations.

V. EDUCATION

The Psychiatry Clinical Service serves as a training site for students, interns, and residents in the disciplines of medicine (psychiatry), psychology, nursing, social work, and occupational therapy. Trainees work under the supervision of the Psychiatry Clinical Service faculty and staff who are responsible for monitoring the quality of clinical care provided. Discipline directors are responsible for ensuring that training assignments are properly supervised and are commensurate with the trainee's educational level.

In addition, all Psychiatry Clinical Service members may attend UCSF departmental courses for CME credits.

VI. PSYCHIATRY CLINICAL SERVICE CONSULTATION CRITERIA

The Psychiatry Clinical Service Consultation Criteria are outlined in Appendix H.

VII. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

A. An appropriate medical screening examination shall be provided to all persons who present themselves to the ZSFG Psychiatry Emergency Service and who request, or have request made on their behalf, for an examination or treatment of a medical condition. In such an event, the Hospital shall not seek authorization from an individual's insurance company until a medical screening examination has been provided and any necessary stabilizing treatment has been initiated. The patient will not be transferred to another facility unless the patient's condition is stabilized or it is in the patient's best interest to be transferred due to the hospital's inability to provide the needed services or level of care.

B. An appropriate medical screening examination shall be provided to persons, including visitors, who present themselves at an area of the Hospital's main campus other than the Emergency Department if they request, or have a request made on their behalf, for examination or treatment for what may be an emergency medical condition. Where there is no verbal request, a request will nevertheless be considered to exist if a prudent

layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment.

C. The medical screening exam must be performed by a physician or other qualified medical personnel as designated by the clinical service.

D. In the event that a request is made for emergency care in a Hospital department off the Hospital's main campus, such as a Community Primary Care Services Clinic, EMTALA does not apply. The clinic shall provide whatever assistance is within its capability and shall call the local emergency medical services to take the individual to an emergency department.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) & UTILIZATION MANAGEMENT

The Psychiatry Clinical Service is committed to strive towards maintaining the highest possible standard of practice. The Psychiatry Clinical Service PIPS Plan is detailed in APPENDIX E.

A. GOALS and OBJECTIVES

The Psychiatry Clinical Service is committed to strive towards maintaining the highest possible standard of practice. The purpose of the PIPS Program of the Department of Psychiatry is to promote desired patient outcomes by evaluating and improving processes that most affect patient care. The PIPS Program is a multidisciplinary effort, dependent upon the continued commitment and involvement of all staff, including both clinical and administrative, to provide our patients with the highest degree of quality care possible.

B. RESPONSIBILITY

The Psychiatry Department's Executive Committee guides and directs all departmental PIPS activities.

C. REPORTING

All Performance Improvement/Patient Safety activities are reported to the Executive Committee and the ZSFG PIPS Committee through annual reports and presentations. Nursing specific quality improvement activities are also reported to the Nursing Quality Improvement Coordinating Committee. The Assault & Battery Review Board is an important standing multidisciplinary committee that is engaged in PIPS activity. In addition, the Acute and Emergency Services Staff meeting reviews relevant findings to disseminate them to clinical staff. The Department of Psychiatry's PIPS Program is fully integrated into the ZSFG PIPS Program.

D. CLINICAL INDICATORS

The Psychiatry Clinical Service's PIPS Program conducts ongoing monitoring of AWOLS, assaults (including sexual assaults), death/suicide, suicide attempts, seclusion and restraint, patient complaints, code blues, development of disabling or life threatening conditions, and medication errors. (See APPENDIX E for additional information.)

E. CLINICAL SERVICE PRACTITIONER PERFORMANCE PROFILES (OPPE)

Performance improvement and patient care information are collected biannually and are included in the clinical service practitioners' performance profile.

F. MONITORING AND EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Psychiatry Clinical Services PIPS Program collects Medical Staff peer reviews and medication monitoring. In addition, the Psychiatry Clinical Service has a Significant Event Program, Patient Complaint and Grievance Process, and a Patient Satisfaction Survey Process. (see APPENDIX E for additional information)

G. DISCHARGE PLAN AND EXIT RECORD

The requirements for discharge plan and exit record are detailed in APPENDIX F

H. INFORMED CONSENT

All decisions for treatment should involve the active participation of the patient when competent, and should be made after appropriate discussions of risks, benefits, and alternatives.

Documentation of "Informed Consent" on medical staff approved forms is required for All Psychiatric Medications.

I. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1) **Physicians**
   All requirements and details are delineated in APPENDIX F.

2) **Housestaff**
   Details are outlined in the APPENDIX B

3) **Affiliated Professionals**
   Annual UCSF or CCSF Performance Evaluation. Ongoing monitoring requirements and details are delineated in APPENDIX B.

4) **ZSFG Employees other than Affiliated Professionals**
   Annual UCSF or CCSF Performance Evaluation.

J. COMMITTEE STRUCTURE

The Psychiatry Clinical Service will maintain the following committees:

Executive Committee
Division Directors Committee
Acute and Emergency Services Staff Committee
Assault & Battery Review Board
Residency Training Committee

X. MEDICAL RECORDS

The members of the service are committed to the maintenance of complete, accurate, and timely medical records.

1. The requirements as set forth in the ZSFG Medical Staff Bylaws and the Rules and Regulations define the minimum standards for records in the service, and
2. Medical Record documentation requirements are detailed in APPENDIX F.

XI. PROTECTION OF PATIENT PRIVACY

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

B. Members of the Medical Staff shall abide by the following:

1. Protected Health information shall only be accessed, discussed or divulged as required for the performance of job duties;
2. User IDS and/or passwords shall only be disclosed to Hospital Information Systems staff;
3. Members shall not log into Hospital information systems or authenticate entries with the user ID or password of another; and
4. Members shall only install software on Hospital computers that have been appropriately licensed and authorized by Hospital Information Systems staff.

C. Members agree that violation of this section regarding Protection of Patient Privacy may result in corrective action as set forth in these Bylaws.

XII. PSYCHIATRY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM

It is the policy of the Psychiatry Clinical Service to provide supervision of psychiatric housestaff for their work in the clinical service. Details are outlined in Section 1.15 of the Psychiatric Clinical Policy and Procedures manual (Appendix C). See CHN Intranet Site, Housestaff Competencies link.

Psychiatry residents who are providing clinical care during regular business hours 8:00AM-5:00PM are supervised by an attending psychiatrist associated with the individual service. After hours and on weekends, psychiatry residents providing clinical care are supervised by a Back-Up Attending Psychiatrist who provides supervision by telephone and is available to assist on-site as indicated. Psychiatry residents providing clinical care in the Psychiatry Emergency Service (PES) are supervised by a PES attending psychiatrist who is on-site 24/7.

XIII. 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 Psychiatry Clinical Services shall meet as frequently as necessary, but at least quarterly, to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XIV. ADOPTION AND ADMENDMENT

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

APPENDIX A – PSYCHIATRY PRIVILEGE REQUEST FORM

Zuckerberg San Francisco General Hospital

Delineation of Privileges

Psychiatry 2020

Privilege	Status	Approved

Psych PSYCHIATRY 2019
(08/2020 MEC)

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

34.10 ADULT (CORE) PRIVILEGES - PSYCHIATRISTS (MD/DO) ___
Diagnostic assessment and treatment of psychiatric and substance abuse disorders; including mental status exam; treatment planning; individual psychotherapy; group psychotherapy; family psychotherapy; emergency psychiatry assessment and treatment; crisis management; evaluation of medical status; use of psychotropic drugs approved by the FDA; detoxification following substance abuse; and behavior modification of patients 16 years and older. Placement of all legally applicable involuntary mental health holds for the purpose of evaluation and treatment of patients of all ages.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.20 BEHAVIORAL HEALTH CENTER PRIVILEGES - PSYCHIATRISTS (MD/DO) ___
Diagnostic assessment and treatment of psychiatric and substance abuse disorders; including mental status exam; treatment planning; individual psychotherapy; group psychotherapy; family psychotherapy; emergency psychiatry assessment and treatment; crisis management; evaluation of medical status; use of psychotropic drugs approved by the FDA; detoxification following substance abuse; and behavior modification.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

______________________________ ______________
Medical Director, Behavioral Health Center Date

34.30 SUBSPECIALITY PRIVILEGES (MD/DO) ___
Note: If You Are Requesting Specialized Privileges, You Need To Request Separate Adult Core Privileges Unless You Intend To Restrict Your Practice Exclusively To The Subspecialty Area(s).
In addition to criteria noted in 34.10, psychiatrists must possess training that qualifies them as subspecialists in an area of psychiatry and must provide evidence of qualifications, i.e. certificate of completion of specialized training in a recognized area or subspecialty board certification.

34.31 CHILD PSYCHIATRY ___
Psychiatric assessment and treatment (see Basic Privileges above) of patients under 19 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Currently Board-eligible, Board certified, or Re-Certified in Child Psychiatry or documentation of 2 years or more of applicable clinical experience in Child Psychiatry approved by the Chief of Psychiatry

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.32 ADOLESCENT PSYCHIATRY (MD/DO) ___
Psychiatric assessment and treatment (see Basic Privileges above) of patients from 14 through 18 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Possess Basic Privileges in Psychiatry; Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology in General Psychiatry who in addition to general psychiatry training has two years or more of documented sufficient, specialized training and experience in working with adolescents and their families approved by the Chief of Psychiatry, and has demonstrated competence to examine and treat adolescents comprehensively, or a member of the Service prior to 10/17/00.

PROCTORING: 5 proctored adolescent cases within the first year.

REAPPOINTMENT: 4 cases in each 2 year period

34.33 ELECTROCONVULSIVE THERAPY (ECT) - ADULT PATIENTS (MD/DO) ___
Assessment of candidate patients, patient selection; ECT treatment; post-treatment monitoring of patients in collaboration with SFGHTC Anesthesia staff.

PREREQUISITES: Possess Basic Privileges in Psychiatry; documentation successful completion of specific ECT training within the past 3 years (if training completed prior to 3 years ago, documentation of ECT clinical activity in good standing with an average of at least 5 cases annually during the prior 3 years), or a member of the Service prior to 10/17/00.

PROCTORING: 5 proctored cases by physician privileged for ECT treatment at SFGHTC or other institution required prior to independent practice of ECT (i.e. if first 5 treatment cases; if proctored by a staff member of another institution, proctoring must be completed prior to granting of privilege).

REAPPOINTMENT: Peer review of 5 cases in each 2 year period is required for reappointment.

34.40 ADULT (CORE) PRIVILEGES - LICENSED CLINICAL PSYCHOLOGISTS (PhD/PsyD/EdD) ___
Diagnostic assessment and treatment of psychiatric and substance abuse disorders, including mental status examination, treatment planning, individual psychotherapy, group psychotherapy, family psychotherapy, behavior modification, and cognitive behavioral therapy of patients 18 years and older.

PREREQUISITES: Completion of a doctoral degree in psychology from an APA accredited program and licensure by the State of California, Board of Psychology on the basis of the doctoral degree in psychology

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.50 SPECIALIZED PRIVILEGES (PhD/PsyD/EdD) ___
Note: If You Are Requesting Specialized Privileges, You Need To Request Separate Adult Core Privileges Unless You Intend To Restrict Your Practice Exclusively To The Subspecialty Area(s).
In addition to criteria noted in 34.40, psychologists must apply for each privilege individually and provide documentation indicating appropriate training and proficiency in the activity or technique.

34.51 PSYCHOMETRIC EVALUATION ___
Testing and measurement of psychological variables including intelligence, aptitude, and personality traits

PREREQUISITES: Minimum of one year of experience (1500 hours) providing psychometric evaluation in a clinical setting, including test administration, scoring, and interpretation, as well as written report. Proficiency in delivering these services in an autonomous fashion must be verified by a supervisor or prior work setting and approved by the Chief Psychologist. \

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period 5 proctored cases within the first year

a. Along With Initialing For Privileges 34.51, Please Initial Here To Indicate If You Are Requesting Privileges For Children And Adolescent (Under 19 Years Of Age) Psychometric Evaluation ____________ ___

b. Along With Initialing For Privileges 34.51, Please Initial Here To Indicate If You Are Requesting Privileges For Adult (18 Years Of Age And Older) Psychometric Evaluation ___________ ___

34.52 NEUROPSYCHOLOGICAL EVALUATION ___
Note: Neuropsychology Privileges Subsumes Psychometric Evaluation Privileges Specialized diagnostic assessment of disorders of neurocognitive function.

PREREQUISITES: Completion of the equivalent of a full-time post-doctoral internship in clinical neuropsychology or 2 years of work experience as a clinical neuropsychologist. This experience must be verified by former supervisor or work setting, including the ability to proficiently deliver these services in an autonomous fashion. Experience must be approved by the Chief Psychologist.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

a. Along With Initialing For Privileges 34.52, Please Initial Here To Indicate If You Are Requesting Privileges For Children And Adolescent (Under 19 Years Of Age) Psychometric Evaluation ___________ ___

b. Along With Initialing For Privileges 34.52, Please Initial Here To Indicate If You Are Requesting Privileges For Adult (18 Years Of Age And Older) Psychometric Evaluation ___________ ___

34.53 CHILD AND ADOLESCENT PSYCHOLOGY ___
Psychological assessment and treatment (see Basic Privileges above for Clinical Psychologists) of patients under 19 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Documentation of a least one year of didactic instruction and supervised clinical experience in child and adolescent assessment and treatment; approved by Chief Psychologist.

PROCTORING: 5 cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.54 ADDICTION MEDICINE ___
Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and board admissible, certified or re-certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, American Board of Family Medicine, American Board of Pediatrics, American Board of Psychiatry and Neurology, or American Board of Emergency Medicine. Approval of the Director of the Addiction Medicine Service required for all applicants.

PROCTORING: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

REAPPOINTMENT: Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

____ ____________________
Addiction Medicine Director/Designee Date

34.60 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

_______________________________ _______________
CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_______________________________ _______________
Applicant Date

APPROVED BY

_______________________________ _______________
Division Chief Date

_______________________________ _______________
Service Chief Date

APPENDIX B – CREDENTIALING OF MEDICAL AND AFFILIATED STAFF

POLICY:

It is the policy of the Department of Psychiatry, Zuckerberg San Francisco General Hospital, to certify the clinical competence of all medical and affiliated staff, including newly appointed staff. Newly appointed staff are proctored during the initial six months of their appointment, and also undergo continuous monitoring of clinical practice (outlined below). Upon completion of the proctoring process, information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Department or his/her designee, who then makes appropriate recommendations to continue or revise the status of the staff member. For subsequent reappointment to the medical staff, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Department or his/her designee, who then makes appropriate recommendations to reappoint or revise the status of the staff member.

All materials gathered for evaluation purposes are kept in confidential files in the Department of Psychiatry.

PURPOSE:

To ensure that medical and affiliated staff of the Department of Psychiatry are able to demonstrate well-developed skills in the following areas:

Interview of psychiatric patients
Diagnosis of psychiatric patients
Development of appropriate treatment plan
Use of psychotropic medications (MD/DO/NP only)
Facility with standard psychological therapies

BASIC QUALIFICATIONS FOR CONSIDERATION OF APPOINTMENT TO THE MEDICAL STAFF:

1. Psychiatrists must have successfully completed an approved ACGME residency training program in Psychiatry, be Board Admissible or Board Certified by the American Board of Psychiatry and Neurology, and possess Medical Licensure from the Medical Board of California. The requirement for Board certification or admissibility may be waived at the discretion of the Chief of Service after careful review of the applicant's qualifications and experience. Such a waiver request shall be put in writing by the Chief of Service to the ZSFG Credentials Committee, and will outline the applicant's qualifications and experience.

2. Clinical Psychologists must hold a doctorate degree in psychology from an APA-accredited program, and be licensed on the basis of the doctorate degree in psychology by the State of California Board of Psychology. The requirement for an APA accredited training program may be waived at the discretion of the Chief Psychologist after careful review of the applicant's qualifications/experience and verification that the applicant has completed the same number of internship hours as those required by an APA accredited training program and as required by the State of California, Board of Psychology. Such a waiver will be requested in writing by the Chief Psychologist to the ZSFG Credentials Committee, and will outline the applicant's qualifications and experience.

3. Nurse Practitioners and Physician Assistants must hold the following qualifications:

<u>Nurse Practitioners:</u>

1. Active California Registered Nurse license
2. Successful completion of a Nurse Practitioner program which conforms to the California BRN standards.
3. Certification to practice and prescribe in the state of California as a Nurse Practitioner
4. At least one year of experience as a Registered Nurse or Nurse Practitioner in psychiatry and/or adult health
5. All other requirements listed in the Bylaws and the Rules and Regulations

<u>Physician Assistants</u>:

1. Active California Physician Assistant license
2. Successful completion of a Physician Assistant Training Program which conforms to California Medical Board standards
3. At least one year of experience as a Physician Assistant in Psychiatry and/or adult health
4. All other requirements listed in the Bylaws and the Rules and Regulations

PROCESS:

I. Proctoring of Newly Appointed Medical and Affiliated Staff – Divisions will choose who proctors

A. A minimum of one proctor is assigned to each newly appointed staff member. The assigned proctor(s) comprise experienced medical staff member(s). It is the responsibility of the proctor(s) to observe the actual practices of the applicant and document their observations. The observations may be made in one of two ways:

1. On an ad hoc basis, the proctor may concurrently review the clinical care of individual patients and complete the proctoring forms.

2. The new staff member may serve as a case discussant in a case conference. This involves review by the new staff member of the patient's history, interview of the patient in the presence of other staff members, development of a differential diagnosis and discussion of a treatment plan.

B. Each new staff member receives a minimum of six (6) clinical reviews during the initial six months of their appointment, documented on the proctoring form.

C. <u>PES On-Call Physicians:</u> Before working independently, PES on-call physicians are reviewed on four clinical assessments upon initial employment. Six months after initial employment, the physician is reviewed on two more clinical assessments. Thus, at the end of the six-month proctoring process, six case reviews have occurred. The proctoring period may be extended in the event that the new staff member is not scheduled for clinical care activities frequently enough

to complete six clinical reviews during the initial six months of employment. Each assessment is carried out by the senior attending psychiatrist on duty in PES at the time the on-call physician is scheduled to work, and is documented on the PES Orientation/Proctoring form. Each assessment includes:

1. One observed interview (more if needed)
2. Clinical assessment
3. Diagnostic formulation
4. Treatment and planning
5. Completion of necessary documentation

D. Concerns of the proctor regarding a proctored practitioner's performance will be documented and the issue will be brought to the immediate attention of both the Deputy Chief and Service Chief of the Department for necessary action.

II. Continuous Monitoring of Clinical Practice

A. The clinical practice of all medical and affiliated staff in the Department of Psychiatry is monitored according to the monitoring plan developed by the PIPS Committee, and includes primarily peer review. Examples of unusual or deviant practice are reported to the Department's Chief as provided in this policy and are available for review at the time reappointment to the medical staff.

B. Clinician-specific information for Ongoing Professional Practice Evaluation (OPPE) related to clinical practice is reviewed by the Chief of the department or his/her designee when the staff member is being considered for reappointment to the medical staff. Appropriate information would include the following:

~~1. Attributable/preventable mortality~~
~~2. Peer review completion~~
~~3. UOs about interpersonal and communication skills~~
~~4. Patients' complaints~~
~~5. UOs about professionalism~~
~~6. Chart completion~~

1. Attributable/preventable mortality
2. Adverse drug reporting events
3. NP/PA - Appropriateness of clinical decision-making
4. Completion of annual training modules
5. Maintenance of State Licensing CME requirements
6. SAFE reports about interpersonal and communication skills
7. Patients' complaints
8. SAFE reports about provider professional behavior
9. Flu vaccine policy compliance
10. Percent closed Epic clinical notes within 3 days
11. Complaints from non-ZSFG DPH clinicians/staff

C. Performance problems will be reviewed by the Deputy Chief and Service Chief of the Department for necessary action.

III. Credentialing

A. Licensure/Certification:
All medical and affiliated staff members are required to provide the following information to the Academic Personnel Analyst to ensure that each member's file contains current licensure/certification information:

1. Copies of current licensure/certification, as applicable:

   Professional license
   DEA Certification (MD/DO/NP only)

2. As the above individual licenses/certificates expire, it is the responsibility of the medical staff member to apply for their renewal in a timely manner and provide the Academic Personnel Analyst with a current copy of each prior to or upon expirations.

B. Medical and Affiliated Staff Appointment/Reappointment Paperwork:
All medical staff members are required to complete in full and submit the necessary medical/affiliated staff appointment/reappointment paperwork within the time limit specified by the office requesting the paperwork.

C. Medical Staff Members Assigned as Proctors:
All medical staff members assigned as proctors to junior members are required to complete the necessary proctoring documentation in accordance with the ZSFG Department of Psychiatry Proctoring Policy (see Section II of this policy). It is the responsibility of either the peer reviewer or the individual medical staff member, whichever applies, to ensure that all documentation is completed in full and submitted within the time limit specified by the Quality Management Office.

D. Failure to Meet Documentation/Paperwork Compliance Deadlines:
In the event that the documentation/paperwork summarized in 1, 2 and 3 below is not provided within the time limit specified (as outlined in A, B, C, and D above), per ZSFG Medical Staff Bylaws and the Rules and Regulations, the medical staff member will no longer qualify for medical staff and their appointment and privileges will be terminated.

1. Medical Staff members are responsible for providing the following documentation:
   a. Licensure/Certification
      Professional License
      DEA Certification (MD/DO/NP only)

   b. Appointment/Reappointment Paperwork

2. Proctors are responsible for providing the following documentation:
   a. Proctoring documentation

3. Supervisors are responsible for arranging and/or providing the following:
   a. Peer review findings
   b. Recommendation requests

APPENDIX C – HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. EDUCATION OBJECTIVES

Rotation on the Psychiatry Service at ZSFG is primarily designed to provide the PGY-1 psychiatry resident with a comprehensive experience in the emergency and inpatient treatment of major mental illness. An emphasis is placed upon thorough assessment and diagnosis of the major mental disorders, as well as the major treatment modalities of inpatient psychiatry and emergency psychiatry. Clinical interviewing, crisis stabilization, family intervention, and psychopharmacology are among the important topics of study. Rotations for advanced residents (PGY-2 through PGY-4) focus on outpatient, case management, and consultation liaison psychiatry, with training experiences tailored to provide an in-depth exposure to these different treatment settings and the development of fundamental competencies in these clinical areas.

B. SUPERVISION AND EVALUATION

Residents at ZSFG are supervised and evaluated in an ongoing way via multiple channels.

1. Residents are not members of the medical staff. The clinical and medico-legal responsibility for their patient care activities rests with their supervisors, who are attending level members of the Active and Courtesy medical staff. The routine credentialing processes for medical staff membership permits monitoring of the quality of care provided. The same standards of quality apply as when the supervising attending member of the medical staff is the sole provider. The close involvement of the responsible attending psychiatrist is documented in the patients' medical records by written entries, co-signatures on key documents, treatment plans, discharge forms, diagnosis forms, etc.

2. In the PGY 1 year, residents on the ZSFG Inpatient Psychiatric Units meet at least daily with their on-ward supervisor, who interviews patients with them and directly supervises their work. The on-ward supervisor will also read and make notes in the patient's medical chart. The residents also meet once a week with their off-ward supervisor. (As for evaluation, each of these supervisors is responsible for ongoing feedback as well as a written evaluation at the end of each ~~three-month~~ rotation, which is discussed with the resident. It is the responsibility of the supervisor to provide written evaluations within the deadlines set by the Residency Training Program Office.)

3. In the PGY 1 year, residents rotating on the Psychiatric Emergency Service (PES) are supervised by the PES faculty attending psychiatrist, who interviews patients with them and directly supervises their work. The supervisor will also read and make notes in the patient's medical chart.

4. Residents rotating on the Psychiatric Consultation Liaison Service are supervised by an Attending Psychiatrist in several ways. The Attending Psychiatrist is accessible by pager throughout the work week to review urgent and emergent clinical issues. The resident attends daily general service and team rounds that provide settings for further clinical review. A weekly Case Conference provides a forum for the residents to intensively

review their clinical care of a patient. Finally, each resident meets weekly with their service supervisor to review challenging or problematic clinical issues

5. Advanced UCSF residents working on other services in the Department of Psychiatry are supervised by faculty attending psychiatrists and psychologists assigned to the service. The faculty attendings are responsible for the clinical care provided by the residents.

6. After hours, weekends, and holidays, on-call residents in-house are supervised by the faculty backup attending psychiatrist who is available by pager and able to come to the hospital if clinically indicated. Residents are strongly encouraged to call the faculty back-up for any clinical or administrative question, and are ***required*** to call for the following: new admissions to the Jail Psychiatric Unit, unexpected patient discharges from inpatient psychiatry, new consult requests ***TO*** non-psychiatric services, new consultation requests ***FROM*** non-psychiatric services, any significant changes in medical condition or treatment plan for current psychiatric inpatients, AWOL of a patient on an involuntary psychiatric hold, assault occurring on an inpatient psychiatry unit, administration of involuntary emergency medications, initiation of seclusion or restraint, and any difficult to resolve staff conflicts or system issues. The faculty attending psychiatrist is responsible for all clinical services provided by the on-call resident. In addition, licensed psychiatrists in the Psychiatric Emergency Service are available to the on-call resident for face-to-face consultation.

7. The Site Director meets with each of the PGY 1 residents to review their evaluation and progress in the program midway during their six month rotations. The evaluations and summary of the meetings are then placed in their permanent file.

APPENDIX D – PSYCHIATRY HOUSESTAFF COMPETENCIES

Psychiatry Milestones, The Accreditation Council for Graduate medical Education can be viewed at the link below:

https://ucsf.box.com/s/sxozupuluc260nsqebre9d3ijlgqohl8

APPENDIX E – PERFORMANCE IMPROVEMENT AND PATIENT SAFETY PLAN

PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN DEPARTMENT OF PSYCHIATRY

Purpose

The purpose of the PIPS program of the Department of Psychiatry at San Francisco General Hospital is to promote desired patient outcomes by evaluating and improving processes that most affect patient care.

The PIPS program is a multidisciplinary effort, dependent upon the continued commitment and involvement of all staff, including both clinical and administrative, to provide our patients with the highest degree of quality care possible.

Goals

1. Improvement of patient outcomes and patient safety.
2. Improvement of the processes of care.
3. Awareness, understanding and involvement of all staff in quality and performance improvement through the integration of the concepts of quality into daily practice.
4. Coordination and integration of the processes of care between providers.

Objectives

1. To educate all staff in the concepts of performance improvement (PI) and patient safety.
2. To promote responsibility and accountability for the performance improvement process by each member of the staff.
3. To evaluate the quality and appropriateness of care through ongoing monitoring and evaluation activities specific to the Department of Psychiatry.
4. To design new processes that are effective, consistent with the organization's mission, that consider staff and patient needs, ideas, and expectations, and that are based on up to date information.
5. To identify and study processes/issues from a variety of data sources including: patient surveys, staff meetings, committee reports, PI reports, audits, infection control data, risk management, patient complaint data.
6. To determine trends or patterns that warrant further evaluation.
7. To conduct monitoring activities designed to evaluate processes that are high risk, high volume and problem prone.
8. To utilize the information obtained through surveys and identify the needs and expectations of patients and others; e.g. staff, providers.

9. To take corrective action on problems identified or processes that could be improved.

10. To re-evaluate the corrective actions taken and monitor the response.

11. To facilitate the collaboration of all PI groups and committees to identify and resolve intradepartmental and interdepartmental problems.

12. To recognize and support staff participation in unit and program based performance improvement and patient safety activities.

Authority and Accountability

A. All performance improvement and patient safety activities are reported to the Department of Psychiatry Executive Committee, and the ZSFG PIPS Committee. Nursing-specific performance improvement and patient safety activities are also reported to the Nursing Quality Improvement Coordination Committee. In addition, the Acute and Emergency Staff meeting, Medical Staff Meeting and Psychiatric Nursing Executive Committee review relevant findings in order to apply to clinical practice.

B. Inpatient and PES PIPS Activities

The Inpatient Units and PES are integral parts of the department's PIPS Program. All units are involved in ongoing PI monitoring activities and unit staff participate in Department wide PIPS task forces. PIPS information is disseminated to the units through leadership meetings, Acute and Emergency Staff meeting, Medical Staff meetings and the Nursing QI Coordinating Committee.

In addition, Nursing reports to the Psychiatry Nursing QI Coordinating Committee. The purpose of this committee is to coordinate and provide continuity from a nursing perspective. [See Department of Nursing QI Plan for description.]

