

San Francisco General Hospital and Trauma Center

STANDARDIZED PROCEDURES INITIAL AND REAPPOINTMENT CRITERIA ~~2016~~2017

PROVIDER NAME: _____

Major site: _____

CLINICAL SERVICE: MEDICINE

Other sites: _____

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
CORE				
CORE HCM: Acute/Urgent Care Combine with Primary Care Combined Core Function	Proctoring period 3 months. 5 chart reviews and 1 direct observation 3-months in-length or time to review 10 cases and 5 chart reviews which should represent all core procedures.	5 chart reviews 5-chart reviews every 2-years. May incorporate from other chart reviews.		
HCM: Primary Care	Proctoring period 3 months. 5 chart reviews and 1 direct observation 3-months in-length or time to review 10 cases and 5 chart reviews which should represent all core procedures.	5 chart reviews 5-chart reviews every 2-years. May incorporate from other chart reviews.		DELETED – combined Primary Care with Acute/urgent Care
Discharge of Inpatients	5 chart reviews and 1 direct observation with 1 case representing each core protocol Acute, Urgent and Primary Care. Discharge of Inpatients and Furnishing /Drug Orders. 3-months in length or time to review 10 cases and 5 chart reviews which should represent all core procedures.	5 chart reviews with at least 1 case representing each core protocol every 2-years; may incorporate primary care or urgent care chart reviews.		
Furnishing Medications/Drug Orders	Proctoring period 3 months. 5 chart reviews and 1 direct observation 3-months in-length or time to review 10 cases and 5 chart reviews which should represent all core procedures.	5 chart reviews with at least 1 case representing each core protocol 5-chart reviews every 2-years; may incorporate from other chart reviews.		
SPECIAL				

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
Occupational Health Screening	3 months in length or time to review 10 cases and 5 chart reviews which should represent all core procedures. 5 chart reviews and 1 direct observation to cover both Occ Health protocols	5 chart reviews every 2 years. 5 chart reviews to cover both Occ Health protocols		
Evaluation and Treatment of Occupational Illness/Injury and Exposure to Physical Chemical and Biological Hazards	5 chart reviews and 1 direct observation to cover both Occ Health protocols	5 chart reviews to cover both Occ Health protocols		
RESTRICTED TO BREAST CLINIC NP'S Management of Benign and Malignant Breast Conditions	3 months in length. Direct observation of 3 cases and 5 chart reviews.	5 chart reviews every 2 years.		
eReferral	Concurrent review of first 20 cases.	Review of 5 + eReferral consultations every 2 years.		
Evaluation and Treatment of Occupational Illness/Injury	Direct observation of 3 cases.	4 chart reviews every 2 years.		
Abdominal Paracentesis	Complete 4 observed Direct observation of 4 procedures for new provider and 4 chart reviews prior to completion of proctoring. One of the procedures may be performed on a simulated model. 2 procedures for an experienced provider. Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the past 2 years. Chart review of all observed cases.	Perform 4 procedures and 42 chart reviews every 2 years. If requirements not met, provider will be proctored through 1 successful procedure. Only one of the procedures may be performed on a simulated model.		
Arthrocentesis and Intraarticular Injections	New practitioner to procedure, a	Perform 4 procedures and 2 chart review		

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STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
	<u>minimum of 2 observed procedures and 2 chart reviews. Direct observation of 3 procedures for new provider and 2 procedure for experienced provider</u> Chart review of all observed cases	every 2 years.		
Bone Marrow Aspiration and Biopsy	Direct observation of 3 procedures <u>and chart reviews</u> for new provider and 2 procedure for experienced provider Chart review of all observed cases. <u>Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the past 2 years.</u>	Perform <u>12</u> procedures and 2 chart review every 2 years.		
Buprenorphine Induction and Maintenance	THIS PROTOCOL IS BEING DELETED. Review of 5 charts by a provider with DEA X license.	Review of 2 charts by a provider with DEA X license every 2 years.		THIS PROTOCOL IS BEING DELETED
Colonoscopy	Direct observation of 150 procedures, including 50 colonic mucosal biopsies and 50 polypectomies for a new provider. Direct observation of 10 procedures, including 5 mucosal biopsies and 5 polypectomies for an experienced provider. Review of 75 procedure notes. Review of video tapes.	Perform 10 colonoscopies with 5 mucosal biopsies and 5 polypectomies and 20 chart reviews every 2 years. Maintain ACLS certification. Passing Procedural Sedation test with score of more than 80%.		
EGD	Direct observation of 150 procedures with	Direct observation of 10 upper endoscopies		

