Title: Community Primary Care

I. Policy Statement

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

B. All standardized procedures are to be kept in a unit-based manual. A copy of these signed procedures will be kept in an operational manual in the individual clinical sites within the Community Primary Care Clinical Service and on file in the Medical Staff Office.

II. Functions To Be Performed

Each practice area will vary in the functions that will be performed, such as primary care in a clinical, specialty clinic care setting or inpatient care in a unit-based hospital setting.

A Nurse Practitioner (NP) is a Registered Nurse who has additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness; and who has met the requirements of Section 1482 of the Nurse Practice Act. Nurse Practitioners provide health care, which involves areas of overlapping practice between nursing and medicine. These overlapping activities require standardized procedures. These standardized procedures include guidelines stating specific conditions requiring the Nurse Practitioner to seek physician
A Certified Nursing Midwife (CNM) is a registered nurse who has had additional training in midwifery and who has met the requirements of Section 1460 of the Nurse Practice Act. The Scope of Practice of the CNM includes the care of women during the antepartal, intrapartal, postpartal, interconceptional periods, provides family planning planning, conducts deliveries and cares for the newborn and infant.

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

The NP/CNM/PA conduct physical exams, diagnoses and treats illness, order and interpret tests, counsel on preventative health care, assists in surgery, performs invasive procedures and furnish medications/issue drug orders as established by state law.

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

A. Setting
1. Location of practice is the various clinical sites within the Community Primary Care Service.
2. Role in each setting may include primary and urgent care in all settings.

B. Supervision
1. Overall Accountability:
The NP/CNM/PA is responsible and accountable to: the clinic Medical Director, Chief of Service, supervising physician and other supervisors as applicable.
2. A consulting attending physician, will be available to the NP/CNM/PA, by phone, in person, or by other electronic means at all times.

3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical, or laboratory findings.
   d. Upon request of patient, affiliated staff, or physician.
   e. Initiation or change of medication other than those in the formulary (ies).
   f. Problem requiring hospital admission or potential hospital admission.
   g. Acute, severe respiratory distress
   h. An adverse response to respiratory treatment or a lack of Therapeutic response.

IV. Scope of Practice

1. Health Care Management: Primary Care
2. Health Care Management: Acute and Urgent Care
3. Health Care Management: Prenatal Care
4. Furnishing Medications and Drug Orders
5. Procedure: Arthrocentesis and Intraarticular Injections
6. Procedure: Buprenorphine Induction and Maintenance
7. Procedure: Endometrial Biopsy
8. Procedure: eReferal, Specialty Triage
9. Procedure: Incision and Drainage of Skin Abscesses
11. Procedure: Insertion and Removal of Intrauterine Device
12. Procedure: Surface Trauma and Wound Care
13. Procedure: Splinting
15. Procedure: Tattoo Removal

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

A. Basic Training and Education
   1. Active California Registered Nurse/Certified Nurse Midwife/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
4. Maintenance of certification of Basic Life Support (BLS) that must be from an 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 and DEA Number if applicable.
8. Physician Assistants are required to sign and adhere to the San Francisco General Hospital and Trauma Center Delegation of Service Agreement (DSA). Copies of DSA must be kept at each practice site for each PA.

B. Specialty Training
1. Specialty requirements: FNP, CNM, ANP, PNP.
2. At least two (2) years of Clinical Experience in specialty area desired.
3. All Affiliated Staff that will participate in the Buprenorphine protocol must have completed an 8 hour training program in the use of buprenorphine.

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/CNM/A’s ability to practice.
   a. Clinical Practice
      - Length of proctoring period will be 3 months and will include 5 chart reviews and 1 case of direct observation.
      - The evaluator will be the Medical Director, Chief of Service or physician designee.

2. Bi-Annual Reappointment: Medical Director, and/or designated physician and/or supervisor must evaluate the NP/CNM/PA’s appropriate clinical competency for the setting by review of 5 charts and direct observation as determined by the evaluator.

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

4. Ongoing:
   a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision that will be used. These methods are 1) Examination of the patient by Supervising Physician the same day as care is given by the PA, 2) Supervising Physician shall review, audit and countersign every medical record written by PA within thirty (30) days of the encounter, 3) Supervising Physician shall review, sign and date the medical records of at least five percent (5%) of the patients managed by the PA within 30 days of the date of treatment under protocols which shall be adopted by Supervising Physician and PA, pursuant to section 1399.545 (e) (3) of the Physician Assistant Regulations. Protocols are intended to govern the performance of a Physician Assistant for some or all tasks. Protocols shall be developed by the supervising physician, adopted from, or referenced to, text or other sources. Supervising Physicians shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

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

C. Review Schedule
   1. The standardized procedure will be reviewed every three years by the NP/PA and the Medical Director and as practice changes.
D. Revisions
1. All changes or additions to the standardized procedures are to be approved by the CIDP accompanied by the dated and signed approval sheet.
Protocol #1: Health Care Management – Primary Care

A. DEFINITION
This protocol covers the procedure for age-appropriate health care management in primary care, clinics within the Community Primary Care Clinical Service including health centers, health center satellite locations, and the Ambulatory Care Call Center. Scope of care includes health care maintenance and promotion, management of common acute illness and chronic stable illnesses.

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

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

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

D. PLAN
1. Treatment
   a. Age appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
   b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   c. Immunization update.
   d. Referral to specialty clinics and supportive services, as needed.
2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
   d. 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.

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

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

E. RECORD KEEPING
All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.
Protocol #2: Health Care Management – Acute/Urgent Care

A. DEFINITION
This protocol covers the procedure for patient visits for urgent problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions at health sites within the Community Primary Care Clinical Service including health centers, health center satellite locations, and the Ambulatory Care Call Center.