C. Department of Psychiatry Executive Committee

The Department of Psychiatry Executive Committee guides and directs all departmental performance improvement and patient safety activities

1. Objectives

    a. Plan and implement the department wide PIPS program.

    b. Development and approval of the PIPS plan.

    c. Selection of topics for department wide projects, and approval of PIPS outcome monitors and projects.

    d. Review and discussion of the findings of PIPS studies and projects. When applicable initiation of plans of action to improve patient care using data gathered from Sentinel Event Reviews, Drug Usage Evaluations and PI monitoring activities and projects.

    e. Identification of opportunities to improve care and reduce barriers to quality patient care.

    f. Approval and implementation of recommendations for quality of care improvements.

    g. Allocation of resources to facilitate the development, implementation, monitoring, evaluation and follow up of performance improvement activities.

h. Assessment of the effectiveness of the PIPS program, at least annually, to determine its impact on patient care and service delivery.

i. Support the design and evaluation of new processes using the CQI process.

2. Committee Membership
The Executive Committee meets monthly. Standing committee members include:
Chief of Psychiatry, [committee chairperson]
Deputy Chief of Psychiatry
Medical Director of Psychiatry Emergency Services,
Director of Psychiatry Residency Training
Nursing Director for Acute Psychiatry
Clinical Director for the Division of Substance Abuse and Addiction Medicine
Director of Citywide
Director, Division of Integrated Behavioral Health
ZSFG Chief Integrative Officer
Division Director of Infant Child and Adolescent Psychiatry
Director of Psychiatry Administration
Director of Alliance Health Project
Director of Trauma Recovery Services

D. Departmental/Program Monitoring and Activities

Through continuous monitoring and evaluation, the patient focused functions and organizational functions are improved. Indicators based on the scope of service and important aspects of care are generated and studied at the departmental, unit, or service level. Both outcomes and processes are monitored and when an improvement opportunity is identified an action plan designed to improve the function or process is developed and implemented.

1. Peer Review and Medication Monitoring – Evaluation of the adequacy and appropriateness of care is monitored annually through the Peer Review and Medication Monitoring processes. Medication monitoring processes measured include prescribing and ordering, preparing and dispensing, administration and monitoring the medications effects on patients. Peer review criteria, primarily documentation based, are reviewed by Medical Staff for compliance to documentation standards. When non-compliance is noted, staff are counseled regarding specific means of meeting the criteria. Results from Peer Review and Medication Monitoring are quantified annually, and reviewed by the administrative leadership.

Sentinel Event (SE) Review/Root Cause Analysis (RCA) – All unusual occurrences which meet Level I and Level II criteria are addressed. This process includes in-depth investigation of the incident, a determination of whether standards of care were met and, when appropriate, a SE Level I Review and Root Cause Analysis. The significant event reviews are designed to identify opportunities to improve processes, staff performance and the quality of patient care outcomes. These reviews are conducted with the oversight of the ZSFG Risk Management Committee.

2. Drug Usage Evaluations – Standards relating to the ongoing evaluation of drug usage are applied using specific criteria to measure appropriateness and effectiveness of medications used in the Department of Psychiatry. Criteria based studies are conducted that focus on frequently prescribed medications [high volume], medication that carries with it a significant degree of risk for the patient [high risk and/or drugs that are used for a specific diagnosis or condition. Results of Drug Usage Evaluations include the

mechanisms for improvement in the use of the medication and are disseminated to the Medical Staff, Executive Committee and PIPS Committees.

3. Patient Complaint/Grievance- The department is committed to providing quality care and service in accordance with our patients needs and desires. When a patient or a patient's significant other(s) is dissatisfied with any aspect of care provided within the psychiatry department, the Deputy Chief and Director of Psychiatry Nursing will be notified and an investigation will be conducted. The Deputy Chief and Director of Psychiatry Nursing will collaboratively work with the patient and the treatment team to resolve all patient complaints. All complaints received will be tracked and reported annually to the Patient Concern Subcommittee of the ZSFG Performance Improvement and Patient Safety Committee (PIPS) [See Department of Psychiatry Patient Complaint Policy #8.2]

Reporting of PIPS Activities

The activities of each committee are documented. This provides a way to monitor problems that are identified in the PIPS forum and to insure implementation of improvements. Priority is given to those aspects of patient care that are high risk, high volume and/or problem prone.

All departmental PIPS activities are reported to the ZSFG PIPS through annual reports and presentations. The Department of Psychiatry program is fully integrated into the ZSFG PIPS program.

EFECTIVE DATE: MARCH 2002
REVISED: May 2012
May, 2014
August 2016
November 2018
October 2020

CROSS REFERENCE: Unusual Occurrence: Significant Event Management
Significant Event Review Program
Patient Complaint Policy

Approved By:

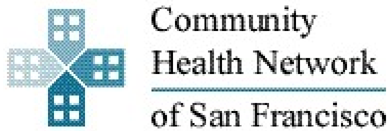
_______________________________________ _______________________
Chief, Department of Psychiatry Date

_______________________________________ _______________________
Director of Administration, Psychiatry Date

_______________________________________ _______________________
Director, Psychiatric Nursing Division Date

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

APPENDIX F – MEDICAL RECORDS DOCUMENTATION



The Integrated Delivery System
Of San Francisco's Department of
Public Health

DEPARTMENT OF PSYCHIATRY

5.3A

TITLE: **Medical Record Documentation Policy - Medical Staff**

POLICY: It is the policy of the San Francisco General Hospital Department of Psychiatry that medical services provided to patients are documented in accordance with the procedure as stated in this document.

PURPOSE: To ensure adequate and consistent standards of medical records charting in the Department of Psychiatry.

PROCEDURE:

A) Medical Staff Psychiatric Emergency Service (PES):

PES is responsible for initiating the following:

- psychiatric service record
- PES intake evaluation form/initial assessment (including medical history)
- admission orders
- ZSFG registration and admission forms
- voluntary admission/patient consent for medication, or, 5150/5150 advisement forms
- informed consent/medication advisement forms
- medical screening exam

The inpatient attending physician is responsible for evaluating the patient and documenting an Initial Psychiatric Assessment and Treatment Plan within 24 hours of inpatient admission. Inpatient attending physician progress notes shall be completed on all inpatients deemed by Utilization Management to be receiving an acute level of care.

Medical Staff- Consultation/Liaison Service (C/L):

The Consultation/Liaison (C/L) staff is responsible for completing the following documentation:

- consultation report
- daily follow up notes on hospitalized patients held on 5150 involuntary holds after leaving the ED, and others as clinically indicated
- PSR form
- Attending or Resident transfer note if admitted to Inpatient Psychiatry
- Medication consents (as appropriate) and legal status documents

If a patient is admitted after 4:30 p.m., C/L is responsible for completing the admission orders to inpatient psychiatry. If a patient is admitted between 8:00 a.m. and 4:30 p.m., the inpatient unit staff is responsible for completing the admission orders.

B) Medical Staff - Jail Psychiatric Services (JPS):

For patients admitted from JPS to 7L, JPS is responsible for completing the following forms. These forms must accompany the patient upon transfer.

JPS evaluation form

5150

For admissions between 8:30 a.m. and 4:30 p.m., the inpatient medical and unit staff staff are responsible for the following:

- patient evaluation
- PSR
- Inpatient admission orders
- physical exam
- Initial Psychiatric Assessment and Interdisciplinary Plan of Care (IPOC)
- ZSFG registration and admission forms
- voluntary admission/patient consent for medication forms or 5150/5150 advisement forms (if appropriate)

Medication consent forms for night and weekend admissions from JPS, the on-call resident and attending faculty back- up assume the above responsibilities. The responsibilities of the inpatient resident and attending physician are as previously outlined.

C) Medical Staff Inpatient Unit:

A. Admission Orders: Review admission orders from PES and revise as indicated.

B. Admission Note:

The initial psychiatric assessment is completed and placed in the database section of the chart and includes the following categories:

- chief complaint
- history of present illness
- pertinent medical, psychiatric, substance abuse, alcohol withdrawal, family, educational, occupational and social history
- active medical problems/findings
- TB screening status
- Physical exam status
- patient's personal strengths
- patient's level of function
- mental status examination
- ICD-10 diagnosis initial plan of care with goals/rationale that substantiate the medical necessity of acute inpatient admission.
- treatment interventions
- disposition plan
- indication of patient's level of involvement in the plan, and signature if obtainable
- Attending physician signature with name and CHN#

C. Physical Examination and Review of Systems: See P&P #2.11.01

D. Interdisciplinary Plan of Care:

The Treatment Team will review and update the Interdisciplinary Plan of Care every week.

E. Progress Notes:

Progress notes are written each day (7 days/week) by the psychiatry attending for all patients deemed by Utilization Management to be receiving acute care. These notes should address the current mental status; assessment (including documentation of medical necessity for acute care), disposition and treatment plan specifically addressing problems outlined in the initial and subsequent plans. Rationale for medication order changes (including dose and type) must be documented.

F. Discharge Plan and Exit Record:

The Patient Discharge Summary (ICD-10 diagnoses, and Post-hospital care referral) must be completed at the time of discharge.

a. A clinician to clinician discussion of the patient's medical care needs is required for patients who are being discharged to another hospital or jail.

b. Written Discharge Summary: The attending physician certifies oversight and responsibility for the patient's hospital course by signing the written discharge summary.

Discharge Plan:

1. Identifying information:

- Patient's name, B#, Date of Birth (if possible, use addressograph stamp)
- Admission/Discharge dates
- Admission/Discharge units
- Admission/Discharge legal status

2. Treatment Information:

a. ICD-10 diagnoses

b. Medication upon discharge (and amount given at discharge)

c. Brief summary of hospitalization - include the following:

reasons for admission

mental status

course of treatment

medication response

complications

suicidal and assaultive behavior/ideation

abnormal physical exam and lab data

3. Resident physician's signature (if completed by Resident physician)

4. Attending physician's signature.

H. Monitoring:

The Attending Psychiatrist is responsible for reviewing and ensuring the completeness of medical staff, resident, and medical student documentation

Revised: June, 1995
May, 1999
May, 2000
March, 2002
August 2004
May, 2010
May, 2012
May, 2014
May, 2016
October 2020

Approved:
October 2020

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

Mark Leary, MD
Deputy Chief, Department of Psychiatry

APPENDIX G – CHIEF PSYCHIATRY CLINICAL SERVICE JOB DESCRIPTION

CHIEF OF PSYCHIATRY CLINICAL SERVICE
JOB DESCRIPTION

Position Summary:

The Chief of the Psychiatry Clinical Service directs and coordinated the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (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 the Psychiatry 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 the Psychiatry 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 the Psychiatry 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.

APPENDIX H -

PSYCHIATRIC CONSULTATION SERVICE
DIVISION OF Acute and Emergency Services/ ZSFG DEPARTMENT OF PSYCHIATRY

The mission of the Consultation Services is to assist the clinical staff to identify, evaluate and intervene with acute management difficulties of patients who are emotionally impaired or mentally disordered.

1. *Referral Criterion*
   - Medically admitted adults at ZSFG

2. *Service Priorities*

   High
   - Patients currently on a legal psychiatric hold (5150, 5250 and TCon)
   - Patients immediately at risk for suicidal behavior
   - Patients with a mental disorder and immediate risk for assaultive behavior
   - Patients with severely disorganized or chaotic behavior

   Routine
   - Evaluation for psychiatric diagnosis
   - Evaluation for non-emergent psychiatric intervention
   - Evaluation for psychiatric aftercare
   - Advisory opinion regarding informed consent
   - Patients in whom a mental disorder may significantly influence cooperation with staff or treatment
   - Enhancement of the provider/patient relationship
   - Patients transferred down from Psychiatry

3. *To Refer*

   Place consult request order in Epic EHR
   Monday - Friday, 8:00 a.m. - 5:00 p.m. - 327-9058
   Other hours throughout the week - 327-9058 - **(Emergency / Urgent Cases Only)**

4. *Please provide the following information:*
   - Patient name
   - Medical Record Number
   - Service
   - Attending Physician
   - Patient Location
   - Brief description of patient and referral question

5. Please inform the patient that you have asked us to see him/her.

Please Note: We are able to optimize our assistance and coordination of services when we are contacted early in the day and as early in the week as possible. We must see all patients admitted on psychiatric holds at least once.

PSYCHIATRY CLINICAL SERVICE
RULES AND REGULATIONS
2024

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

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I. PSYCHIATRY CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The mission of the Psychiatry Clinical Service is to provide the highest quality care to individuals with a variety of mental disorders and psychosocial problems, especially those from ethnic and minority groups, who largely depend on the public sector. In support of this mission and to further the academic collaboration between the City and the University, the Psychiatry Clinical Service is committed to providing training, research and evaluation, and direct patient care that will enhance the treatment of consumers of our services. Scope of Service Statements for specific units/services are maintained in the ZSFG Psychiatry Clinical Service Policy and Procedures Manual, Section 5.1B.

B. MEMBERSHIP REQUIREMENTS

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

CPR Certification is required for Affiliated Professionals.

C. ORGANIZATION OF PSYCHIATRY CLINICAL SERVICE

1. **The Officers of the Psychiatry Clinical Service are:**
   a. Chief of Service
   b. Deputy Chief
   c. Director of Administration

2. **Chief of Service (refer to APPENDIX G for additional information)**
   a. Appointment and review of the Chief of Service will occur by the process specified in the ZSFG Medical Staff Bylaws.

   b. Responsibilities

      1) Overall direction of the clinical, teaching, and research activities for the service.

      2) Review and recommendation of all new appointments, requests for privileges and reappointments.

      3) Overall direction of the Performance Improvement/Patient Safety and CQI activities for the Service.

      4) Appointment of the remaining officers of the service and of service committee members.

      5) Financial affairs of the service.

      6) Attendance at the Medical Executive Committee, the Chiefs of Service meetings and other meetings as called from time to time by the Executive Administrator or the Chief of Staff.

      7) Disciplinary actions as necessary, as set forth in these Rules and Regulations and in the Bylaws and Rules and Regulations of the Medical Staff.

3. **Deputy Chief:**

   a. Responsibilities: Assists the Chief of Service with the above.

4. Director of Administration:

a. Responsibilities: Provides overall direction for the budget of the department, human resources, and overall operations of the Service.

5. Attending Responsibilities (Psychiatrists, Psychologists):
Overall direction of clinical care is the responsibility of the supervising attending clinical staff of the Psychiatry Clinical Service. Specific attending job descriptions are maintained in the ZSFG Psychiatry Clinical Service Job Description Manual, (Refer to Appendix C).

II. CREDENTIALING

A. CREDENTIALING OF MEDICAL STAFF AND AFFILIATED PROFESSIONAL STAFF (refer to APPENDIX B)

B. NEW APPOINTMENTS

The process of application for membership to the Medical Staff or Affiliated Professional Staff of ZSFG through the Psychiatry Clinical Service is in accordance with ZSFG Medical Staff Bylaws and the Rules and Regulations.

C. REAPPOINTMENTS

The process of reappointment to the Medical Staff or Affiliated Professional Staff of ZSFG through the Psychiatry Clinical Service is in accordance with ZSFG Bylaws and the Rules and Regulations.

D. PRACTITIONER PERFORMANCE PROFILES

It is the policy of the Psychiatry Clinical Service to certify clinical competence of all medical staff and affiliated professionals, including newly appointed staff members. Information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Psychiatry Clinical Service, who then makes appropriate recommendations to continue or revise the status of the staff member. For subsequent reappointment to the medical staff or affiliated professional staff, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who makes appropriate recommendations to reappoint or revise the status of the staff member. All materials gathered for evaluation purposes are kept in confidential files in the Psychiatry Clinical Service. Details are outlined in the Psychiatry Clinical Service Credentialing of Medical and Affiliated Professional Staff Policy and Procedure 5.1A (Refer to Appendix B).

E. MODIFICATION OF CLINICAL SERVICE PRIVILEGES

Periodic re-determination of clinical service privileges and the increase in, or curtailment of same, shall be based upon direct observation of care provided, review of records of patients treated in the hospital, review of the records of the Medical Staff which document the evaluation of the member's provision of professional care. Clinical privileges will also be reviewed in the event of a change in job duties/responsibilities to determine that appropriate privileges are assigned. This process for modification of clinical service is in accordance with the ZSFG Bylaws and the Rules and Regulations.

F. STAFF STATUS CHANGE

The process for Staff Status Change for members of the Psychiatry Clinical Service is in accordance with ZSFG Bylaws and the Rules and Regulations.

G. AFFILIATED PROFESSIONALS

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

H. STAFF CATEGORIES

The Psychiatry Clinical Service staff fall into the same staff categories which are described in the ZSFG Bylaws and the Rules and Regulations, as well as these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES (refer to APPENDIX A)

A. DEVELOPMENT OF PRIVILEGE CRITERIA

Psychiatry Clinical Service privileges are developed in accordance with ZSFG Medical Staff Bylaws, and the Rules and Regulations.

B. ANNUAL REVIEW OF CLINICAL SERVICE PRIVILEGE REQUEST FORM

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

C. CLINICAL PRIVILEGES

Psychiatry Clinical Service privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws and the Rules and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Psychiatry Clinical Service or his/her designee.

1. Privileges to practice in the Psychiatry Clinical Service will be commensurate with clinical training and documentation of an acceptable standard of clinical practice. The specifics of the process are set forth in the Bylaws and the Rules and Regulations of the ZSFG Medical Staff. Privileges, which will be assigned, are described in detail in the Privileges Request Form for Privileges in Psychiatry Service (Refer to Appendix A).

2. Privileges are delineated by consensus of the Active members of the clinical service, and are approved by the Chief of Service or his/her designee, subject to the approval of the Credentials Committee of the medical staff.

3. Individual privileges are subject to review and revision at an initial appointment, throughout the period of proctoring, at the time of reappointment, at the time as judged necessary by the Chief of Service, or at any time recommended by 2/3s of the clinical service's Active staff.

D. TEMPORARY PRIVLEGES

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

IV. PROCTORING AND MONITORING

A. REQUIREMENTS

It is the policy of the Psychiatry Clinical Service, ZSFG, to certify that clinical competence of all medical/affiliated professionals, during the first two years of the initial appointment. Upon completion of the two years, information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who then makes appropriate recommendation to continue or revise the status of the staff member. For subsequent reappointment to the medical/affiliated professionals, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Psychiatry Clinical Service or his/her designee, who makes appropriate recommendations to reappoint or revise the status of the staff member. All materials gathered for evaluation purposes are kept in confidential files in the Psychiatry Clinical Service. Details are outlined in the Psychiatry Clinical Service Credentialing of Medical Professional Staff Policy and Procedure 5.1A (Refer to Appendix B)

B. ADDITIONAL PRIVILEGES

Requests for additional privileges for the Psychiatry Clinical Service shall be in accordance with ZSFG Medical Staff Bylaws and the Rules and Regulations.

C. REMOVAL OF PRIVILEGES

Requests for removal of privileges for the Psychiatry Clinical Service shall be in accordance with ZSFG Medical Staff Bylaws and the Rules and Regulations.

V. EDUCATION

The Psychiatry Clinical Service serves as a training site for students, interns, and residents in the disciplines of medicine (psychiatry), psychology, nursing, social work, and occupational therapy. Trainees work under the supervision of the Psychiatry Clinical Service faculty and staff who are responsible for monitoring the quality of clinical care provided. Discipline directors are responsible for ensuring that training assignments are properly supervised and are commensurate with the trainee's educational level.

In addition, all Psychiatry Clinical Service members may attend UCSF departmental courses for CME credits.

VI. PSYCHIATRY CLINICAL SERVICE CONSULTATION CRITERIA

The Psychiatry Clinical Service Consultation Criteria are outlined in Appendix H.

VII. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA)

A. An appropriate medical screening examination shall be provided to all persons who present themselves to the ZSFG Psychiatry Emergency Service and who request, or have request made on their behalf, for an examination or treatment of a medical condition. In such an event, the Hospital shall not seek authorization from an individual's insurance company until a medical screening examination has been provided and any necessary stabilizing treatment has been initiated. The patient will not be transferred to another facility unless the patient's condition is stabilized or it is in the patient's best interest to be transferred due to the hospital's inability to provide the needed services or level of care.

B. An appropriate medical screening examination shall be provided to persons, including visitors, who present themselves at an area of the Hospital's main campus other than the Emergency Department if they request, or have a request made on their behalf, for examination or treatment for what may be an emergency medical condition. Where there is no verbal request, a request will nevertheless be considered to exist if a prudent

layperson observer would conclude, based on the person's appearance or behavior, that the person needs emergency examination or treatment.

C. The medical screening exam must be performed by a physician or other qualified medical personnel as designated by the clinical service.

D. In the event that a request is made for emergency care in a Hospital department off the Hospital's main campus, such as a Community Primary Care Services Clinic, EMTALA does not apply. The clinic shall provide whatever assistance is within its capability and shall call the local emergency medical services to take the individual to an emergency department.

VIII. DISCIPLINARY ACTION

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

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) & UTILIZATION MANAGEMENT

The Psychiatry Clinical Service is committed to strive towards maintaining the highest possible standard of practice. The Psychiatry Clinical Service PIPS Plan is detailed in APPENDIX E.

A. GOALS and OBJECTIVES

The Psychiatry Clinical Service is committed to strive towards maintaining the highest possible standard of practice. The purpose of the PIPS Program of the Department of Psychiatry is to promote desired patient outcomes by evaluating and improving processes that most affect patient care. The PIPS Program is a multidisciplinary effort, dependent upon the continued commitment and involvement of all staff, including both clinical and administrative, to provide our patients with the highest degree of quality care possible.

B. RESPONSIBILITY

The Psychiatry Department's Executive Committee guides and directs all departmental PIPS activities.

C. REPORTING

All Performance Improvement/Patient Safety activities are reported to the Executive Committee and the ZSFG PIPS Committee through annual reports and presentations. Nursing specific quality improvement activities are also reported to the Nursing Quality Improvement Coordinating Committee. The Assault & Battery Review Board is an important standing multidisciplinary committee that is engaged in PIPS activity. In addition, the Acute and Emergency Services Staff meeting reviews relevant findings to disseminate them to clinical staff. The Department of Psychiatry's PIPS Program is fully integrated into the ZSFG PIPS Program.

D. CLINICAL INDICATORS

The Psychiatry Clinical Service's PIPS Program conducts ongoing monitoring of AWOLS, assaults (including sexual assaults), death/suicide, suicide attempts, seclusion and restraint, patient complaints, code blues, development of disabling or life threatening conditions, and medication errors. (See APPENDIX E for additional information.)

E. CLINICAL SERVICE PRACTITIONER PERFORMANCE PROFILES (OPPE)

Performance improvement and patient care information are collected biannually and are included in the clinical service practitioners' performance profile.

F. MONITORING AND EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

The Psychiatry Clinical Services PIPS Program collects Medical Staff peer reviews and medication monitoring. In addition, the Psychiatry Clinical Service has a Significant Event Program, Patient Complaint and Grievance Process, and a Patient Satisfaction Survey Process. (see APPENDIX E for additional information)

G. DISCHARGE PLAN AND EXIT RECORD

The requirements for discharge plan and exit record are detailed in APPENDIX F

H. INFORMED CONSENT

All decisions for treatment should involve the active participation of the patient when competent, and should be made after appropriate discussions of risks, benefits, and alternatives.

Documentation of "Informed Consent" on medical staff approved forms is required for All Psychiatric Medications.

I. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE

1) Physicians
All requirements and details are delineated in APPENDIX F.

2) Housestaff
Details are outlined in the APPENDIX B

3) Affiliated Professionals
Annual UCSF or CCSF Performance Evaluation. Ongoing monitoring requirements and details are delineated in APPENDIX B.

4) ZSFG Employees other than Affiliated Professionals
Annual UCSF or CCSF Performance Evaluation.

J. COMMITTEE STRUCTURE

The Psychiatry Clinical Service will maintain the following committees:

Executive Committee
Division Directors Committee
Acute and Emergency Services Staff Committee
Assault & Battery Review Board
Residency Training Committee

X. MEDICAL RECORDS

The members of the service are committed to the maintenance of complete, accurate, and timely medical records.

1. The requirements as set forth in the ZSFG Medical Staff Bylaws and the Rules and Regulations define the minimum standards for records in the service, and
2. Medical Record documentation requirements are detailed in APPENDIX F.

XI. PROTECTION OF PATIENT PRIVACY

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

B. Members of the Medical Staff shall abide by the following:

1. Protected Health information shall only be accessed, discussed or divulged as required for the performance of job duties;
2. User IDS and/or passwords shall only be disclosed to Hospital Information Systems staff;
3. Members shall not log into Hospital information systems or authenticate entries with the user ID or password of another; and
4. Members shall only install software on Hospital computers that have been appropriately licensed and authorized by Hospital Information Systems staff.

C. Members agree that violation of this section regarding Protection of Patient Privacy may result in corrective action as set forth in these Bylaws.

XII. PSYCHIATRY CLINICAL SERVICE HOUSESTAFF TRAINING PROGRAM

It is the policy of the Psychiatry Clinical Service to provide supervision of psychiatric housestaff for their work in the clinical service. Details are outlined in Section 1.15 of the Psychiatric Clinical Policy and Procedures manual (Appendix C). See CHN Intranet Site, Housestaff Competencies link.

Psychiatry residents who are providing clinical care during regular business hours 8:00AM-5:00PM are supervised by an attending psychiatrist associated with the individual service. After hours and on weekends, psychiatry residents providing clinical care are supervised by a Back-Up Attending Psychiatrist who provides supervision by telephone and is available to assist on-site as indicated. Psychiatry residents providing clinical care in the Psychiatry Emergency Service (PES) are supervised by a PES attending psychiatrist who is on-site 24/7.

XIII. 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 Psychiatry Clinical Services shall meet as frequently as necessary, but at least quarterly, to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

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

XIV. ADOPTION AND ADMENDMENT

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

APPENDIX A – PSYCHIATRY PRIVILEGE REQUEST FORM

Zuckerberg San Francisco General Hospital

Delineation of Privileges

Psychiatry 2020

Privilege	Status	Approved

Psych PSYCHIATRY 2019
(08/2020 MEC)

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

34.10 ADULT (CORE) PRIVILEGES - PSYCHIATRISTS (MD/DO) ___
Diagnostic assessment and treatment of psychiatric and substance abuse disorders; including mental status exam; treatment planning; individual psychotherapy; group psychotherapy; family psychotherapy; emergency psychiatry assessment and treatment; crisis management; evaluation of medical status; use of psychotropic drugs approved by the FDA; detoxification following substance abuse; and behavior modification of patients 16 years and older. Placement of all legally applicable involuntary mental health holds for the purpose of evaluation and treatment of patients of all ages.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.20 BEHAVIORAL HEALTH CENTER PRIVILEGES - PSYCHIATRISTS (MD/DO) ___
Diagnostic assessment and treatment of psychiatric and substance abuse disorders; including mental status exam; treatment planning; individual psychotherapy; group psychotherapy; family psychotherapy; emergency psychiatry assessment and treatment; crisis management; evaluation of medical status; use of psychotropic drugs approved by the FDA; detoxification following substance abuse; and behavior modification.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

____________________________________ ____________________
Medical Director, Behavioral Health Center Date

34.30 SUBSPECIALITY PRIVILEGES (MD/DO) ___
Note: If You Are Requesting Specialized Privileges, You Need To Request Separate Adult Core Privileges Unless You Intend To Restrict Your Practice Exclusively To The Subspecialty Area(s).
In addition to criteria noted in 34.10, psychiatrists must possess training that qualifies them as subspecialists in an area of psychiatry and must provide evidence of qualifications, i.e. certificate of completion of specialized training in a recognized area or subspecialty board certification.

34.31 CHILD PSYCHIATRY ___
Psychiatric assessment and treatment (see Basic Privileges above) of patients under 19 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Currently Board-eligible, Board certified, or Re-Certified in Child Psychiatry or documentation of 2 years or more of applicable clinical experience in Child Psychiatry approved by the Chief of Psychiatry

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.32 ADOLESCENT PSYCHIATRY (MD/DO) ___
Psychiatric assessment and treatment (see Basic Privileges above) of patients from 14 through 18 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Possess Basic Privileges in Psychiatry; Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Psychiatry and Neurology in General Psychiatry who in addition to general psychiatry training has two years or more of documented sufficient, specialized training and experience in working with adolescents and their families approved by the Chief of Psychiatry, and has demonstrated competence to examine and treat adolescents comprehensively, or a member of the Service prior to 10/17/00.

PROCTORING: 5 proctored adolescent cases within the first year.

REAPPOINTMENT: 4 cases in each 2 year period

34.33 ELECTROCONVULSIVE THERAPY (ECT) - ADULT PATIENTS (MD/DO) ___
Assessment of candidate patients, patient selection; ECT treatment; post-treatment monitoring of patients in collaboration with SFGHTC Anesthesia staff.

PREREQUISITES: Possess Basic Privileges in Psychiatry; documentation successful completion of specific ECT training within the past 3 years (if training completed prior to 3 years ago, documentation of ECT clinical activity in good standing with an average of at least 5 cases annually during the prior 3 years), or a member of the Service prior to 10/17/00.

