



Committee on Interdisciplinary Practice

STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN ASSISTANT

PREAMBLE

Title: Combined Psychiatry

I. Policy Statement

- A. It is the policy of 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 Title 16, 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 SFGH Department of Psychiatry Nursing Office, Operational Manual in the PES staff room, OTOP Medical Director's office, Community Focus Program at 939 Market Street, **AIDS Health Project at 1930 Market Street** and the ED Case Management Nurse Practitioner office and on file in the Medical Staff Office.

SUBSTANCE ABUSE SERVICES

Substance Abuse Services, located in Ward 93 and 95, Building 90, operates under the Department of Psychiatry, Division of Substance Abuse and Addiction Medicine (DSAAM). It offers outpatient programs that include the Opiate Treatment Outpatient Program (OTOP), Office-based Buprenorphine Induction Clinic (OBIC), and the **Stimulant Treatment Outpatient Program (STOP)** including research study, Substance Abuse Research Project (SARP) with the mission “to improve the quality of life for patients and the public by reducing the dangers of drug abuse and its consequences, providing culturally sensitive care and treatment to patients, including those who suffer

from multiple medical, psychological and social problems and commitment to increasing and disseminating knowledge of drug abuse and treatment through research and training”.

Opiate Treatment Outpatient Program (OTOP), located in Building 90, Ward 93 and 95 and its three satellite locations, 141 Leland Avenue, San Francisco, CA. 94134, 1678 Newcomb Avenue, San Francisco, CA. 94124 and 1885 Mission Street, San Francisco, CA., 94103 is an approved Narcotic Treatment Program (NTP), sponsored by Community Behavioral Health Services (CBHS)/ Department of Public Health, accredited by the Commission on Accreditation of Rehabilitation Facility (CARF), operates in compliance with the State of California Code of Regulations (C.C.R.), Title 9, and is licensed by the Department of Alcohol and Drug Programs, in accordance with the provisions of subchapter 2, Licensure of Methadone Treatment Programs, Article 1, Program Licensure, section 10010, Licensure Requirement.

OTOP operates in compliance with the federal controlled substance law, 21 C.F.R. 291.505, “Conditions for the use of narcotic drugs, appropriate methods of professional practice for medical treatment of the narcotic addiction of various classes of narcotic addicts under section 4 of the Comprehensive Drug Abuse Prevention and Control Act of 1970”. The program adheres to the rules and regulations set forth by the Food and Drug Administration and the Department of Drug Enforcement Administration, Department of Justice.

OBIC, located at 1380 Howard Street, 2nd floor, San Francisco, California, 94103, is a joint project between San Francisco General Hospital and Trauma Center (SFGH)/Substance Abuse Services /CHN Clinics and the Community Behavioral Health Services (CBHS)/Department of Public Health (DPH) to help expand opiate replacement therapies to office-based treatment settings. The clinic provides opioid replacement therapy with the novel therapeutic agent, Buprenorphine.

STOP, located at 982 Mission Street, San Francisco, California 94110, is a social model outpatient treatment program. It is an intensive outpatient program for stimulant abuse and dependence. The programs help participants attain a drug-free lifestyle by educating clients about the entire spectrum of stimulant addiction and its effects on the individual, learning new methods for coping with life stresses, getting past recurring cravings and triggers, expanding one’s repertoire of social relationships, and finding new ways of experiencing pleasure without using mood altering drugs.

UCSF/SARP, located in Building 20, Ward 21, conducts research projects to investigate interventions to diminish or eliminate addiction or reduce its harms. The research projects are reviewed and approved by the Committee on Human Research (CHR) which is the Institutional Review Board (IRB) for UCSF.

CASE MANAGEMENT

The Emergency Department (EDCM) Case Management Program is a case management program at San Francisco General Hospital and Trauma Center developed by the Division of Psychosocial Medicine within the Department of Psychiatry. Its purpose is to meet the psychosocial needs of patients with complex problems who frequently rely on the Emergency Department (ED) to address medical, substance abuse, social service, or psychological problems.

The Nurse Practitioner functions to address the particular needs of EDCM patients who typically present with complex medical disorders often complicated by substance abuse, homelessness, poverty and other severe psychosocial factors. This involves caring for patients at the EDCM site as they drop in or are diverted from the ED, as well as seeing patients in a regularly scheduled clinic at the General Medical Clinic (GMC). The NP/PA works in coordination and collaboration with the clinical EDCM team including the primary care Attending Physician, Psychiatrist, social worker case managers, as well as the staffs of the GMC and ED.