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to the presenting complaint and/or disease process.
   b. Pertinent past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

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

C. DIAGNOSIS
Assessment of data from the subjective and objective findings to identify disease processes and a statement of the current status of the disease.

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation
   b. Problem that is not resolved after reasonable trial of therapies
   c. Unexplained historical, physical or laboratory findings
d. Uncommon, unfamiliar, unstable, and complex patient conditions

e. Upon request of patient, NP, PA, or physician

f. Initiation or change of medication other than those in the formularies.

g. Any Problem requiring hospital admission or potential hospital admission.

3. Education
   Patient education should include treatment modalities.
   Discharge information and instructions.

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

E. RECORD KEEPING
   All information from patient visits will be recorded in the medical record. (e.g.: admission notes, progress notes, procedure notes)
   For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum sample of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.
Protocol # 3: Health Care Management – Prenatal Care

A. DEFINITION
This protocol covers the procedure for the routine prenatal care of essentially healthy women. This includes the provision of comprehensive education and primary care during the prenatal and postpartum period and the promotion of a healthy pregnancy and optimal outcome in all appropriate sites within the Community Primary Care clinical service.

B. DATA BASE
1. Subjective Data
   a. Complete appropriate history.
   b. Symptoms relevant to the prenatal health process.

2. Objective Data
   a. Initial prenatal visit includes a complete physical examination with sizing of uterus and fetal heart tones if at least 10 weeks.
   b. Routine follow-up visits, the physical exam to include:
      1. Blood pressure
      2. Weight and weight gained or lost since last visit.
      3. Urinalysis at initial visit and then at every visit >/= 26 weeks gestation or prn based on risk factors.
      4. Fetal heart tones
      5. Abdominal exam for fundal height (starting at 20 wks gestation) and presentation (starting at 36 weeks).
      6. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
      7. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.
   c. Pelvic examination when indicated by history.

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

D. PLAN
1. Therapeutic Treatment Plan
   a. Appropriate screening tests, and/or diagnostic tests for purposes of disease identification.
1. Routine prenatal labs, including but not limited to: blood type and screen, Rubella titer, CBC, hemoglobinopathy evaluation, HBsAG, RPR, HIV antibody, pap smear (if indicated), clean catch urine culture, chlamydia, gonorrhea and GBS culture.
2. First and Second Trimester integrated genetics screening, if desired by patient
3. Glucose Load Test (GLT) at 24 to 28 weeks Gestational Age. Do 1 hr. GLT at 1st visit if at high-risk for Diabetes (as per SFGH GDM Screening Protocol). Do a 3 hr GTT if 1 hr GLT elevated.
4. If patient is RH Negative repeat antibody screen and order Rhogam at 28 weeks.
5. Order and review all imaging studies as appropriate.
   b. Initiation or adjustment of medication as described in Furnishing/Drug Orders protocol.
   1. Furnishing of prenatal vitamins.
   c. Immunization update.
   d. Referral to specialty clinics and supportive services as needed (e.g. nutritionist, social work, health education WIC).

2. Patient conditions requiring consultation as per Preamble section III b 2.
   a. Acute decompensation of patient situation.
   b. Problem that is not resolved after reasonable trial of therapies.
   c. Unexplained historical, physical, or laboratory findings.
   d. Upon request of patient, affiliated staff or physician.
   e. Initiation or change of medication other than those in the formulary (ies).
   f. With the exception of labor-related diagnoses, problem requiring hospital admission or potential hospital admission.

3. Education
   a. Normal process and progression of pregnancy.
   b. Psychosocial issues pertinent to pregnancy, age of client and home situation.
   c. Signs and symptoms of complications
   d. Fetal kick counts.
   e. Stages of labor.
   f. Pain management during labor and delivery.
   g. Infant nutrition: breast or formula feeding.
   h. Postpartum family planning.
4. Follow-up (Intervals determined by risk factors)
   a. Every 4-8 weeks until 28 weeks gestational age.
   b. Every 2 to 4 weeks from 28 to 38 weeks gestational age.
   c. Every week after 38 weeks gestational age.

E. RECORD KEEPING
All information from patient visits will be recorded in the medical record. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within 30 days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

F. Management of HIV-Infected Pregnant Women at The Bay Area Perinatal AIDS Center (BAYPAC)

1. Obstetric and HIV care of BAYPAC patients by the BAYPAC nurse practitioner will be co-managed by the BAYPAC attending., Reproductive Infectious Disease fellow and/or other OB attending.

2. Obstetric care will be transferred to the OB attending(with continued NP management of HIV care co-managed by the OB attending) for the following conditions:
   a. Renal insufficiency or failure.
   b. Heart disease, Class II or greater.
   c. Hyperthyroidism.
   d. Rh isoimmunization.
   e. Uncontrolled seizure disorder.
   f. Neoplasia.
   g. High order multiple gestations (>2 fetuses).
   h. Twin gestation other than dichorionic, diamniotic, concordant growth.
   i. Acute hepatitis.
   j. Psychiatric conditions with psychosis.
   k. Isoimmune thrombocytopenia.
   l. Severe anemia (hemoglobin <7, not responding to iron and nutrition therapy).
   m. Uterine or cervical malformation or incompetence.
   n. Significant chronic illness (i.e., lupus, RA, Crohns).
   o. Preterm pre-eclampsia.
   p. Severe pre-eclampsia.
3. Record Keeping
   a. Patient visit, consent forms, and other procedure specific documents will be recorded in HERO and LCR as appropriate.
Protocol #4: Furnishing Medications/Drug Orders

A. DEFINITION

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

B. DATA BASE

1. Subjective Data
   a. Age appropriate history and review of symptoms relevant to the presenting complaint or disease process to include current medication, allergies, current treatments, and substance abuse history.
   b. Pain history to include onset, location, and intensity.