PROCTORING: 5 proctored cases by physician privileged for ECT treatment at SFGHTC or other institution required prior to independent practice of ECT (i.e. if first 5 treatment cases; if proctored by a staff member of another institution, proctoring must be completed prior to granting of privilege).

REAPPOINTMENT: Peer review of 5 cases in each 2 year period is required for reappointment.

34.40 ADULT (CORE) PRIVILEGES - LICENSED CLINICAL PSYCHOLOGISTS (PhD/PsyD/EdD) ___
Diagnostic assessment and treatment of psychiatric and substance abuse disorders, including mental status examination, treatment planning, individual psychotherapy, group psychotherapy, family psychotherapy, behavior modification, and cognitive behavioral therapy of patients 18 years and older.

PREREQUISITES: Completion of a doctoral degree in psychology from an APA accredited program and licensure by the State of California, Board of Psychology on the basis of the doctoral degree in psychology

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.50 SPECIALIZED PRIVILEGES (PhD/PsyD/EdD) ___
Note: If You Are Requesting Specialized Privileges, You Need To Request Separate Adult Core Privileges Unless You Intend To Restrict Your Practice Exclusively To The Subspecialty Area(s).
In addition to criteria noted in 34.40, psychologists must apply for each privilege individually and provide documentation indicating appropriate training and proficiency in the activity or technique.

34.51 PSYCHOMETRIC EVALUATION ___
Testing and measurement of psychological variables including intelligence, aptitude, and personality traits

PREREQUISITES: Minimum of one year of experience (1500 hours) providing psychometric evaluation in a clinical setting, including test administration, scoring, and interpretation, as well as written report. Proficiency in delivering these services in an autonomous fashion must be verified by a supervisor or prior work setting and approved by the Chief Psychologist. \

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period 5 proctored cases within the first year

a. Along With Initialing For Privileges 34.51, Please Initial Here To Indicate If You Are Requesting Privileges For Children And Adolescent (Under 19 Years Of Age) Psychometric Evaluation ____________ ___

b. Along With Initialing For Privileges 34.51, Please Initial Here To Indicate If You Are Requesting Privileges For Adult (18 Years Of Age And Older) Psychometric Evaluation ___________ ___

34.52 NEUROPSYCHOLOGICAL EVALUATION ___
Note: Neuropsychology Privileges Subsumes Psychometric Evaluation Privileges Specialized diagnostic assessment of disorders of neurocognitive function.

PREREQUISITES: Completion of the equivalent of a full-time post-doctoral internship in clinical neuropsychology or 2 years of work experience as a clinical neuropsychologist. This experience must be verified by former supervisor or work setting, including the ability to proficiently deliver these services in an autonomous fashion. Experience must be approved by the Chief Psychologist.

PROCTORING: 5 proctored cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

a. Along With Initialing For Privileges 34.52, Please Initial Here To Indicate If You Are Requesting Privileges For Children And Adolescent (Under 19 Years Of Age) Psychometric Evaluation ___________ ___

b. Along With Initialing For Privileges 34.52, Please Initial Here To Indicate If You Are Requesting Privileges For Adult (18 Years Of Age And Older) Psychometric Evaluation ___________ ___

34.53 CHILD AND ADOLESCENT PSYCHOLOGY ___
Psychological assessment and treatment (see Basic Privileges above for Clinical Psychologists) of patients under 19 years of age, including clinical interactions with adult individuals connected to the child, as indicated for the assessment and treatment of the child.

PREREQUISITES: Documentation of a least one year of didactic instruction and supervised clinical experience in child and adolescent assessment and treatment; approved by Chief Psychologist.

PROCTORING: 5 cases within the first year

REAPPOINTMENT: 4 cases in each 2 year period

34.54 ADDICTION MEDICINE ___
Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and board admissible, certified or re-certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, American Board of Family Medicine, American Board of Pediatrics, American Board of Psychiatry and Neurology, or American Board of Emergency Medicine. Approval of the Director of the Addiction Medicine Service required for all applicants.

PROCTORING: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

REAPPOINTMENT: Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

____________________________________ ____________________
Addiction Medicine Director/Designee Date

34.60 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

________________________________ ________________
CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

________________________________ ________________
Applicant Date

APPROVED BY

________________________________ ________________
Division Chief Date

________________________________ ________________
Service Chief Date

APPENDIX B – CREDENTIALING OF MEDICAL AND AFFILIATED STAFF

POLICY:

It is the policy of the Department of Psychiatry, Zuckerberg San Francisco General Hospital, to certify the clinical competence of all medical and affiliated staff, including newly appointed staff. Newly appointed staff are proctored during the initial six months of their appointment, and also undergo continuous monitoring of clinical practice (outlined below). Upon completion of the proctoring process, information gathered from proctoring, peer review and/or monitoring activities is reviewed by the Chief of the Department or his/her designee, who then makes appropriate recommendations to continue or revise the status of the staff member. For subsequent reappointment to the medical staff, information gathered from continuous monitoring of the staff member's clinical practice is reviewed by the Chief of the Department or his/her designee, who then makes appropriate recommendations to reappoint or revise the status of the staff member.

All materials gathered for evaluation purposes are kept in confidential files in the Department of Psychiatry.

PURPOSE:

To ensure that medical and affiliated staff of the Department of Psychiatry are able to demonstrate well-developed skills in the following areas:

Interview of psychiatric patients
Diagnosis of psychiatric patients
Development of appropriate treatment plan
Use of psychotropic medications (MD/DO/NP only)
Facility with standard psychological therapies

BASIC QUALIFICATIONS FOR CONSIDERATION OF APPOINTMENT TO THE MEDICAL STAFF:

1. Psychiatrists must have successfully completed an approved ACGME residency training program in Psychiatry, be Board Admissible or Board Certified by the American Board of Psychiatry and Neurology, and possess Medical Licensure from the Medical Board of California. The requirement for Board certification or admissibility may be waived at the discretion of the Chief of Service after careful review of the applicant's qualifications and experience. Such a waiver request shall be put in writing by the Chief of Service to the ZSFG Credentials Committee, and will outline the applicant's qualifications and experience.

2. Clinical Psychologists must hold a doctorate degree in psychology from an APA-accredited program, and be licensed on the basis of the doctorate degree in psychology by the State of California Board of Psychology. The requirement for an APA accredited training program may be waived at the discretion of the Chief Psychologist after careful review of the applicant's qualifications/experience and verification that the applicant has completed the same number of internship hours as those required by an APA accredited training program and as required by the State of California, Board of Psychology. Such a waiver will be requested in writing by the Chief Psychologist to the ZSFG Credentials Committee, and will outline the applicant's qualifications and experience.

3. Nurse Practitioners and Physician Assistants must hold the following qualifications:

Nurse Practitioners:

1. Active California Registered Nurse license
2. Successful completion of a Nurse Practitioner program which conforms to the California BRN standards.
3. Certification to practice and prescribe in the state of California as a Nurse Practitioner
4. At least one year of experience as a Registered Nurse or Nurse Practitioner in psychiatry and/or adult health
5. All other requirements listed in the Bylaws and the Rules and Regulations

Physician Assistants:

1. Active California Physician Assistant license
2. Successful completion of a Physician Assistant Training Program which conforms to California Medical Board standards
3. At least one year of experience as a Physician Assistant in Psychiatry and/or adult health
4. All other requirements listed in the Bylaws and the Rules and Regulations

PROCESS:

I. Proctoring of Newly Appointed Medical and Affiliated Staff – Divisions will choose who proctors

A. A minimum of one proctor is assigned to each newly appointed staff member. The assigned proctor(s) comprise experienced medical staff member(s). It is the responsibility of the proctor(s) to observe the actual practices of the applicant and document their observations. The observations may be made in one of two ways:

1. On an ad hoc basis, the proctor may concurrently review the clinical care of individual patients and complete the proctoring forms.

2. The new staff member may serve as a case discussant in a case conference. This involves review by the new staff member of the patient's history, interview of the patient in the presence of other staff members, development of a differential diagnosis and discussion of a treatment plan.

B. Each new staff member receives a minimum of six (6) clinical reviews during the initial six months of their appointment, documented on the proctoring form.

C. PES On-Call Physicians: Before working independently, PES on-call physicians are reviewed on four clinical assessments upon initial employment. Six months after initial employment, the physician is reviewed on two more clinical assessments. Thus, at the end of the six-month proctoring process, six case reviews have occurred. The proctoring period may be extended in the event that the new staff member is not scheduled for clinical care activities frequently enough

to complete six clinical reviews during the initial six months of employment. Each assessment is carried out by the senior attending psychiatrist on duty in PES at the time the on-call physician is scheduled to work, and is documented on the PES Orientation/Proctoring form. Each assessment includes:

1. One observed interview (more if needed)
2. Clinical assessment
3. Diagnostic formulation
4. Treatment and planning
5. Completion of necessary documentation

D. Concerns of the proctor regarding a proctored practitioner's performance will be documented and the issue will be brought to the immediate attention of both the Deputy Chief and Service Chief of the Department for necessary action.

II. Continuous Monitoring of Clinical Practice

A. The clinical practice of all medical and affiliated staff in the Department of Psychiatry is monitored according to the monitoring plan developed by the PIPS Committee, and includes primarily peer review. Examples of unusual or deviant practice are reported to the Department's Chief as provided in this policy and are available for review at the time reappointment to the medical staff.

B. Clinician-specific information for Ongoing Professional Practice Evaluation (OPPE) related to clinical practice is reviewed by the Chief of the department or his/her designee when the staff member is being considered for reappointment to the medical staff. Appropriate information would include the following:

1. Attributable/preventable mortality
2. Adverse drug reporting events
3. NP/PA - Appropriateness of clinical decision-making
4. Completion of annual training modules
5. Maintenance of State Licensing CME requirements
6. SAFE reports about interpersonal and communication skills
7. Patients' complaints
8. SAFE reports about provider professional behavior
9. Flu vaccine policy compliance
10. Percent closed Epic clinical notes within 3 days
11. Complaints from non-ZSFG DPH clinicians/staff

C. Performance problems will be reviewed by the Deputy Chief and Service Chief of the Department for necessary action.

III. Credentialing

A. Licensure/Certification:
All medical and affiliated staff members are required to provide the following information to the Academic Personnel Analyst to ensure that each member's file contains current licensure/certification information:

1. Copies of current licensure/certification, as applicable:

   Professional license
   DEA Certification (MD/DO/NP only)

2. As the above individual licenses/certificates expire, it is the responsibility of the medical staff member to apply for their renewal in a timely manner and provide the Academic Personnel Analyst with a current copy of each prior to or upon expirations.

B. Medical and Affiliated Staff Appointment/Reappointment Paperwork:
All medical staff members are required to complete in full and submit the necessary medical/affiliated staff appointment/reappointment paperwork within the time limit specified by the office requesting the paperwork.

C. Medical Staff Members Assigned as Proctors:
All medical staff members assigned as proctors to junior members are required to complete the necessary proctoring documentation in accordance with the ZSFG Department of Psychiatry Proctoring Policy (see Section II of this policy). It is the responsibility of either the peer reviewer or the individual medical staff member, whichever applies, to ensure that all documentation is completed in full and submitted within the time limit specified by the Quality Management Office.

D. Failure to Meet Documentation/Paperwork Compliance Deadlines:
In the event that the documentation/paperwork summarized in 1, 2 and 3 below is not provided within the time limit specified (as outlined in A, B, C, and D above), per ZSFG Medical Staff Bylaws and the Rules and Regulations, the medical staff member will no longer qualify for medical staff and their appointment and privileges will be terminated.

1. Medical Staff members are responsible for providing the following documentation:
   a. Licensure/Certification
      Professional License
      DEA Certification (MD/DO/NP only)

   b. Appointment/Reappointment Paperwork

2. Proctors are responsible for providing the following documentation:
   a. Proctoring documentation

3. Supervisors are responsible for arranging and/or providing the following:
   a. Peer review findings
   b. Recommendation requests

APPENDIX C – HOUSESTAFF TRAINING PROGRAM AND SUPERVISION

A. EDUCATION OBJECTIVES

Rotation on the Psychiatry Service at ZSFG is primarily designed to provide the PGY-1 psychiatry resident with a comprehensive experience in the emergency and inpatient treatment of major mental illness. An emphasis is placed upon thorough assessment and diagnosis of the major mental disorders, as well as the major treatment modalities of inpatient psychiatry and emergency psychiatry. Clinical interviewing, crisis stabilization, family intervention, and psychopharmacology are among the important topics of study. Rotations for advanced residents (PGY-2 through PGY-4) focus on outpatient, case management, and consultation liaison psychiatry, with training experiences tailored to provide an in-depth exposure to these different treatment settings and the development of fundamental competencies in these clinical areas.

B. SUPERVISION AND EVALUATION

Residents at ZSFG are supervised and evaluated in an ongoing way via multiple channels.

1. Residents are not members of the medical staff. The clinical and medico-legal responsibility for their patient care activities rests with their supervisors, who are attending level members of the Active and Courtesy medical staff. The routine credentialing processes for medical staff membership permits monitoring of the quality of care provided. The same standards of quality apply as when the supervising attending member of the medical staff is the sole provider. The close involvement of the responsible attending psychiatrist is documented in the patients' medical records by written entries, co-signatures on key documents, treatment plans, discharge forms, diagnosis forms, etc.

2. In the PGY 1 year, residents on the ZSFG Inpatient Psychiatric Units meet at least daily with their on-ward supervisor, who interviews patients with them and directly supervises their work. The on-ward supervisor will also read and make notes in the patient's medical chart. The residents also meet once a week with their off-ward supervisor. (As for evaluation, each of these supervisors is responsible for ongoing feedback as well as a written evaluation at the end of each ~~three-month~~ rotation, which is discussed with the resident. It is the responsibility of the supervisor to provide written evaluations within the deadlines set by the Residency Training Program Office.)

3. In the PGY 1 year, residents rotating on the Psychiatric Emergency Service (PES) are supervised by the PES faculty attending psychiatrist, who interviews patients with them and directly supervises their work. The supervisor will also read and make notes in the patient's medical chart.

4. Residents rotating on the Psychiatric Consultation Liaison Service are supervised by an Attending Psychiatrist in several ways. The Attending Psychiatrist is accessible by pager throughout the work week to review urgent and emergent clinical issues. The resident attends daily general service and team rounds that provide settings for further clinical review. A weekly Case Conference provides a forum for the residents to intensively

review their clinical care of a patient. Finally, each resident meets weekly with their service supervisor to review challenging or problematic clinical issues

5. Advanced UCSF residents working on other services in the Department of Psychiatry are supervised by faculty attending psychiatrists and psychologists assigned to the service. The faculty attendings are responsible for the clinical care provided by the residents.

6. After hours, weekends, and holidays, on-call residents in-house are supervised by the faculty backup attending psychiatrist who is available by pager and able to come to the hospital if clinically indicated. Residents are strongly encouraged to call the faculty back-up for any clinical or administrative question, and are ***required*** to call for the following: new admissions to the Jail Psychiatric Unit, unexpected patient discharges from inpatient psychiatry, new consult requests ***TO*** non-psychiatric services, new consultation requests ***FROM*** non-psychiatric services, any significant changes in medical condition or treatment plan for current psychiatric inpatients, AWOL of a patient on an involuntary psychiatric hold, assault occurring on an inpatient psychiatry unit, administration of involuntary emergency medications, initiation of seclusion or restraint, and any difficult to resolve staff conflicts or system issues. The faculty attending psychiatrist is responsible for all clinical services provided by the on-call resident. In addition, licensed psychiatrists in the Psychiatric Emergency Service are available to the on-call resident for face-to-face consultation.

7. The Site Director meets with each of the PGY 1 residents to review their evaluation and progress in the program midway during their six month rotations. The evaluations and summary of the meetings are then placed in their permanent file.

APPENDIX D – PSYCHIATRY HOUSESTAFF COMPETENCIES

Psychiatry Milestones, The Accreditation Council for Graduate medical Education can be viewed at the link below:
https://ucsf.box.com/s/sxozupuluc260nsqebre9d3ijlgqohl8

APPENDIX E – PERFORMANCE IMPROVEMENT AND PATIENT SAFETY PLAN

PERFORMANCE IMPROVEMENT AND PATIENT SAFETY (PIPS) PLAN DEPARTMENT OF PSYCHIATRY

Purpose

The purpose of the PIPS program of the Department of Psychiatry at San Francisco General Hospital is to promote desired patient outcomes by evaluating and improving processes that most affect patient care.

The PIPS program is a multidisciplinary effort, dependent upon the continued commitment and involvement of all staff, including both clinical and administrative, to provide our patients with the highest degree of quality care possible.

Goals

1. Improvement of patient outcomes and patient safety.
2. Improvement of the processes of care.
3. Awareness, understanding and involvement of all staff in quality and performance improvement through the integration of the concepts of quality into daily practice.
4. Coordination and integration of the processes of care between providers.

Objectives

1. To educate all staff in the concepts of performance improvement (PI) and patient safety.
2. To promote responsibility and accountability for the performance improvement process by each member of the staff.
3. To evaluate the quality and appropriateness of care through ongoing monitoring and evaluation activities specific to the Department of Psychiatry.
4. To design new processes that are effective, consistent with the organization's mission, that consider staff and patient needs, ideas, and expectations, and that are based on up to date information.
5. To identify and study processes/issues from a variety of data sources including: patient surveys, staff meetings, committee reports, PI reports, audits, infection control data, risk management, patient complaint data.
6. To determine trends or patterns that warrant further evaluation.
7. To conduct monitoring activities designed to evaluate processes that are high risk, high volume and problem prone.
8. To utilize the information obtained through surveys and identify the needs and expectations of patients and others; e.g. staff, providers.

9. To take corrective action on problems identified or processes that could be improved.

10. To re-evaluate the corrective actions taken and monitor the response.

11. To facilitate the collaboration of all PI groups and committees to identify and resolve intradepartmental and interdepartmental problems.

12. To recognize and support staff participation in unit and program based performance improvement and patient safety activities.

Authority and Accountability

A. All performance improvement and patient safety activities are reported to the Department of Psychiatry Executive Committee, and the ZSFG PIPS Committee. Nursing-specific performance improvement and patient safety activities are also reported to the Nursing Quality Improvement Coordination Committee. In addition, the Acute and Emergency Staff meeting, Medical Staff Meeting and Psychiatric Nursing Executive Committee review relevant findings in order to apply to clinical practice.

B. Inpatient and PES PIPS Activities

The Inpatient Units and PES are integral parts of the department's PIPS Program. All units are involved in ongoing PI monitoring activities and unit staff participate in Department wide PIPS task forces. PIPS information is disseminated to the units through leadership meetings, Acute and Emergency Staff meeting, Medical Staff meetings and the Nursing QI Coordinating Committee.

In addition, Nursing reports to the Psychiatry Nursing QI Coordinating Committee. The purpose of this committee is to coordinate and provide continuity from a nursing perspective. [See Department of Nursing QI Plan for description.]

C. Department of Psychiatry Executive Committee

The Department of Psychiatry Executive Committee guides and directs all departmental performance improvement and patient safety activities

1. <u>Objectives</u>

   a. Plan and implement the department wide PIPS program.

   b. Development and approval of the PIPS plan.

   c. Selection of topics for department wide projects, and approval of PIPS outcome monitors and projects.

   d. Review and discussion of the findings of PIPS studies and projects. When applicable initiation of plans of action to improve patient care using data gathered from Sentinel Event Reviews, Drug Usage Evaluations and PI monitoring activities and projects.

   e. Identification of opportunities to improve care and reduce barriers to quality patient care.

   f. Approval and implementation of recommendations for quality of care improvements.

   g. Allocation of resources to facilitate the development, implementation, monitoring, evaluation and follow up of performance improvement activities.

h. Assessment of the effectiveness of the PIPS program, at least annually, to determine its impact on patient care and service delivery.

i. Support the design and evaluation of new processes using the CQI process.

2. Committee Membership
The Executive Committee meets monthly. Standing committee members include:
Chief of Psychiatry, [committee chairperson]
Deputy Chief of Psychiatry
Medical Director of Psychiatry Emergency Services,
Director of Psychiatry Residency Training
Nursing Director for Acute Psychiatry
Clinical Director for the Division of Substance Abuse and Addiction Medicine
Director of Citywide

Division Director of Infant Child and Adolescent Psychiatry
Director of Psychiatry Administration
Director of Alliance Health Project
Director of Trauma Recovery Services
Director of Integrated Behavioral Health
ZSFG Chief Integrative Officer (ex oficio)

D. Departmental/Program Monitoring and Activities

Through continuous monitoring and evaluation, the patient focused functions and organizational functions are improved. Indicators based on the scope of service and important aspects of care are generated and studied at the departmental, unit, or service level. Both outcomes and processes are monitored and when an improvement opportunity is identified an action plan designed to improve the function or process is developed and implemented.

1. Peer Review and Medication Monitoring – Evaluation of the adequacy and appropriateness of care is monitored annually through the Peer Review and Medication Monitoring processes. Medication monitoring processes measured include prescribing and ordering, preparing and dispensing, administration and monitoring the medications effects on patients. Peer review criteria, primarily documentation based, are reviewed by Medical Staff for compliance to documentation standards. When non-compliance is noted, staff are counseled regarding specific means of meeting the criteria. Results from Peer Review and Medication Monitoring are quantified annually, and reviewed by the administrative leadership.

Sentinel Event (SE) Review/Root Cause Analysis (RCA) – All unusual occurrences which meet Level I and Level II criteria are addressed. This process includes in-depth investigation of the incident, a determination of whether standards of care were met and, when appropriate, a SE Level I Review and Root Cause Analysis. The significant event reviews are designed to identify opportunities to improve processes, staff performance and the quality of patient care outcomes. These reviews are conducted with the oversight of the ZSFG Risk Management Committee.

2. Drug Usage Evaluations – Standards relating to the ongoing evaluation of drug usage are applied using specific criteria to measure appropriateness and effectiveness of medications used in the Department of Psychiatry. Criteria based studies are conducted that focus on frequently prescribed medications [high volume], medication that carries with it a significant degree of risk for the patient [high risk and/or drugs

that are used for a specific diagnosis or condition. Results of Drug Usage Evaluations include the mechanisms for improvement in the use of the medication and are disseminated to the Medical Staff, Executive Committee and PIPS Committees.

3. Patient Complaint/Grievance- The department is committed to providing quality care and service in accordance with our patients needs and desires. When a patient or a patient's significant other(s) is dissatisfied with any aspect of care provided within the psychiatry department, the Deputy Chief and Director of Psychiatry Nursing will be notified and an investigation will be conducted. The Deputy Chief and Director of Psychiatry Nursing will collaboratively work with the patient and the treatment team to resolve all patient complaints. All complaints received will be tracked and reported annually to the Patient Concern Subcommittee of the ZSFG Performance Improvement and Patient Safety Committee (PIPS) [See Department of Psychiatry Patient Complaint Policy #8.2]

Reporting of PIPS Activities

The activities of each committee are documented. This provides a way to monitor problems that are identified in the PIPS forum and to insure implementation of improvements. Priority is given to those aspects of patient care that are high risk, high volume and/or problem prone.

All departmental PIPS activities are reported to the ZSFG PIPS through annual reports and presentations. The Department of Psychiatry program is fully integrated into the ZSFG PIPS program.

EFECTIVE DATE: MARCH 2002
REVISED: May 2012
May, 2014
August 2016
November 2018
October 2020

CROSS REFERENCE: Unusual Occurrence: Significant Event Management
Significant Event Review Program
Patient Complaint Policy

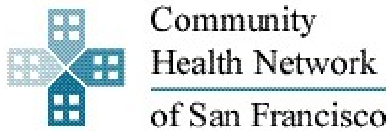
Approved By:

______________________________ ____________________
Chief, Department of Psychiatry Date

______________________________ ____________________
Director of Administration, Psychiatry Date

______________________________ ____________________
Director, Psychiatric Nursing Division Date

APPENDIX F – MEDICAL RECORDS DOCUMENTATION



The Integrated Delivery System
Of San Francisco's Department of
Public Health

DEPARTMENT OF PSYCHIATRY

5.3A

TITLE: **Medical Record Documentation Policy - Medical Staff**

POLICY: It is the policy of the San Francisco General Hospital Department of Psychiatry that medical services provided to patients are documented in accordance with the procedure as stated in this document.

PURPOSE: To ensure adequate and consistent standards of medical records charting in the Department of Psychiatry.

PROCEDURE:

A) Medical Staff Psychiatric Emergency Service (PES):

PES is responsible for initiating the following:

- psychiatric service record
- PES intake evaluation form/initial assessment (including medical history)
- admission orders
- ZSFG registration and admission forms
- voluntary admission/patient consent for medication, or, 5150/5150 advisement forms
- informed consent/medication advisement forms
- medical screening exam

The inpatient attending physician is responsible for evaluating the patient and documenting an Initial Psychiatric Assessment and Treatment Plan within 24 hours of inpatient admission. Inpatient attending physician progress notes shall be completed on all inpatients deemed by Utilization Management to be receiving an acute level of care.

Medical Staff- Consultation/Liaison Service (C/L):

The Consultation/Liaison (C/L) staff is responsible for completing the following documentation:

- consultation report
- daily follow up notes on hospitalized patients held on 5150 involuntary holds after leaving the ED, and others as clinically indicated
- PSR form
- Attending or Resident transfer note if admitted to Inpatient Psychiatry
- Medication consents (as appropriate) and legal status documents

If a patient is admitted after 4:30 p.m., C/L is responsible for completing the admission orders to inpatient psychiatry. If a patient is admitted between 8:00 a.m. and 4:30 p.m., the inpatient unit staff is responsible for completing the admission orders.

B) Medical Staff - Jail Psychiatric Services (JPS):

For patients admitted from JPS to 7L, JPS is responsible for completing the following forms. These forms must accompany the patient upon transfer.

JPS evaluation form

5150

For admissions between 8:30 a.m. and 4:30 p.m., the inpatient medical and unit staff staff are responsible for the following:

- patient evaluation
- PSR
- Inpatient admission orders
- physical exam
- Initial Psychiatric Assessment and Interdisciplinary Plan of Care (IPOC)
- ZSFG registration and admission forms
- voluntary admission/patient consent for medication forms or 5150/5150 advisement forms (if appropriate)

Medication consent forms for night and weekend admissions from JPS, the on-call resident and attending faculty back- up assume the above responsibilities. The responsibilities of the inpatient resident and attending physician are as previously outlined.

C) Medical Staff Inpatient Unit:

A. Admission Orders: Review admission orders from PES and revise as indicated.

B. Admission Note:

The initial psychiatric assessment is completed and placed in the database section of the chart and includes the following categories:

- chief complaint
- history of present illness
- pertinent medical, psychiatric, substance abuse, alcohol withdrawal, family, educational, occupational and social history
- active medical problems/findings
- TB screening status
- Physical exam status
- patient's personal strengths
- patient's level of function
- mental status examination
- ICD-10 diagnosis initial plan of care with goals/rationale that substantiate the medical necessity of acute inpatient admission.
- treatment interventions
- disposition plan
- indication of patient's level of involvement in the plan, and signature if obtainable
- Attending physician signature with name and CHN#

C. Physical Examination and Review of Systems: See P&P #2.11.01

D. Interdisciplinary Plan of Care:

The Treatment Team will review and update the Interdisciplinary Plan of Care every week.

E. Progress Notes:

Progress notes are written each day (7 days/week) by the psychiatry attending for all patients deemed by Utilization Management to be receiving acute care. These notes should address the current mental status; assessment (including documentation of medical necessity for acute care), disposition and treatment plan specifically addressing problems outlined in the initial and subsequent plans. Rationale for medication order changes (including dose and type) must be documented.

F. Discharge Plan and Exit Record:

The Patient Discharge Summary (ICD-10 diagnoses, and Post-hospital care referral) must be completed at the time of discharge.

a. A clinician to clinician discussion of the patient's medical care needs is required for patients who are being discharged to another hospital or jail.

b. Written Discharge Summary: The attending physician certifies oversight and responsibility for the patient's hospital course by signing the written discharge summary.

Discharge Plan:

1. Identifying information:

- Patient's name, B#, Date of Birth (if possible, use addressograph stamp)
- Admission/Discharge dates
- Admission/Discharge units
- Admission/Discharge legal status

2. Treatment Information:

a. ICD-10 diagnoses

b. Medication upon discharge (and amount given at discharge)

c. Brief summary of hospitalization - include the following:

reasons for admission

mental status

course of treatment

medication response

complications

suicidal and assaultive behavior/ideation

abnormal physical exam and lab data

3. Resident physician's signature (if completed by Resident physician)

4. Attending physician's signature.

H. Monitoring:

The Attending Psychiatrist is responsible for reviewing and ensuring the completeness of medical staff, resident, and medical student documentation

Revised: June, 1995
May, 1999
May, 2000
March, 2002
August 2004
May, 2010
May, 2012
May, 2014
May, 2016
October 2020

Approved: October 2020

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

Mark Leary, MD
Deputy Chief, Department of Psychiatry

APPENDIX G – CHIEF PSYCHIATRY CLINICAL SERVICE JOB DESCRIPTION

CHIEF OF PSYCHIATRY CLINICAL SERVICE
JOB DESCRIPTION

Position Summary:

The Chief of the Psychiatry Clinical Service directs and coordinated the Service's clinical, educational, and research functions in keeping with the values, mission, and strategic plan of Zuckerberg San Francisco General Hospital (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 the Psychiatry 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 the Psychiatry 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 the Psychiatry 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.