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

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

Physician assistants (PA) are health care providers licensed to practice medicine with physician supervision and who have

attended and successfully completed an intensive training program accredited by the Accreditation Review Commission on education for the Physician Assistant (ARC-PA). Upon graduation, physician assistants take a national certification examination developed by the National Commission on Certification of PAs in conjunction with the National Board of Medical Examiners. To maintain their national certification, PAs must log 100 hours of continuing medical education every two years and sit for a recertification examination every six 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/PA conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventative health care, perform invasive procedures and furnish medications/issue drug orders as established by state law.

III. Circumstances Under Which NP/PA May Perform Function

A. Setting

1. Location of practice is Psychiatric Emergency Services, inpatient units, outpatient clinics, emergency department, and other community based clinics and in the client's home as needed.
2. Role in each setting may include management of primary, acute and chronic medical and psychiatric conditions, hospital and PES admissions and discharges and facilitating community residential treatment program admissions and discharges.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to the Department of Psychiatry Deputy Chief, Medical Director, designated supervising physicians on units or clinics or attending and other supervisors as applicable.
2. A consulting physician will be available to the NP/PA by phone, in person, or by other electronic means at all times.
3. Physician consultation is to be obtained as specified in the protocols and under the following circumstances:
 - a. Acute decompensation of patient situation

- b. Unexplained physical, psychiatric, or laboratory findings.
- c. Upon request of patient, affiliated staff, or physician.
- d. Problem requiring hospital admission or potential hospital admission.
- e. Problem that is not resolved after reasonable trial of therapies.

IV. Scope of Practice:

1. Health Care Management: Acute/Urgent Care
2. Health Care Management: Primary Care (OTOP Program only)
3. Health Care Management: Substance Abuse
4. Furnishing Medications/Drug Orders
5. Discharge of Inpatients
6. Procedure: Buprenorphine Induction
7. Procedure: Abdominal Paracentesis
8. Procedure: Waived Testing

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 from American Nurses Credentialing Center (ANCC), (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider.
5. Possession of a National Provider Identifier or must have submitted an application.
6. Copies of licensure and certificates must be on file in the Medical Staff Office.
7. Furnishing Number.
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: Adult Nurse Practitioner, Family Nurse Practitioner, Pediatric Nurse Practitioner or Psychiatric Mental Health Nurse Practitioner.
2. Academic and clinical training in the field of psychiatric/mental health, including psychiatric and substance use assessments and psychiatric care planning that is equivalent to that of the Psychiatric NP.
3. All Affiliated Staff who will participate in the Buprenorphine protocol must have completed on the job training by a certified physician provider within one month of employment.

VI. Evaluation

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

1. Initial: at the conclusion of the standardized procedure training, the Medical Director, Medical Manager and/or designated physician and other supervisors will assess the NP/PA's ability to practice.
 - a. Clinical Practice
 - Length of proctoring period will be up to three months. The evaluator will be the Medical Director and/or designated supervising physicians as applicable.
 - The method of evaluation in clinical practice will be five clinical reviews, including chart reviews and/or direct observation upon initial appointment.
2. Follow-up: areas requiring increased proficiency as determined by the initial or annual evaluation will be re-evaluated by the Medical Director, and/or designated physician, at appropriate intervals.
3. Ongoing Professional Performance Evaluation (OPPE): Every six months, affiliated staff will be monitored for compliance to department specific indicators and reports will be sent to the Medical Staff Office.
4. Biennial Reappointment: Medical Director and/or designated physician must evaluate the NP/PA's clinical competence as noted in attached Proctoring and Reappointment Grid. This includes 4 chart reviews every two years unless difference is noted in procedures.
5. Physician Assistants:
 - a. Physician Assistants have 3 forms of supervision. Their Delegation of Service Agreement will note which form of supervision 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.

VII. Development and Approval of Standardized Procedure

A. Method of Development

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

B. Approval

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

C. Review Schedule

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

D. Revisions

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

Protocol #1: Health Care Management – Acute/Urgent Care

A. DEFINITION

This protocol covers the procedure for patient visits for urgent medical, substance abuse and/or psychiatric problems, which include but are not limited to common acute problems, uncommon, unstable, or complex conditions at OTOP and OBIC **STOP**, Community Focus, **AIDS Health Project**, Inpatient Units, PES, CRT and other community outreach programs

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/surgical/psychiatric history, substance use, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.

2. Objective Data

- a. Physical exam and/or mental status exam if 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. OBIC clinic has a CLIA waiver and performs CLIA-waived POCT for toxicology and pregnancy testing.

C. DIAGNOSIS

Assessment of data including DSM-IV TR Diagnostic criteria for Psychiatric Disorders and Substance Dependence/Withdrawal based on 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.