2. Objective Data
   a. Physical exam consistent with history and clinical assessment of the patient.
   b. Describe physical findings that support use for CSII-III medications.
   c. Laboratory and imming evaluation, as indicated, relevant to clinical condition.
d. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20.

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

D. PLAN
1. Treatment
   a. Initiate, adjust, discontinue, and/or renew drugs and devices.
   b. When ordering respiratory treatments, a subjective history along with clinical presentations will be used to assess for need of therapy, type of medication, administration of medications, type of medication delivery device and frequency of treatments. Patient response will be monitored and documented.
   c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
      i. location of practice
      ii. diagnosis, illness, or condition for which medication is ordered
      iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
   d. To facilitate patient receiving medications from a pharmacist provide the following:
      i. name of medication
      ii. strength
      iii. directions for use
      iv. name of patient
      v. name of prescriber and title
      vi. date of issue
      vii. quantity to be dispensed
      viii. license no., furnishing no., and DEA no. if applicable

2. Patient conditions requiring physician consultation
   a. Problem which is not resolved after reasonable trial of therapies.
b. Initiation or change of medication other than those in the formulary.
c. Unexplained historical, physical or laboratory findings.
d. Upon request of patient, NP, PA, or physician.
e. Failure to improve pain and symptom management.
f. Acute, severe respiratory distress
g. An adverse response to respiratory treatment or lack of therapeutic response.
h. Patients on maintenance buprenorphine

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

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

E. RECORD KEEPING
All medications furnished by NPs and all drug orders written by PAs will be recorded in the medical record\LCR\MAR as appropriate. The medical record of any patient cared for by a PA for whom the supervising physician and surgeon’s schedule II drug order has been issued or carried out shall be reviewed and countersigned and dated by a supervising physician and surgeon within seven (7) days.
A. DEFINITION
This protocol covers arthrocentesis of the knee and elbow. The procedure is insertion of a needle into the joint space to aspirate fluid for analysis and/or inject medicine.

1. This procedure can be completed at any health site within the Community Primary Care Clinical Service.

2. Performance of procedure:
   a. Indications
      • Joint aspiration should be performed if the injured joint is greatly distended with a tight effusion and in cases in which the cause of the joint effusion is unknown. Aspiration of the affected joint and subsequent analysis of this will distinguish among hemarthrosis, effusion, fracture and septic arthritis.
   b. Precautions
      • Patients with a coagulopathy
   c. Contraindications
      • Severe dermatitis or soft tissue infection overlying the joint.

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.
   b. The procedure is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).
   c. Laboratory, to include gram stain and culture (minimum) with crystals, glucose and cell count (ideal), and imaging evaluation, as indicated, relevant to history and exam.
   d. All Point of Care Testing (POCT) will be performed according to SFGH POCT policy and procedure 16.20.
C. DIAGNOSIS
Assessment of subjective and objective data to identify disease processes.

D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained, 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. All patients requiring this procedure.

3. Education
   Patients will be informed that pain relief may occur immediately due to the early onset of certain drug preparations, but the longer lasting pain relief may take a few days. The possibility of increased pain for 24-48 hours following an injection may occur on an infrequent basis. Patients will also be informed that more than one injection may be needed for the best possible outcome. Patient will be instructed in signs and symptoms of infection and procedures to follow if they occur.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
F. Summary of Prerequisite, Proctoring and Reappointment Competency

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<thead>
<tr>
<th>Prerequisite</th>
<th>1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.</th>
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<td>2. Training will include:</td>
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<td>b. Risks and benefits of procedure and medication.</td>
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<td>c. Related anatomy and physiology.</td>
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<td>d. Consent process consistent with hospital policy.</td>
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<td>e. Time out policy and procedure.</td>
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<td>f. Wound infection and wound healing mechanisms.</td>
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<td>g. Use of required equipment.</td>
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<td>h. Steps in performing procedures.</td>
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<td></td>
<td>i. Ability to interpret results and formulate follow-up plans</td>
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<td>j. Ability to recognize complications</td>
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<th>Proctoring Period</th>
<th>1. New provider to procedure, a minimum of 2 successful observed demonstrations.</th>
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<td>2. Experienced provider to procedure, a minimum of 1 successful observed demonstration.</td>
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<td>3. Explanation needed for any exceptions to minimum requirements.</td>
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<td>4. Chart review will be done on all observed procedures.</td>
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<td>5. Documentation of completion of training must be sent to the Medical Staff office.</td>
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<tr>
<th>Reappointment Competency Documentation</th>
<th>1. The evaluator will be an Attending Physician or Chief Resident</th>
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<td>2. Perform a minimum of 1 procedure every two years.</td>
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<td>3. One chart review every two years.</td>
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Procedure #6: Buprenorphine Induction and Maintenance Protocol

A. DEFINITION
This protocol covers the procedure for initiating and continuing sublingual buprenorphine treatment for opioid replacement for the adult outpatient population. Prior to treatment initiation, confirm patient eligibility for DPH buprenorphine treatment, including diagnosis of opioid dependence and a review of the inclusion/exclusion criteria. Treatment initiation can occur at the Office-based Buprenorphine Induction Clinic (OBIC) designed specifically for this purpose. Treatment can also be initiated by a registered (has a DEA “X” number) physician’s choice at DPH outpatient clinics. Treatment will follow DPH/OBIC Policy and Procedures.