APPENDIX H -

PSYCHIATRIC CONSULTATION SERVICE
DIVISION OF Acute and Emergency Services/ ZSFG DEPARTMENT OF PSYCHIATRY

The mission of the Consultation Services is to assist the clinical staff to identify, evaluate and intervene with acute management difficulties of patients who are emotionally impaired or mentally disordered.

1. *Referral Criterion*
   - Medically admitted adults at ZSFG

2. *Service Priorities*

   High
   - Patients currently on a legal psychiatric hold (5150, 5250 and TCon)
   - Patients immediately at risk for suicidal behavior
   - Patients with a mental disorder and immediate risk for assaultive behavior
   - Patients with severely disorganized or chaotic behavior

   Routine
   - Evaluation for psychiatric diagnosis
   - Evaluation for non-emergent psychiatric intervention
   - Evaluation for psychiatric aftercare
   - Advisory opinion regarding informed consent
   - Patients in whom a mental disorder may significantly influence cooperation with staff or treatment
   - Enhancement of the provider/patient relationship
   - Patients transferred down from Psychiatry

3. *To Refer*
   Place consult request order in Epic EHR
   Monday - Friday, 8:00 a.m. - 5:00 p.m. - 327-9058
   Other hours throughout the week - 327-9058 - **(Emergency / Urgent Cases Only)**

4. *Please provide the following information:*
   - Patient name
   - Medical Record Number
   - Service
   - Attending Physician
   - Patient Location
   - Brief description of patient and referral question

5. Please inform the patient that you have asked us to see him/her.

Please Note: We are able to optimize our assistance and coordination of services when we are contacted early in the day and as early in the week as possible. We must see all patients admitted on psychiatric holds at least once.

Summary of Changes

Document Name:	Standardized Procedure: Department of Medicine
Clinical Service:	Pulmonary & Critical Care Medicine
Date of last approval:	
Summary of SOP updates:	Addition of Clinical Site
Scope of Practice:	Protocol #1: Core: Acute/Urgent Care Protocol #2: Core: Primary Care Protocol #3: Discharge of Inpatient Protocol #4: Furnishing Medications/Drug Orders Protocol #20: Procedure: Moderate Sedation

City and County of San Francisco

Department of Public Health

London Breed
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Gabriel Ortiz, MD, PhD
Chief of Staff

SFHN Credentials Committee
Standardized Procedure and/or Privileges Submission Form

Directions:

1. *Summarize the content changes that were made to the SP/protocols or Privileges using the table in Section I*
2. *Complete Section II: Follow instructions outlined in table*
3. *Email the revised SP with track changes and this completed form to the Michelle Mai, ZSFG Medical Staff Analyst (michelle.mai@sfdph.org), the CIDP Coordinator (erika.kiefer@sfdph.org), Nursing Manager (Jennifer.Berke@sfdph.org), and CIDP Co-Chairs (vagn.petersen@sfdph.org) (Vanessa.Aspericueta@sfdph.org).*

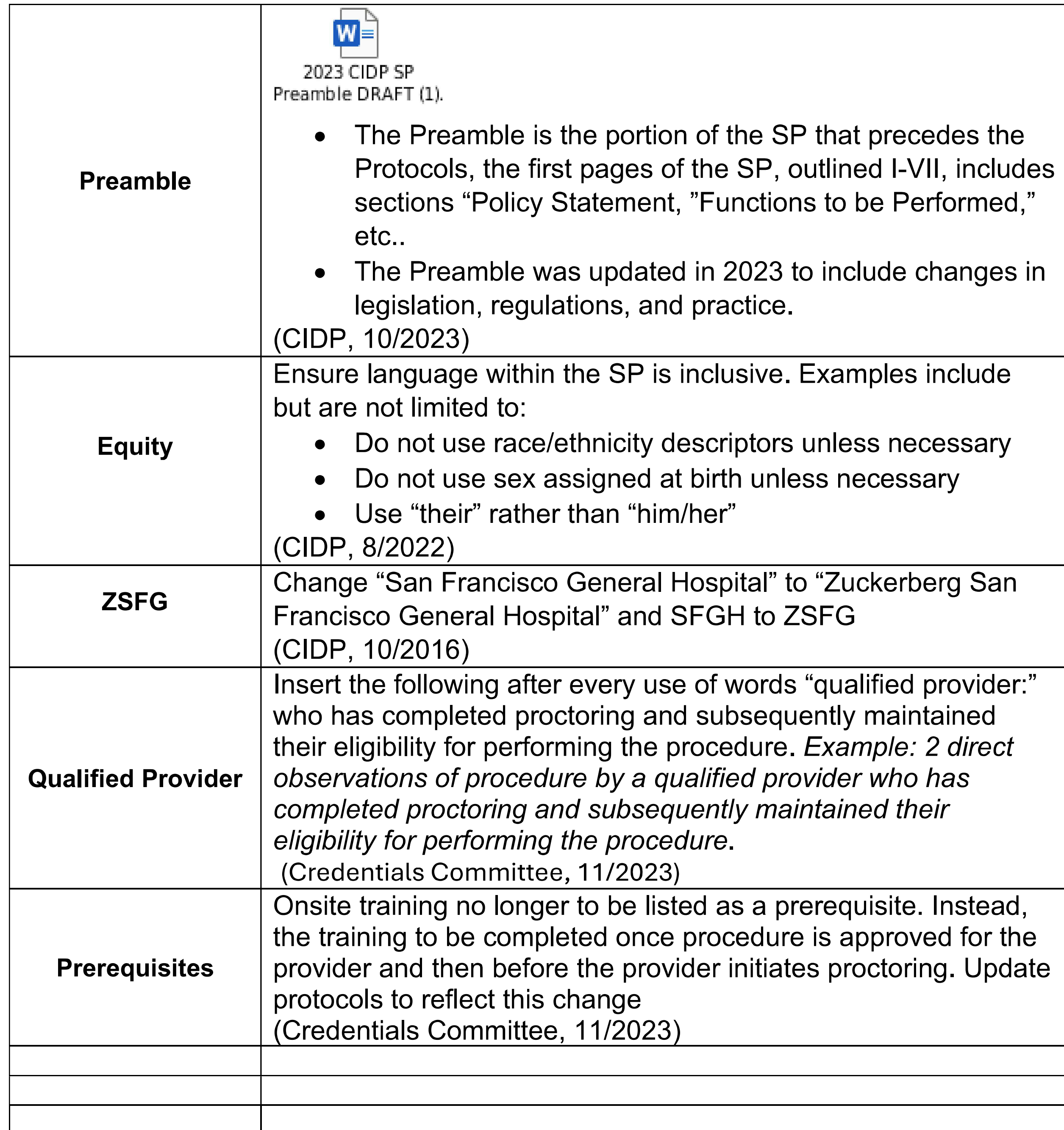
Section I: Summary of Changes for Committee approval

Date changes to SP/Privileges approved by CIDP:10/2/24	
Person completing this form:	
Standardized Procedure Title:	Interventional Radiology
Department:	Radiology
Dept Chief:	Mark Wilson MD
SP Author(s):	Ryan Sincic NP
Update #1:	Standardized revisions: All the changes instructed in the summary of changes template and outlined in the Section II of this spread sheet were applied to Radiology SP.
Update #2:	Protocol #4: Removed time component language regarding how long it would take to prepare for and complete eConsult proctoring in Radiology Department.
Update #3:	

*Include additional rows to table, if needed

Section II: Standardized Revisions

Update the SP as instructed below.



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

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

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

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Interventional Radiology

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I.Policy Statement

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

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Radiology Department Office and on file in the Medical Staff Office.

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II. Functions to be Performed

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

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

guidelines stating specific conditions requiring the NP to seek physician consultation.

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). While functioning as a member of the Community Health Network, PAs perform health care-related functions under physician oversight and with the utilization of standardized procedures and Practice Agreement (documents supervising agreement between supervising physician and PA).

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

1. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). Inpatient settings to include ICU and inpatient units. Outpatient settings to include the Radiology Department and Emergency Department.
2. Role in the outpatient and inpatient setting may include performing physical exams, diagnosing, and treating illnesses, ordering, and interpreting tests, counseling on preventative health care, performing invasive procedures and furnishing medications.

B. Supervision

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

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IV. Scope of Practice

Protocol #1 Health Care Management: Interventional Radiology Service
Protocol #2 Furnishing Medications/Drug Orders
Protocol #3 Discharge of Patients
Protocol #4 eConsult
Protocol #5 Surface Trauma and Wound Care
Protocol #6 Lumbar Puncture/Lumbar Drain Insertion
Protocol #7 Chest Tube and Drainage Catheter Removal
Protocol #8 Abdominal Paracentesis
Protocol #9 Interventional Radiology Procedural Assistant
Protocol #10 Central Venous Catheter Placement
Protocol #11 Tunneled Central Venous Catheter Placement
Protocol #12 Tunneled Central Venous Catheter Removal
Protocol #13 Chest Port Central Venous Catheter Placement
Protocol #14 Chest Port Central Venous Catheter Removal
Protocol #15 Gastrostomy Catheter Exchange
Protocol #16 Pleural Catheter Placement
Protocol #17 Tunneled Pleural Catheter Placement
Protocol #18 Thoracentesis
Protocol #19 Procedural Sedation
Protocol #20 Lower Extremity Venous Sclerotherapy
Protocol #21 Hip Aspiration and Injection
Protocol #22 Shoulder Aspiration and Injection
Protocol #23 Nephrostomy Catheter Exchange
Protocol #24 Cholecystostomy Catheter Exchange
Protocol #25 Abscess Drainage Catheter Exchange
Protocol #26 CT Guided Spinal Steroid Injections

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
1. Active California Registered Nurse/ Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) by an approved American Heart Association provider.

5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number within 12 months of hire for NPs.
8. Physician Assistants are required to sign and adhere to the Zuckerberg San Francisco General Hospital and Trauma Center Practice Agreement. Copies of Practice Agreement must be kept at each practice site for each PA.

B. Specialty Training

1. Specialty requirements
    a. NP specialty certification as an ANP, FNP, ACNP.
    b. Current ACLS certification if requesting Procedural Sedation protocol.
    c. Pass National Certification as a Physician Assistant.
    d. Specialty training will be provided by the Radiology/Interventional Radiology attendings as part of the orientation process.
    e. For Minor Procedure Protocol training please refer to each Procedure Protocol.

2. Amount of previous experience in specialty area expected for this position.
    a. Two years experience as a Registered Nurse or Nurse Practitioner in an emergency department, acute care or intensive care unit in an acute care hospital within 6 months of hire.
    b. Two years experience as a PA in an emergency department, acute care or intensive care unit in an acute care hospital within 6 months of hire.

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

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

1. Length of proctoring period will be three (3) months. The term may be shortened or lengthened at the discretion of the supervising clinical provider; however, the proctoring period shall not exceed the six (6) months

CCSF probationary period. At the end of the proctoring term, the NP/PA will be generally supervised by Chief of Interventional Radiology Service Attending, or designated clinical provider.

2. The evaluator will be the Chief of Interventional Radiology or designated clinical provider.
3. The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
   a. All cases are presented to the evaluator
   b. Medical Record review is conducted for out-patient discharge medication
   c. Medical Record review may be conducted retrospectively by the clinical supervisor.
   d. Proctoring will include a minimum evaluation of five (5) chart reviews and direct observations, with at least one case representing each core protocol, discharge of inpatients, and furnishing medications/drug orders, if applicable.
   e. Procedural skills are incorporated into the competency assessment orientation

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

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

VI. Development and Approval of Standardized Procedure

A. Method of Development

Standardized procedures are developed collaboratively by the NPs/PAs, Physicians, and Administrators, and must conform to the

Commented [DJ(4]: DIRECTIONS: Fill in the blanks

eleven steps of the standardized procedure guidelines as specified in
Title 16, CCR Section 1474.

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

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

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

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

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Interventional Radiology

I. Policy Statement

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

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B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the Radiology Program Office (Room 1x55) and on file in the Medical Staff Office.

II. Functions To Be Performed

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The following standardized procedures are formulated as process protocols to explain the overlapping functions performed by the NP/PA in their practice. Each practice area will vary in the functions that will be performed, such as primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

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

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

The NP/PA conducts physical exams, diagnoses and treats illness, orders and interprets tests, counsels on preventative health care, assists in surgery, performs invasive procedures and furnishes medications/issues drug orders as established by state law.

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III. Circumstances Under Which NP/PA May Perform Function

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A. Setting

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1. Location of practice is the inpatient and outpatient settings at Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG). Inpatient settings to include ICU and inpatient units. Outpatient settings to include the Radiology Department and Emergency Department.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to: Chief of Interventional Radiology.
2. A consulting physician, which may include attendings, and credentialed fellows, by phone, in person, or by other electronic means at all times.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
a. Acute decompensation of patient situation
b. Unexplained historical, physical, or laboratory findings.
c. Upon request of patient, affiliated staff, or physician.
d. Problem requiring hospital admission or potential hospital admission.
e. Acute, severe respiratory distress.
f. An adverse response to respiratory treatment, or a lack of therapeutic response.

IV. Scope of Practice

Protocol #1 Health Care Management: Interventional Radiology Service
Protocol #2 Furnishing Medications/Drug Orders
Protocol #3 Discharge of Patients
Protocol #4 eConsult
Protocol #5 Surface Trauma and Wound Care
Protocol #6 Lumbar Puncture/Lumbar Drain Insertion
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Protocol #21 Hip Aspiration and Injection
Protocol #22 Shoulder Aspiration and Injection

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Protocol #23 Nephrostomy Catheter Exchange
Protocol #24 Cholecystostomy Catheter Exchange
Protocol #25 Abscess Drainage Catheter Exchange
Protocol #26 CT Guided Spinal Steroid Injections

V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education
1. Active California Registered Nurse/Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses (BRN)/Accreditation Review Commission on education for the Physician Assistant (ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider. Must have certification of Advanced Cardiac Life Support (ACLS) training if requesting Procedural Sedation Protocol.
5. Possession of a Medicare/Medical Billable Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the ZSFG Physician Assistant Practice Agreement (PAPA) Copies of PAPA must be kept at each practice site for each PA.

B. Specialty Training
1. Specialty requirements
a. NP specialty certification as an ANP, FNP, ACNP.
b. Current ACLS certification if requesting Procedural Sedation protocol.
c. Pass National Certification as a Physician Assistant.
d. Specialty training will be provided by the Radiology/Interventional Radiology attendings as part of the orientation process.
e. For Minor Procedure Protocol training please refer to each Procedure Protocol.

2. Amount of previous experience in specialty area expected for this position.
a. Two years experience as a Registered Nurse or Nurse Practitioner in an emergency department, acute care or intensive care unit in an acute care hospital within 6 months of hire.
b. Two years experience as a PA in an emergency department, acute care or intensive care unit in an acute care hospital within 6 months of hire.

C. Evaluation of NP/PA Competence in performance of standardized procedures. For procedures please refer to specific Procedure Protocol.

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1. Initial: at the conclusion of the standardized procedure training, the Medical Director and/or designated physician and/or other supervisors, as applicable will assess the NP/PA's ability to practice.

a. Clinical Practice
- Length of proctoring period will be three months. The term may be shortened or lengthened at the discretion of the supervising physician. This proctoring will also include 30 chart reviews (15 neuro IR and 15 body IR)., which will include direct observation of NP/PA clinic encounters of 5 body IR and 5 neuro IR cases. The evaluator will be the Chief of Interventional Radiology or Clinical Supervising Physician Designee.
- The method of evaluation in clinical practice will be those needed to demonstrate clinical competence
a. Ten (10) directly observed clinical encounters are presented to the evaluator
b. For directly observed clinical encounters evaluator reviews co-signs orders and progress notes
c. For directly observed clinical encounters, co-signatures by a licensed physician must be concurrent to patient care
d. For directly observed clinical encounters, medical record review is conducted for in-patient medication ordering and out-patient discharge medication
e. Medical Record review may be conducted retrospectively by the Clinical Supervising Physician

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

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

4. Biennial Reappointment: Medical Director, designated physician or designated same discipline peer must evaluate the NP/PA Clinical competence. Case numbers will be found in each procedure.

VI. Development and Approval of Standardized Procedure

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

B. Approval

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

~~C. Review Schedule~~

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

~~D. Revisions~~

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

Protocol #1: Health Care Management – Interventional Radiology Services

A. DEFINITION

This protocol covers the procedure for health care management in specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses. Settings to include; Emergency Department, Radiology Department, Outpatient Clinics, ICU and Inpatient Units.

B. DATA BASE

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

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

C. DIAGNOSIS

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

D. PLAN

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

d. Patient consent obtained consistent with hospital policy before procedure is performed and according to Department of Radiology Guidelines.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Unexplained historical, physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or change of medication other than those in the formularies.
   e. Acute, severe respiratory distress
   f. An adverse response to respiratory treatment, or a lack of therapeutic response.

3. Education
   a. Patient education appropriate to diagnosis and should include treatment modalities and lifestyle counseling (e.g. diet and exercise).
   b. Discharge information and instructions.

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

E. RECORD KEEPING
All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes).

Protocol #2: Furnishing Medications/Drug Orders

A. DEFINITION

"Furnishing "of drugs and devices by nurse practitioners (NPs) and certified nurse midwives (CNMs) is defined as the act of making a pharmaceutical agent/s available to the patient in accordance with a standardized procedure.

A "drug order" is a medication order issued and signed by a physician assistant. Physician assistants may issue drug orders for controlled substances Schedule II -V with possession of an appropriate DEA license.

All drug orders for controlled substances shall be approved by the supervising physician for the specific patient prior to being issued or carried out. Alternatively:

- PAs may prescribe controlled substances without patient specific approval if they have completed education standards as defined by the California Physician Assistant Committee. A copy of the Certificate must be attached to the physician assistant's Physician Assistant Practice Agreement.

- NPs and CNMs may order Schedule II - V controlled substances when in possession of an appropriate DEA license. Schedule II - III medications for management of acute and chronic illness need a patient specific protocol.
- PAs, NPs and CNMs with an x-waiver may prescribe medications containing buprenorphine for the purpose of treating patients with opiod use disorder.

The practice site (clinic or inpatient), scope of practice of the NP/PA, as well as Service Chief or Medical Director, determine what formulary/ies will be listed for the protocol. The formulary/ies that will be used are: Zuckerberg San Francisco General Hospital and Trauma Center/Community Health Network, Community Behavioral Health Services, Laguna Honda Hospital, Jail Health Services, San Francisco Health Plan, Medi-Cal and AIDS Drug Assistance Program. This protocol follows ZSFG Administrative policy on Furnishing Medications (policy no. 13.02) and the writing of Drug Orders. (Policy no. 13.05).

B. DATA BASE

1. Subjective Data

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

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

C. DIAGNOSIS

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

D. PLAN

1. Treatment
    a. Initiate, adjust, discontinue, and/or renew drugs and devices.

    b. NPs may order Schedule II - III controlled substances for patients with the following patient specific protocols. Insert the following:
        1. location of practice
        2. diagnoses, illnesses, or conditions for which medication is ordered
        3. parameters for acute conditions including maximum daily morphine equivalents and duration of treatment
        4. parameters for treatment with chronic opioids including checking CURES, toxicology screening, treatment plan and clinic specific policies

        5. names of medications, daily maximums, refill limitations and time period for follow-up.
    c. To facilitate patient receiving medications from a pharmacist provide the following:
        1. name of medication
        2. strength
        3. directions for use
        4. name of patient

5. name of prescriber and title
6. date of issue
7. quantity to be dispensed
8. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring Consultation
   a. Initiation or change of medication other than those in the formulary.
   b. Unexplained historical, physical or laboratory findings.
   c. Upon request of patient, NP, PA, or physician.
   d. Failure to improve pain and symptom management.

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

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

E. RECORD KEEPING

All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record as appropriate

Protocol #3: Discharge of Patients

A. DEFINITION
This protocol covers the discharge of patients from ZSFG. The direction to discharge a patient will come from the attending physician. This protocol covers patients who are admitted by the Radiology/Interventional Radiology Service to the inpatient Wards, patients in the Radiology Department and those sent to PACU, 4C, Acute Dialysis (H47) and Chronic Dialysis (Ward 17) to recover from interventional procedures and treatment.

B. DATA BASE
1. Subjective Data
   a. Review: heath history and current health status

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

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

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

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

d. Initiation or change of medication other than those in the formulary.
e. Referral to specialty services not provided by DPH.

3. Education
   a. Review patient course and what will need follow-up.
   b. Provide instructions on:
      - follow-up clinic appointments
      - outpatient laboratory/diagnostic tests
      - discharge medications
      - signs and symptoms of possible complications
      - whom to call if have symptoms of complications

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

E. RECORD KEEPING
All information from patient hospital stay will be recorded in the medical record.

PROTOCOL #4: eConsult Review

A. DEFINITION

eConsult review is defined as the review of outpatient imaging consultation requests via the online eConsult system. An imaging request is defined as a request for advanced imaging study, such as MRI, CT or Ultrasound, submitted by a health care provider to the radiology department. A review of imaging request is defined as determination of appropriateness and urgency (priority) of a requested imaging study, based on the provided subjective and objective data.

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

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

3. Proctoring: 15 reviews of the eConsult consultation decisions will be performed by the Chief of Service or designee ~~concurrently for the first three months~~.

B. DATA BASE

1. Subjective Data
   a. eConsult imaging request review will include the review of medical and surgical history, which is relevant to determination of appropriateness and priority of the imaging study. The scope of the review will be limited to the data provided by the referring provider on the electronic referral. The reviewer will request further information from the referring provider if information provided is not complete or does not allow for an adequate assessment of urgency and appropriateness of the referral.

b. The review will include the review of allergy history to anticipate contrast reactions.
c. The review will include the review of special patient data that may affect the imaging study. This data may include, but is not limited to patient's language requirements, mobility issues, anxiety and need for sedation. Review of these special patient data will help anticipate problems during performance of the study, and thereby improve efficiency of the department.

2. Objective Data
   a. The review will include the review of physical exam findings, which are relevant to the determination of appropriateness and priority of the imaging study. The review will be limited in scope to the data provided by the referring provider.
   b. The record of prior radiological exams will be reviewed, to exclude (duplicate entries of the same study), and to help assess appropriateness of imaging. The record of prior radiological exams will be retrieved by the eConsult system automatically, however in some cases the reviewer may need to consult the electronic medical record.
   c. The record of laboratory findings, which are relevant to imaging, such as Creatinine and eGFR, will be automatically retrieved by the eConsult system. However, in some cases the reviewer may need to consult the electronic medical record to retrieve further information.

C. DIAGNOSIS

Establishing the correct diagnosis is the goal of radiological imaging, therefore the eConsult review is not aimed at establishing the final diagnosis. However, it is essential to know the preliminary or provisional diagnosis in order to assess the appropriateness and priority of the imaging study. A correct ICD10 code of the preliminary diagnosis is also crucial to successful billing of the radiological procedures. eConsult review will include the preliminary diagnosis as provided by the referring provider through the eConsult system.

D. PLAN

1. Review of eConsult
   a. All data provided via the eConsult consultation request will be reviewed and assessed for appropriateness of the imaging request and priority (urgency) of the study. The review will be based on the published appropriateness guidelines of the American College of Radiology. The reviewer will also consider factors, which are local to ZSFG, such as availability

constraints and wait times in assigning priority to the imaging requests.

b. Any missing data that is needed for the initial assessment of the patient will be requested from the referring provider.

2. Patient conditions requiring Attending Radiologist Review
   a. Upon request of the referring NP, PA or physician
   b. Complex imagining questions, not clearly addressed by the American College of Radiology guidelines.
   c. Problems requiring emergent imaging studies.
   d. Problems requiring relatively counter-indicated imaging studies, when the benefits outweigh the risks.
   e. Problems requiring emergent/urgent surgical intervention.

3. Education
   Provider education appropriate to the referring problem including usefulness, indications, counter-indications of imaging studies. The reviewer will also advise the referring clinicians regarding the limitations of availability of certain studies at ZSFG.

4. Scheduling of Appointments
   Dependent upon the urgency of the referral, the eConsult will be forwarded to the scheduler for the next available imaging appointment.

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

E. RECORD KEEPING

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

During the proctoring period, the eConsult consultation request will be printed and the provider recommendations will be written on the printout. These will be cosigned by the proctor and filed in the provider's educational file. The recommendations will then be entered into the electronic medical record and forwarded to the scheduler.

Protocol #5: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment and management of wounds.

1. Location to be performed: For purposes of this procedure, the protocol will be completed in the inpatient and outpatient unit(s) at ZSFG

2. Performance of procedure:
   a. Indications
      Patient's presenting for assessment and treatment of lacerations, abrasions and avulsions.
   b. Precautions (require attending physician consultation):
      - Coagulopathy
      - Potential for Foreign Bodies within wound
      - Malnutrition
      - Diabetes
      - Immunocompromized State
      - Peripheral Vascular Disease
      - Unexplained historical, physical or laboratory findings.

3. Contraindications requiring attending physician consultation
   a. Vascular compromise or cases where direct pressure does not stop bleeding
   b. Wounds requiring large area of debridement or excision prior to closure
   c. Wounds with bone fragments or fracture
   d. Wounds with tendon, ligament, vessel or nerve involvement
   e. Head laceration with galea disruption
   f. Facial lacerations with cosmetic consideration (e.g. eyelids and vermillion borders)
   g. Lacerations penetrating into joints
   h. Children under the age of 10
   i. Lacerations greater than 12 hours old or lacerations to the hand greater than 6 hours old
   j. Wounds requiring repair of cartilage
   k. Through and through lip lacerations
   l. Unexplained historical, physical or laboratory findings that could compromise safety of the procedure.

B. DATA BASE

1. Subjective Data

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed. Physical exam of the wound including a description of its location, extent, depth and appearance of discharge, erythema, swelling or ecchymosis
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Inability to approximate wound edges
   e. Persistent or uncontrolled bleeding
   f. Scalp wounds involving the galea
   g. Upon request of patient, NP, PA, or physician
   h. Initiation or adjustment of medication other than those in the formularies.

i. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

a. ~~Specialty training will be provided by the Interventional Radiology attendings as part of the orientation process.~~
~~b.~~ Observe 2 wound care and surface trauma care procedures with MD.

Proctoring Period:

a. New practitioner to procedure, a minimum of 3 successful observed demonstrations.
b. Experience practitioner to procedure, a minimum of 2 successful observed demonstrations.
c. Three medical record reviews/audits by the Chief of Interventional Radiology or Clinical Supervising Physician designee.
d. Proctoring may be performed by experienced qualified (MD/NP/PA) <u>who has completed proctoring and subsequently maintained their eligibility for performing the procedure</u> and signed by the Chief of the Department of Interventional Radiology or qualified provider designee <u>who has completed proctoring and subsequently maintained their eligibility for performing the procedure</u>.

Evaluation of Reappointment Competency

a. Evaluation will be performed by Supervising Physician and/or his or her designee.
b. Demonstration of 3 procedures completed every 2 years.
c. Three chart reviews needed every 2 years

Protocol #6: Lumbar Puncture/Lumbar Drain Insertion

A. DEFINITION

Lumbar catheter insertion is defined as placement of a lumbar Cerebral Spinal Fluid (CSF) drainage catheter located within the subarachnoid space as decided upon by the Interventional Radiology team and in accordance with the Neuro-Interventional Radiology Attending Physician.

1. Locations to be performed: For purposes of this procedure, the protocol will be completed in the Radiology Department or inpatient units at ZSFG.

2. Performance of procedure:
   a. Indications
      1. Lumbar puncture should be performed primarily on patients with severe headache with or without fever of unknown origin, especially if an alteration of consciousness is present. Aspiration of the spinal fluid with subsequent analysis may be necessary to the diagnosis of CSF infection, bleeding or embolus (e.g. meningitis, syphilis, subarachnoid hemorrhage, MS).
      2. A lumbar drain should be placed primarily for the purposes of CSF diversion. This procedure should be considered in the presence of a persistent CSF leak, operative cases requiring temporary decompression/diversion during the postoperative period, in cases of documented mental status improvement following serial high volume LP taps, in lieu of or until a definitive mode of diversion is achieved i.e. EVD or VP shunt.

   b. Precautions (Requiring a physician consultation)
      1. Mass effect, subarachnoid hemorrhage or obstructive hydrocephalus: will typically obtain a head CT to rule out these conditions.
      2. Platelets should be greater than or equal to 100,000
      3. Patients on anticoagulants or who have bleeding tendencies (ex.Atrial fibrillation. Von Willebrand's, Hemophilia, Liver disease)
      4. ASA/NSAIDS/Cox II Inhibitors taken within past 5 days.

   c. Contraindications (Requiring a physician consultation)
      1. Infection in the tissues near the puncture site.