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 and/or electronically in the LCR, Methasoft and/or HERO. 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 #2: Health Care Management – Primary Care (OTOP Program only)

A. DEFINITION

This protocol covers the procedure for appropriate health care management in primary care, psychiatric care and substance abuse services. Scope of care includes health care maintenance and promotion and care of chronic stable illnesses.

B. DATA BASE

1. Subjective Data

- a. Screening: appropriate history that includes but is not limited to: past medical history, surgical history, hospitalizations/injuries, habits, family history, psychiatric 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. Mental status examination
- 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 SFGHMC 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, uncontrolled).

D. PLAN

1. Treatment

- a. 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 #3: Health Care Management – Substance Abuse

A. DEFINITION

This protocol covers the procedure for appropriate health care management in primary care, psychiatric care, substance abuse services (OTOP and /or 1380 Howard Street San Francisco, Ca 94103) and inpatient units (4th, 5th, 6th, 7th floors) of the San Francisco General Hospital and Trauma Center.

As a Substance Abuse Service, this protocol also covers the procedure for appropriate intake history and physical for patients who meet diagnostic criteria for substance dependence / withdrawal seeking medical treatment for the following outpatient programs: Opiate Treatment Outpatient Program (OTOP), Substance Abuse Research Project (SARP) and Office-Based Induction Clinic (OBIC) and **Stimulant Treatment Outpatient Program (STOP)**

Scope of care includes substance detoxification and maintenance treatments, health care promotion and maintenance treatment, management of common acute medical and/ or psychiatric illness and chronic stable conditions.

As an accredited and licensed Narcotic Treatment Program, OTOP provides both short/long term methadone detoxification and maintenance treatment to meet patient needs.

Opioid withdrawal may exacerbate existing medical/psychiatric conditions. NP/PA/MD's collaborate in assessing and managing these conditions through the use of standardized protocols.

DEFINITION:

Methadone Maintenance as defined in 21 CFR 291.505 “the dispensing of a narcotic drug at a relatively stable dosage levels in the treatment of an individual for dependence on heroin or other morphine-like drugs.”

Methadone Detoxification as defined in 21 CFR 291.505 “the dispensing of narcotic drug in decreasing doses to an individual to alleviate adverse physiological or psychological effects incident to withdrawal from continuous or sustained use of a narcotic drug and as a method of bringing the individual to a narcotic drug-free state within such period.”

On 9/21/01, the California Department of Alcohol and Drug Programs issued a change in policy to allow for Long term Methadone Detoxification Programs in California in order to fulfill treatment needs of patients with significant substance use and psychosocial issues.

“Long term detoxification is a period of more than 30 days but not in excess of 180 days.”

“Short term detoxification is for a period not in excess of 30 days.”

OBIC uses Buprenorphine (Subutex or Suboxone), a pharmaceutical agent used only for opioid replacement in the treatment of patients with opioid dependence.

B. DATA BASE

1. Subjective Data

- a. Substance Use: document history of at least one year of substance addiction: include type of current substance use (amount per day), frequency, route, method of use, most recent use (date and time), assess current substance withdrawal symptoms

EXCLUSION CRITERIA: oversedation, altered mental status, assaultive/threatening behavior, current suicidal/homicidal ideation.

- b. Screening: appropriate history that includes but is not limited to: past medical/surgical history, psychiatric history, domestic violence, hospitalizations/injuries, current medications, allergies, and treatments.
- c. On-going/continuity: chief complaint, review of pertinent systems and history relevant to the disease process or presenting complaint.
- d. Pain history to include onset, location and intensity

2. Objective Data

- a. Physical exam consistent with history and clinical assessment of the patient including psychiatric evaluation if appropriate to presenting symptoms.
 - For patients seeking opiate treatment, emphasis on signs of opiate withdrawal (pupillary size, lacrimation, rhinorrhea, yawning, diaphoresis, piloerection, restlessness, presence of needle tracks, scar from prior incision and drainage of skin abscess due to intravenous / intramuscular drug use.
 - Assessment of possible substance intoxication, including but not limited to alcohol odor, nystagmus,

positive Romberg test, client disinhibition, or other altered mental status.

- b. Laboratory and imaging evaluation, as indicated, relevant to history and exam including the following:
 - drug toxicology screening test
 - urine HCG screening for female patients of child bearing potential
- c. All Point of Care Testing (POCT) will be performed according to the SFGHMC POCT policy and procedure 16.20.

