UNIVERSITY OF CALIFORNIA, SAN FRANCISCO SCHOOL OF NURSING
UCSF Nurse-Midwifery/WHNP Education Program

Syllabus and Clinical Notebook
N414.15D Ambulatory Sexual and Reproductive Health (SRH)

Course Information

Course Number:	N414.15D Clinical Practicum: Year 2
Course Title:	Ambulatory Sexual and Reproductive Health Clinical Practicum: Year 2
Course Units:	4.5
Course Time:	Primarily GYN-focused: ten full days or twenty half-days, and: Primarily Antepartum-focused: ten half-days or five full days, or most sessions of one Centering cohort Clinical experiences may be a mix of AP and GYN within one setting. Overall, the focus is on a larger portion of GYN.
Quarter:	Fall 2024, Winter 2025
Faculty of record:	Cynthia Belew, MS, CNM, WHNP-C Clinical Professor Cynthia.Belew@ucsf.edu 415-305-8660

Course Description

Supervised clinical experience in which students learn the assessment, interventions, and management skills applicable to midwifery practice.

Prerequisites:

N270, NSL413.15A, N414.15A, N281A, N281B, N259.01, N259.02, N259.04 past or concurrent.

Course Objectives

At the end of the course, the participant will be able to:

1. Apply clinical theory to inform data collection, assessment, management (including pharmacotherapeutics), and evaluation of common antepartum and reproductive health presentations and selected complications.
2. Utilize concepts of shared decision-making and patient-centered care in clinical practice.
3. Communicate effectively in written and verbal forms with an interdisciplinary health careteam, including the patient.
4. Use communication technologies to integrate and coordinate care.
5. Use patient-care technologies to deliver and enhance care.
6. Demonstrate professional accountability.

ACNM Core Competencies covered:

1. Midwifery Management Process
2. Applies knowledge, skills and abilities in the antepartum period
3. Applies knowledge, skills, and abilities in the preconception period.
4. Applies knowledge, skills, and abilities in gynecologic care.
5. Applies knowledge, skills, and abilities in peri-menopausal and postmenopausal care.

Teaching Method

Clinical experience/patient contact

Texts

At a minimum, the student should have the items listed below instantly available (on a mobile app or electronic or paper version) and be familiar with their use:

- The GYN Order of Report
- The Managing Contraception Handbook
- The CDC STI Treatment Guidelines
- The CDC Medical Eligibility Criteria for Contraception
- The USPSTF Guidelines for Cervical Cancer Screening
- The ASCCP Consensus Guidelines for Abnormal Cervical Cancer Screening tests.

See links to these items and other recommended peripheral brain items posted on the CLE page.

Course Requirements

1. **Complete required clinical sessions across two quarters**
   a. Students are required to attend all assigned clinical shifts and arrive on time.
   b. Pre-charting is expected. Typically, 60-90 minutes before each shift, Elicit preceptor input to identify which charts to focus on.

   Missed Clinical Policy:
   c. The student will inform the preceptor of an absence before the scheduled shift begins. The student is responsible for rescheduling missed clinical hours and should promptly notify faculty if any difficulty is anticipated in attaining the required shifts.
   d. Notify the course FOR of the absence and coverage, with information about the date of the make-up session to the FOR within one week of the absence.
   e. Make-up shifts must be completed by the end of the academic quarter.

2. **Complete all site onboarding on time,** including any EMR training and site orientation.

3. **Send professional introductions** to their preceptors before the start of each rotation, including the Biosketch and individual learning goals.

4. Individual **clinical learning goals:** submit before the first shift of each rotation

5. **Participate in weekly clinical goal-setting with preceptors**

6. **Check-in with course faculty** at least twice per quarter by phone or email

7. **Maintenance and timely completion of InPlace logbook data**
    a. Do not include pre-charting hours
    b. Do not log visits that you only shadow. But if you participate in any element of care (counseling, discussion about the care plan) that may be included
    c. InPlace data (case longs and time logs) must be up-to-date and complete by the end of the quarter, or the student will receive an "unsatisfactory" for the course and be unable to proceed to the next clinical rotation. The student is responsible for using the Midwifery InPlace data entry guide for correct data entry and tracking.