2. Increased intracranial pressure, if suspected rule out with head CT
3. Coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint or procedure to be performed.
      1. Presence of motor or sensory deficits
      2. Presence of headache or meningitic symptoms
      3. Presence of continued or new CSF leak.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.

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

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained consistent with hospital policy before procedure is performed.
   b. Time out performed per hospital policy.
   c. Referral to specialty clinic, supportive services for provider as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Resistance met on drain insertion
   c. Patient complaint of nerve root pain
   d. Failure to obtain CSF drainage or flow
   e. Upon request of patient, NP, PA, or physician

f. Initiation or adjustment of medication other than those in the formularies.

3. Education
   Discharge information and instructions.

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
a. ~~Specialty training will be provided by the Interventional Radiology attendings as part of the orientation process.~~ ~~c.~~ Observe 2 lumbar punctures/drain insertions with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure. d. Successful completion of these requirements as determined by the Chief of Interventional Radiology or Clinical Supervising Physician designee is needed prior to independent practice.
Evaluation of Reappointment Competency: a. Evaluation will be performed by Supervising Physician and/or his or her designee.

b. Demonstration of 3 procedures every 2 years.
c. Three chart reviews every 2 years.

Protocol #7: Chest Tube and Drainage Catheter Removal

A. DEFINITION

For the purposes of this protocol, a drainage catheter is defined as an indwelling catheter placed for therapeutic removal of fluid. A chest tube is defined as an indwelling catheter placed in the thoracic cavity for therapeutic removal of fluid or air.

1. Location to be performed: The removal of a chest tubes and drainage catheters will be performed on the inpatient units, Emergency Department, or Radiology Department.
2. Indications
   a. Patient symptoms related to intrapleural air/fluid have diminished
   b. Patients current chest radiograph/ laboratory studies support procedure
3. Precautions/Contraindications requiring attending consultation
   a. Relevant diagnostic modalities indicate continued presence of air/fluid.

B. DATA BASE

1. Subjective Data
   a. Comfort, c/o shortness of breath, exercise tolerance.
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications
   c. Relevant history and review of symptoms including but not limited to: results respiratory, allergies.

2. Objective Data
   a. Appropriate physical exam including but not limited to: results of previous chest imaging, quantity and quality of output from the Chest Tube, evaluation for air leak, oxygen saturation, and breath sounds, to confirm appropriateness of procedure.
   b. Evaluation of the chest tube insertion site for signs of infection including but not limited to purulence, erythema, induration, fluctuance, foul odor.
   c. Review of current medication regiment including recent analgesia administration.
   d. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   e. All Point of Care Testing (POCT) will be performed according to ZSFG POCT policy and procedure 16.20.

C. DIAGNOSIS

Resolution of pneumothorax, hemothorax, effusion, suspected malfunction of the chest tube to function adequately (e.g. suspected clotted tube, proximal hole external to chest wall cavity). Prior to chest tube removal, the Interventional Radiology Service will complete an assessment of the subjective and objective data- see above.

D. PLAN

1. Therapeutic Treatment Plan
    a. Explain procedure to the patient, if possible. If patient unable to understand, advise bedside nurse of procedure and plan.
    b. Patient consent obtained before procedure is performed and obtained according to hospital policy.
    c. Time out performed per hospital policy.
    d. Diagnostic tests to confirm appropriateness of procedure.
    e. This procedure is performed following standard medical technique according to the departmental guidelines/ standards.
    f. Observe patient for signs of respiratory compromise immediately following procedure including (as indicated) respiratory rate, pattern, oxygen saturation. For ventilated patients, observe the measured airway pressures post removal.

2. Patient conditions requiring Attending Consultation
    a. Acute decompensation of patient situation including but not limited to acute shortness of breath, persistent desaturation post removal.
    b. Evidence of, or suspicion of air intra-thoracic air entrapment at the time of or immediately after removal (e.g. audible leaking from the chest wound site at the time of removal, increased intrathoracic pressures on ventilated patients).
    c. Inability to remove the chest tube fractured or retained catheter.
    d. Given evidence of increasing or unstable pneumothorax on post-pull imaging.
    e. Upon request of patient, NP, PA, or physician

3. Education

    Provide patient education related to the procedure. If patient is unable to comprehend instructions due to decreased mental status, provide nursing instruction prior to performance. If patient is on a ventilator or positive pressure ventilation advise respiratory therapist prior to performance.

4. Follow-up
    a. Reassess the patient frequently following the procedure.
    b. As appropriate, obtain a follow up chest radiograph 4-6 hours after the completion of the procedure.
    c. Advise the patient and the nurse not to disrupt the occlusive dressing for at least 72 hours post removal.

E. RECORD KEEPING

1. A comprehensive procedural note and post procedure assessments will be documented in the medical record. Any sutures not removed at the time of the chest tube removal shall be described in this note.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care : a. ~~Specialty training will be provided by Interventional Radiology attendings as part of the orientation process.~~ ~~b.~~ Observe 2 chest tube removals with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure. d. Successful completion of these requirements as determined by the Chief of Interventional Radiology or Clinical Supervising Physician designee is needed prior to independent practice.
Evaluation of Reappointment Competency: a. Evaluation will be performed by Supervising Physician and/or his or her designee. b. Demonstration of 3 procedures every 2 years. c. 3 chart reviews every 2 years.

Protocol #8: Abdominal Paracentesis

A. Definition - Abdominal paracentesis entails inserting a needle through the abdominal wall into the peritoneal cavity under local anesthetic for aspiration of peritoneal fluid (ascites).
   1. Locations to be performed: Emergency Department, inpatient units, Radiology Department.

   2. Performance of Procedure: (When possible paracentesis should be performed bedside with ultrasound guidance; an alternative is to have fluid localized and transport patient on same bed used for marking, i.e. patient is not moved).
      i. Indications:
         a. New onset ascites, i.e. to identify the etiology (infectious, malignant, cirrhotic).
         b. Pt with ascites, fever, abdominal pain, i.e. to evaluate for spontaneous bacterial peritonitis.
         c. Symptomatic treatment of tense ascites.
      ii. Precautions (the following conditions necessitate attending physician consultation and ultrasound guided paracentesis):
         a. Abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
         b. Intra-abdominal adhesions or suspicion for loculated fluid.
         c. Pregnancy
      iii. Contraindications:
         a. Fibrinolysis or DIC.
         b. Cellulitis at puncture site.

B. Data Base

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

   2. Objective Data
      a. Physical exam appropriate to presenting symptoms.
      b. Laboratory, Point of Care Testing (POCT), and imaging studies, as indicated, relevant to history and exam.

D. Plan

1. Therapeutic Treatment Plan.
   a. Informed consent obtained prior to procedure and according to hospital policy.
   b. Time out performed according to hospital policy.
   c. Diagnostic tests for purpose of identifying disease etiology. Send for cytology as relevant.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders Protocol.
   e. Referral to specialty clinic, supportive services for provider as needed.

2. Patient conditions requiring attending consultation
   a. All patients with conditions listed in precaution section.
   b. Acute decompensation of patient.
   c. Upon the request of the patient, PA, NP or physician.

3. Education
   a. Appropriate and relevant patient and family education in written and/or verbal format.
   b. Contact information for follow up should needle puncture site result in leaking ascitic fluid.
4. Follow-up
   a. As indicated and appropriate for procedure performed.

E. Record Keeping
Patient visit, consent forms, and other transfusion-specific documents (completed transfusion report and “blood sticker”) will be included in the medical record.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. ~~Specialty training will be provided by Interventional Radiology attendings as part of the orientation process.~~ ~~b.~~ Observe 3 Abdominal Paracentesis procedures with MD.
Proctoring Period: a. New practitioner to procedure, a minimum of 5 successful observed demonstrations. b. Experience practitioner to procedure, a minimum of 3 successful observed demonstrations. c. Proctoring may be performed by experienced qualified (MD/NP/PA)

who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Evaluation of Reappointment Competency: a. Evaluation will be performed by Supervising Physician and/or his or her designee. b. Demonstration of 3 procedures every 2 years. c. Three chart reviews every 2 years.

Protocol #9 Interventional Radiology Procedural Assistant

A. DEFINITION

This protocol covers the participation of the Nurse Practitioner who provides assistance to Interventional Radiology Attendings during interventional radiology procedures, where an Interventional Radiology Attending or Neuro-Interventional Radiology Attending is the primary operator and is present in the interventional radiology suite or at the patient bedside during procedures performed outside the IR suite. The assisted procedures are: angiography, venography, angioplasty, venoplasty, vascular embolization procedures, image guided biopsies, drainage procedures, drainage catheter placements, transjugular intrahepatic portosystemic shunts, inferior vena cava filter placements, gastrostomy tube placements, liver biopsies, chest tube placement, thoracentesis, chest port placements, chest port removals, tunneled central venous catheter removal, central venous catheter removal procedures and venous access procedures. Assistance refers to the process where under an attending's direct supervision and direction, the Nurse Practitioner assists the attending operator in the technical steps of the procedure but does not independently perform them. Technical steps of the procedure are the administration of medications, obtaining vascular access, suturing, preparation of instruments, tissue dilation, tissue dissection, tissue cutting, manipulation of intra-corporeal instruments, manipulation of intra-corporeal needles, manipulation of intra-corporeal catheters and drain insertions.

1. Location to be performed: Radiology Department, inpatient units, and Emergency Department.

2. Performance of procedure:
   a. Indications
      This protocol addresses patients presenting to the Radiology Department, or patients undergoing interventional radiology procedures on the inpatient units, or in the Emergency Department.
   b. Precautions
      None
   c. Contraindications
      None.

B. DATA BASE

1. Subjective Data
   a. History of chief complaint and review of symptoms relevant to the suggested procedure, possible organ systems affected by the procedure, mechanism of injury and type of injury
   b. Pertinent past medical history including current medications, allergies, clotting disorders, previous wound history, previous vascular disease history, previous history of infection.

2. Objective Data
   a. Physical exam of the system prescribed for procedure, i.e. for neurovascular procedures performing neurologic exam, for vascular procedures providing an examination of associated tissues perfused.
   b. When a drain is implemented, data will include quantity and quality of drainage, level of set negative pressure, and assessment of the site.
   c. Appropriate motor, sensory and vascular exam of the involved area.
   d. The procedure is performed following standard procedural technique according to departmental guidelines.
   e. Laboratory and imaging evaluation, as indicated, relevant to history and exam. Appropriate laboratory values to be considered include (but are not limited to): complete blood count and coagulation studies, nutritional status and electrolytes.
   f. All Point of Care Testing (POCT) will be performed according to ZSFG POCT Policy and Procedure 16.2.

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease process requiring intervention.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Explain procedure to the patient (if patient unable to receive information due to mental status, explain to surrogate and/or bedside RN) Explain the procedure to the family.
   c. Diagnostic tests for purposes of disease identification.
   d. Time out per hospital policy.
   e. Biopsy tissue is sent to pathology if specimen collected.

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

2. Patient conditions requiring Attending
   a. All assisted interventional radiology procedures shall be performed in direct consultation with an Interventional Radiology Attending or Neuro-Interventional Radiology Attending, who will be in the IR suite during assisted procedures.

3. Education:
   Discharge information and instructions.

4. Follow-up:
   As appropriate for procedure performed.

E. RECORD KEEPING
1. Documentation of a detailed procedure note will be recorded in the medical record. Required follow up of the wound (e.g. suggested suture removal dates, ongoing care to be delivered by nursing/wound care orders, or future drain change) will be indicated in the procedure note and in daily progress notes.
2. All procedural dictations are reviewed and cosigned by an Attending Physician for quality assurance purposes.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of 10 observed cases. ~~b. Specialty Training Provided by Interventional Radiology Attendings.~~
Proctoring Period: a. All procedures will have direct supervision from a consulting Attending Interventional Radiologist or Neuro-Interventional Radiologist. Review will be done after each case. b. Proctoring period will be three months in length.
Reappointment Competency Documentation: a. Minimum number of 10 procedures must be completed every two years. b. 10 chart reviews needed every two years.

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Protocol #10: Central Venous Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of central venous catheters. A central venous catheter refers to a device used for central venous infusion or dialysis.

1. Location to be performed: Radiology Department, inpatient units, PACU, Emergency Department.

2. Performance of procedure:
   a. Indications: Central venous access for delivery of medications, nutrition blood products, and frequent blood sampling. Dialysis for renal failure.
   b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
   c. Contraindications requiring attending physician consultation: Patients who have exhibited prior intolerance to the materials of construction.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
b. Time out performed per hospital policy.
c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.)

3. Education
   Instructions for clinical staff.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: ~~a. Completion of training on site.~~ a~~b~~. Observe two CVC placements with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 10 CVC placements without need for procedural intervention by training

provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful placement of 5 CVCs every two years. b. Direct observation of one CVC placement procedure will be performed every two years by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. 3 chart reviews will be performed every two years. d. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure, will be the proctor/evaluator.

Protocol #11: Tunneled Central Venous Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of central venous catheters which are placed for the purposes of central venous infusion or hemodialysis. For the purposes of the protocol/procedure a central venous catheter refers to a venous access device, which is tunneled under the skin to the catheter exit site.

1. Location to be performed: Placement of tunneled central venous catheters will be conducted in the Radiology Department.

2. Performance of procedure:
   a. Indications: Central venous access for delivery of medications, nutrition, blood products, and frequent blood sampling. Hemodialysis as indicated by presence of acute and/or chronic renal failure/insufficiency.
   b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting.
   c. Contraindications requiring attending consultation: Absolute contraindications to tunneled central venous catheter placement include bacteremia or sepsis, infection at the insertion site, and disseminated intravascular coagulopathy. Relative contraindications include neutropenia, recent but resolved sepsis, and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.

B. DATA BASE

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

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

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

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. ~~Completion of training on site.~~ ~~b.~~ Observe two tunneled hemodialysis catheter placements with

qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 10 tunneled hemodialysis catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure b. and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful placement of 10 tunneled hemodialysis catheter placements every 2 years. b. Direct observation of one hemodialysis access catheter placement procedure will be performed every 2 years by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. 3 chart reviews will be performed every 2 years.

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Protocol #12: Tunneled Central Venous Catheter Removal

A. DEFINITION

This procedure/protocol covers removal of tunneled central venous catheters (CVC). For the purposes of the protocol/procedure a tunneled central venous catheter refers to venous access devices used for central venous infusion and/or hemodialysis, which is tunneled under the skin to the catheter exit site.

1) Location to be performed: Removal of tunneled central venous catheters may occur in the Radiology Department, inpatient units, Emergency Department, PACU, and 4C.

2) Performance of procedure:
   i. Indications: Discontinuation of catheters in patients with suspected CVC infections or for CVCs that are no longer medically needed.
   ii. Precautions requiring attending physician consultation: patients with central venous obstruction or abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department...
   iii. Contraindications: No absolute contraindications.

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
b. Time out performed per hospital policy.
c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.)

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Requirements, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. ~~Completion of training on site.~~ ~~b.~~ Observe one tunneled CVC removal with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for

performing the procedure, trainee will perform 5 tunneled hemodialysis catheter removals without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee. who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency Documentation: a. Continued proficiency will be documented on annual evaluation or re-credentialing through the successful removal of 2 tunneled CVC annually and no unexpected complications. b. 2 chart reviews will be performed annually. c. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure, will be the proctor/evaluator.
Any additional comments:

Protocol #13: Chest Port Central Venous Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of chest port central venous catheters. A chest port central venous catheter refers to a device used for central venous access with an infusion port which lies underneath the skin, typically at the upper anterior chest, and a catheter tip which lies in a central vein.

1. Location to be performed: Radiology Department.

2. Performance of procedure:
   a. Indications: Central venous access for delivery of medications, nutrition, blood products, and frequent blood sampling.
   b. Precautions requiring attending physician consultation: patients with recent infections, patients with abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department...
   c. Contraindications requiring attending physician consultation: presence of known or suspected infections, septicemia, or peritonitis. Patients who have exhibited prior intolerance to the materials of construction, or patients whose body size or tissue is insufficient to accommodate the size of the port or catheter.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.)

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
a. ~~Completion of training on site.~~ ~~b.~~ Observe two chest port placements with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider who has completed

proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 10 chest port placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful placement of 5 chest port central venous infusion catheter placements every two years. b. Direct observation of one chest port placement procedure will be performed every two years by a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. 3 chart reviews will be performed every two years. d. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the proctor/evaluator.

Protocol #14: Chest Port Central Venous Catheter Removal

A. DEFINITION

This procedure/protocol covers removal of chest port central venous catheters (CVC). For the purposes of the protocol/procedure a chest port central venous catheter refers to venous access devices used for central venous infusion which is tunneled under the skin to a subcutaneous port.

1) Location to be performed: Chest port CVCs will be removed in the Radiology Department.

2) Performance of procedure:
   i. Indications: Discontinuation of catheters in patients with suspected CVC infections or for CVCs that are no longer medically needed.
   ii. Precautions requiring attending physician consultation: patients with central venous obstruction, abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
   iii. Contraindications: No absolute contraindications.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
b. Time out performed per hospital policy.
c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.)

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. ~~Completion of training on site.~~ ~~b.~~ Observe removal of one chest port CVC with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for

performing the procedure, trainee will perform 5 chest port removals without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency Documentation: a. Continued proficiency will be documented on annual evaluation or re-credentialing through the successful removal of 2 chest ports every two years and no unexpected complications. b. 2 chart reviews will be performed every two years. c. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure, will be the proctor/evaluator.
Any additional comments:

Procedure: Protocol #15: Gastrostomy Catheter Exchange

A. DEFINITION

This protocol/procedure covers the exchange or removal of percutaneous gastrostomy and gastrojejunostomy catheters/tubes. For the purposes of this procedure a gastrostomy tube would be defined as catheter inserted percutaneously into the stomach, and with catheter end located in the stomach, duodenum or proximal jejunum.

1. Location to be performed: Gastrostomy catheter exchange will take place in Radiology Department, Emergency Department or inpatient units at Zuckerberg San Francisco General HospitalSan Francisco General Hospital. Gastrojejunostomy exchange will take place in the Radiology department or operating room at Zuckerberg San Francisco General HospitalSan Francisco General Hospital.

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: Gastrostomy tubes which have been in place less than 6 weeks and replacement of gastrostomy catheters that have completely fallen out of the body.
   c. Contraindications requiring attending physician consultation: immature gastrostomy tracts that may require fluoroscopic replacement.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug -
   e. Referral to physician, specialty clinics, and supportive services, as needed.
   f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Requirements, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:
a. ~~Completion of training on site.~~ ~~b.~~ Observe one gastrostomy exchange with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. Observe one gastrojejunostomy exchange with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.

Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 3 gastrostomy exchanges and 3 gastrojejunostomy exchanges with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure, and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful exchange of one gastrostomy tube and one gastrojejunostomy tube annually. b. Direct observation of one gastrojejunostomy tube exchange every 2 years will be performed with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. 2 chart reviews will be performed every 2 years, of one gastrostomy and one gastrojejunostomy. d. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator.

Protocol #16: Pleural Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of a percutaneous pleural catheter. For the purposes of this protocol a pleural catheter or chest tube refers to a catheter placed using thoracentesis followed by dilation and catheter exchange over a wire method for obtaining access to the intra-pleural space for drainage of pleural fluid, in which the catheter may or may not have a locking cope loop.

1. Location to be performed: Radiology Department, inpatient units, PACU and emergency department.

2. Performance of procedure:
   a. Indications: pleural effusions and pneumothorax.
   b. Precautions requiring attending physician consultation, pulmonary bullae. Pleural adhesions and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines, which are posted in the Radiology Department.
   c. Contraindications: need for emergent thoracotomy, skin infection over insertion site.

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: ~~a. Completion of training on site.~~ ~~b.~~a. Qualification to perform thoracentesis. ~~c.~~b. Observe two pleural catheter placements with qualified provider.
Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for

performing the procedure, trainee will perform 10 pleural catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful placement of 3 pleural catheters every 2 years. b. Direct observation of two pleural catheter placement procedures will be performed every 2 years. c. 3 chart reviews will be performed every 2 years. d. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the proctor/evaluator.

Procedure: Protocol #17: Tunneled Pleural Catheter Placement

A. DEFINITION

This procedure/protocol covers the placement of a tunneled percutaneous pleural catheter. For the purposes of this protocol a tunneled pleural catheter and tunneled chest tube are used interchangeably and refer to a pleural catheter placed using thoracentesis followed by dilation and subcutaneous tunneling to an adjacent exit site for drainage of pleural fluid.

1. Location to be performed: Radiology Department, inpatient units, PACU and emergency department.

2. Performance of procedure:
   a. Indications: chronic pleural effusions.
   b. Precautions requiring attending physician consultation, pulmonary bullae. Pleural adhesions and coagulopathies with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines, which are posted in the Radiology Department.
   c. Contraindications: active infection, parapneumonic effusions, skin infection over insertion site.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan

a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
b. Time out performed per hospital policy.
c. Diagnostic tests for purposes of disease identification.
d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
e. Referral to physician, specialty clinics, and supportive services, as needed.
f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: ~~a. Completion of training on site.~~ ~~b.~~ Qualification to perform thoracentesis. a. b. ~~c.~~ Observe two pleural catheter placements with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 10 tunneled

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pleural catheter placements without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful placement of 3 tunneled pleural catheters every 2 years. b. Direct observation of two pleural catheter placement procedures will be performed every 2 years. c. 3 chart reviews will be performed every 2 years. d. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the proctor/evaluator.

Protocol #18: Thoracentesis

A. DEFINITION: Insertion of a needle into the pleural space to aspirate fluid for analysis and/or relieve pressure caused by accumulation of pleural fluid.

1. Location to be performed: Radiology Department, inpatient units, and emergency department.

2. Performance of procedure
   Indications
   a. For the purposes of this protocol, thoracentesis may be used to determine the cause of a pleural effusion or
   b. To relieve the symptoms of respiratory distress

   Contraindications
   a. Infection in the tissues near the puncture site.
   b. Acute respiratory compromise
   c. Abnormal blood clotting with laboratory results (INR, PTT, Platelets) falling outside of standard procedural guidelines which are posted in the Radiology Department.
   d. Significant pulmonary parenchymal disease

B. DATA BASE

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

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

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

D. PLAN

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care a. ~~Onsite training by a qualified provider.~~No prerequists to begin proctoring. Training will be provided during proctoring period.
Proctoring Period a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 5 thoracentesis procedures without need for procedural intervention by training provider and such additional procedures as may be necessary to

verify clinical competence. b. Experienced provider to procedure, a minimum of 3 successful observed demonstrations c. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency a. The evaluator will be the Chief of Interventional Radiology or designated qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. b. Ongoing competency evaluation. 1. Perform a minimum of 3 procedures every 2 years. 2. Two chart reviews every 2 years.

Protocol #19: Procedural Sedation/Moderate Sedation (ACLS required)

A. DEFINITION

Procedural Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. The following guidelines describe the minimum requirements for the delivery of procedural sedation ZSFG policy number 19.8 titled, “Procedural Sedation: Moderate and Deep”) by the Nurse Practitioner/Physician Assistant during procedures in adults within a monitored setting.

For the purpose of this protocol, the setting is specifically in the Radiology Department. The Nurse Practitioner/Physician Assistant practices under the supervision of the Chief of Interventional Radiology or designee. Practitioners inducing a level of moderate sedation are to be trained to rescue patients whose sedation becomes deeper than initially intended as evidenced by partial or complete loss of protective reflexes, and the inability to maintain a patent airway. Respiratory and cardiovascular monitoring, provisions for managing airway and cardiovascular emergencies must be in place. Procedure may only be done in the designated areas for procedural sedation within the Radiology Department, which are equipped and staffed, according to departmental and hospital policy.

Materials necessary for procedural sedation and rescue include:

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

Indications:

a. Procedural sedation may be indicated for procedures in which a need for moderate sedation is anticipated to manage procedural discomfort, including but not limited to chest tubes, and tunneled central venous catheters.

Precautions/Contraindications requiring attending physician consultation:

a. Inability to obtain informed patient consent.
b. Anticipated difficult intubation.
c. The patient's American Society of Anesthesiologists (ASA) physical status; consultation with Anesthesia Service should be considered for patients who have an ASA class of 3 or above. A procedure requiring sedation would not be done on a patient with an ASA class above a three (3) without anesthesia assistance.
d. When the patient's cardiovascular status will not permit positioning in a recumbent position.

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

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

C. DIAGNOSIS/ASSESSMENT
1. A judgment as to the appropriateness of the procedure and safety of sedation for the particular patient, that includes consideration of the patient's age, medical condition, and the procedure and sedation side effects and risks.
2. Assignment of an ASA physical status. Patients with a Physical ASA class of IV or V will not undergo conscious sedation by the Nurse Practitioner/Physician Assistant in the Radiology Department.
3. Assignment of the pre-procedure Modified Aldrete Score.
4. Evidence of verification of compliance with the NPO status (adult: minimum 8 hours (solids) and 2 hours (liquids) before procedure to decrease risk of aspiration).
5. Assess and document the benefits of sedation against the risk of possible aspiration.
6. A responsible adult is available to take the patient home after the procedure.

D. PLAN

1. Therapeutic Treatment Plan shall follow SFGH policy number 19.8 titled “Procedural Sedation: Moderate and Deep”
   a. Informed consent for the procedure and sedation must be obtained and documented by the nurse practitioner/physician assistant prior to the delivery of sedation. The consent form must list the procedure to be performed as well as the sedation planned.
   b. Pre-Procedure patient education shall be given and documented, to include, but not be limited to:
      1. Informed consent for the procedure and sedation and answering the patient's questions to their satisfaction; orientation to the procedures and equipment.
      2. Risks, benefits, and alternatives.
      3. Review of the pain scale and the patient's responsibility to inform staff of their pain status and any unexpected changes they might experience.
      4. Date/time of procedure.
      5. Necessity of an escort for discharge to home and/or an appropriate mode of transportation home.
   c. Re-assessment immediately prior to the procedure to include:
      1. Indication for procedure.
      2. Two patient identifiers.
      3. A “time out” documented.
      4. Vital signs (blood pressure, cardiac rhythm, heart rate, oxygen saturation, and end-tidal carbon dioxide).
      5. An assessment of level of movement and consciousness, and responsiveness.
   d. The Procedure:
      1. Verify pre-procedure assessment and monitoring guidelines.
      2. Administer appropriate medications as indicated.
      3. Continuously assess the patient’s response (level of consciousness, blood pressure, heart rate, respirations, oxygen saturation, ETCO2, rhythm, and pain level). Vital signs will be documented no less frequently than every 5 minutes beginning with the first administration of sedation.
      4 Cardiac monitoring if patient has any cardiac history.
      5. Reversal agents, if indicated.
   e. Post-procedure
      1. Monitor level of consciousness, respiratory and cardiovascular parameters, and pain level.
   f. Termination of Treatment
      1. If the patient does not tolerate the procedure, has significant unanticipated compromise, or otherwise indicated.

2. Patient conditions requiring Attending Consultation
   a. Physical ASA status 3 or above.

b. Aspiration.
c. Acute decompensation of patient situation.
d. Unexplained historical, physical or laboratory findings.
e. Upon request of patient, NP, PA, or physician.
f. Problem requiring hospital admission or potential hospital admission.

3. Education

Patient will be instructed on signs and symptoms of complications. A 24 hour emergency advice number will be given to the patient for any post-procedural problems. Examination findings/pathology results will be provided to the patient by the primary care provider, telephone, or during an appointment in the Interventional Radiology Department.

4. Follow-up

A. If the patient is transferred to the recovering unit:
   1. The patient must be accompanied by trained and/or licensed personnel.
   2. The clinical unit performing the procedure must give a verbal report to the Recovery Room nurse caring for the patient. Items to report include, but are not limited to:

      a. Pertinent medical history.
      b. The procedure performed.
      c. The condition of the patient; including pain score.
      d. The sedation agents administered, the total dosage and the last dose and time of sedation agent given.
      e. Any significant clinical events occurring during and post-procedure.
      f. Any additional orders relating to the post-procedural/moderate sedation care.

B. Any patient receiving a reversal agent (naloxone or flumazenil) must be monitored for at least two (2) hours after administration of the agent to detect potential re- sedation. In addition an Unusual Occurrence Report must be completed. See Hospital Policy 19.08 for other criteria requiring the submission of an unusual occurrence report.

