

Committee on Interdisciplinary Practice Policy and Procedures

I. STATEMENT OF POLICY:

At Zuckerberg San Francisco General and its affiliated clinics, affiliated and RN staff provide patient care services as permitted by law and accreditation regulations, and in keeping with all applicable rules, policies, and procedures of the institution. An appropriate authorization process is followed to ensure that any individual providing patient care has the required education, training, licensure/certification and competency requirements.

II. PURPOSE:

To outline the duties of the Committee on Interdisciplinary Practice (CIDP) at Zuckerberg San Francisco General and its affiliated clinics in the oversight of interdisciplinary medical practice by affiliated and registered nursing (RN) staff, including the review and approval of standardized procedures (SPs).

III. DEFINITIONS:

For the purposes of this Policy and Procedure, “affiliated staff” means an advanced practice registered nurse: Nurse Practitioner (NP), Certified Nurse Midwife (CNM), or Certified Registered Nurse Anesthetist (CRNA); Physician Assistant (PA); Clinical Pharmacist practicing in an expanded role; Acupuncturist; and Optometrist.

IV. PROCEDURE:

A. Credentialing

1. To be eligible to provide services, an affiliated staff member must
 - a. Have written approval, with job descriptions and, if applicable, standardized procedures, from the clinical service chief or department chair and/or the appropriate administrative department to provide services under the supervision of an active medical staff member
 - b. Complete the credentialing process and be approved through the appropriate committee structure as delineated in both the Bylaws and the Credentialing Policy and Procedure
2. All categories of affiliated staff must meet hospital HIPAA requirements and complete any training modules required for hospital clinical systems
3. Credentialing Process: The Medical Staff Office (MSO) is responsible for verifying all affiliated staff credentials via primary source at initial application and at a two- year reappointment.

B. CIDP Scope of Services Oversight

1. The duties of the CIDP shall be to oversee the practice of affiliated staff as well as to oversee the development, review and approval of SPs for affiliated staff and RNs who perform overlap functions as required by Title 22 (see Appendix) and the Medical Staff Bylaws.

2. As per Title 22, CIDP membership shall include, at a minimum, the director of nursing, the chief executive officer or designee, and an equal number of physicians appointed by the Executive Committee of the medical staff and registered nurses appointed by the director of nursing. Licensed or certified health professionals other than registered nurses who are performing or will perform functions as described in Title 22 shall also be included in the Committee.
3. CIDP is accountable to:
 - a. the Governing Body for establishing policies and procedures for interdisciplinary practice.
 - b. Medical Staff via the Credentials Committee for reviewing and approving all SPs according to Title 22.
 - c. the Chief Nursing Officer for establishing a system for identifying nurses who are qualified to practice under each SP.
4. The Committee shall establish and administer SPs for RNs and affiliated staff at the hospital and affiliated clinics as follows (see Appendices Title 22 and Review and Approval of Standardized Procedures):
 - a. Identify the overlap functions that require the adoption of SPs and ensure that affiliated staff and RNs perform them only in accordance with SPs.
 - b. Prescribe a required form for SPs that meets Board of Nursing requirements.
 - c. Establish a method for the review and approval of proposed SPs and for the review and approval of existing SPs every three years.
 - d. Review and approve (as to both form and content) SPs with approval to be given by a majority of physician and RN members of the CIDP, after consultation with appropriate persons in the medical, nursing, or applicable specialties under review.
 - e. Following CIDP approval, obtain approval of SPs from the Credentials Committee, Medical Executive Committee and the Joint Conference Committee (in that order).
 - f. Ensure that there is a system in place for identifying affiliated staff and RNs who are qualified to practice under each SP, both on an initial and on a continuing basis (see C. Evaluation/Performance Assessment), and
 - g. Ensure that the names of RNs and affiliated staff approved to perform functions according to each SP are on file with the clinical supervisor and, in the case of affiliated staff, the Medical Staff Office.
5. The committee shall oversee Affiliated Professional Staff who practice at the hospital, as follows:
 - a. Identify specific categories of such practitioners that might perform services at the hospital and affiliated clinics and make appropriate recommendations.
 - b. Make recommendations concerning the minimum standards of practice applicable to such practitioner categories at the Hospital and affiliated clinics.
 - c. Make recommendations concerning the supervision required for such practitioners at the Hospital and affiliated clinics.
 - d. Review applications for appointment or reappointment to affiliated professional status in accordance with the Medical Staff Bylaws, Rules and Regulations.