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
	procedural sedation for a new provider. Direct observation of 15 direct observations with procedural sedation for an experienced provider. Review of 75 procedure notes. Review of video tapes	and 5 upper endoscopies with mucosal biopsy. Maintain ACLS certification. Passing procedural sedation class with passing score of 80%. 20 chart reviews.		
Esophageal Manometry and Prolonged pH Monitoring	Perform a minimum of 5 procedures for a new provider and 3 procedures for an experienced provider. Review of 20 procedure notes. Review of video tapes. <u>Designation of experienced practitioner requires 1) previous proctoring and 2) ongoing performance assessment within the past 2 years.</u>	Perform 10 procedures every 2 years		
Exercise Treadmill Test	Direct observation of 3 procedures for new provider and 2 procedure for experienced provider <u>Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the past two years.</u> Chart review of all observed cases	Perform 2 procedures and 2 chart review every 2 years		
High Resolution Anoscopy	Perform 50 procedures and 3 chart reviews.	Perform 20 procedures and 3 chart reviews every 2 years.	<u>NO ONE DOING THIS PROCEDURE AT THIS TIME. SHOULD IT BE DELETED OR LEFT IN?</u>	<u>Left protocol in</u>
Incision and Drainage of	Direct observation of	Performance of 1	<u>NO ONE</u>	<u>Left protocol in</u>

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
Skin Abscesses with Administration of Local Anesthesia	2 procedures for new provider and 1 procedure for experienced provider Chart review of all observed cases. <u>Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the past two years.</u>	procedure and 1 chart review every 2 years.	<u>DOING THIS PROCEDURE AT THIS TIME SHOULD IT BE DELETED OR LEFT IN</u>	
Intraperitoneal Chemotherapy	PROTOCOL DELETED Direct observation of 3 procedures for new provider and 2 procedure for experienced provider Chart review of all observed cases	Perform 2 procedures and 2 chart review every 2 years		Protocol Deleted
Intraventricular Chemotherapy via Ommaya Reservoir	Direct observation of 3 procedures for new provider and 2 procedure for experienced provider Chart review of all observed cases	Perform 2 procedures and 2 chart review every 2 years		
Lumbar Puncture	Direct observation of 3 procedures for new provider and <u>3 CHART REVIEWS</u> . 2 procedures and 2 chart reviews for experienced provider. <u>Designation of experienced practitioner requires documentation previous proctoring and ongoing performance within the past two years.</u> <u>One of the procedures may be performed on a simulated model.</u>	Perform 3 procedures and <u>3+</u> chart review every 2 years. <u>Proctoring for 1 of the procedures may be performed on a simulated model.</u>		
Lumbar Puncture with Administration of	Direct observation of 3 procedures for new	Perform 2 procedures and <u>2+</u> chart review		

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
Intrathecal Chemotherapy	provider and 3 chart reviews . 2 procedures and 2 chart reviews for an experienced provider. Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the past 2 years. Minimum of 2 chart reviews.	every 2 years		
Procedural Moderate Sedation	Direct observation by a qualified provider of 30 procedures for a new provider and 10 observations for an experienced provider. Review of 30 procedure notes. Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the last two years.	Completion of 3 procedures every 2 years. Maintain BLS certification. Pass the Procedural Sedation test with a passing score of 98% every 2 years.		
Ordering Blood Transfusions	Read and Sign SFGH Policy and Procedure 2.3. Read Blood Transfusion section of the Laboratory Manual. Review of 1 transfusion order.	Complete review of the 3 education modules and pass with a score of 80% every 2 years. Review of 2 transfusion orders every 2 years. Review any reports from the Hospital Transfusion Committee.		
Ordering Chemotherapy	All new providers will have all chemo orders cosigned for 3 months. Experienced providers will have 2 orders reviewed by the Clinical Director. Designation of experienced	3 chemotherapy orders and 2-3 chart reviews every 2 years.		