C. DIAGNOSIS

Assessment of data including DSM-IV TR diagnostic criteria for Psychiatric Disorders and Substance Dependence / Withdrawal based on the subjective and objective findings identifying risk factors and disease processes. May include statement of current status of disease (e.g. stable, unstable, uncontrolled).

D. PLAN

1. Treatment

- a. Appropriate screening tests and/or diagnostic tests for purposes of disease identification.
- b. Initiation or adjustment of medication per Furnishing/Drug Orders protocol with the exception of:
 - Controlled Substance II (Methadone), dose induction, adjustment discontinuation and/or renewal is consistent with State and Federal guidelines
 - Controlled Substance III (Buprenorphine) refer to Protocol #6: Buprenorphine Induction.
- 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 including persistent opioid withdrawal symptoms intractable to subsequent methadone dose adjustment.
- 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.
- c. Emphasis on Harm Reduction and safety

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 and/or electronically in the LCR, Methasoft and /or HERO.

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. 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 #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 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 Psychiatric Services, 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 include: 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. 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 imaging evaluation, as indicated, relevant to history and exam.

- d. All Point of Care Testing (POCT) will be performed according to the SFGH POCT policy and procedure 16.20. OBIC clinic has their own CLIA License and uses CLIA waived POCT for pregnancy and toxicology testing.

C. DIAGNOSIS

Assessment of data including current DSM diagnostic criteria for Substance Use Disorders/Withdrawal syndromes based upon 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. Obtain informed consent for psychiatric medications as indicated.
- b. Respiratory medications and treatments will be written based on the assessment from the history and physical examination findings and patient response to prior or current treatment.
- c. Nurse Practitioners may order Schedule II - III controlled substances for patients with the following patient specific protocols. These protocols may be listed in the patient chart, in the medications sections of the LCR, or in the Medication Administration Record (MAR). The protocol will include the following:
 - i. location of practice
 - ii. diagnoses, illnesses, or conditions for which medication is ordered
 - iii. name of medications, dosage, frequency, route, and quantity, amount of refills authorized and time period for follow-up.
For Methadone Induction and management to treat Opiate dependence/withdrawal in a Narcotic Treatment Program(NTP) refer to CCR(Title 9) and CFR.
For Buprenorphine(Subutex/Suboxone) Induction and management refer to Protocol #5.
- 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. Informed Consent for Psychiatric Medications

The NP/PA is authorized to provide patients with information regarding psychiatric conditions, the likely effects and possible side effects of psychiatric medications and alternative treatments, in order to obtain informed consent from the patient according to department guidelines.

3. Patient Conditions requiring Consultation

- a. Problem which is not resolved after reasonable trial of therapies.
- b. Initiation or change of medication other than those in the formulary.
- c. Unexplained historical, physical or laboratory findings.
- d. Upon request of patient, NP, PA, or physician.
- e. Failure to improve pain and symptom management.

4. 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.

5. 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.

Protocol #5: Discharge of Inpatients

A. DEFINITION

This protocol covers the discharge of psychiatric inpatients from San Francisco General Hospital and Trauma Center. Direction to discharge a patient will come from the attending physician

B. DATA BASE

1. Subjective Data

- a. Review: health 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, ensure that appropriate treatments have been completed, identify clinical problems that still require follow-up and assure 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 clinical psychopharmacologist as indicated.
- e. Referral to physician, specialty clinics and supportive services as needed.
- f. Discontinue psychiatric legal holds.

2. Patient conditions requiring Attending Consultation

- a. Acute decompensation of patient situation.
- b. Unexplained history, 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.

3. Education
 - a. Review inpatient 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
4. Follow-up
 - a. 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 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.

Protocol #6: Buprenorphine Induction

A. DEFINITION

This protocol covers the procedure for initiating (inducing) buprenorphine treatment for opioid replacement for adult patients with a diagnosis of opioid dependence. Prior to performing the intake medical history and physical examination, confirm patient eligibility for buprenorphine treatment, including diagnosis of opioid dependence and review of other inclusion/exclusion criteria.

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:
 - Substance use history. Review current opioid use, i.e. type of opiate, frequency and method of use, last use. Review alcohol, sedative, stimulant, and other substance use/abuse.
 - Previous opioid and other drug treatments (e.g. methadone replacement, residential treatment, etc.), including patient response to treatment and perceived effectiveness. **Note: For clients on Methadone, a taper down to dose of 30 mg/day or less is recommended prior to buprenorphine induction.
 - Sequellae of substance abuse (e.g. hepatitis C, HIV disease, violence, psycho-social and functional problems).
 - Past and current medical problems, including psychiatric problems, medications, allergies, and health care providers.