1. Inclusion Criteria
   - Patient is at least 18 years old
   - Patient meets current DSM criteria for Opioid Dependence
   - Patient, if female, is not pregnant, trying to become pregnant, or nursing. It is recommended that patients receiving buprenorphine (suboxone) use adequate birth control methods pill, IUD, condom with spermicide, abstinence etc. as its safety in pregnancy has not been fully established. Methadone is the medication of choice for this population.
   - Patient is eligible for care at a SFDPH site and has completed registration process.

2. Exclusion Criteria
   - Patient has serious uncontrolled/unrelated psychiatric problems (suicidality, active psychosis, etc.)
   - Patient has serious/uncontrolled/untreated medical problems (hypertension, hepatic failure, asthma, diabetes, etc.)
   - Patient currently uses more than 30 mg/day of methadone
   - Patient has a chronic pain disorder for which opiate analgesic medication is required/evaluated on case by case basis)
   - Patient is dependent on alcohol
   - Patient uses high doses of non-prescribed or misuses prescribed benzodiazepines, sedatives or hypnotics
   - Patient requires the structure of a higher level of care (i.e. methadone maintenance)
   - Patient has a known allergy/hypersensitivity to buprenorphine or naloxone (suboxone is a combination
B. DATA BASE

1. Subjective Data
   a. Chief Complaint. Review patient opioid withdrawal symptoms including cravings, anxiety, discomfort, pain, nausea, hot or cold flushes. Include patient subjective rating of these symptoms (mild, moderate, or severe).
   b. Health History. A review and confirmation of the following are recommended for all patients:
      i. Substance use history. Review current opioid habit, i.e. type of opiate, frequency and method of use, last use. Review alcohol, sedative, stimulant, and other substance use/abuse.
      ii. Previous opioid and other drug treatments (e.g. methadone replacement, residential treatment, etc.), including patient response to treatment and perceived effectiveness. **Note: For patients on Methadone, a taper down to dose of 30 mg/day or less is recommended prior to buprenorphine induction.
      iii. Sequellae of substance abuse (e.g. hepatitis C, HIV disease, violence, psycho-social and functional problems).
      iv. Past and current medical problems, including psychiatric problems, medications, allergies, and current health care providers.
      v. For female clients of childbearing age, assessment and documentation of effective use of birth control.

2. Objective Data
   a. Physical exam, including Mental Status Examination (MSE) and also include the following:
      • Documentation of opioid withdrawal symptoms if present, including elevated BP, increased HR, mydriasis, tremors, agitation/restlessness. Also note the presence or absence of yawning, rhinorrhea, piloerection, diaphoresis, lacrimation, vomiting and muscle fasciculations. To assess opioid withdrawal severity, use the Clinical Opioid Withdrawal Scale (COWS).
      • Assessment of possible needle use sequellae, including presence of track marks, abscesses, cellulitis.
      • Assessment of possible substance intoxication, including but not limited to etoh odor, nystagmus,
positive Romberg test, client disinhibition, or other altered mental status.

b. Laboratory results, including the following
   • Drug toxicology screening test
   • Liver panel (AST, ALT, total bilirubin and alkaline phosphatase—results over 5 times the normal upper limit are a buprenorphine contraindication)
   • HCG screening for female clients of child-bearing potential

C. DIAGNOSIS
1. Opioid Dependence per current DSM criteria.
2. If in opioid withdrawal include severity (mild, moderate, severe), based on COWS score.

D. PLAN
1. Treatment
   a. Ensure that the following consent, agreement, and authorization forms are signed and completed prior to patient induction:
      • Consent for Treatment
      • HIPAA privacy practices notice (if not already in CHN/DPH medical record)
      • IBIS Patient Handbook
   b. Medication—buprenorphine induction and upward titration
      • DAY #1. For mild withdrawal give buprenorphine 2 to 4mg SL. For patients exhibiting moderate to severe withdrawal, give buprenorphine 4mg SL. Observe client for 30 minutes to 1 hour after which time an additional dose of buprenorphine 2 to 4mg SL may be given at the physician’s discretion. The physician may prescribe or dispense take-home buprenorphine 2 to 6mg for patient self-administration later in the day/evening if continued opioid withdrawal is expected. Total buprenorphine dose for 1st 24 hours typically ranges between 6mgs and 14mgs with an average of 12mgs.
Adjunctive Medications

In addition to the use of buprenorphine as described above, additional medications can be prescribed/provided for symptom management. These may include the following: Clonidine 0.1 to 0.3mg PO q4 to 6 hours PRN lacrimation, diaphoresis, rhinorrhea, piloerection; phenergan 25mg PO q4 to 6 hours PRN nausea/vomiting; imodium 4mg PO x 1 PRN diarrhea, then 2mg PO PRN each loose stool or diarrhea thereafter, NTE 16mg/24h; ibuprofen 400 to 800 mg PO 4 to 6 hours with food PRN myalgias/arthritis, NTE 2400mg/24hours.

- **DAY #2** Repeat day 1 buprenorphine dose PLUS an additional 2 to 4mg as needed based on presenting withdrawal severity. Consider take-home doses of 2-4mgs if appropriate. Doses of 8-16 mgs are typical for Day 2.

- **DAY #3** Additional Days/Titr ation up Repeat plan as per day 2, increasing buprenorphine dose each day by 2 to 4mg until the patient no longer exhibits signs of opioid withdrawal. Doses of 12-16 mgs are typical for Day 3. Most patients experience good control of withdrawal and cravings by the end of their first 3-5 days on Suboxone.

Target Dose: The dose that results in the optimal relief of objective and subjective opioid withdrawal symptoms. This is expected to be in the range of 12 to 20mg daily, though doses from 4 to 32 mg/day may be required to suppress opioid withdrawal effects. Maximum daily dose is 32mg.