6. The CIDP shall meet as often as necessary but at least on a quarterly basis. Minutes will be kept of all meetings.
7. Meeting minutes will document the presence of the MD and RN members, whether a majority of both RN and MDs is present, and, if so, the results of votes (see Appendix-CIDP Meeting Minutes Template)
8. Upon final approval by the Governing Body, CIDP staff person will oversee completion of signature sheet by physician supervisors, non-physician supervisors/nurse managers, medical director or division chief, chief of service, chairs of the CIDP and Credentials committees, and all affiliated staff/RNs practicing under the SP (See Appendix-Standardized Procedure Signature Sheet)
9. Current copies of all SPs will be kept on file with the Medical Staff Office.

C. Evaluation/Performance Assessment:

SPs outline the requirements for prerequisites, training, supervision and assessing competency. Proctoring requirements for initial appointment and for reappointment are clearly enumerated in each SP. Ongoing sources for assessments are annual performance evaluations by clinical managers and supervising physicians, as well as data available via performance improvement resources (e.g. medical records, patient relations, risk management, etc.) used for OPPE. (See Appendices: Performance Evaluation template and Medical Staff Services Policy & Procedure: Ongoing Professional Practice Evaluation (OPPE))

V. RESPONSIBILITY

- A. This policy resides in the Medical Staff Organization Policy and Procedure Manual. Copies are located in the Medical Staff Services Department.
- B. Review and Renewal Requirements: as required by change of law or practice, by the CIDP. The review is facilitated by the Director of Medical Staff Services. Any changes must be approved by the CIDP, Credentials, Medical Executive Committee and the Joint Conference Committee

VI. APPENDICES

- Appendix I: Title 22
- Appendix II: Review and Approval of Standardized Procedures
- Appendix III: Ongoing Professional Practice Evaluation (OPPE)
- Appendix IV: Standardized Procedure Signature Sheet
- Appendix V: CIDP Meeting Minutes Template

Appendix I: Title 22

Title 22 California Code of Regulations Division 5 Page 129 **§70706. Interdisciplinary Practice and Responsibility for Patient Care**

(a) In any facility where registered nurses will perform functions requiring standardized procedures pursuant to Section 2725 of the Business and Professions Code, or in which licensed or certified healing arts professionals who are not members of the medical staff will be granted privileges pursuant to Section 70706.1 there shall be a Committee on Interdisciplinary Practice established by and accountable to the Governing Body, for establishing policies and procedures for interdisciplinary medical practice.

(b) The Committee on Interdisciplinary Practice shall include, as a minimum, **the director of nursing, the administrator or designee and an equal number of physicians appointed by the Executive Committee of the medical staff, and registered nurses appointed by the director of nursing. Licensed or certified health professionals other than registered nurses who are performing or will perform functions as in (a) above shall be included in the Committee.**

(c) The Committee on Interdisciplinary Practice shall establish **written policies and procedures** for the conduct of its business. Policies and procedures shall include but not be limited to:

(1) **Provision for securing recommendations from members of the medical staff** in the medical specialty, or clinical field of practice under review, and from persons in the appropriate nonmedical category who practice in the clinical field or specialty under review.

(2) Method for the approval of standardized procedures in accordance with Sections 2725 of the Business and Professions Code in which **affirmative approval of the administrator of designee and a majority of the physician members and a majority of the registered nurse members** would be required and that prior to such approval, consultation shall be obtained from facility staff in the medical and nursing specialties under review.

(3) Providing for maintaining **clear lines of responsibility** of the nursing service for nursing care of patients and of the medical staff for medical services in the facility.

(4) **Intended line of approval for each recommendation of the Committee.**

§70706.2. Standardized Procedures

(a) The Committee on Interdisciplinary Practice shall be responsible for:

(1) Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the facility, and initiating the preparation of such standardized procedures in accordance with this section.

(2) The review and approval of all such standardized procedures covering practice by registered nurses in the facility.

(3) Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the director of nursing. (b) Each standardized procedure shall:

(1) Be in writing and show date or dates of approval including approval by the Committee on Interdisciplinary Practice.