8. **Timely completion of preceptor and site evaluations** in InPlace
    a. The FOR reviews preceptor evaluations quarterly and is responsible for timely follow-up. Your evaluations will inform use of the sites and preceptors in the future
    b. The FOR is not blinded to student identity; this allows for appropriate follow-up. Preceptor evaluations are shared with the preceptor annually, anonymously and in aggregate when three or more evaluations are available.

9. **Satisfactory clinical performance evaluations** (see section below on "Evaluations")
    a. Unsatisfactory clinical performance will be followed up with a Collaborative Academic Success Plan. See details below.

Grading System

Satisfactory/Unsatisfactory grade. Grading is "in process" during the Fall.
The course grade will be designated as satisfactory or unsatisfactory by the FOR at the completion of the two-quarter course The final grade will be awarded at the end of the Winter quarter, or at the end of two clinical quarters.

Grading and Clinical Evaluation

Grading is based on the demonstration of increasing competency in the achievement of clinical learning objectives and the successful completion of course requirements.
By the end of this course, each student will demonstrate proficiency and consistency in the management of common antepartum and reproductive health presentations at a minimum level of "intermediate" or "advanced beginner," contextualized by the student's exposure to various clinical presentations.

For Centering Pregnancy rotations, please see the appendix about specific objectives, expectations and feedback.

Rating Scale:

0. **Critical Deficiency** (unsafe practice): the student demonstrates critical deficiencies in knowledge,skill, and attitude to safely perform the role function.
1. Basic (direct guidance): The student performs the task under the direct guidance of the preceptor(for >75% of skill/time).
2. **Novice** (extensive guidance): Student performs the task under extensive guidance of the preceptor (for 50-75% of skill/time).
3. **Intermediate** (frequent guidance): Student performs the task under frequent guidance of the preceptor (for 25-50% of skill/time).

4. **Advanced Beginner** (occasional guidance): Student performs the task under occasional guidance of the preceptor (for <25% of skill/time).
5. **Competen**t (safe independent practice): Student performs the task safely and effectively using own judgment without supporting cues.

Preceptors are the primary evaluators of the student's clinical competency. They are responsible for identifying the student's level of competency from basic to competent, reinforcing desired behaviors, and providing honest feedback regarding progress and goals. The FOR reviews the clinical evaluations and periodically checks in with preceptors regarding student progress.
The bottom line in evaluating clinical performance is safety. Clinical performance is safe when the individual knows what they know, knows what they don't know, seeks help appropriately, maintains effective communication, demonstrates adequate skill, and utilizes the steps of the management process in providing safe care.

If a student is uncertain if their progress is on track, they should check in with the preceptor. If this is difficult for any reason, schedule a meeting with the course FOR.

If a student perceives that their self-evaluation during clinical sessions is significantly and consistently different than that of the preceptor, they should

- discuss the difference with the preceptor directly.
- If no resolution is reached after the conversation with the preceptor, the student should request a meeting with the FOR for problem-solving. At this meeting, a follow-up session will be arranged to ensure progress is being evaluated accurately after further clinical shifts and to discuss further problem-solving strategies as needed.

Expected clinical caseload:
Students will see increasingly more clients over the course of the rotation. Expectations are that by the end of the rotation the student will meet the following expectations:

- GYN: complete an uncomplicated GYN annual visit in < 50 minutes and a family planning visit or problem-oriented visit in less than 30 minutes
- Antepartum: In a half-day clinic, the student sees 5 revisits or the equivalent. A new OB or postpartum visit counts as two revisits

Evaluations:

All forms are in appendices at the end of this syllabus.

Name of Form	When / How Often	When / Who Completes
Goal Setting Form	Each clinical session	Student and preceptor start each shift with review of goals based on clinical objectives and previous clinical sessions. Preceptor and student will end each shift with a discussion of student clinical goal setting and preceptor goal setting for teaching

Formative Clinical Evaluation Tool	Twice per quarter Mid-point and end of rotation	Midwifery program staff will schedule evaluations for the integration preceptor at least twice throughout the quarter. Students and the FOR will review in IinPlace..
Student Evaluation of Preceptor	At the end of each rotation	Student will complete evaluation in InPlace FOR reviews preceptor evaluations quarterly and is responsible for timely follow-up. The FOR is not blinded to student identity: this allows for appropriate follow-up. Preceptor evaluations are shared with the preceptor anonymously and in aggregate when three or more evaluations are available annually.
Summative Clinical Evaluation	At the end of the clinical rotation	The FOR compiles all evaluations and communications with preceptors to complete
Student Evaluation of Site	At the end of the clinical rotation	Student completes and FOR reviews