2. Patient conditions requiring Attending Consultation
   a. All buprenorphine orders, initial as well as subsequent, come from the registered physician. The NP administers and dispenses buprenorphine only as dictated by this standardized procedure/protocol.
   b. Acute decompensation of patient situation
   c. Unexplained historical, physical or laboratory findings
   d. Upon request of patient, NP, or physician
   e. Problem requiring hospital admission or potential hospital admission.
3. Education
   a. Patient education appropriate to diagnosis including harm reduction and substance abuse counseling.
   b. Anticipatory guidance and safety education that is age and risk factor appropriate.

4. Counseling must be available on site or by referral as indicated. While not mandatory, counseling is recommended at onset of treatment and as clinically indicated thereafter.

5. Maintenance
   Buprenorphine dispensing (and administration, if indicated) can occur in clinic or pharmacy with frequency determined by the provider. Once a stable dose is achieved, follow-up pharmacy visits will occur at least every twenty eight (28) days and medical visits occur based on medical need at a minimum of every three months. When stable, buprenorphine dispensing and medication pick-up should be transferred to the Community Behavioral Health Service pharmacy or other community pharmacy at the prescribing physician's discretion. If buprenorphine treatment was initiated at the OBIC clinic, the OBIC provider will arrange referral to a community-based buprenorphine provider after treatment stability.

E. RECORD KEEPING
   All information relevant to patient care will be recorded in the medical record and/or LCR as appropriate.
Procedure # 6: Endometrial Biopsy

A. DEFINITION
Evaluation of the endometrium by obtaining tissue for pathological diagnosis.

1. Indications:
Women considered at increased risk for endometrial cancer (including but not limited to: abnormal uterine bleeding, endometrial cells on Pap, unopposed estrogen therapy, tamoxifen therapy) will be evaluated by endometrial biopsy as well as others requiring evaluation of endometrial tissue (infertility, infection) will be evaluated by endometrial biopsy.

2. Precautions:
Consult an MD before performing biopsies on women with extreme retroversion or anteversion of the uterus. Also, consult when the procedure requires manual dilatation of the cervix.

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 SFGHMC POCT policy and procedure 16.20.

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

D. PLAN
1. Therapeutic Treatment Plan
a. Patient consent obtained before procedure is performed,
b. Diagnostic tests for purposes of disease identification.
c. Screening tests performed as part of age-appropriate health maintenance.
d. Biopsy tissue is sent to pathology.
e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP, PA, or physician
   e. 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 and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, counter sign and date a minimum of five percent (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problems, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. SUMMARY OF PREREQUISITES, PROCITORING AND REAPPOINTMENT COMPETENCY

<table>
<thead>
<tr>
<th>Prerequisites:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. At least 6 months experience in women's health care.</td>
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<tr>
<td>2. Provider will observe a qualified provider do procedure 2 times</td>
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<table>
<thead>
<tr>
<th>Proctoring Period:</th>
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</thead>
<tbody>
<tr>
<td>1. New provider to procedure, a minimum of 2 successful observed demonstrations</td>
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<tr>
<td>2. Experienced provider to procedure, a minimum of 1 successful observed demonstrations</td>
</tr>
<tr>
<td>3. Explanation needed for any exceptions to minimum requirements</td>
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<tr>
<td>4. Two chart reviews.</td>
</tr>
</tbody>
</table>
Reappointment Competency Documentation:

1. The evaluator will be an attending physician or chief resident.
2. Perform a minimum of 1 procedure every 2 years.
3. I chart review every 2 year.
Procedure #7: eReferral Specialty Triage

A. DEFINITION

eReferral review is defined as the review of new outpatient consultation requests via the online eReferral system. A new outpatient is defined as a patient that has neither been consulted upon by the specialty service, admitted to the specialty service nor seen in the specialty clinic within the previous two years.

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

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

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

B. DATA BASE

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

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

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

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

   2. Patient conditions requiring Attending Review
      a. Acute decompensation in patient condition
      b. Unexplained historical, physical or laboratory findings
      c. Upon request of the referring NP, PA, or physician
      d. Problem requiring hospital admission or potential hospital admission
      e. When recommending complex imaging studies or procedures for the referring provider to order
      f. Problem requiring emergent/urgent surgical intervention

   3. Education
      a. Provider education appropriate to the referring problem including disease process, additional diagnostic evaluation and data gathering, interim treatment modalities and lifestyle counseling (e.g. diet, exercise).
4. Scheduling of Appointments
   a. Dependant upon the urgency of the referral, the eReferral will be forwarded to the scheduler for either next available clinic appointment scheduling or overbook appointment scheduling.

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

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

   During the proctoring period, the eReferral consultation request will be printed and the provider recommendations will be written on the print out. These will be cosigned by the proctor and filed in the provider’s educational file. The recommendations will then be entered into the LCR and forwarded to the scheduler.
Procedure #7: Incision and drainage of skin abscesses

A. DEFINITION
Incision and Drainage (I&D) of abscesses involves making an incision in the skin to draw pus from the abscess. This protocol excludes abscesses on the face, neck, perirectal and genitalia.

1. Location to be performed: For the purposes of this protocol, the procedure may be completed at all of the health care sites within the Community Primary Care Clinical Service.