- (2) Specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances.
- (3) State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure.
- (4) Specify any experience, training or special education requirements for performance of the functions.
- (5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the functions.
- (6) Provide for a method of maintaining a written record of those persons authorized to perform the functions.
- (7) Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated.
- (8) Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
- (9) State any limitations on settings or departments within the facility where the standardized procedure functions may be performed.
- (10) Specify any special requirements for procedures relating to patient recordkeeping.
- (11) Provide for periodic review of the standardized procedure. (c) If nurses have been approved to perform procedures pursuant to a standardized procedure, the names of the nurses so approved shall be on file in the office of the director of nursing.

Appendix II: Review and Approval of Standardized Procedures

Review and Approval of Standardized Procedures (SPs):

1. CIDP staff person provides current templates and sample SPs as needed to clinical service authors.
2. SP is written/revise by clinical service authors, including consultation with medical and affiliated staff in the clinical field of practice under review and with the assistance of committee members as needed.
3. SP is reviewed and approved by Medical Director or Service Chief, as applicable.
4. SP is submitted to CIDP.
5. CIDP staff person reviews SP for correct format.
6. Staff person forwards SP to 2 CIDP members (one MD reviewer and one RN or other affiliated staff reviewer), who have been designated as primary reviewers.
7. Primary CIDP reviewers relay comments to authors for suggested revisions.
8. Authors forward final draft to CIDP staff person.
9. CIDP staff person forwards meeting agenda and final draft to all committee members for electronic review.
10. During CIDP meeting, primary reviewers (and, in cases of new or significantly revised SPs, author) present SP, highlighting significant changes.
11. SP approval requires affirmative approval of the administrator or designee, a majority of the physician members, and a majority of the registered nurse members.
12. If a majority of either group is not present, electronic votes will be solicited subsequent to the meeting, and final approval will be deferred to when/if a majority of each group affirms it.
13. In the event that the SP is not approved, SP is returned to authors for further revision.
14. CIDP staff person forwards approved SPs to Credentials Committee.
15. Documentation of the review and approval process will include:
 - a. dates of the above steps and names of authors and primary reviewers
 - b. meeting minutes that reflect approval by a majority of physician and RN members

Appendix III: Ongoing Professional Practice Evaluation

San Francisco General Hospital and Trauma Center

MEDICAL STAFF SERVICES POLICY AND PROCEDURE: ONGOING PROFESSIONAL PRACTICE EVALUATION Effective Date: 12/18/12

PURPOSE: To provide guidelines for ongoing professional practice evaluation (OPPE) which allows the hospital to identify professional practice trends that impact quality of patient care and patient safety. To assure that the hospital, through the activities of its Medical Staff, assesses the ongoing professional practice and competency of its Medical Staff and Affiliated Staff members, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competency, practice and care.

GOALS:

1. Monitor clinical performance of providers to identify opportunities for practice and performance improvement of individual practitioners credentialed on the SFGH Medical Staff and Affiliated Staff.
2. Monitor trends in performance by analyzing aggregated data and case findings
3. Improve quality of care provided by practitioners

POLICY: OPPE is used to assess the competence of all practitioners credentialed on the SFGH Medical Staff and Affiliated Staff. Data is collected, analyzed, and evaluated by Chiefs of Service or their designee every six months. Criteria for measures relevant to the Service's scope of practice may include:

- deaths
- length of stay patterns
- readmissions <30days
- transfusion data
- Unusual Occurrence Reports, Sentinel Events, Patient Complaints
- Review of operative and other clinical procedures reports and complication rates
- Morbidity and mortality data
- Other relevant criteria as developed by the clinical services in cooperation with the organized Medical Staff

The Medical Staff is responsible for ensuring that OPPE is consistently implemented and that clearly defined indications are uniformly applied.

PROCEDURE:

Individual Clinical Services, with Medical Staff concurrence have determined the type of metrics to be monitored and evaluated, relevant to their specialty. The type of data to be collected may include, but is not limited to, high volume and/or high risk procedures. Continuing review of patient care and the professional performance of practitioners is the responsibility of the chiefs

of service or designee as delineated in the medical staff bylaws. All OPPE that triggers additional comment or investigation will be reviewed to determine whether there are any performance improvement initiatives that need to be addressed related to organizational processes or clinical practices.