C. The outpatient is discharged “to home”:
   1. By a specific discharge order from a physician or nurse practitioner/physician assistant; or by a registered nurse who has been approved to discharge the patient according to an approved standardized procedure.

2. Written post-procedural instruction along with a 24-hour emergency telephone number will be given to the patient for assistance with post-procedural problems.
3. Outpatients who are discharged to home must be accompanied by a responsible adult and have an appropriate mode of transportation.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the Medical record as appropriate. The patient status and compliance with discharge criteria must be documented in the patient's medical record by the physician, nurse practitioner, physician assistant, or registered nurse discharging the patient. Document all findings in the computerized procedure database, usually the PACS system.

F. Summary of prerequisites, proctoring & reappointment of competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care:

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

B. Training Program
1. Read and sign ZSFG Hospital Policy 19.08 "Procedural Sedation – Moderate and Deep"
2. Completion of the ZSFG Procedural Sedation module and Test with a passing score of 90%.
3. Completion of Advanced Cardiac Life Support (ACLS) training.
4. Completion of the Registered Nursing Moderate Sedation Education Module.
5. Furnishing License and/or DEA number.

Proctoring A. Direct observation by IR attending staff credentialed in moderate sedation for a minimum of 30 procedures with moderate sedation, while an experienced practitioner to moderate sedation requires a minimum of 10 successful observed demonstrations. B. Review of 30 procedure notes by interventional radiology attendings.
Reappointment Competency: A. Ongoing competency will include the successful completion of 15 procedures every 2 years. B. Direct observation of one observed moderate sedation case will be conducted by the Medical Director or other designated attending physicians every 2 years. C. Maintenance of ACLS and BLS Certification. D. Passing of Procedural Sedation test with a passing score of 90%

Protocol #20: Lower Extremity Venous Sclerotherapy

A. DEFINITION

For purposes of this protocol sclerotherapy refers to lower extremity venous sclerotherapy. Sclerotherapy is a medical procedure to eliminate varicose veins and spider veins. Sclerotherapy involves an injection of solution directly into the vein. The sclerosing agent irritates the lining of the blood vessel, causing to collapse and the blood to clot.

1) Location to be performed: Interventional Radiology- Building 5 and Building 25

2) Performance of procedure:
   i. Indications Symptomatic superficial venous insufficiency with symptoms including edema, pain, restless legs, and/or ulceration.
   ii. Precautions the following list of conditions necessitate attending physician consultation:
      a. Current phlebitis
      b. History of, or current DVT.
   iii. Contraindications
      a. Pregnancy
      b. Any allergy to the sclerosing agent

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent is obtained before the procedure is performed and filed according to hospital policy.
   b. Time out is performed before the procedure per hospital policy.
   c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care Specialty training will by provided by Interventional Radiology attendings as part of the orientation process. a. Observe 1 Sclerotherapy procedure with MD. b. US-guided PICC line or IV placement, with documentation of training completed by either Radiology/IR SP protocol, or ZSFG RN training in US-guided IV or PICC placement. c. Observation of 5 patient pre-evaluations in the Vein Clinic or Vascular Surgery Clinic.
Proctoring Period: a. New practitioner to procedure, a minimum of 10 successful observed demonstrations. b. Experienced practitioner to procedure, a minimum of 4 successful observed demonstrations. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency Documentation: a. Demonstration of 4 procedures every 2 years. b. Minimum 4 chart reviews every 2 years. c. Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.
Any additional comments:

Protocol #21: Hip Aspiration and Injection

A. DEFINITION

Hip aspiration and injection is a medical procedure which involves placing a needle percutaneously into hip joint, followed by aspiration and/or injection of liquid agents.

1) Location to be performed: Interventional Radiology- Building 5 and Building 25

2) Performance of procedure:
   i. Indications: Analysis of hip fluid in evaluation of infectious and non-infectious arthritis. Treatment of hip pain or inflammation.
   ii. Precautions the following list of conditions necessitate attending physician consultation:
      a. Patients with abnormal blood clotting reflected by anticoagulant usage or laboratory values outside of interventional radiology standard consensus guidelines.
   iii. Contraindications
      a. Pregnancy
      b. Any allergy to procedural medications.
      c. Injections are contraindicated for severe dermatitis, soft tissue swelling suspicious for infection.

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent is obtained before the procedure and filed according to hospital policy.
   b. Time out is performed before procedure per hospital policy.
   c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
   d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician.
   e. Initiation or adjustment of medication other than those in the formularies.
   f. Problem requiring hospital admission or potential hospital admission.
   g. Severe dermatitis, soft tissue swelling suspicious for infection (see also contraindications).

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the paper or electronic medical record as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care:

~~a. Specialty training will by provided by Interventional Radiology attendings as part of the orientation process.~~

~~b.~~a. Observe 1 hip aspiration and/or injection procedure with MD.

Proctoring Period:

a. New practitioner to procedure, a minimum of 5 successful observed demonstrations.
b. Experienced practitioner to procedure, a minimum of 3 successful observed demonstrations.
c. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure. Chart review of all observed cases.

Reappointment Competency Documentation:

a. Demonstration of 2 procedures every 2 years.
b. Minimum 2 chart review needed to monitor ongoing competency every 2 years.
c. Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.

Any additional comments:

Procedure: Protocol #22: Shoulder Aspiration and/or Injection

A. DEFINITION

Shoulder aspiration and injection is a medical procedure which involves placing a needle percutaneously into shoulder joint, followed by aspiration and/or injection of liquid agents.

1) Location to be performed: Interventional Radiology- Building 5 and Building 25

2) Performance of procedure:
   i. Indications: Analysis of shoulder fluid in evaluation of infectious and non-infectious arthritis. Treatment of shoulder pain or inflammation.
   ii. Precautions the following list of conditions necessitate attending physician consultation:
      a. Patients with abnormal blood clotting reflected by anticoagulant usage or laboratory values outside of interventional radiology standard consensus guidelines.
   iii. Contraindications
      a. Pregnancy
      b. Any allergy to procedural medications.
      c. Injections are contraindicated for severe dermatitis or soft tissue swelling suspicious for infection.

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
    a. Patient consent is obtained before the procedure and filed according to hospital policy.
    b. Time out is performed before the procedure per hospital policy.
    c. Diagnostic tests for purposes of disease identification; may or may not include ultrasound to assess target veins.
    d. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Unexplained historical, physical or laboratory findings
    c. Uncommon, unfamiliar, unstable, and complex patient conditions
    d. Upon request of patient, NP, PA, or physician
    e. Initiation or adjustment of medication other than those in the formularies.
    f. Problem requiring hospital admission or potential hospital admission.
    g. Severe dermatitis, soft tissue swelling suspicious for infection (see also contraindications).

3. Education

    Discharge information and instructions.

4. Follow-up

    As appropriate for procedure performed.

E. RECORD KEEPING

Patient visit, consent forms, and other procedure specific documents will be recorded in the paper or electronic medical record - as appropriate.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to the initiation of proctoring and the provision of direct patient care:

~~a. Specialty training will by provided by Interventional Radiology attendings as part of the orientation process if NP/PA does not have previous experience, defined as active privileges for this procedure at another institution within the past six months.~~

~~b.~~a. Observe 1 shoulder aspiration and/or injection procedure with MD.

Proctoring Period:

a. New practitioner to procedure, a minimum of 5 successful observed demonstrations.
b. Experienced practitioner to procedure, a minimum of 3 successful observed demonstrations.
c. Proctoring may be performed by experienced qualified (MD/NP/PA) who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
d. Chart review of all observed cases

Reappointment Competency Documentation:

a. Demonstration of 2 procedures every 2 years.
b. Minimum 2 chart reviews every 2 years.
c. Evaluation will be performed by any supervising Interventional Radiology Attending and signed off by the Chief of Interventional Radiology or a designee.

Any additional comments:

Protocol #23: Nephrostomy Catheter Exchange

A. DEFINITION

This protocol/procedure covers the exchange or removal of percutaneous nephrostomy and nephroureterostomy catheters. For the purposes of this procedure a nephrostomy tube would be defined as catheter inserted percutaneously into the renal pelvis, and with catheter end located in the renal pelvis, or bladder. A nephroureterostomy catheter would be defined as a special subtype of nephrostomy catheter, that is inserted percutaneously into the renal pelvis, and with catheter end located in the bladder.

1. Location to be performed: Nephrostomy catheter exchange will take place in Radiology Department and Interventional Radiology procedural rooms at Zuckerberg San Francisco General Hospital~~San Francisco General Hospital~~.

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: IR Attending will be consulted prior to any planned nephrostomy catheter exchange.
   c. Contraindications requiring attending physician consultation: immature nephrostomy tracts and nephrostomy tubes which have been in place less than 6 weeks.

B. DATA BASE

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

2. Objective Data
   a. Physical exam appropriate to the procedure to be performed.

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

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

D. PLAN
1. Therapeutic Treatment Plan
    a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
    b. Time out performed per hospital policy.
    c. Diagnostic tests for purposes of disease identification.
    d. Initiation or adjustment of medication per Furnishing/Drug -
    e. Referral to physician, specialty clinics, and supportive services, as needed.
    f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
    a. Acute decompensation of patient situation.
    b. Unexplained physical or laboratory findings
    c. Upon request of patient, NP, PA, or physician
    d. Initiation or adjustment of medication other than those in the formularies.
    e. Problem requiring hospital admission or potential hospital admission.

3. Education
Discharge information and instructions.

4. Follow-up
As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. Completion of training on site. b. Completion of training on gastrostomy and gastrojejeunostomy exchange as outlined in separate hospital approved standardized procedure. b. c. Completion of training on Interventional Radiology Procedural Assistant cd. Observe two nephrostomy exchange with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. de. Observe two nephroureterostomy exchange with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider, trainee will perform 4 nephrostomy exchanges and 4 nephroureterostomy exchanges with qualified provider without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by qualifying experienced MD/NP/PA and signed off by the Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful exchange of one nephrostomy tube and one nephroureterostomy tube annually. b. Direct observation of one nephroureterostomy tube exchange every 2 years will be performed with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. 2 chart reviews will be performed every 2 years of one nephrostomy and one nephroureterostomy. d. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator.

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Protocol #24: Cholecystostomy Catheter Exchange

A. DEFINITION

This protocol/procedure covers the exchange or removal of percutaneous cholecystostomy catheters/tubes. For the purposes of this procedure a cholecystostomy tube would be defined as catheter inserted percutaneously into the gallbladder, and with catheter end located in the gallbladder.

1. Location to be performed: cholecystostomy catheter exchange will take place in Radiology Department and Interventional Radiology procedural rooms or operating room at Zuckerberg San Francisco General Hospital ~~San Francisco General Hospital~~.

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: IR Attending will be consulted prior to any planned cholecystostomy catheter exchange.
   c. Contraindications requiring attending physician consultation: immature cholecystostomy tracts, cholecystostomy tubes which have been in place less than 6 weeks.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug -
   e. Referral to physician, specialty clinics, and supportive services, as needed.
   f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. ~~Completion of training on site.~~ ~~b.~~ Completion of training on gastrostomy and gastrojejeunostomy exchange as outlined in separate hospital approved standardized procedure. b~~c~~. Completion of training on Interventional Radiology Procedural Assistant c~~d~~. Observe two cholecystostomy drain exchange with qualified provider who has completed proctoring and subsequently

maintained their eligibility for performing the procedure.
Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 5 cholecystostomy catheter exchanges with qualified provider without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified (MD/NP/PA) and signed by the Chief of the Department of Interventional Radiology or qualified provider designee.
Reappointment Competency: a. Successful exchange of two cholecystostomy tubes annually. b. Direct observation of one cholecystostomy tube exchange every 2 years will be performed with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. 2 chart reviews will be performed every 2 years. d. The Chief of the Interventional Radiology Department or qualified provider designee will be the evaluator.

Protocol #25: Abscess Drainage Catheter Exchange

A. DEFINITION
This protocol/procedure covers the exchange or removal of percutaneous abscess catheters/tubes. For the purposes of this procedure an abscess drain would be defined as catheter inserted percutaneously with end draining intracorporal free fluid or contained collections. Fluid drained by these catheters may be infected or sterile and may contain fluid leaked or secreted from other organ systems.

1. Location to be performed: Abscess drain exchange will take place in Radiology Department and Interventional Radiology procedural rooms or operating room at Zuckerberg San Francisco General Hospital.~~will take place in Radiology Department, and Interventional Radiology procedure rooms at San Francisco General Hospital.~~

2. Performance of procedure:
   a. Indications: malpositioned, malfunctioning catheter, optimization of drainage therapy, or as part of routine exchange and catheter maintenance.
   b. Precautions requiring attending physician consultation: Unexplained physical or laboratory findings

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

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

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

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time out performed per hospital policy.
   c. Diagnostic tests for purposes of disease identification.
   d. Initiation or adjustment of medication per Furnishing/Drug -
   e. Referral to physician, specialty clinics, and supportive services, as needed.
   f. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained physical or laboratory findings
   c. Upon request of patient, NP, PA, or physician
   d. Initiation or adjustment of medication other than those in the formularies.
   e. Problem requiring hospital admission or potential hospital admission.

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and provision of direct patient care: a. ~~Completion of training on site.~~ ~~b.~~ Completion of training on gastrostomy and gastrojejeunostomy exchange as outlined in separate hospital approved standardized procedures. b~~c~~. Completion of training on Interventional Radiology Procedural Assistant c~~d~~. Observe two abscess drain exchange with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure.

Proctoring Period: a. Under direct observation of a qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure, trainee will perform 5 abscess drain exchanges with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure without need for procedural intervention by training provider and such additional procedures as may be necessary to verify clinical competence. b. Proctoring may be performed by experienced qualified provider MD/NP/PA who has completed proctoring and subsequently maintained their eligibility for performing the procedure and signed by the Chief of the Department of Interventional Radiology or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure.
Reappointment Competency: a. Successful exchange of two abscess drain exchanges annually. b. Direct observation of one abscess drain exchange every 2 years will be performed with qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. c. 2 chart reviews will be performed every 2 years, of one nephrostomy and one nephroureterostomy. d. The Chief of the Interventional Radiology Department or qualified provider designee who has completed proctoring and subsequently maintained their eligibility for performing the procedure will be the evaluator.

Protocol #26: CT Guided Spinal Steroid Injections

A. DEFINITION

Using CT guidance to inject steroid medication near where the nerve root exits the spinal column, the intrathecal sac, or into the facets.

1) Location to be performed: *Outpatient and In Patient*

2) Performance of procedure:
   i. Indications Back pain with corresponding imaging findings of transforaminal stenosis, facet arthropathy, or canal stenosis.
   ii. Precautions Hypertension < 160/100, hyperglycemia
   iii. Contraindications Active infection, Hypertension > 160/100, lack of correspondent imaging findings for target. Anticoagulants contraindicated for intra-laminar (epidural) injections.

B. DATA BASE

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

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

C. DIAGNOSIS

Assessment of subjective and objective data to identify disease processes.

D. PLAN

1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed and obtained according to hospital policy.
   b. Time-out performed per hospital policy.

c. Diagnostic tests for purposes of disease identification.
d. Biopsy tissue is sent to pathology.*(ONLY IF TISSUE IS SENT)*
e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
f. Referral to physician, specialty clinics, and supportive services, as needed.

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

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Requirements to be completed prior to initiation of proctoring and direct patient care: A. Completion of training on site B. Observe 10 procedures by qualified provider who has completed proctoring and subsequently maintained their eligibility for performing the procedure. C. Completion of a Pain Management Training and Injection Certification through a credentialed program a. Example: Empire Medical Pain Management Training Certification Program, eligible for board certification through the American Academy of Procedural Medicine (AAOPM) D. Prior credentialing for Lumbar Puncture
Proctoring Period: A. Perform 10 procedures with direct supervision B. Chart review and review of referrals for 10 cases c. Any qualified provider (MD, NP, PA) who has completed proctoring

and subsequently maintained their eligibility for performing the procedure can proctor.
Reappointment Competency Documentation: a. Minimum number of procedures that must be completed in two years or state number of procedures annually: 5 b. Minimum number of chart reviews needed in a two years or state number of chart reviews annually: 10 c. No direct observation of procedure is needed for reappointment
Any additional comments: These are comparable to the standard training protocol for the nurse practitioners performing this procedure at the Connecticut Back Center, which is credentialed by the North American Spine Society.

2020 INTERVENTIONAL RADIOLOGY STANDARDIZED PROCEDURE
APPROVALS

Medical Director or Division Chief Approval or Service Chief Approval:
Mark Wilson, MD
Author: Ryan Sincic, NP

CIDP Approval Date: 09/02/2020
Credentials Approval Date: 09/08/2020
MEC Approval Date: 09/17/2020
Gov. Body Approval Date: 09/22/2020

Addendum: Protocol #26 CT Guided Spinal Steroid Injections was approved by Credential 9-28-22. Note entered by Justin Dauterman, MSN, RN, NPD-BC

Zuckerberg San Francisco General MEC Radiology Report 2024

Mark W. Wilson, MD
Hideyo Minagi Professor of Radiology
Chief, Department of Radiology
Zuckerberg San Francisco General Hospital and Trauma Center

Scope of Service

- Comprehensive provision of diagnostic imaging and interventional radiology services
- 24/7 coverage for emergent exams and procedures
- Hospital based department
- Inpatient IR admitting service
- Outpatient IR and spine procedure clinics
- Support Stroke, Trauma, Oncology, Women's health, OR, Inpatient and Outpatient services

Services Provided

- Abdominal Imaging
- Thoracic Imaging
- Neuroimaging
- General and OB Ultrasound
- Breast Imaging and Tomosynthesis
- Musculoskeletal Emergency Imaging
- Interventional Radiology
- Neurointerventional Radiology and Stroke Treatment
- *Afterhours Emergency Radiology Service*

Imaging Modalities

- Building 5 (Current configuration)
  - 1 MRI scanners (1.5 T)
  - 1 CT scanner (64 slice)
  - IR Suite (Single plane C-arm with CT scanner)
  - Outpatient Ultrasound
  - General X-ray rooms
  - Portable X-ray

Imaging Modalities

- Avon Center
  - General Mammography
  - Digital Breast Tomosynthesis
  - Breast US
  - Breast biopsy and needle localization
  - Mammography Van for greater access
  - DEXA bone densitometry unit

Imaging Modalities

- Building 25
  - 2 MRI scanners (Both 3 T, 1 intra-operative)
  - 4 CT scanners (2 in ED, 2 in basement level, 1 with PET)
  - IR Suite (Single plane C-arm with CT scanner)
  - IR Suites (2 Biplane fluoro units. One is the Cath Lab)
  - Hybrid OR/IR suite (OR 8)
  - Ultrasound (3 bays and portable)
  - General X-ray rooms
  - Fluoroscopy
  - Portable X-ray

Radiology Leadership Structure

Christopher Hess, MD, PhD
Chair of UCSF Radiology & Biomedical Imaging

Mark W. Wilson, MD
Vice-Chair and Chief of Radiology at ZSFG

Mary McGinty RT (R) (M) ARRT
Director of Imaging and Pathology

Lorel Hiramoto, BA
Site Director, UCSF Radiology at ZSFG

Radiology Leadership Structure

Additional Faculty Director Roles:

- Clinical Operations – Jason Talbott, MD, PhD
- Well-being/DEI – Preethi Raghu, MD
- IT/Informatics – Jared Narvid, MD
- Research – Michael Ohliger, MD, PhD
- Quality – Brian Haas, MD
- Chair of Radiation Safety – Alex Rybkin, MD

ZSFG Radiology Faculty

(over the years)

1960's

Present

New ZSFG Radiology Faculty

Christopher Brunson, MD
Assistant Professor of Clinical Radiology
Interventional Radiology

Alyssa Kirsch, MD
Assistant Professor of Clinical Radiology
Abdominal Imaging and US

New ZSFG Radiology Faculty

Weiya Mu, MD
Assistant Professor of Clinical Radiology
Neuroimaging

Allen Ye, MD
Assistant Professor of Clinical Radiology
Neuroimaging

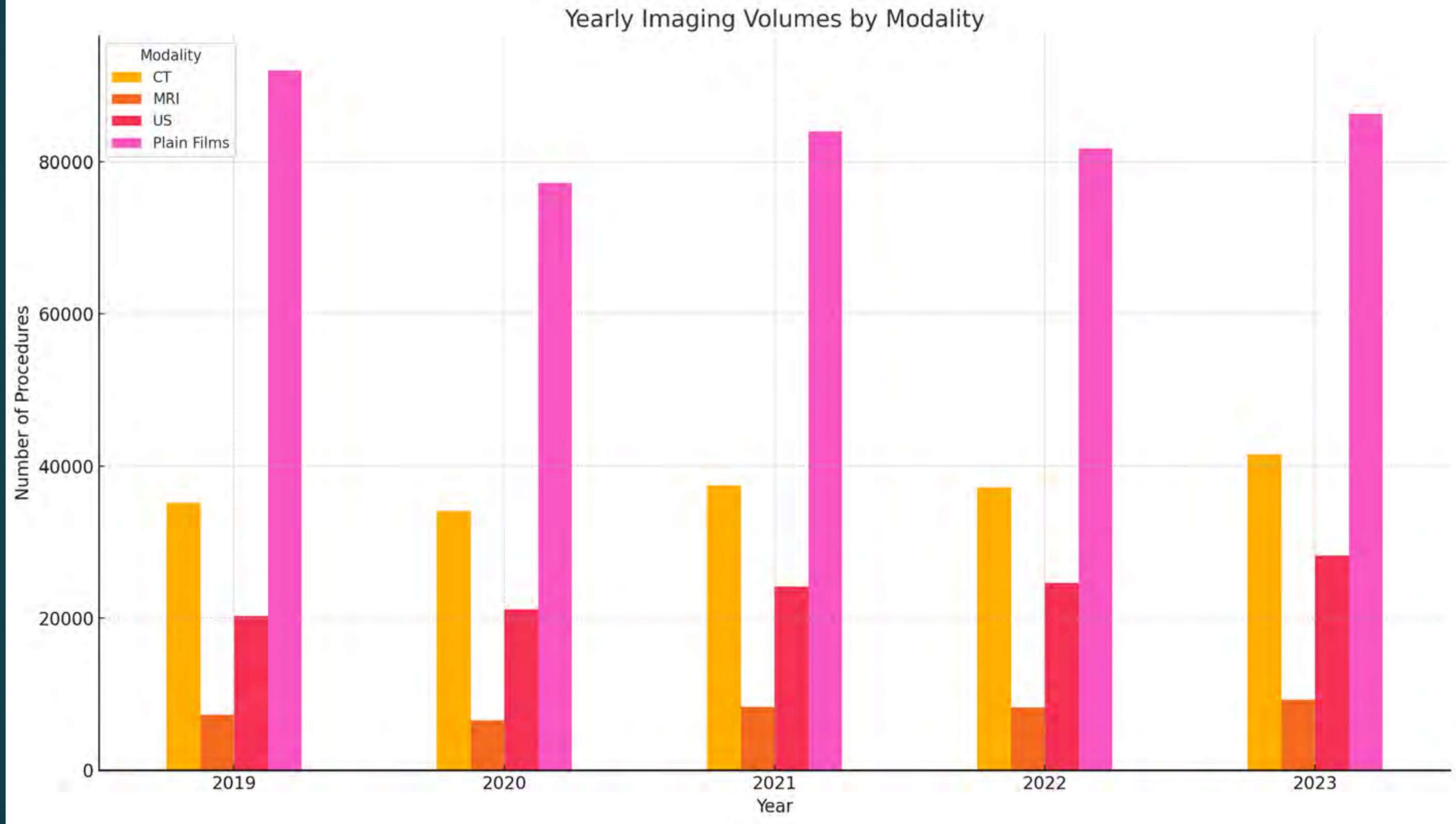
ZSFG Radiology Faculty Coverage
Active Faculty

	Abdominal Imaging	Musculo-skeletal & General Imaging	Ultrasound	Thoracic Imaging	Neuro-radiology	Neuroendo-vascular (NES)	Breast Imaging	Interventional (IR)
Active Faculty (21)								
Chris Brunson, MD								X
Ellen Chang, MD		X						
Miles Conrad, MD								X
Shital Gandhi, MD			X		X			
Brian Haas, MD				X				
Alissa Kirsch, MD	X		X					
Vishal Kumar, MD								X
Terry Lynch, MD		X						
Weiya Mu, MD					X			
Sujal Nanavati, MD								X
Jared Narvid, MD					X			
Michael Ohliger, MD, PhD	X							
Preethi Raghu, MD	X		X					
Amrutha Ramachandran, MD					X			
Alexander Rybkin, MD	X	X	X					
Lori Strachowski, MD			X				X	
Jason Talbott, MD, PhD					X			
Thienkhai Vu, MD	X	X		X				
Mark Wilson, MD								X
Allen Ye, MD					X			
Esther Yuh, MD					X			

ZSFG Radiology Faculty Coverage
Courtesy Faculty

	Abdominal Imaging	Musculo-skeletal & General Imaging	Ultrasound	Thoracic Imaging	Neuro-radiology	Neuroendo-vascular (NES)	Breast Imaging	Interventional (IR)
Courtesy Faculty (24)								
Matthew Amans, MD						X		
Hailey Choi, MD	X		X					
Shirley Chou, MD							X	
Maggie Chung, MD							X	
Daniel Cooke, MD						X		
Rita Freimanis, MD							X	
Heather Greenwood, MD							X	
Jessica Hayward, MD							X	
Steven Hetts, MD						X		
Omar Hassan, MD	X		X					
William Hong, MD	X		X					
Sina Houshmand, MD	X		X					
Bonnie Joe, MD, PhD							X	
Tatiana Kelil, MD							X	
Nandan Keshav, MD	X		X					
Amie Lee, MD							X	
Ben Li, MD (OB-Gyn)			X					
Kazim Narsinh, MD						X		
Elissa Price, MD							X	
Dorothy Shum, MD			X					
Jae Song, MD				X				
Kang Wang, MD	X		X					
Sean Woolen, MD	X		X					

ZSFG Radiology Exam Volumes



ZSFG Radiology Training Programs

Resident Training

Residency Program Director: Soonmee Cha, MD
Associate Program Director (ZSFG): Jared Narvid, MD

ZSFG is a vital educational hub for our residency

ZSFG Radiology
Training Programs

Resident Training

13 residents each rotation block

- Five PGY 2 level
- Five PGY 3 level
- Three PGY 4–5 level

4-week rotation blocks in all radiology specialties:

Interventional Radiology	Neuroradiology
Abdominal Imaging	Ultrasound
Breast Imaging	Thoracic Imaging
Emergency Radiology	Musculoskeletal Imaging

Direct attending-to-resident teaching every day in each specialty

Residents begin night-float call in PGY 3 year, working with ER attendings up to midnight and with remote attending back-up after 12 am – 8 am

ZSFG Radiology
Training Programs

Resident Education Activities and Resources

Dedicated core curriculum lectures (American Board of Radiology requirement)

Teaching conference twice daily

iMacs in all reading rooms (Pub Med, Stat Dx, Resident website etc.)

iPads and Laptops for education and research

Remodeled Minagi Library (Video conf. and new AV equipment)

Ultrasound phantoms for training in US-guided procedures

Monthly meetings with Program Director Department Chair

>99% pass rate on American Board of Radiology Exam over last 10 years

ZSFG Radiology Training Programs

Fellowship Training (AI, BI, Neuro) – Highly Integrated w/ ML and SFVAMC

Abdominal Imaging/US Fellowship

- 3.0 FTE ZSFG abdominal imaging fellows combined with 3.0 FTE SFVAMC fellows and 4.0 FTE Moffitt fellows in 3-site rotation

Breast Imaging Fellowship

- 2.0 FTE ZSFG mammography fellows

Neuroradiology Fellowship – Fellows rotate over from UCSF

- 0.20 FTE ZSFG neuroradiology fellow

ZSFG Radiology
Clinical &Teaching Conferences

1. Resident teaching conference (twice daily)
2. Med-Surg conference
3. Gyn. Tumor board
4. OB/Gyn conference
5. Medicine M+M
6. GI conference
7. Tumor board
8. Liver tumor conference
9. Neuro conference
10. Ortho conference
11. Monthly QI conference

Radiology Faculty Committee Participation

- MEC (Wilson)
- CPG (Wilson)
- CPG Finance Committee (Wilson)
- Cancer Committee (Vu)
- Credentials Committee (Conrad, Wilson)
- Trauma Peer Review Committee (Gandhi)
- Radiation Safety Committee (Rybkin - Chair)
- PERT Planning Committee (Conrad)
- Sedation Committee (Kumar)
- Public Health Pathways for Youth (Kumar)
- Liver Tumor Board (Kumar, Ohliger)
- CIDP (Wilson)
- BIDC (Strachowski, Joe, Freimanis, Greenwood, Hayward, Kelil, Lee, Price)
- Radiology Quality and Safety Committee (Haas, Wilson, Rybkin, Talbott, Ohliger)
- PIPS (Haas)
- Equity Council (Raghu, Kumar,Wilson)
- Several Search Committees