2. Performance of procedure:
   i. Indications:
      - Abscess amenable by size and location to I&D with local anesthesia
      - Known allergies/adverse reactions to material used for incision and drainage, immune compromised
   ii. Precautions:
      - Large abscesses that require extensive incising or debridement
   iii. Contraindications:
      - Deep abscesses that may require more extensive anesthesia
      - Abscesses that invade the palmar or plantar spaces
      - Suspected pseudo aneurysm must be ruled out by further diagnostic evaluation
   iv. Exclusions:
      - Abscesses on the face, neck, perirectal area, and genitalia

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.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to SFGHMC 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. Explain procedure to the patient
   c. Time out performed per hospital policy.
   d. Diagnostic tests for purposes of disease identification.
   e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring 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 and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Documentation

<table>
<thead>
<tr>
<th>Prerequisite</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The NP/PA will observe a privileged provider (MD, NP or PA) 2 times.</td>
</tr>
<tr>
<td>2. Procedure performed following standard medical technique according to departmental standards.</td>
</tr>
<tr>
<td>3. One year experience in wound care.</td>
</tr>
<tr>
<td>4. Training will include:</td>
</tr>
<tr>
<td>a. Indications for procedure and treatment</td>
</tr>
<tr>
<td>b. Risks and benefits of procedure and medications</td>
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<tr>
<td>c. Related anatomy and physiology</td>
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<tr>
<td><strong>d.</strong> Consent process consistent with hospital policy</td>
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<tr>
<td><strong>f.</strong> Use of required equipment</td>
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<tr>
<td><strong>h.</strong> Ability to interpret results and formulate follow up plans</td>
</tr>
</tbody>
</table>

### Proctoring Period
1. New provider to procedure will have a minimum of 2 successful observed demonstrations.
2. Experienced provider to procedure will have a minimum of 1 successful observed demonstration.
3. Explanation will be needed for exceptions to the minimum requirements.
4. Documentation of training or experience will be sent to the Medical Staff Office.

### Reappointment Competency Documentation
1. The evaluator will be an Attending Physician or Chief Resident.
2. Perform a minimum of 1 procedure every 2 years.
3. 1 chart review every 2 years.
Procedure #8: Procedure: Insertion and Removal of Contraceptive Implant

A. DEFINITION
The contraceptive implant is placed under the skin of the upper arm via a preloaded inserter.

1. Location to be performed: This procedure can be completed at all Community Primary Care Health sites.
2. Indications:
   a. A woman desires long acting, reversible contraceptive.
   b. Precautions:
      i. Chronic use of drugs that are potent inducers of hepatic enzymes because of potential for decreased efficacy and unintended pregnancy.
      ii. May have drug interactions with anti-HIV medications and some herbal products.
      iii. See drug precautions/interactions in Implanon prescribing information.
   c. Contraindications:
      i. Known or suspected pregnancy
      ii. Current or past history of thrombotic disease
      iii. Hepatic tumors, active liver disease
      iv. Known, suspected or history of breast cancer
      v. Undiagnosed abnormal genital bleeding
      vi. Hypersensitivity to any components of Implanon

B. DATA BASE
1. Subjective Data
   a. History and review of symptoms relevant to Implanon insertion, including sexual history to rule out preexisting pregnancy.
   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, including a negative pregnancy test.
   d. All Point of Care Testing (POCT) will be performed according to SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS
Assessment of subjective and objective data to identify if patient is eligible for Implanon insertion/removal.
D. PLAN
1. Therapeutic Treatment Plan
   a. Patient consent obtained before procedure is performed.
   b. Timing of insertion: see prescribing information.
   c. Implanon inserted/removed as described in prescribing information.
   d. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
   e. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Difficult insertions/removals.
   b. Acute decompensation of patient situation.
   c. Upon request of patient, NP, CNM, PA, or physician

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

4. Follow-up
   As appropriate for Implanon insertion/removal.

E. RECORD KEEPING
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring, and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisites:</th>
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<tbody>
<tr>
<td>1. Completion of a company sponsored training program</td>
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<thead>
<tr>
<th>Proctoring Period:</th>
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</thead>
<tbody>
<tr>
<td>1. New provider to procedure, a minimum of 2 successful observed demonstrations of insertions and removals.</td>
</tr>
<tr>
<td>2. Experienced provider to procedure, a minimum of 1 successful observed demonstration of an insertion and removal.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Reappointment Competency Documentation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 1 chart review of an insertion and 1 chart review of a removal will be needed every two years.</td>
</tr>
</tbody>
</table>
Procedure #9: Procedures: Insertion and removal of Intrauterine Device

A. DEFINITION
Intrauterine devices offer a highly effective, safe, long-term contraception.

1. Indications: Patient desires intrauterine device.

2. Precautions:
   a. Abnormalities of the uterus resulting in distortion of the uterine cavity
   b. Postpartum endometritis or postabortal endometritis in the past 3 months

3. Contraindications:
   a. Pregnancy of suspicion of pregnancy
   b. Acute pelvic inflammatory disease or current behavior suggestion of a high risk for pelvic inflammatory disease
   c. Know or suspected uterine or cervical malignancy
   d. Genital bleeding of unknown etiology
   e. Mucopurulent cervicitis
   f. Wilson’s disease (for Paraguard IUD ™)
   g. Allergy to any component of Paraguard IUD ™
   h. A previously placed IUD that has not been removed

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 SFGHMC POCT policy and procedure 16.20.

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

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

2. Patient conditions requiring Attending Consultation
   a. Acute decompensation of patient situation.
   b. Unexplained historical, physical or laboratory findings
   c. Uncommon, unfamiliar, unstable, and complex patient conditions
   d. Upon request of patient, NP/CNM/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
   a. Discharge information and instructions.