2. Objective Data

- a. Physical exam, including MSE. Include the following:
 - Documentation of opiate withdrawal symptoms, 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 Opiate Withdrawal Scale (COWS).
 - Assessment of possible needle use, including presence of track marks, abscesses, cellulitis.

- Assessment of possible substance intoxication, including but not limited to alcohol 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
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 to Treatment
 - Consent to Participate in Program Evaluation
 - Authorization to Exchange Health Info
 - Authorization to Disclose Health Info
 - HIPAA privacy practices notice
 - Signed receipt of OBIC Patient Handbook
 - b. Medication—buprenorphine induction and upward titration
 - DAY #1. For mild withdrawal obtain MD order for Suboxone 2 to 4mg SL. For patients exhibiting moderate to severe withdrawal, obtain MD order for Suboxone 4mg SL. Observe client for 30 minutes to 1 hour after which time an additional dose of Suboxone 2 to 4mg SL may be prescribed at the physician's discretion. The physician may order take-home Suboxone doses for patient self-administration later in the day/evening should withdrawal symptoms re-emerge. Total Suboxone dose for 1st 24 hours typically ranges between 6mg and 14mg with an average of 12mg.

Adjunctive Medications

In addition to the use of buprenorphine (Suboxone) 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; donnatal 1 to 2 tabs PO q4 to 6 hours PRN nausea, agitation; 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/artralgias, 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 to 4mg if appropriate. Doses of 8-16 mg are typical for Day 2.
- DAY 3/Additional Days. 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 mg 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 24 mg/day may be required to suppress opioid withdrawal effects. Maximum daily dose is 24mg.

2. Patient conditions requiring Attending Consultation
 - a. All buprenorphine orders, initial as well as subsequent, come from the OBIC physician. The NP administers and dispenses buprenorphine only as dictated by this standardized procedure/protocol.
 - b. Acute decompensation of patient situation
 - c. Unexplained history, 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 lifestyle counseling.
- b. Anticipatory guidance and safety education that is age and risk factor appropriate.

4. Follow-up

Subsequent observed doses of buprenorphine occur daily on weekdays at OBIC clinic until a stable dose is achieved. Once a stable dose is achieved, follow-up visits occur based on patient need- based on medical assessment. After the patient stabilizes at OBIC clinic, buprenorphine care and prescribing is transferred to a community physician at the discretion of the OBIC physician.

E. RECORD KEEPING

All clinical notes at OBIC will be recorded in the LCR and the local OBIC chart kept at 1380 Howard Street. 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

Prerequisite:
On the job training by a certified physician provider.
Proctoring:
Direct observation of the care of 2 patients.
Reappointment Competency:
4 procedures and 4 chart reviews every 2 years.

Protocol #7: Procedure: Abdominal Paracentesis

- A. Definition - Abdominal paracentesis is a procedure that entails inserting a trocar and cannula through the abdominal wall under local anesthetic for aspiration of peritoneal fluid (ascites). The term ascites denotes the accumulation of fluid in the peritoneal cavity.
1. Locations to be performed: General Medical Clinic,
 2. Performance of Procedure: When possible any 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 between markup and procedure
 - 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;
 - a. INR greater than 4.0, platelets less than 30K.
 - b. Intra-abdominal adhesions or suspicion for loculated fluid.
 - c. Pregnancy
 - d. Necessity for ultrasound guided paracentesis if any conditions listed above are present.
 - iii. Contraindications:
 - a. Fibrinolysis or Disseminated Intravascular Coagulation
 - b. Cellulitis at puncture site.
- B. Data
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.
- C. Diagnosis
- Assessment of data from the subjective and objective findings to identify disease processes.

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. Sent 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 any condition 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 patient follow up should the 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, Care/Vue, LCR and other patient data bases, as appropriate. 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.

F. Summary of Prerequisites, Proctoring and Reappointment Competency

Prerequisites: 1. Training will be done on site by a qualified provider.
Proctoring: 1. Providers new to procedure must complete a minimum of 4 successful procedures prior to completion of proctoring period. 2. Experienced providers must complete a minimum of 2 successful

procedures prior to completion of proctoring period.

Reappointment Competency Documentation:

1. To maintain ongoing competency a minimum of 4 procedures every 2 years must be met. If not met, provider will be proctored through 1 successful procedure.
2. Four chart reviews every two years.
3. Evaluation must be done by Medical Director or designated physician.

Any additional comments: N/A

Procedure #5: 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.

- d. 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

- a. 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

<p>Prerequisites:</p> <p>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,</p>
<p>Proctoring:</p> <p>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.</p>
<p>Reappointment Competency Documentation:</p> <p>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%.</p>
<p>Any additional comments: N/A</p>