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
	practitioner requires documentation of previous proctoring and ongoing performance assessment within the past two years.			
Skin Biopsies	Successfully Perform 3 of each type of biopsy with chart review of each procedure (Shave, Punch, and Excision) for a new provider and 2-observe 1 of each for an experienced provider with chart review. Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the past two years.	Perform 1 of each type of biopsy (Shave, Punch, and Excision) and 1 chart review of each type every 2 years.	PROTOCOL IS NOT BEING DONE ON SERVICE. Question of deletion or leaving in?	Protocol remains
Surface Trauma and Wound Care	Direct observation of 3 procedures for a new provider and 1 procedure for an experienced provider. Chart review of all observed cases.	Performance of 4 procedures every 2 years.	Protocol is not being done on service. Question of deleting or leaving in?	Protocol Deleted
Thoracentesis	Direct observation of 3 procedures and 3 chart reviews for new provider and 2 procedure for experienced provider Designation of experienced practitioner requires documentation of previous proctoring and ongoing performance assessment within the past two years. Proctoring for one of the procedures may be performed on a	Perform 3 procedures and 3 chart reviews every 2 years Proctoring for 1 of the procedures may be performed on a simulated model.		

STANDARDIZED PROCEDURES	INITIAL PROCTORING	REAPPOINTMENT CRITERIA	MET/UNMET*	COMMENTS
	simulated model.			
Waived Testing a. Fecal Occult Blood b. Vaginal pH testing c. Urine Pregnancy d. Urine Dipstick	Completion of Healthstream quizzes for each test and receive a score of 80%.	Completion of Healthstream quizzes for each test and receive a score of 80%.		
Tattoo Removal	PROTOCOL DELETED Performance of 25 cases by a provider with privilege for this procedure.	Completion of 5 procedures and 5 chart reviews every 2 years.		Protocol Deleted

Chief of Service or designee

Date

* Clinical data relevant to privileges or performance evaluation of standardized procedures, is available for review in the provider's file located in the Clinical Service office.



Zuckerberg San Francisco General Hospital and Trauma Center
Committee on Interdisciplinary Practice
STANDARDIZED PROCEDURE – NURSE PRACTITIONER / PHYSICIAN
ASSISTANT

PREAMBLE

Title: Department of Medicine

I. Policy Statement

- A. It is the policy of Zuckerberg San Francisco General Hospital and Trauma Center that all standardized procedures are developed collaboratively and approved by the Committee on Interdisciplinary Practice (CIDP) whose membership consists of Nurse Practitioners, Nurse Midwives, Physician Assistants, Pharmacists, Registered Nurses, Physicians, and Administrators and must conform to all eleven steps of the standardized procedure guidelines as specified in 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 1M Clinic room 1M 13, Cardiology 5G1, Cardiac Catheterization Lab, Unit 5B Nurse Lounge, ~~GI Fellows Conference Room~~, Hematology/Oncology Administration Office, GI Conference Room 3D22, Occupational Health Clinic, ~~HERO Medical record system~~ Ward 86 administration office, Ward 92 nursing office 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 and in performance of procedures.

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 patients 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: Inpatient Units, 5B Research Unit, Adult Medical Clinic and Medical Specialty Clinics on Ward 92, 4C Infusion Center, 3 D Gastroenterology Clinic, Occupational Health Service, Positive Health Clinic, Hematology/Oncology Clinic, 1M and 5F Cardiology Clinics, Ward 17 Renal Dialysis Service and the Emergency Department.
- 2). Role may include primary care, urgent care, furnishing medications, performing procedures and coordinating admissions and discharges. Role may also include admissions, transfers and discharges. Role may also include clinical research studies.

B. Supervision

1. Overall Accountability:
The NP/PA is responsible and accountable to: site Medical Director, Chief of Service, designated physician and other supervisors as applicable.
2. A consulting physician, who may include attendings, chief residents and fellows, 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. 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.
 - i. Problem requiring invasive or surgical procedure.
 - j. Need for transfusion.
 - k. Review of electrocardiograms, if no prior interpretation or change from previous recording.
 - l. Protocol clarification, dose escalation, dose limiting toxicity, dose de-escalation, dose modification and management of toxicity and/or adverse event reporting.
 - m. Upon oncology providers seeing a newly diagnosed oncology patient in outpatient clinic.
 - n. Whenever situations arise which go beyond the intent of the Standardized Procedures and/or protocols or the competence, scope of practice or experience of the NP/PA.
 - o. Conditions severe enough to warrant partial or total disability work status prescription.
 - p. Any problem requiring transfer of care to the Emergency Department.
4. For cardiology and GI providers only: NP/PA management of medical emergencies, including cardio-pulmonary arrest, shock and life-threatening bleeding shall include initial evaluation and stabilization of the patient through the utilization of Advanced Cardiac Life Support (ACLS), alerting the supervising physician and activation of the Code Blue Team by dialing X61122.