4. Follow-up
   a. As appropriate for procedure performed.

E. RECORD KEEPING
   All information relevant to patient care will be recorded in the medical record (e.g.: admission notes, progress notes, procedure notes, discharge notes). For physician assistants using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5) per cent sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment, the most significant risk to the patient.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisite:
   1. Prior experience or training required for this procedure.
   2. 6 months experience in women’s health care.
   3. Review of departmental policies and procedures.
Proctoring:
1. Direct observation of 2 successful insertions by a qualified provider.
2. Documentation of training course completion.

Reappointment Competency Documentation:
1. Performance of one procedure every 2 years.
2. One chart review every 2 years.
Procedure # 10: Surface Trauma and Wound Care

A. DEFINITION

This protocol covers the initial assessment of wounds seen in the Community Primary Care Clinical Service that are beyond simple cuts and abrasions. These wounds may require local anesthesia and suturing.

1. Location to be performed: this procedure can be completed any all health sites within the Community Primary Care Clinical Service.

2. Performance of procedure/minor surgery:
   a. Indications: This protocol covers patients presenting to the Community Primary Care Service for assessment and treatment of lacerations, avulsions, bites and stings, burns and abscesses.
   b. Precautions
      • Immunocompromised patients.
   c. Contraindications:
      • Wound infection
      • Wound that has remained open for longer than six (6) hours.
      • Lacerations to the hand greater than 6 hours old.
      • Vascular compromise or cases when direct pressure does not stop bleeding.
      • Wounds requiring large areas of debridement or excision prior to closure.
      • Wounds with bone fragments involved.
      • Wounds with tendon, ligament, vessel or nerve involvement.
      • Head lacerations where galea disruption is greater than 2 cm.
      • Facial lacerations with cosmetic considerations (i.e., eyelids and vermilion borders).
      • Lacerations penetrating into joints.
      • Patients requiring conscious sedation.

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, tetanus prophylaxis history, 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. Appropriate motor, sensory and vascular exam of the involved area according to the departmental resources (i.e. specialty guidelines).
   d. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   e. All Point of Care Testing (POCT) will be performed according to SFGHMC 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, 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, nurse practitioner, physician assistant, or physician
   d. Initiation or change of medication other than those in the formulary(ies)
   e. Problem requiring hospital admission or potential hospital admission

3. Education
   Discharge information and instructions.
4. **Follow-up**
   As appropriate for procedure performed.

**E. RECORD KEEPING**

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

For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five percent (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

**F. SUMMARY OF PREREQUISITES, PROCTORING AND REAPPOINTMENT COMPETENCY**

<table>
<thead>
<tr>
<th>Prerequisite</th>
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<tbody>
<tr>
<td>1. New provider will attend a wound care/suturing course or lab at AN outside facility or through SFGH.</td>
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<tr>
<td>2. Training will include:</td>
</tr>
<tr>
<td>a. Indications for procedure and treatment</td>
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<tr>
<td>b. Risks and benefits of procedure</td>
</tr>
<tr>
<td>c. Related anatomy and physiology</td>
</tr>
<tr>
<td>d. Consent process consistent with hospital policy</td>
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<tr>
<td>e. Time out process consistent with hospital policy</td>
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<tr>
<td>f. Wound infection and wound healing mechanisms</td>
</tr>
<tr>
<td>g. Use of required equipment</td>
</tr>
<tr>
<td>h. Steps in performing procedure</td>
</tr>
<tr>
<td>i. Ability to recognize complications.</td>
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<tr>
<th>Proctoring Period</th>
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<tbody>
<tr>
<td>1. New provider to procedure, a minimum of 2 successful observed demonstrations.</td>
</tr>
<tr>
<td>2. Experienced provider to procedure, a minimum of 1 successful observed demonstration.</td>
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<tr>
<td>3. Explanation needed for any exceptions to minimum requirements.</td>
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<tr>
<td>4. Documentation of completion of training must be sent to the medical staff office.</td>
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<tr>
<th>Reappointment Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Evaluator will be the Medical Director, Physician-in-Charge or other attending physician.</td>
</tr>
</tbody>
</table>
2. Must perform wound care/suturing a minimum of 1 time every two years.
3. One chart review every two years.
Procedure #11: Splinting

A. DEFINITION

Splinting involves the immobilization of joints and/or limbs or appendages to stabilize and protect fractures, and/or to provide comfort for patients with fractures, sprains, or other musculoskeletal injuries.

1. Location to be performed: This procedure may be completed at all health care sites within the Community Primary Care Clinical Service.

2. Performance of procedure:
   a. Indications: fractures, sprains, tendon injuries, other musculoskeletal injuries and conditions for which splinting may be part of the standard of care for treatment
   b. Precautions: known allergies/adverse reactions to materials used for splinting
   c. Contraindications: open fractures, otherwise complicated fractures or other musculoskeletal conditions, coagulation disorder

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.
   b. Laboratory and imaging evaluation, as indicated, relevant to history and exam.
   c. All Point of Care Testing (POCT) will be performed according to SFGH POCTMC 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. Explain procedure to the patient.
   d. Diagnostic tests for purposes of disease identification.
e. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
f. Referral to physician, specialty clinics, and supportive services, as needed.

2. Patient conditions requiring Attending Consultation
   a. Acute decompenstation 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, nurse practitioner, physician assistant, or physician
   e. Initiation or change of medication other than those in the formulary(ies)
   f. Problem requiring hospital admission or potential hospital admission

3. Education
   Discharge information and instructions.

4. Follow-up
   As appropriate for procedure performed.

E. RECORD KEEPING

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

For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
<thead>
<tr>
<th>Prerequisites</th>
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<tbody>
<tr>
<td>1. Procedure performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).</td>
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<tr>
<td>2. Training will include:</td>
</tr>
<tr>
<td>a. Indications for procedure and treatment</td>
</tr>
<tr>
<td>b. Risk and benefits of procedure</td>
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<tr>
<td>c. Related anatomy and physiology</td>
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<tr>
<td>d. Obtain Consent consistent with hospital policy</td>
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<tr>
<td>e. Perform a time Out consistent with hospital policy.</td>
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<tr>
<td>f. Use of required equipment</td>
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</table>
g. Steps in performing procedure  
h. Ability to interpret results and formulate follow up plans.  
i. Ability to recognize complications.  