Clinical Learning Objectives

The student must utilize the Midwifery Management Process (defined by ACNM):
The midwifery management process is used for all areas of clinical care and consists of the following steps:

A. Investigate by obtaining all necessary data for the complete evaluation of the woman or newborn.
B. Identify problems or diagnoses and health care needs based on correct interpretation of the subjective and objective data.
C. Anticipate potential problems or diagnoses that may be expected based on the identified problems or diagnoses.
D. Evaluate the need for immediate intervention and/or consultation, collaborative management, or referral with other health care team members as dictated by the condition of the woman, fetus, or newborn.
E. In partnership with the woman, develop a comprehensive plan of care that is supported by a valid rationale, is based on the preceding steps, and includes therapeutics as indicated.
F. Assume responsibility for the safe and efficient implementation of a plan of care that includes the provision of treatments and interventions as indicated.
G. Evaluate the effectiveness of the care given, recycling appropriately through the management process for any aspect of care that has been ineffective.

Expected level by end of the clinical course:

UCSF Nurse-Midwifery Education Program: N414.15A/D + N415.15 Ambulatory Competency	Expected Level by end of Quarter Winter Q1 (45h)	Spring–Q2 (45h)	Summer – Q3 (45h)	Fall--Q4 (~70h) Winter – Q5 (~70h)	Spring-Q6 (130h)
Data Collection					
• Collecting thorough subjective history					
• Thorough and focused chart review					
Skills					
• Focused PE in non-pregnant patient					
• SSE, wet prep, identifying ferning and/or Amsel's criteria					
• Antenatal exam: fundal height/doptones/Leopold's					
• Safe prescribing/ordering ofmeds					
• Procedures: IUD placement, Nexplanon placement					
Assessments/Management					
• Mgmt of family planning methods (initiation/maintenance)					
• Able to identify normal v. abnormal presentations in prenatal care					
• Requests and accurately interprets labs/diagnostic tests – AP + common GYN					
• Requests and accurately interprets labs/diagnostic tests – complex GYN					
• Promotion of wellness: breast + cervical cancer screening; STI screening + treatment; vaginitis tx; vaccine promotion					
• Complete differentials and management plans for common abnormal presentations in pregnancy (eg.,GBS+, GDM, gHTN/pre-e, FGR, cholestasis, prolonged pregnancy, preterm labor, etc.)					
• Mgmt of complex GYN presentations: Abnormal uterine bleeding, pelvic pain, vulvovaginal sxs, infertility					
Communication					
• Comprehensive, accurate, concise notes that demonstrate organized thought process and criticalthinking.					
• Clear and accurate patient education, shared decision-making					
• Team communications: perform physician consults and xfer of care					
Caseload Expectations	1-2pt in half-day	2-3pt in half-day	3-4pt in half-day	AP: 5pt in half-day and GYN:annual <40min; POV <30min	Approx. 2/3 to 3/4 of preceptor caseload

Basic (needs support >75% of time) – [not included] (1/5 on eval)
Novice (need support 50-75% of the time) – orange (2/5 on eval)
Intermediate (need support 25-50% of the time) - yellow (3/5 on eval)
Advanced (need support <25% of the time)- light green (4/5 on eval)
Independent- dark green (5/5 on eval)

Created December 2022
Updated Sept 2023

Clinical objectives:

Theory Grasp
Accurately recall and apply clinical theory base to patient care in provided in triage, intrapartum and postpartum settings inpatient and ambulatory antepartum and GYN sites.
Critically analyze, interpret and apply research findings into evidence-based clinical practice.
Correctly interpret screening and diagnostic tests.
Identify deviations from normal physiologic and psychological processes.
Management
Demonstrate evidence-based management plans based on assessment findings for intrapartum, postpartum and newborn care, including selected complications within scope of practice. Includes an understanding of the structural determinants of health.
Management is based on the midwifery model of care and utilize the nurse-midwifery management process, including appropriate physician involvement for consultation, collaborative management, and/or transfer for medical management, when indicated.
Identify problems, anticipate potential problems, formulate differential diagnoses, and diagnoses based on the correct interpretation of the database.
Develop appropriate and complete therapeutic, diagnostic, and teaching plans for normal and higher risk patients, including health promotion and referral to outside agencies/roles as appropriate.
Demonstrate competency and safety in the prescribing/furnishing/ordering of pharmaceutical therapies, including scheduled medications appropriate to nurse-midwifery and/or WHNP scope of practice.
Assume responsibility for timely implementation of plan of care.
Performance of Clinical Skills
Systematically obtain complete and focused histories and conduct relevant, complete, and focused physical examinations in an organized fashion, appropriate to the clinical presentation.
Perform appropriate clinical procedures safely and effectively; describe method(s) of actions, indications, contraindications, and patient teaching necessary for shared clinical decision-making and informed consent.
Establish and maintain the knowledge necessary to provide diagnosis, treatment, and management of relevant health conditions.
Uses patient-care technologies to deliver and enhance care.
Communication
Perform timely communication with preceptors (and other health care team members) in regard to patient status and care delivery plans.
Builds rapport with patients using skills of engagement, active listening and reflection.
Articulate patient education and management plans.
Timely, accurate, relevant, complete and concise charting.
Provision of clear, organized patient report/sign-out and physician consultation, when indicated.
Uses communication technologies to integrate and coordinate care

Professionalism
Ability to reflect on one's own performance to identify strengths and challenges, set individual learning and improvement goals, and engage in appropriate learning activities to meet those goals.
Dependable, reliable, punctual, trustworthy, professional accountability.
Maintain honesty and integrity with preceptors and staff; team player.
Accept limitations and lack of knowledge; ask for help appropriately.
Demonstrate accountability for own learning. Receive feedback from faculty/preceptors in a professional manner.
Keep preceptor advised of patient's status. ***The preceptor has ultimate responsibility of patient care and ALL plans should be discussed with preceptor in a timely fashion, and ALL patient safety or wellbeing concerns should be discussed with preceptor URGENTLY.***
Adherence to institutional policies, including confidentiality.
Understands the role of the nurse-midwife and/or WHNP in independent management, collaboration, and referral.
Work with individuals in other professions to maintain a climate of mutual respect, shared values and accountability.
Attitude Toward Patients
Demonstrate the promotion of compassionate client- and family-centered care.
Empowerment of clients/patients as partners in health care.
Advocacy for informed choice, shared decision-making, and the right to self-determination.
Integration of cultural humility with responsiveness to the patient's individual needs.
Employs self-awareness regarding the ways in which their identities and unconscious biases impact interactions with patients and/or staff.
Applies frameworks of ethics, human rights, structural competency and cultural humility in the equitable care of all people, but especially disenfranchised populations.

Expectations of Students in Clinical Settings

Please find expectations specific to the antepartum, GYN, and Centering settings in the appendices at the end of this document.

The student functioning in a clinical site will:

a) **Read and adhere to guidelines outlined in the course syllabi for each clinical course.**

b) **Be responsible for their own learning** by:

i. Defining current learning needs and clinical objectives clearly.
ii. Discussing learning needs and goals with clinical preceptors at the beginning of each session.
iii. Preparing for each clinical assignment by reading relevant materials, reviewing prior experiences, and identifying goals for learning and practicing clinical skills.
iv. Maintain up-to-date clinical resources, such as a "peripheral brain," that are readily available at all times in the clinical setting.
v. Seeking direction from clinical preceptors in choosing appropriate clinical experiences to meet the objectives identified for the clinical course and current session. The student's clinical experience is best guided when what is chosen reflects the student's ability, the clinical objectives of the course, and the learning needs identified by the student and faculty.

vi. Realistically evaluating their own progress daily, according to the nurse-midwifery management process and stated course objectives, seeking input from clinical preceptors.

c) **Consistently remain in communication with clinical preceptor regarding patient management decisions**. The student is supervised at all times, although this does not always imply physical presence. The student is responsible to communicate all patient management plans wit the preceptor, who remains primarily responsible for the care provided by the student. It is understood that the preceptor has ultimate accountability for student activities and that the preceptor will screen all clinical experiences for the student.

d) **Be responsible for arranging their own transportation to and from clinical sites**. It is a reasonable expectation that the student travel to clinical sites not accessible by public transportation.

e) Per federal regulations, **comply with the Health Insurance Portability and Accountability Act** (HIPAA) to protect the privacy of patients and maintain confidentiality about their health care. See Appendix on Patient Confidentiality.