Major Faculty Research Directions:

Functional Imaging of Traumatic Brain and Spine Injury
- *Transforming Research and Clinical Knowledge in Traumatic Brain Injury (TRACK-TBI)*
- *Transforming Research and Clinical Knowledge in Spinal Cord Injury (TRACK-SCI)*

Machine learning applied to mammography

Self-Associating Hydrogel for Hydrodissection-Aided Percutaneous Tumor Ablation

Pomalidomide for HHT-related epistaxis

Evaluation of long-term efficacy of a Gore-Tex encoated plug

Automated Analysis of Brain Images

Magnetic catheter manipulation in the MRI environment

Catheter-directed delivery of genes, growth factors, and stem cells

Electronic Informatics Solutions for improving Patient Throughput and Communication of Results

Therapeutic optogenetics for low back pain

Functional brain imaging in setting of HIV/AIDS

Major Faculty Research Directions (cont):

Methamphetamine Associated Heart Failure

Gallbladder cryoablation

Hyperpolarized C^{13} *assessment of infection*

Functional evaluation of pulmonary nodules in patients with suspected lung carcinoma

Evaluation of new cerebral aneurysm and AVM therapies in animal models

Chemofilter – System to remove excess chemotherapy from bloodstream

International TMIST mammography screening trial

Neuroimaging of HIV/AIDS

MRI-based assessment of intracranial hypertension and pulsatile tinnitus

CXR interpretation deep learning and artificial intelligence

Radiogenomic analysis of dysfunctional dialysis fistulas

MR elastography assessment of hepatic cirrhosis

ZSFG Radiology
Faculty Research

Funding sources:

NIH 4 RO1s
2 R21s

DOE

RSNA research awards

SIR research awards

AMFAR

Industry Grants: Siemens, Penumbra

Performance Improvement and Patient Safety

Dialysis Fistula Clinical Intake Process

Radiology Report Turnaround Times

Contrast Reaction Preparedness Training

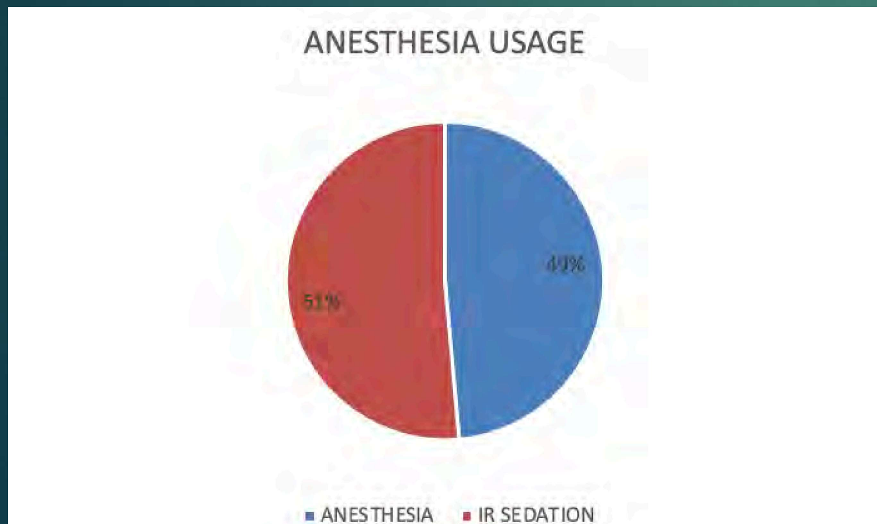
PIPS: Dialysis Fistula Clinical Intake Process

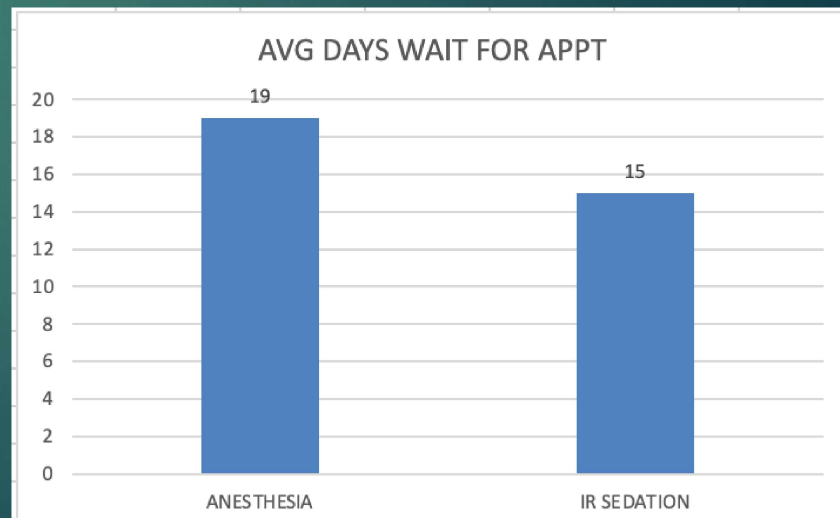
- Goal:
  - Developing a system from improving patient safety during our complex dialysis fistulagrams and declotting procedures.

- How:
  - Worked with Nephrology and Anesthesia to develop appropriate anesthesia referral criteria for fistulagrams and declots.
  - Implementation of an 18-point checklist (Clinical Intake Form) that is reviewed with patients and completed by an NP or PA prior to the patient being scheduled.
  - The patient is scheduled with or without anesthesia based on parameters noted in clinical intake form (e.g., major co-morbidities, prior response to sedation)
  - Preliminary work was completed in early 2023 and the pilot went live 5/1/2023
  - We tracked the number of cases, complications, time from scheduling to date of service, and anesthesia utilization rate.

PIPS: Dialysis Fistula Clinical Intake Process

- Impact:
  - Over 1 year, 107 fistulagrams were completed through the pilot.
  - There were zero intraprocedural complications.
  - Anesthesia usage increased to ~50% for fistulagrams and declots, with slightly increased wait-times; judged to be a very fair trade-off.





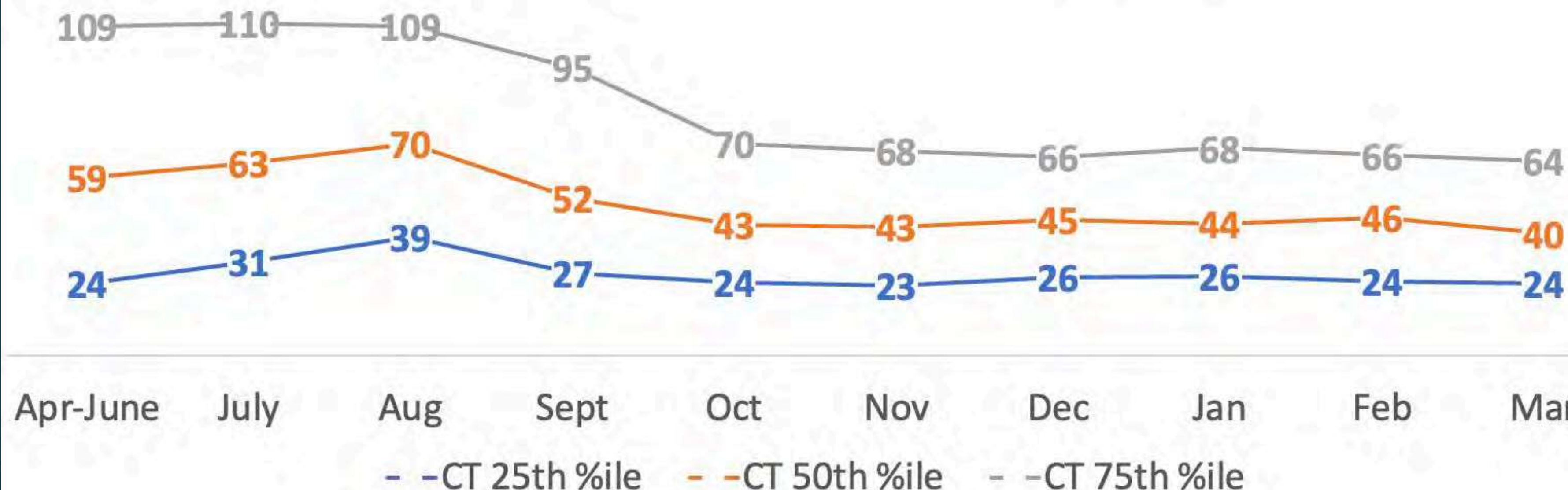
PIPS: Radiology Report Turnaround Times

Resident Fellow Performance Improvement Incentive Program (RFPIIP)

- **Goal:**
  - Improve weekday Emergency Department (ED) CT scan final report turnaround time.
- **How:**
  - Flagging ED scans in the PACS system.
  - Increasing number of attending read-out sessions during the day.
  - Prioritizing ED scans during read-out sessions.

PIPS: Radiology Report Turnaround Times

- Impact:
  - TAT for ED CT scan final reports improved by 47% or 56 min.



PIPS: Contrast Reaction Preparedness Training

- Goal:
  - Ensure preparedness for managing contrast reactions.
  - Target Audience: Radiologists, Technologists, and Nurses.

- How:
  - Pretest to assess baseline knowledge.
  - Didactic sessions including core concepts, protocols, and case studies.
  - Usage of online modules and in-person and virtual simulations
  - 6 session were conducted in FY24
  - Post-test to measure learning outcomes

PIPS: Contrast Reaction Preparedness Training

- Impact:
  - Participants trained: 57
  - Pre-test average score: 50%
  - Post-test average score: 72%
  - Overall knowledge gain: 22% increase in proficiency
  - Plan for continuous improvement including feedback integration, content updates, and refresher training sessions

Finances

FY 2023-24

REVENUE	
CPG Collections and AA Funds	$21,164,322.00
Managed Care Distribution	$ 1,441,256.00
Other income sources (LHH, Endowment, Grants)	$ 649,845.00
Total Revenue	**$23,255,423.00**

EXPENSES	
Clinical Salaries and overhead	$19,095,570.00
Mission Activities	$ 2,237,894.00
Total Expenses	**$21,333,465.00**

Surplus is prior to addition of new faculty hires

Finances
Investments of surplus funds

- **Coding and Billing**
  - Billing coordinator, 1 in-house coder
- **Teaching**
  - Additional resident slot
  - Clinical fellows
  - Educational materials
- **Clinical Support**
  - Nurse practitioners, PA
  - IT expertise
- **Support research mission**
  - IR Lab
  - Research assistants
  - Start-up packages
  - Seed grants
  - Training (CTSI)

ZSFG Interventional Radiology

Mission:

To deliver comprehensive interventional procedures 24/7 with compassion, equity, and excellence.

Personnel:

4.4 Faculty FTEs

11 Nursing FTEs

9 Technologist FTEs

3 Advanced Practice Provider (NP and PA) FTEs

1 Rotating Resident FTE

ZSFG Interventional Radiology

Leadership:

Chief: Mark Wilson, MD*

Nurse Manager: Ashley McClintock, MSN, RN

Supervisor: Loretta Johnson, RT

Other IR faculty:

Christopher Brunson, MD

Miles Conrad, MD, MPH*

Vishal Kumar, MD

Sujal Nanavati, MD*

ZSFG Interventional Radiology

Chris Brunson, MD Elaine Martin, RN Viana Larkin, RN Antoine Pierce, RN Alana Walker, RT Mark Wilson, MD

ZSFG Interventional Radiology

Procedures *(not comprehensive)*:

Category	IR Procedures
Oncology	- Chemoembolization (TACE)
	- Ablation therapies (RFA, MWA, Cryoablation)
	- Biopsy and Fiducial Marker Placement
	- Portal Vein Embolization (PVE)
	- Venous Access: Tunneled catheters (Hickman), Port-a-Cath, PICC
Trauma	- Embolization for bleeding control
	- Angioplasty and stent placement for vascular injuries
	- Non-vascular interventions (e.g., percutaneous drainage)

ZSFG Interventional Radiology

Procedures *(not comprehensive)*:

Category	IR Procedures
Cerebral Vascular Disease/Stroke	- Mechanical thrombectomy for acute ischemic stroke
	- Aneurysm coiling
	- Carotid artery stenting
	- Intra-arterial thrombolysis
	- AVM (Arteriovenous Malformation) embolization
Nephrology	- Dialysis access creation and maintenance (e.g., fistuloplasty)
	- Percutaneous nephrostomy
	- Renal artery angioplasty and stenting
	- Ureteral stenting
	- Embolization for renal bleeding or tumors
	- Venous Access: Tunneled and Nontunneled Dialysis Catheters

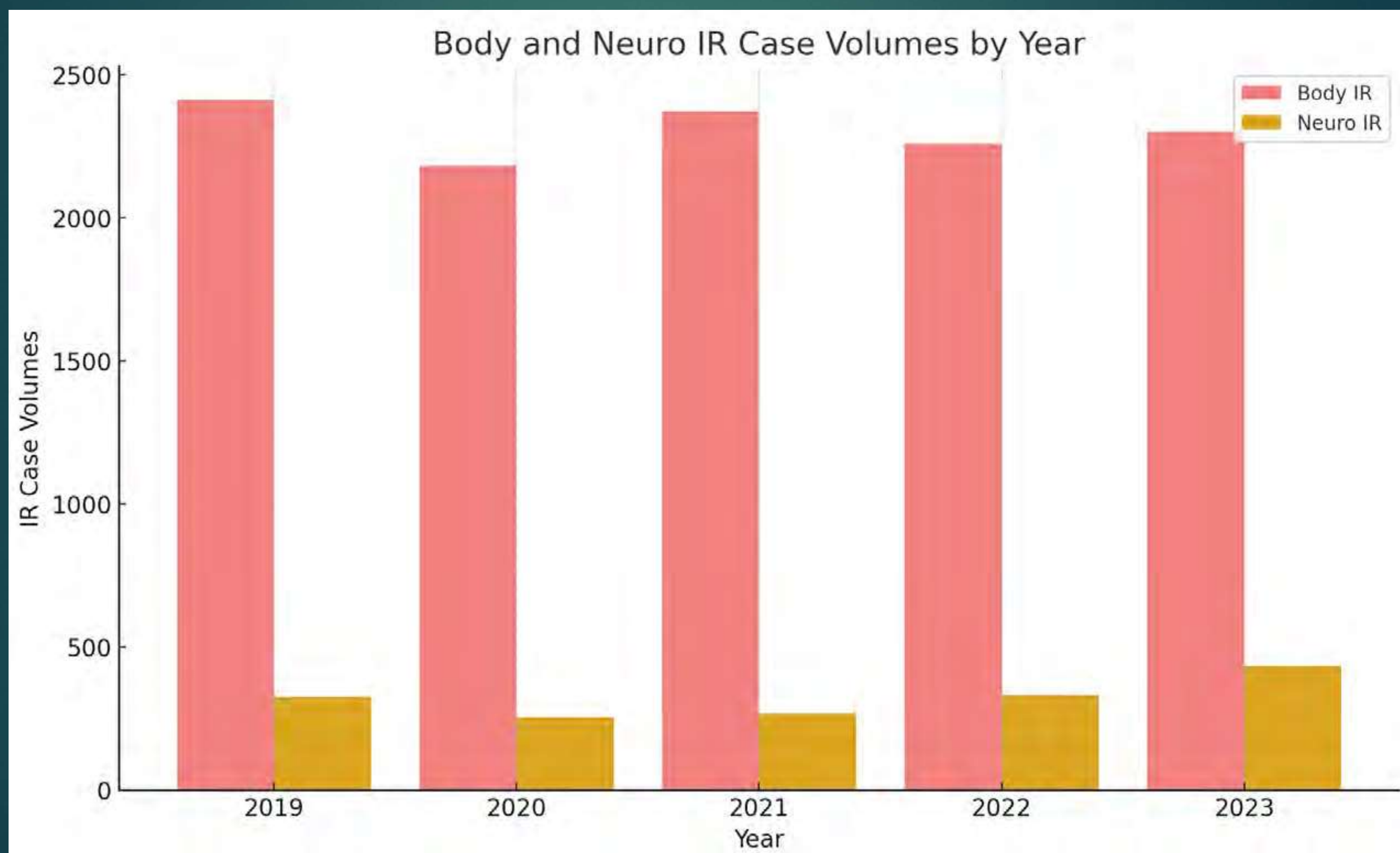
ZSFG Interventional Radiology

Procedures *(not comprehensive)*:

Category	IR Procedures
Pulmonary/Thoracic Diseases	- Pulmonary AVM embolization
	- Bronchial artery embolization for hemoptysis
	- Pulmonary biopsy
	- Pleural effusion management (e.g., pleural catheter or drainage)
	- Stent placement for tracheobronchial obstruction
Infectious Disease	- Abscess drainage (e.g., liver, lung, kidney)
	- Catheter placement for percutaneous drainage
	- Venous Access: PICC lines for long-term antibiotics
	- Image-guided aspiration and biopsy for diagnosis
	- Musculoskeletal and spinal infection drainage (e.g., vertebral or paraspinal abscess drainage)

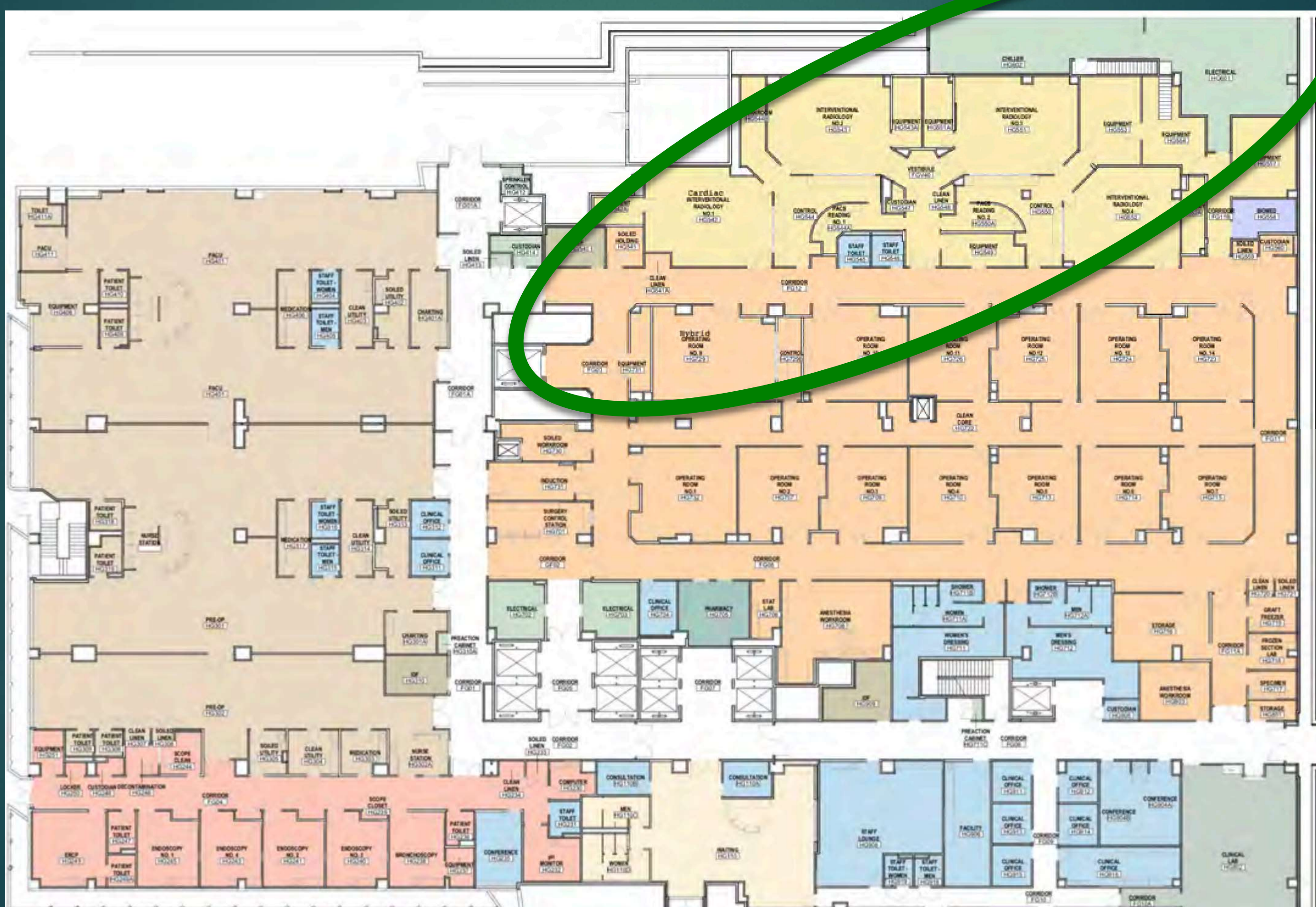
ZSFG Interventional Radiology

IR Case Volumes



ZSFG Interventional Radiology

Equipment: ZSFG IR is in the OR space



ZSFG Interventional Radiology

Equipment:

IR 2: Single plane C-arm linked to CT scanner – Body IR

IR 3: Bi-Plane unit linked to MRI scanner – Neuro and Body IR

IR 4: MRI Scanner

Cath Lab: Bi-Plane unit – Interventional Cardiology

OR 8: C-arm unit – Vascular surgery, IR and Cath Lab back-up

Space configured for maximum versatility !

ZSFG Interventional Radiology

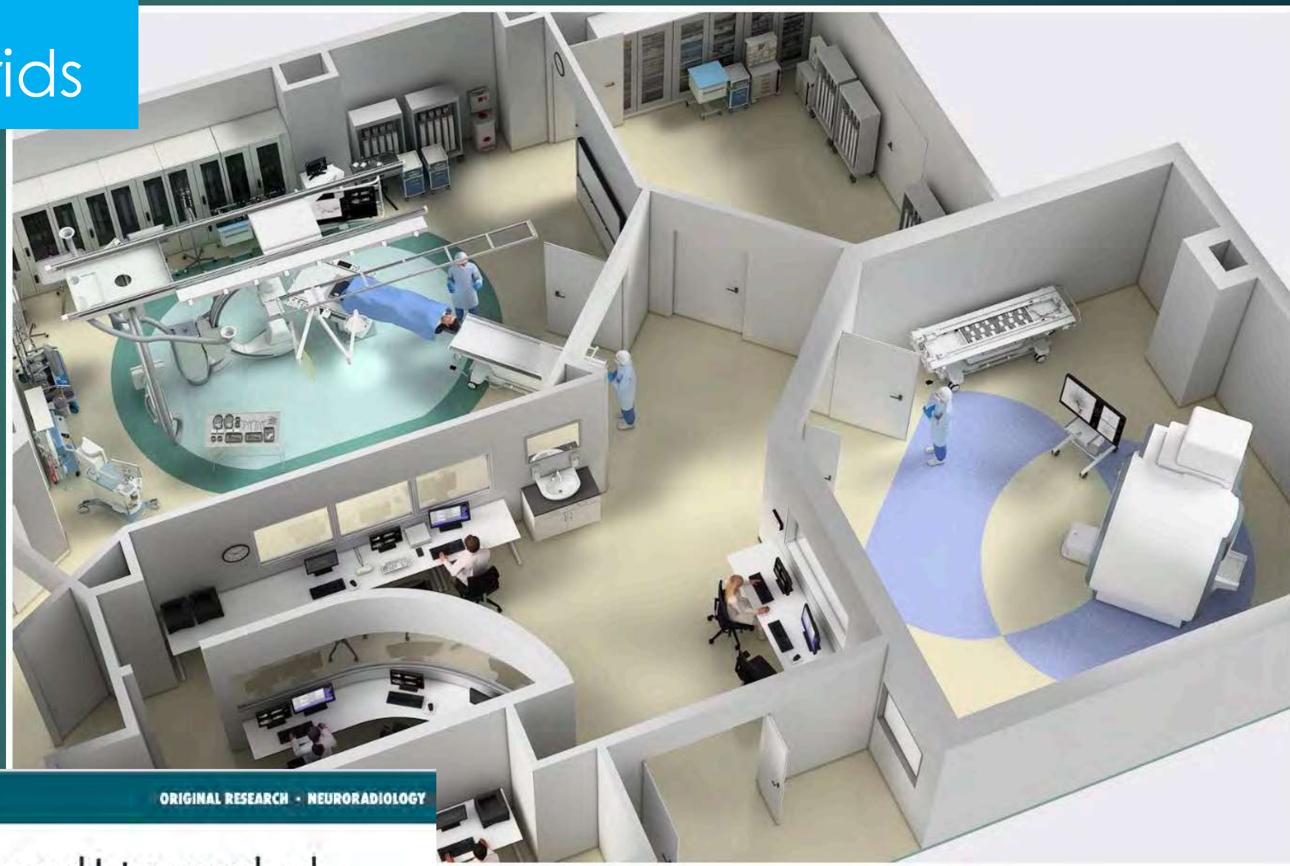
Equipment: Hybrids

IR 2: Single plane C-arm linked to CT scanner

ZSFG Interventional Radiology

Equipment: Hybrids

IR 3 and 4:
Bi-Plane unit linked to 3T MRI scanner



Radiology

ORIGINAL RESEARCH • NEURORADIOLOGY

Combined Use of X-ray Angiography and Intraprocedural MRI Enables Tissue-based Decision Making Regarding Revascularization during Acute Ischemic Stroke Intervention

Kazim H. Narsinh, MD • Bridget F. Kilbride, BS • Kerstin Mueller, PhD • Daniel Murph, MD • Alexander Copelan, MD • Jonathan Massachi, MS • Jeffrey Vitt, MD • Chung-Huan Sun, MD • Himanshu Bhat, PhD • Matthew R. Amans, MS • Christopher F. Dowd, MD • Van V. Halbach, MD • Randall T. Higashida, MD • Terilyn Moore, BSRT • Mark W. Wilson, MD • Daniel L. Cooke, MD • Steven W. Hetts, MD

ZSFG Interventional Radiology

Advantages of IR in the OR:
- Prompt access to anesthesia support
- Proximity to other operating rooms
- Ability to treat sicker, unstable patients