IV. Scope of Practice

- Protocol #1: Health Care Management: Acute/Urgent
- Protocol #2: Health Care Management: Primary Care
- Protocol #3: Discharge of Inpatient
- Protocol #4: eReferral Review
- Protocol #5: Furnishing Medications/Drug Orders
- Protocol #6: Routine Occupational Health Screening
- Protocol #7: Evaluation and treatment of Occupational Illness/Injury and Exposure to Physical Chemical and Biological

Hazards

- Protocol #8: Procedure: Abdominal Paracentesis
Protocol #9: Procedure: Arthrocentesis and Intraarticular Injections
Protocol #10: Procedure: Bone Marrow Aspiration and Biopsy
~~Protocol #11: Procedure: Buprenorphine Induction and Maintenance~~
Protocol #1211: Procedure: Colonoscopy
Protocol #1312: Procedure: Esophagogastroduodenoscopy (EGD)
Protocol #1413: Procedure: Esophageal Manometry and Prolonged Ambulatory pH Monitoring
Protocol #145: Procedure: Exercise Tread Mill Test
Protocol #146: Procedure: High Resolution Anoscopy
Protocol #157: Procedure: Incision and Drainage Skin Abscesses with Administration of Local Anesthesia
~~Protocol #18: Procedure: Intraperitoneal Chemotherapy~~
Protocol #169: Procedure: Intraventricular Chemotherapy Administration via Ommaya Reservoir
Protocol #1720: Procedure: Lumbar Puncture
Protocol #1824: Procedure: Lumbar Puncture with the Administration of Intrathecal Chemotherapy
Protocol #1922: Procedure: Procedural Sedation
Protocol #2023: Procedure: Ordering Blood Transfusions
Protocol #214: Procedure: Ordering Chemotherapy
Protocol #225: Procedure: Skin Biopsies
Protocol #2623: Procedure: Surface Trauma and Wound Care
Protocol #2724: Procedure: Thoracentesis
Protocol #2825: Procedure: Waived Testing
~~Protocol #29: Procedure: Tattoo Removal~~

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V. Requirements for the Nurse Practitioner/Physician Assistant

A. Basic Training and Education

1. Active California Registered Nurse/Physician Assistant license.
2. Successful completion of a program, which conforms to the Board of Registered Nurses(BRN)/Accreditation Review Commission on education for the Physician Assistant(ARC)-PA standards.
3. Maintenance of Board Certification (NP)/National Commission on the Certification of Physician Assistants (NCCPA) certification. Nurse Practitioners hired prior to the current Board requirement will be "grandfathered" in when up for reappointment.
4. Maintenance of certification of Basic Life Support (BLS) that must be from an American Heart Association provider. Please note ACLS or other certification may be required for specific procedures.
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 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: NP Specialization in Acute Medicine, Family Medicine, Adult Medicine, Geriatric Medicine or Physician Assistant.
2. Two (2) years experience as a registered-nursenurse practitioner/physician assistant in an adult medical clinic or an inpatient acute med/surg, critical care or Emergency Department setting or previous experience in Oncology within the last three (3) years preferred.
- ~~3. All Affiliated Staff who will participate in the Buprenorphine protocol must have on the job training by a certified physician.~~
- ~~3.4.~~ Clinical research and human subjects training (Research Unit only).
- ~~4.5.~~ All staff working in Occupational Health will receive training from an OHS Physician in:
 - a. California and CCSF Workers Compensation procedures.
 - b. Management of body fluid exposures.
- ~~5.6.~~ Board certification or eligibility for board certification by the National Board for Certification of Hospice and Palliative Nurses (NBCHPN), as a Hospice & Palliative APN (HPAPN) (Palliative Care NP only).

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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 and/or designated physician and other supervisors, as applicable will assess the NP/PA's ability to practice.
 - a. Clinical Practice
 - Length of proctoring period will be 3 months; review of cases and medical record reviews will be as listed in each protocol or procedure.
 - The evaluator will be Medical Director, Chief of Service

and/or designated physician or privileged provider as applicable.

- The method of evaluation in clinical practice will be those needed to demonstrate clinical competence as noted in each procedure.