f) In addition to the HIPAA guidelines, **comply with institution-specific regulations and policies regarding patient privacy and confidentiality**. Students are required to be vigilant in protecting of the rights of our patients, and the maintenance of the privacy of all communications among all members of the health care team.

g) **Utilize interpreter services when indicated**. Effective clinical care requires bidirectional patient communication. This includes the ability to engage the patient, elicit concerns and questions, explain risks and benefits, obtain informed consent, and negotiate treatment. UCSF and ZSFGH require the use of trained medical interpreters in all clinical encounters with patients with limited English proficiency. Trained medical interpreters are available in all inpatient and ambulatory settings; depending on the setting, interpreters are available in person, via telephone, or via videoconferencing medical interpreting stations. Students wishing to speak a non-English language with patients are required to be ALTA Certified Bilingual Clinicians or ALTA (Academic Language Therapy Association) certified. Certified Bilingual Clinicians may use their tested non-English language skills in their direct communication with patients. Certified Bilingual Clinicians are not trained interpreters and may not provide third-party medical interpretation. More details about this option is available upon request.

h) **In Case of Needle-stick or Other Exposure to Blood-Borne Pathogens**:

Practice universal infection prevention precautions always. In the event of a needle-stick, blood borne pathogen-related laceration, splash, or other exposure, notify your clinical preceptor immediately and follow site-specific exposure guidelines. Testing may be available at the clinical site. Students are also advised to call the UCSF Needlestick Hotline 24-hour pager immediately at 415-353-STIC (7842) and notify the course FOR. See the Student Health website for more detailed information, *https://studenthealth.ucsf.edu/needlestick-injuries*

i) **Maintain up-to-date Castle Branch profile**, including, but not limited to: immunization records, criminal background check, drug screening (as required by clinical site), TB status, current letter of health, proof of health insurance, RN license, CPR and NRP certifications. The School of Nursing issues each student's Castle Branch profile. Delinquencies may delay or prohibit the student from participating in the clinical experience.

Expectations of Preceptors in Clinical Settings

The expectations of preceptors in clinical settings include:

1) Demonstration of current knowledge and clinical competency.
2) Model patient-centered, respectful care that is free from bias and discrimination.
3) Provide a supportive learning environment:
    a) Incorporates the student into the health care team and makes the student feel welcome.
    b) Plans learning experiences (e.g., patient selection) and goals with the student to facilitate achieving individual needs and overall course objectives.
    c) Facilitates independent student decision-making.
4) Approachable and accessible: Is readily available to the student for consultation as needed.
5) Provide feedback
    a) Provide formal and informal feedback in a clear and timely manner.
    b) Identify and builds on the student's strengths.
    c) Identify the student's areas for growth and suggest strategies for improvement.
    d) Encourage the student to overcome challenges and make progress in growing into the provider role; invest in the student's success.
6) Seek to improve precepting skills, actively solicits and incorporates student feedback about effective precepting style.
7) Employ self-awareness regarding how their identities and unconscious biases impact interactions with students and/or patients.
8) Address the impact of racism and/or other structural oppression in health care. (see Appendix J Structural Vulnerability Assessment Tool and Appendix K on Allyship in Action).
9) Treats the students, patients, and staff with respect.
10) Report progress and problems to the FOR promptly to ensure that a Collaborative Academic Success Plan can be implemented at least two weeks before the end of the rotation, if necessary.

Collaborative Academic Success Plans

Collaborative Academic Success Plans (CASP) are the mechanism by which students are supported to meet specific course and/or program objectives if they have not met criteria for satisfactory academic progress or otherwise have not yet demonstrated specialty content mastery. A CASP may be developed related to specific didactic or clinical course content to address progress and trends in content mastery in the specialty program.

If a student is not projected to meet the course or program objectives within the specified course timeframe or within the expectations set forth for demonstrating content mastery, the student will be counseled by the FOR or Program Director, and a Collaborative Academic Success Plan (CASP) will be developed. The purpose of the written CASP is to assist the student's learning process by clarifying specific areas needing improvement, providing meaningful ways to support the student, developing strategies for improvement with the student, and detailing measurable outcomes that denote successful mastery of objectives.

CASP documentation facilitates clear communication of expectations, agreed-upon strategies to meet goals, and a timeline. A CASP is developed collaboratively between students, faculty, and/or the Director. The student is key in the development of the CASP, and their input will be actively solicited and contribute significantly to the content. The FOR shares all CASPs with the student's academic advisor and the Program Director. The Program Director will notify the FHCN Department Vice Chair, who monitors departmental student academic progress.