<table>
<thead>
<tr>
<th>Proctoring Period</th>
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<tr>
<td>1. New provider to procedure, a minimum of 2 successful observed demonstrations.</td>
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<tr>
<td>2. Experienced providers to procedure, a minimum of 1 successful observed demonstration.</td>
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<td>3. Explanation needed for any exceptions to minimum requirements.</td>
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<td>4. Documentation of completion of training must be sent to the Medical Staff Office.</td>
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<thead>
<tr>
<th>Reappointment Competency Documentation</th>
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<tbody>
<tr>
<td>1. The Medical Director, Physician-in-Charge or other attending physician shall be the evaluator.</td>
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<tr>
<td>2. Perform 1 procedure every two years.</td>
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<tr>
<td>3. 1 Chart review every two years.</td>
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Procedure #12: Waived Testing

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

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

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

B. DATA BASE

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

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

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

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

Samples not tested in the presence of the patient or in situations where specimen mix-up can occur, must be labeled with patient's full name and DOB or MRN.
   a. Assess/verify integrity of the test system. Have tests and required materials been stored correctly and are in-date? Have necessary controls been done and come out as expected?

2. Test Results requiring Attending Consultation
   Follow established site-specific protocols or instructions. When in doubt, consult responsible attending physician.

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

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

E. RECORD KEEPING

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

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

F. Summary of Prerequisites, Proctoring and Reappointment Competency
Prerequisites:
Certification as midlevel practitioner practicing within one of the six medical specialties providing primary care: Medicine, Family and Community Medicine, Emergency Medicine, Surgery, Ob/Gyn, Pediatrics,

Proctoring:
Successful completion of Healthstream quizzes for each of the waived tests the practitioner is performing at SFGH, i.e., achievement of passing scores of at least 80% on each module.

Reappointment Competency Documentation:
Renewal required every two years with documentation of successful completion of the required Healthstream quizzes. Provider must have passed each required module with a score of 80%.

Any additional comments: N/A
Procedure #13  Tattoo Removal

A. DEFINITION

The removal of a tattoo (or multiple tattoos) from a patient's skin using the medlite CB laser. The treatment is always conducted in conjunction and consultation with a laser technician from PRI, the company which rents the laser to the City and County of San Francisco. Treatment is scheduled every six to eight weeks, until such time as the desired cosmetic outcome is achieved or complications arise requiring the cessation, suspension, or modification of therapy.

1. Location to be performed: San Francisco General Hospital and Trauma Center and affiliated SFDPH ambulatory settings.

2. Performance of procedure:
   a. Indications:
      1. The presence of one or more tattoos on the patients skin, with a primary focus on gang-related tattoos or tattoos which convey gang-affiliation, especially in areas not usually covered by clothing (face, neck, hands, forearm's etc.)
   b. Precautions:
      1. A health screening questionnaire is completed by all program participants prior to acceptance into the program.
      2. Providers check in with patients prior to each treatment session.
      3. Extensive post-treatment counseling regarding after-care is conducted following each treatment session, along with any supplies needed to properly care for the treatment site.
   c. Contraindications:
      1. Immunodeficiency
      2. Pregnancy
      3. Acute intoxication
      4. Open wounds at or near treatment site
      5. Acute infection at or near treatment site.

B. DATA BASE

1. Subjective Data
   a. History and review of symptoms relevant to tattoo removal
   b. Pertinent past medical history, surgical history, family history, hospitalizations, habits, current medications, allergies.
2. Objective Data  
   a. Physical exam appropriate to tattoo removal.  
   b. The tattoo removal is performed following standard medical technique according to the departmental resources (i.e. specialty guidelines).

C. DIAGNOSIS  
Assessment of subjective and objective data to identify eligibility for tattoo removal.

D. PLAN  
1. Therapeutic Treatment Plan  
   a. Patient consent obtained before procedure is performed.  
   b. Time out performed.  
   c. Diagnostic tests for purposes of disease identification.  
   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. Problem requiring hospital admission or potential hospital admission.

3. Education  
   Discharge information and instructions.

4. Follow-up  
   Six to eight weeks following treatment or as needed to address any concerns or complications.

E. RECORD KEEPING  
Patient visit, consent forms, and other procedure specific documents will be recorded in the medical record and LCR as appropriate. For physician assistants, using protocols for supervision, the supervising physician shall review, countersign and date a minimum of five (5%) sample of medical records of patients treated by the physician assistant within thirty (30) days. The physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent in his/her judgment the most significant risk to patients.
### Summary of Prerequisites, Proctoring and Reappointment Competency

<table>
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<tr>
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<tbody>
<tr>
<td>a. Observation of twenty five tattoo removal clinic sessions. Completion of the laser safety module prepared by the SFGH Laser Safety Committee and baseline eye examination within the previous 1 year.</td>
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<tr>
<th>Proctoring Period:</th>
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<tbody>
<tr>
<td>a. 10 cases by a provider with active privilege for tattoo removal or who has met proctoring and reappointment competency requirements as outlined in the SP.</td>
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<thead>
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<tbody>
<tr>
<td>a. Completion of 5 procedures every 2 years.</td>
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<tr>
<td>b. Completion of 5 chart reviews every 2 years.</td>
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