ZSFG Interventional Radiology

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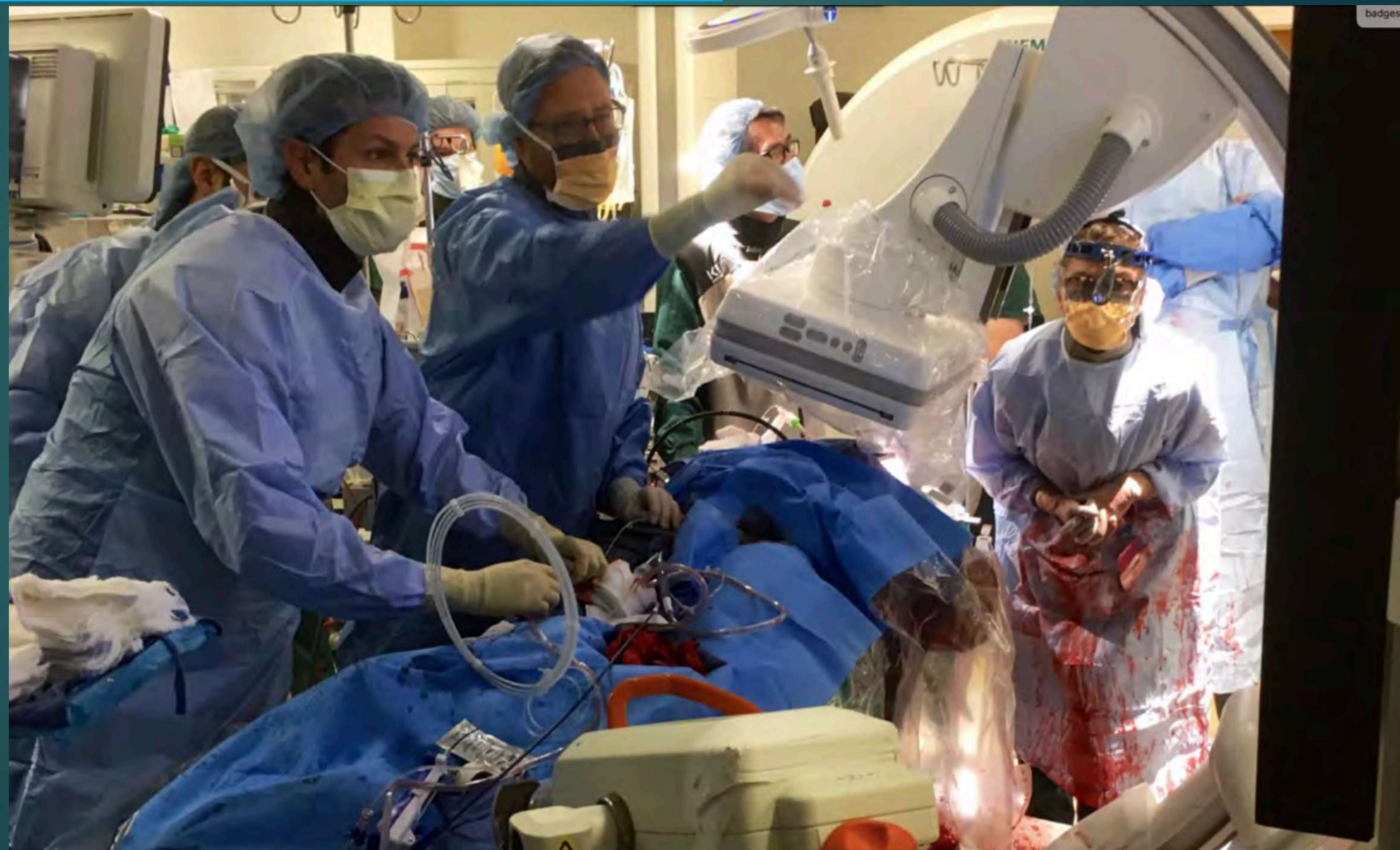
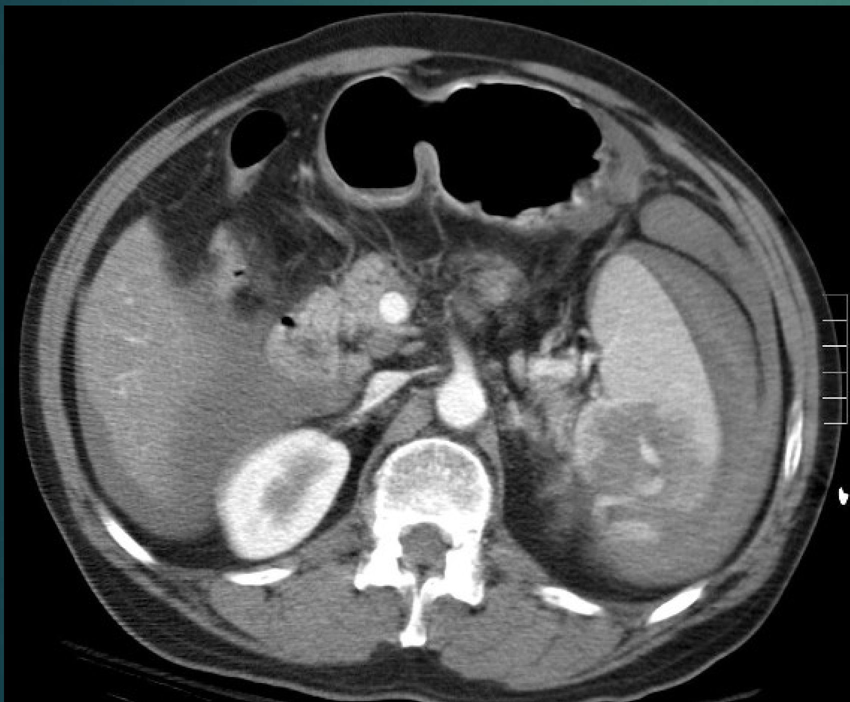


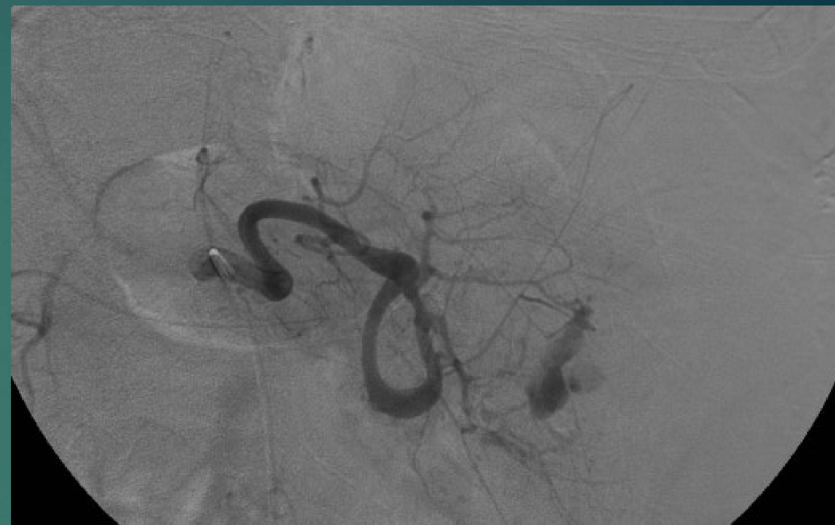
ZSFG Interventional Radiology

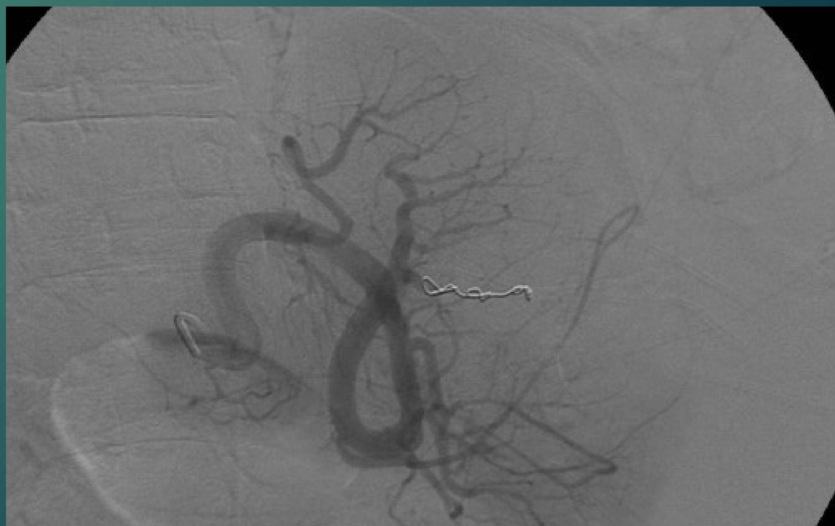
History: Pedestrian Versus Auto

Findings: Grade III splenic laceration

Treatment: Selective coil embolization







ZSFG Interventional Radiology

Multiple Simultaneous Cases !

	IR2	IR3	Cath Lab	OR8
Friday #1	Trauma case	Aneurysm	Stroke	STEMI
Friday #2	GI Bleed	Stroke	Stroke	Rt Heart Cath

2 consecutive Fridays in 2023

ZSFG Interventional Radiology

Education:

1 PGY-3 resident on IR every 4-week rotation

Service is resident- run. No fellows present to dilute their experience

Direct attending supervision for every case.

Vishal Kumar and Miles Conrad are both Bridges Coaches for several years.

In 2024, both were inducted into the Haile Debas Academy of Medical Educators !!

Summary

- Strengths
  - Skilled faculty in all areas of radiology
  - Exceptional equipment and program opportunities with Bldg. 25
  - Strong collaboration between UCSF and DPH
- Challenges
  - Maintaining teaching and research priorities with increasing clinical demands
  - Supporting new programs such as Low Dose CT scanning for Lung Cancer screening with existing stretched resources
- Goals for next academic year
  - UCSF and DPH collaboration in Radiology to improve operational efficiency, while maintaining a safe and caring working and learning environment.

ZSFG/UCSF Department of Psychiatry

Mark Leary, MD
Interim Chief of Psychiatry
2024

Executive Leadership

Jon Dean Green, MPH, MBA
Director of Administration

Angelica Almeida, PhD
Chief Integrative Officer

Dananjali Ratnayaka, MPH, MBA, CRA
Director of Finance

Christina Bloom, RN, MSOL, NEA-BC
Interim Nursing Director

Jessica Ross, MD, PhD
Medical Director, Quality Improvement and Informatics

Clinical Services: ON Campus

Divisions:

- **Acute and Emergency Services** (PES, Inpatient, Consult/Liaison, Jail Behavioral Health)
- **Infant, Child and Adolescent Psychiatry**
- **Substance Abuse and Addiction Medicine**
- **Integrated Behavioral Health**

Clinical Services: OFF Campus

- Divisions:
  - **Alliance Health Project**
    - 1930 Market St (@ Laguna)
  - **Citywide Case Management**
    - 1263 Mission St (@ 8th Street)
  - **Trauma Recovery Services**
    - 2727 Mariposa (@ Bryant)

Acute and Emergency Services:

Psychiatry Emergency Services (PES), Inpatient, & Consultation-Liaison

Mark Leary, MD

Director, Acute & Emergency Services

Emily Lee, MD, MS

Medical Director, Inpatient Psychiatry

Medical Director, PES

G. David Elkin, MD

Co-Director,

Consultation-Liaison

Lee Rawitscher, MD

Co-Director,

Consultation-Liaison

PES and Inpatient Services –

Psychiatric Emergency Services (PES)

- Total Intakes: over ~6000 per year (psych evals in both ED and PES)
- Legal Status on intake: ~50% involuntary / ~50% voluntary
- Licensed for: 18 beds (census cap = 20 -> 21 overnight)
- Average length of stay – 34 hours (licensed for 23 hours max)

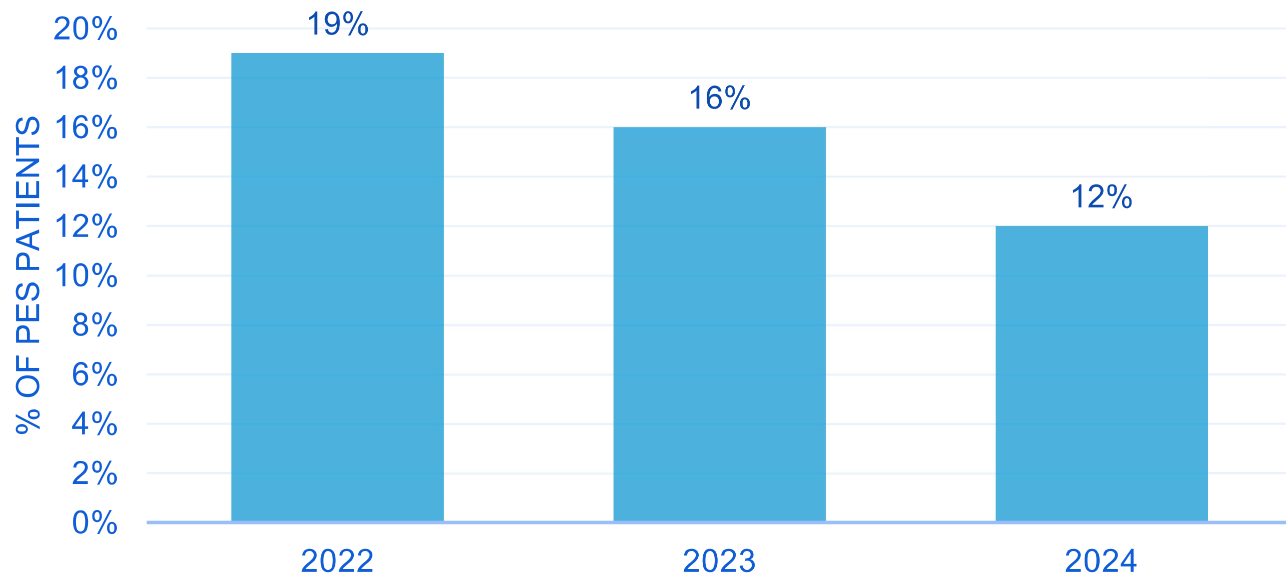
1. PES partners with the Medical ED; BERT staffing in ED
2. PES partners with DPH BHS in **connecting pts to community treatment** (residential, case management, and outpatient for mental health and substance use disorders)

PES and Inpatient Services

Inpatient

- 7B: 22-bed Locked admission acute unit
- 7C: 22-bed Locked step-down acute unit
- 7L: 6-bed Forensic Unit
- H52: 4-bed acute psych/COVID+ unit (started 2020)

Percent of PES Patients Admitted to Inpatient Psychiatry



Jail Behavioral Health Services

- Loren Roth, MD – Medical Director
- Tyler Wheeler, MD; Tianyi Zhang, MD – Attending Psychiatrists
- UCSF/ZSFG Faculty Psychiatrists providing outpatient care at SF County Jail at both 850 Bryant and San Bruno campuses
- Integrates psychiatric care with Jail Inpatient Unit 7L, the JBHS civil service clinicians providing care in the jail, and Citywide Case Management
- Active teaching site for UCSF medical students and residents

Division of Infant, Child and Adolescent Psychiatry

Barbara Krishna Stuart, PhD

Deputy Director, ICAP

Vice Chair For Child and Adolescent Psychology, Clinical and Education

Training Director, UCSF Child and Adolescent Services Multicultural Clinical Training Program

ICAP Services for Children and Adolescents

Child and Adolescent Services Clinic (0-21 years)

- One of very few public specialty mental health clinics providing evidence-based assessments through our Diagnostic Assessment Clinic
- One of the few clinics or the only clinic in the county providing the following evidence-based specialty care:
  - Exposure and response prevention for OCD
  - Trauma-focused CBT and Cue Centered Therapy
  - Family Based Treatment for Eating Disorders
  - Dialectical Behavior Therapy
  - Triple P Parenting Groups

* One of few clinics in San Francisco providing comprehensive psychological services to youth on MediCal, and only one with ability to do so in Spanish

William Martinez, PhD
Associate Professor
Director, Child and Adolescent Services
Director, *Fuerte* Program

Serving newcomer immigrants in middle and high schools

- School-based programming prevention programming for newcomer immigrants
  - Focuses on mental health literacy, early screening and identification, and building a sense of community
- Adapted for telehealth during COVID-19 pandemic with promising feasibility data (Martinez et al., 2022)
- Trained over 100 providers across five Bay Area counties, and three states (CA, OR, VA)
- Over 400 youths have participated in the program
- Family and critical consciousness components feasibility data forthcoming
- Adaptations for Arabic-speaking and Chinese-speaking newcomers forthcoming

ICAP Infant-Parent Program (Prenatal-5)

Infant- Parent Program (pre-5):
Provision of, and training in, Perinatal, Infant, and Early Childhood Mental Health services across the care continuum.

- **Promotion**
- **Prevention & Early Intervention**
- **Treatment**

Kristin Reinsberg, MS, LMFT
Interim Director, Infant-Parent Program

Director, Perinatal, Infant & Early Childhood Mental Health Consultation

Co-Project Director, SAMHSA ECMH Consortium

ICAP Juvenile Justice Behavioral Health/JJBH
(serving ages 12-24 and their families & providers; ~200/yr)

Our Mission: Leverage “technology for good” to expand behavioral health care access nationally for juvenile justice and child welfare system-impacted youth

https://jjbh.org/

ICAP JJBH Faculty Leadership

Marina Tolou-Shams, PhD
JJBH Director
Professor and Vice Chair for Community Engagement, Outreach and Advocacy

Johanna Folk, PhD
JJBH Associate Director
Director, Research, Evaluation, and Analysis, ZSFG Psychiatry
Assistant Professor

Maggie Del Cid, PhD
Interim Director, voicesHEAL and Director, Family Mental Health Navigation Services
Assistant Professor

Division of Integrated Behavioral Health

Integrating Behavioral Health Experts into ZSFG Primary Care & Outpatient/Inpatient Perinatal and Infant Care Settings

Our Settings

- Children's Health Center (Pediatrics)
- Family Health Center (Family & Community Medicine)
- Richard Fine People's Clinic (Internal Medicine)
- Family Birth Center
- Neonatal Intensive Care Unit

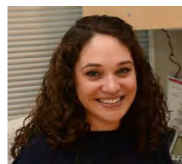
Our Services

- Dyadic Behavioral Health Prevention & Health Promotion
- Collaborative Care Child/Adolescent & Adult Psychiatry
- Consultation, Assessment, Brief Intervention, Short Term Follow Up, Referral & Family Navigation
- Psychological Assessment
- Research, Training & Organizational Consultation, Training & Technical Assistance

Our People

- Faculty psychiatrists (1.3 FTE Adult Providers & .25 FTE Child/Adolescent Providers)
- Faculty/Staff Clinical Psychologists (3.0 FTE Adult & Child Focused Providers)
- LCSW/LMFT dyadic/early childhood mental health providers (2.3 FTE)
- Family Navigator (1.0 FTE)
- Clinical Psychology Interns & Fellows (2.3 FTE) & Psychiatry Residents (.2 FTE) & CHW Intern (.6 FTE)
- Dyadic Technical Assistance Center Staff (2.9 FTE)
- Administration (1.0 FTE)

Working in close collaboration with SFHN Primary Care Behavioral Health, Solid Start, Departments of Pediatrics, OB-GYN, Family & Community Medicine & Internal Medicine, Division of Infant, Child & Adolescent Psychiatry & Child Trauma Research Program



Kate Margolis, PhD
Division Director
Associate Clinical Professor of Psychiatry & Pediatrics

Stephany Medina
Division Administrator

Holly Wong, MBA, MFA
Finance Manager

Division of Integrated Behavioral Health

Adult Services at Family Health Center (13K Unique Patients) & Richard Fine People's Clinic (9K Unique Patients)

Sudha Prathikanti, MD
Medical Director,
Primary Care Psychiatry

Brooke Welch, PsyD
Attending Psychologist

Luther Li-Zhen Arms, MD
Psychiatry Attending

Division of Integrated Behavioral Health

Family-based, Dyadic/Infant & Early Childhood Mental Health Services at the **Children's Health Center** (9K Unique Patients & 3K Ages Birth to 5)

Kate Margolis, PhD
Director
Attending Psychologist

Cheng Qian, PsyD
Psychology Training Lead
Attending Psychologist

Kathryn Hallinan, LMFT
HealthySteps Specialist
Attending Clinician

Janelle Bercun, LCSW
HealthySteps Specialist
Attending Clinician

Roxana Quintero, MA, AMFT, APCC
HealthySteps Specialist

Kathryn Whistler, PsyD
HealthySteps Specialist

Blanca Valle
HealthySteps Coordinator

Division of Substance Abuse and Addiction Medicine (DSAAM)

Substance Use Disorder Treatment, Research, and Education in Service to Our Community

https://dsaam.org/

D. Andrew Tompkins, MD, MHS
DSAAM Director

Opiate Treatment Outpatient Program (OTOP)

Brad Shapiro, MD
Medical Director

Office-based Buprenorphine Induction Clinic (OBIC)

Patricia Wright, MD
Medical Director

Stimulant Treatment Outpatient Program (STOP)

Valerie Gruber, PhD
Program Director

Office Based Opiate Treatment (OBOT)

Andy Whelan, CADC II
Program Manager

Navigation and Care Coordination

Alexandra Haas, MA, LMFT
Director

Research, Education and Special Projects

Caravella McCuistian, PhD, MA
Director

Opiate Treatment Outpatient Program (OTOP) / Ward 93

After **50 years** of providing treatment for OUD to San Franciscans, we remain the city's largest opioid treatment program

(OTP; serving 1000 patients annually)

OTOP offers innovative transition strategies to help patients move from methadone to buprenorphine if needed

We are mobile!

- A mobile methadone van offers treatment to residents of the Bayview neighborhood in partnership with the Metropolitan Baptist Church

https://dsaam.org/otop/

OBOT

Office-Based Opiate Treatment Program

The nation's only methadone program treating patients at their primary care clinic.

Operating since 2003, we can serve up to 75 patients, and is active in three SF clinics plus two pharmacies

Only program licensed to prescribe pill form Methadone for opiate use disorder (OUD) instead of pain management.

Includes substance use disorder (SUD) counseling, social work case management, and primary care from a single location.

Also provides comprehensive services for HIV+ clients including psychiatric and social work services, care coordination and medication services through the Positive Health Program at Ward 86.

Research, Education, and Special Projects

- Implementation of novel, evidence-based behavioral interventions for substance use disorders
- Examining trends in intake reports to improve patient retention
- Invigorating community input into our clinical endeavors
- Engaging community members into advising and participating in research

Stimulant Treatment Outpatient Program (STOP)

Provides substance use counseling integrated within HIV Primary Care

Psychotherapy and education for patients

Services are trauma-informed, culturally informed adaptations of evidence-based practices.

Navigation and Care Coordination

Project JUNO Community

- JUstice-iNvolved Opioid use disorder treatment engagement in COMMUNITY
- Intensive peer navigation and contingency management program at San Francisco County Jail
- Helps justice-involved individuals get connected to medication for OUD and support in reaching their personalized goals after release.
- JUNO Community has just completed its' first year and plans to help link and engage with 200 people over 5 years.

HOUDINI LINK

- Hospital Opioid Use Disorder treatment INItiation and LINKage to care
- Since 2018, HOUDINI LINK has provided intensive patient navigation and contingency management to over 200 patients
- Helps individuals with OUD who are hospitalized at ZSFG get connected to medications and support to reach their personalized goals after discharge.
- HOUDINI LINK in the first 3 years increased treatment linkage after discharge by 460% compared to historical control.

William Hua, PhD — Director, Alliance Health Project

We’re Here! We’re Queer!

Our mission is to support the mental health and wellness of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) and HIV-affected communities in constructing healthy and meaningful lives.

UCSF
Citywide Case Management

Fumi Mitsuishi, MD, MS

Division Director
Sabbatical Leave

Connie Revore, MSSW, MBA

Division Administrator

Carrie Cunningham, MD, MPH

Division Medical Director
And Interim Division Director

UCSF Citywide Case Management

CW 1321 Mission/The Margot

- On-site wrap-around services to 120 formerly homeless clients at the city's newest permanent supportive housing building

CW PES Linkage Team

- Expansion of social work with short-term clinical follow up to increase placement success of patients discharged from PES

CW Minna St Project

- On-site clinical behavioral health support to 75 residents at new transitional residential program serving justice-involved individuals

GAIN Project

- Philanthropy-funded treatment innovation to develop app-based contingency management program

CW STOP Contingency Management

- CalAIM-supported contingency management pilot

CW Enhanced Care Management

- CalAIM-funded integrated care for medically complex CW ICM clients

Division of Trauma Recovery Services (DTRS) Leadership Team

Sarah Metz, Psy.D.

Director, Division of
Trauma Recovery Services

Chief Psychologist, SFGH

Cristina Biasetto, LCSW

TRC Clinical Coordinator

Jody Friedman, LCSW

CASARC Clinical
Coordinator

Christina Weyer Jamora, RN,
PhD., CBIST

Director, Neuropsychology Service

Jessica Thayer, PA-C, MMSc

RTC Clinical Forensic Nurse
Manager

Jessica Marques, MSN, FNP-BC

CASARC Clinical Forensic Nurse
Manager

Division of Trauma Recovery Services

On campus and off campus services

- Trauma Recovery Center
  - Survivors International
  - Neurotrauma Outreach Program
- Rape Treatment Center
- Child and Adolescent Support, Advocacy and Resource Center
- Neuropsychology

DTRS Forensic Services

Provided by RTC and CASARC Nurse Practitioners and Physician Assistants

Rape Treatment Center

- Survivors age 18+
- 500 Acute sexual assault medical-forensic exams per year

Children and Adolescent Support, Advocacy and Resource Center

- Survivors age 0-17
- 200 Multidisciplinary Forensic Interviews per year
- 100 Non-Acute medical-forensic exams per year
- 100 Acute medical-forensic exams per year

ZSFG Neuropsychology services

ZSFG Neuropsychology Service (2.5 FTE) yearly serves 300+ adult San Francisco Residents.

- Inpatients and Outpatients
- Clinician spoken languages
  - Vietnamese, Cantonese, Mandarin
- Postdoctoral training program

Major diagnoses include:

- •Traumatic brain injury
- •Stroke
- •Dementia
- •Depression
- •PTSD
- •Psychosis

Current inpatient referral to testing mean- 3.2 days

UCSF/ZSFG Psychiatry Residency Training Program

Alissa Peterson, MD, ZSFG Site Director

Andrew Halls, MD, Interim UCSF Residency Director

- PGY1 – 16 residents rotating through Inpatient/PES
- PGY2 – 16 residents rotating through Consult/Liaison
- PGY3,4 – Elective and Senior return rotations on Inpatient, PES, Consult/Liaison, High Risk OB, 6B Child & Adolescent Clinic, among others.
- Child Fellows – 6B Child & Adolescent Clinic

Psychology Training at ZSFG

Program	Trainees
UCSF Child and Adolescent Services Multicultural Clinical Training Program*	• 9 doctoral interns • 2 postdoctoral fellows • 4 master's student
UCSF Clinical Psychology Training Program** (ZSFG Rotation)	• 2 doctoral fellows
Infant-Parent Program Intensive Practice-based Training in Multicultural Infant & Early Childhood Mental Health	• 3 masters students • 2 postdoctoral fellows
Juvenile Justice Behavioral Health Program	• 3 postdoctoral fellows
Citywide Forensics	• 4 doctoral students
Alliance Health Project	• 8 doctoral students

* Accredited by the Commission on Accreditation of the American Psychological Association

UCSF Public Psychiatry Fellowship

2011 - Present

- First Public Psychiatry Fellowship in California
- Began with 2 fellows in 2011, then increased to 4-5
- The fellows have been diverse (Total N=40)
  - 40% non-white if more than one race-hispanic/latino is considered non-white (17% URM); 47% women; 20% LGBTQ
- Highlights from graduates (N=33)
  - 94% Disseminated work in peer-reviewed journals and/or at national meetings
  - 82% Remained in public psychiatry
  - 21% Obtained Medical Director roles in SF

Christina Mangurian, MD, MAS

James Dilley, MD

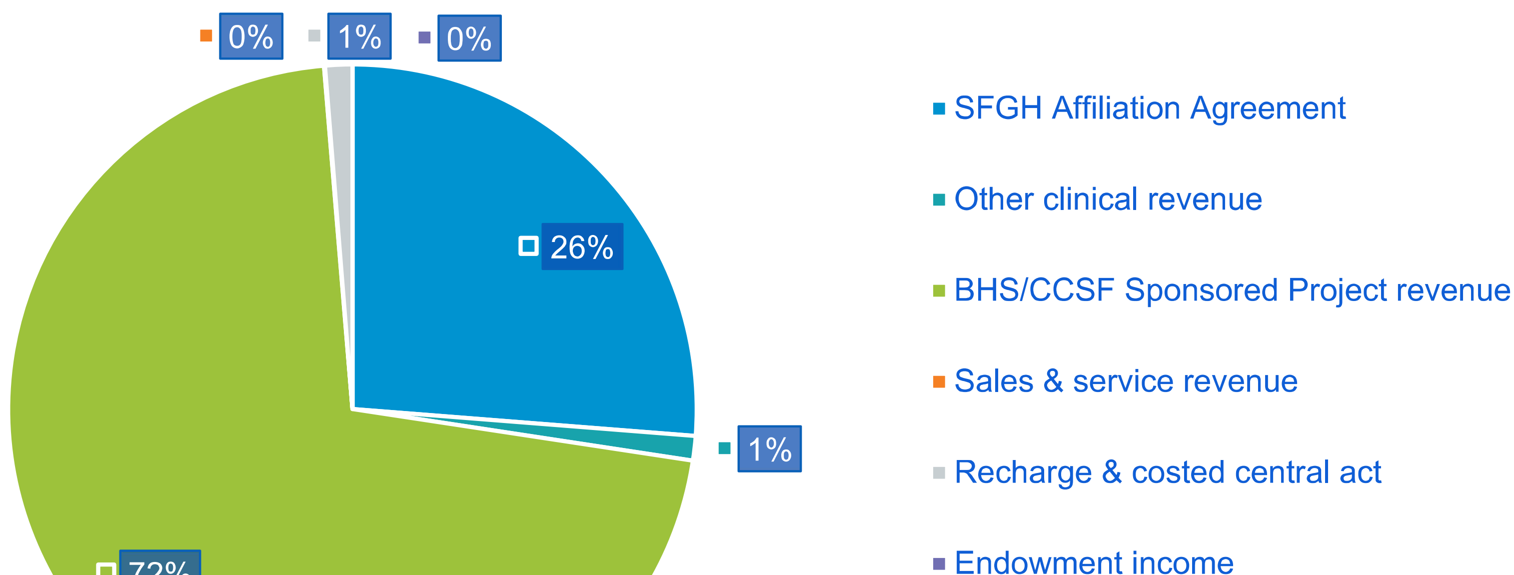
Lucy Ogbu-Nwobodo, MD

N. Kyle Jamison, MD

Brittany Bryant, DSW, LCSW

Chuan Mei Lee, MD, MA

FY 24 ZSFG Psychiatry Funding



Goals

- Reducing inpatient LLOC days by improving flow to LL treatment beds (e.g. MHRC)
- Build out intensive child and adolescent psychiatry services (Inpatient, Partial Hospital, Intensive Outpatient)
- Transition to new PES space with increased census capacity; sustain psychiatry consultation to the ED
- Continue to enhance DPH BHS partnership and improve linkage of PES patients to community based services/treatment
- Continued monitoring and interventions to address racialized and other disparities
- Successful transition to new Chief and Nursing Director

UCSF