Organizational metrics chosen for evaluation may include: 1) deaths 2) lengths of stay 3) readmissions in >30 days 4) transfusion data 5) other cases reviewed, patient complaints, unusual occurrences; sentinel events. Pre-determined thresholds, that trigger Credentials Committee review exist for the following organization metrics: A) deaths rated preventable, or possibly or probably preventable; B) two consecutive 'marginal ratings by the Service Chief or designee in the same metric; C) two consecutive 'unacceptable' ratings in the same metric (these will require FPPE and notification to the Chair of Credentials Committee).

The Medical Staff recognizes the six general competencies as defined by the Accreditation Council for Graduate Medical Education (ACGME) as a general framework for evaluating practitioners.

Determination to grant, continue, reduce or revoke privileges or standardized protocols/procedures may be based on, but are not limited to, the following competencies:

GENERAL COMPETENCIES:

1. Patient Care

Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

2. Medical / Clinical Knowledge

Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

3. Practice Based Learning Environment

Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.

4. Interpersonal and Communication Skills

Practitioners are expected to demonstrate interpersonal communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of the health care team.

5. Professionalism

Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

6. Systems Based Practice

Practitioners are expected to demonstrate both an understanding of the context and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

The OPPE process may include:

- Periodic chart review
- Direct observation
- Evaluation of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient, including consulting physicians, nursing and administrative personnel

Collected data and clinical activity reports for each provider will be maintained in the clinical service files. The Service Chiefs or designee will submit written summation of the OPPE findings on the approved cover sheet to the Medical Staff Office for presentation to and review by the Credentials Committee Chair. The Chair will determine if significant findings should be submitted for review at Credentials Committee and/or the Medical Executive Committee.

The OPPE cover sheet will become part of the practitioner's credentials file and will be included in the decision to continue current privilege(s), recommend changes to current privilege(s), or recommend a Focused Professional Practice Evaluation (FPPE).

All reviews shall be considered a part of the confidential peer review activity of the Medical Staff and are intended to enhance the quality and safety of patient care, and as such is entitled to peer review protection and privilege.

REFERENCES:

Joint Commission Hospital Accreditation Standards

HCPPro: Sample Ongoing Professional Practice Evaluation (OPPE) Policy

APPROVAL

Credentials Committee: October 29, 2012

Medical Executive Committee: November 15, 2012

Joint Conference Committee: December 11, 2012

Health Commission:

Appendix IV: Standardized Procedure Signature Sheet



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STANDARDIZED PROCEDURE SIGNATURE SHEET

Standardized Procedure title: _____

Status: ___ **New Standardized Procedure**
 ___ **Approved Standardized Procedure for renewal**

Department: _____

These protocols/standardized procedures have been approved by CIDP, Credentials, MEC Committees and Governing Body as documented below. The non-physicians Practitioners, their physician and non-physician supervisors, and Clinical Service Chiefs have signed below.
NO PRACTICE MAY BEGIN UNTIL ALL APPROVALS and SIGNATURES ARE OBTAINED.

AUTHORIZED PRACTITIONERS

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Name: _____
 (Print Name)

Title: _____
Degree: _____ RN#: _____
Furnish #: _____ or N/A: _____
Signature: _____
Date: _____

Author

Name: _____ Signature: _____

(Print Name)

Title: _____ Date: _____

Supervising Physician(s)

Name: _____

(Print Name)

Title: _____

Signature: _____

Date: _____

Name: _____

(Print Name)

Title: _____

Signature: _____

Date: _____

NON -PHYSICIAN SUPERVISOR(S) and SITE ADMINISTRATOR

Name: _____

(Print Name)

Title: _____

Signature: _____

Date: _____

Name: _____

(Print Name)

Title: _____

Signature: _____

Date: _____

Medical Director or Division Chief Approval

Service Chief Approval

Name: _____

(Print Name)

Title: _____

Clinical Dept: _____

Division: _____

Signature: _____

Date: _____

Phone: _____

Name: _____

(Print Name)

Title: _____

Clinical Dept: _____

Division: _____

Signature: _____

Date: _____

Phone: _____

CIDP Chair Approval Date _____ Chair Signature _____

Credentials Approval Date _____ Chair Signature _____

MEC Approval Date _____ Gov. Body Approval Date _____

MSSD Date: _____

Zuckerberg San Francisco General Hospital

Committee on Interdisciplinary Practice

Meeting Minutes
Date

Appendix V: CIDP Meeting Minutes Template

Members Present/Voted		Members Excused
Administrative Staff		Guests
Topics	Issues and Discussions	Actions/Recommendations