The Program is dedicated to helping students achieve course and program objectives. We believe success relies on clear communication and appropriate support in a high-demand environment.

CASP documentation will be maintained in the SEDS (Shred Education Data System), where student files are securely stored.

Technical Resources

The following resources are available to UCSF students for technical support.

CLE Question/Report Problem

1. UCSF Learning Technology Support (https://learningtech.library.ucsf.edu/)
   - Email: LearningTech@ucsf.edu
   - Phone: (415) 476-9426
   - Hours: Monday-Friday 8:30am-5:00pm (PT)
2. CLE Tech Website (

MyAccess, UCSF Email, Zoom, VPN, Duo Authentication

1. Student IT Support (https://www.library.ucsf.edu/technology/contact/)
   - Email: librarytechcommons@ucsf.edu
   - Phone: (415) 476-4309
   - Hours: Monday-Friday 8:00am-6:00pm (PT)
2. UCSF IT Service Desk (https://it.ucsf.edu/about/teams/ucsf-it-service-desk)
   - Email: itservicedesk@ucsf.edu
   - Phone: (415) 514-4100
   - Hours: 24/7

UCSF Library

- Journal articles off-campus access (https://www.library.ucsf.edu/use/access/)
- Citation management tools (https://guides.ucsf.edu/referencemanagers)
- Literature search help (https://guides.ucsf.edu/nursing)

UCSF and School of Nursing Policies

- UCSF SON Policy on Academic Misconduct
- UCSF SON Statement on Diversity, Equity and Inclusion
- UCSF SON Policy on Learning Environment and Curricular Inclusivity
- UCSF Technology Requirements for Students Policy

UCSF SON Disability Services Policy

UCSF is committed to providing equal access to students with documented disabilities and conditions that create functional limitations to daily activities. To ensure your access to this course and to the program, students with disabilities may contact Student Disability Services (SDS). There you can engage in a confidential conversation about the process for requesting reasonable accommodations in the classroom and clinical settings. Accommodations are not provided retroactively. Students are encouraged to register with SDS as soon as they begin the program. More information can be found online at sds.ucsf.edu or by contacting SDS at 415- 502-6595, *StudentDisability@ucsf.edu*.

Appendices

Appendix A. Clinical Goal Setting Form

CLINICAL GOAL SETTING FORM: AP GYN IP (circle those applicable)

Student: _____ Quarter_____ Year _____ Bring to each clinical session

Post clinical discussion should include both student and preceptor self-assessment, inviting feedback from each other on strengths and areas for improvement as well as goal setting based on reflection of today's session and previous goals. *(consider knowledge, skills, and professional relationships when developing goals and what both would like to keep, stop, start to reach those goals).*

Session 1	**STUDENT GOALS FOR NEXT SESSION: Date_____** *(e.g. keep, stop, start to reach goals) 1.* *2.* *3.*	**PRECEPTOR GOALS FOR NEXT SESSION: preceptor initials_____** *e.g. keep, stop, start* *(what preceptor can do to help SNM reach their goals) 1.* *2.* *3.*
Session 2	**STUDENT GOALS FOR NEXT SESSION: Date_____** *(e.g. keep, stop, start) 1.* *2.* *3.*	**PRECEPTOR GOALS FOR NEXT SESSION: preceptor initials _____** *(what preceptor can do to help SNM reach their goals) 1.* *2.* *3.*
Session 3	**STUDENT GOALS FOR NEXT SESSION: Date_____** *(e.g. keep, stop, start) 1.* *2.* *3.*	**PRECEPTOR GOALS FOR NEXT SESSION: preceptor initials _____** *(what preceptor can do to help SNM reach their goals) 1.* *2.* *3.*
Session 4	**STUDENT GOALS FOR NEXT SESSION: Date_____** *(e.g. keep, stop, start) 1.* *2.* *3.*	**PRECEPTOR GOALS FOR NEXT SESSION: preceptor initials _____** *(what preceptor can do to help SNM reach their goals) 1.* *2.* *3.*

Appendix B. N414.15A Formative Evaluation

UCSF Nurse-Midwifery/WHNP: Formative Clinical Evaluation Tool- Ambulatory

The formative clinical evaluation is used to provide feedback on student progress in meeting course expectations and specific clinical competencies.
Instructions: Please use this evaluation to communicate with the faculty and the students about their performance in the clinical rotation. Please provide enough narrative detail to provide a picture of how the student is progressing. For the Likert scale, please select the rating in accordance with the level of guidance a student requires to perform the skill or competency.