2. Biennial Reappointment: Medical Director, and/or designated physician must evaluate the NP/PA's clinical competence as described in each procedure.
3. Follow-up: areas requiring increased proficiency as determined by the initial or biennial evaluation will be re-evaluated by the Medical Director, and/or designated physician, at appropriate intervals. If staff have not achieved competency within two years of initial appointment, provider may no longer operate under these standardized procedures.

4. Ongoing Professional Performance Evaluation (OPPE)

Every six months, affiliated staff will be monitored for compliance to departmental specific indicators and reports sent to the Medical Staff Office.

5. Physician Assistants:

- 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.

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, Registered Nurses, 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 problems which include but are not limited to common acute ~~problems, uncommon, unstable, or complex~~ subacute and chronic illnesses conditions within the Medicine Service, and in the Emergency Department.

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.
- c. Present status of current symptoms (present, stable or absent)
- d. Pain history to include onset, location and intensity.

2. Objective Data

- a. Physical examination of systems relevant to the problem 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 to identify disease processes. Assessment will include statement of current status of disease (e.g. stable, unstable, or controlled, uncontrolled). ~~To refine the diagnosis and adjust treatment in an effort to maintain wellness.~~ Refine diagnoses as information becomes available and adjust treatment plans accordingly.

D. PLAN

1. Therapeutic Treatment Plan

- a. Appropriate screening tests and/or diagnostic tests for purposes of disease identification.
- b. Review of medical record, laboratory and other test results and specialty consultations.
- c. Initiation or adjustment of medication per Furnishing/Drug Orders protocol.
- d. Referral to physician, specialty clinics, and supportive services, as needed.

- e. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS (ACLS only relevant for GI and Cardiology providers).
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
 - 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. Discharge information and instructions.
 4. Follow-up
As appropriate for patient health status and diagnosis.

E. RECORD KEEPING

All information from patient visits will be recorded in the medical record or Lifetime Clinical Record (LCR)- electronic medical record (EMR) 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.

F. PROCTORING

<u>Prerequisites</u> <ol style="list-style-type: none"> a. <u>Onsite training of procedures by a qualified provider.</u> b. <u>Review of departmental policy and procedure</u>
<u>Proctoring Period</u> <ol style="list-style-type: none"> a. <u>5 chart reviews and 1 direct observation</u>
<u>Reappointment Competency</u> <ol style="list-style-type: none"> a. <u>5 chart reviews</u>

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Protocol #2: Health Care Management – Primary Care/Inpatient Units

A. DEFINITION

This protocol covers the procedure for ~~appropriate~~ health care management in primary care, specialty clinics and inpatient units. Scope of care includes health care maintenance and promotion ~~and~~, management of common acute, subacute and chronic illnesses ~~and chronic stable illnesses~~ within the Medicine Service.

B. DATA BASE

1. Subjective Data

- ~~a. Screening: appropriate history that includes but is not limited to: age, ethnic and national origin, appropriate review of symptoms, 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.~~
 - a. History and review of symptoms relevant to the presenting complaint and/or disease process.
 - b. Past medical history, surgical history, family history, psychosocial and occupational history, hospitalizations/injuries, current medications, allergies, and treatments.
 - c. Review of systems: present status of current symptoms (present, stable or absent)
 - d. 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 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, or controlled and uncontrolled). Refine diagnoses as information becomes available and adjust treatment plans accordingly.

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. Initiation or adjustment of medications as covered in Research Protocols.
- c. Immunization update.
- d. d. Referral to specialty clinics and supportive services, as needed.
- e. Initial treatment and stabilization of patients that may include all modalities of BLS or ACLS (only relevant for GI and cardiology providers).

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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. e Upon request of patient, NP, PA, or physician
- e. f. Initiation or change of medication other than those in the formulary/ies.
- f. g. Problem requiring hospital admission or potential hospital admission.
- g. h. Patients on Chemotherapy, referrals for radiation therapy.
- h. i. Any change in procedures or treatment that varies from the Committee on Human Research approved research protocol.

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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. Discharge information and instructions.

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). The Lifetime Clinical Record (LCR)- electronic medical record (EMR) will be used to obtain and record patient information as required and 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 the patient.

F. PROCTORING

<u>Prerequisites</u>
<u>a. Onsite training of procedures by a qualified provider.</u>
<u>b. Review of departmental policy and procedure</u>
<u>Proctoring Period</u>
<u>a. 5 chart reviews and 1 direct observation</u>
<u>Reappointment Competency</u>
<u>a. 5 chart reviews</u>

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