- **What are the greatest strengths that the student brings to the clinical setting? (INSERT free text box)**
- **How could the student strengthen their clinical performance? (INSERT free text box)**
- **Is the student meeting expectations: yes, not yet, I'm not sure (select one)**
- **Please provide comments on areas where the student is exceeding expectations and/or needs additional focus. (INSERT free text box)**

Clinical Objective	Rating in each category (use scale below for Likert)	Elaboration/ Comments
A. Data Base Collection- Gathers necessary information in a safe, accurate, complete manner to form an appropriate assessment in any setting. This also includes the ability to identify changing information as it occurs in a dynamic clinical experience.		
B. Assessment- Comes to an accurate diagnosis or conclusion based on data collected. Able to form reasonable differential diagnosis based on evidence-based practice and understanding of structural determinants of health.		
C. Management Plan- Develops a plan of action which is safe, individualized, comprehensive, and based on evidence-based practice. Can present plan with rationale.		
D. Implementation of Plan- Carries out plan correctly, safely, sensitively, & clearly. This includes specific skill accomplishments as well as coordination, preparation, & organization in carrying out plans. This also includes implementation of psychosocial skills and equitable care such as client support, cultural humility, shared decision making, and individual client requests or desires.		
E. Evaluation of Management- Evaluates plan to determine effectiveness. Able to adjust & and change assessment & management based on accurate evaluation of the response to intervention. Individualizes patient response & demonstrates flexibility regarding outcomes.		
F. Communication- Demonstrates appropriate communication with clients, preceptor, and others. Builds rapport with patients using skills of engagement, active listening and reflection (Relationship Centered Communication). Case presentation organized pertinent and thorough. Documentation is clear & complete. Uses appropriate medical terminology.		
G. Professionalism - Maintains integrity with faculty, patients and staff**.** Employs self- awareness regarding the ways in which their identities and unconscious biases impact interactions with patients and/or staff. Demonstrates appropriate initiative. Arrives to clinic on time; dressed appropriately. Accepts responsibility for own continued learning. Is able to give and receive feedback.		

Rotation-specific competencies	**Rating in each category (use scale below for Likert)**	**Elaboration/Comments**
• Orders and interprets routine laboratory test results.		
• Provides accurate, appropriate counseling using shared decision-making related to family planning methods and supplies		
• Safely performs insertion of IUD and contraceptive implant		
• Manages side effects of family planning methods		
• Evaluates for variations from normal; initiates care or referrals and/or provides relevant education for prevention and for early identification of complications:		
○ Abnormal uterine bleeding		
○ Cervical cancer screening		
○ Pelvic pain		
○ STIs and vaginitis		
○ Vulvovaginal symptoms		
• Accurately determines estimated date of delivery		
• Accurately performs assessment of fetal growth and fetal heart rate		
• Determines rupture of membranes (term/preterm)		
• Requests and accurately interprets routine lab and diagnostic testing		
• Identifies and provides counseling related to common discomforts of pregnancy		
• Identifies needs, provides appropriate counseling and referral for social issues impacting health		
• Identification of variations from normal pregnancy; independent or collaborative management of:		
○ anemia		
○ inadequate or excessive uterine growth		

○ gestational diabetes		
○ vaginal bleeding		
○ Preterm labor		
○ prolonged and post-term pregnancy		
○ abnormal lie		
○ s/sx indicating onset of hypertensive disorders, including pre-eclampsia		
• Safe prescribing ofmedications		
• Consults and/or transfers care for high-risk patients to physician as appropriate		

Rating Scale

NA	Not observed
0	Critical Deficiency (unsafe practice): the student demonstrates critical deficiencies in knowledge, skill, and attitude to safely perform the role function.
1	Basic (direct guidance): Student performs the task under direct guidance of the preceptor (for >75% ofskill/time).
2	Novice (extensive guidance): Student performs the task under extensive guidance of the preceptor (for 50-75% of skill/time).
3	Intermediate (frequent guidance): Student performs the task under frequent guidance of the preceptor (for 25-50% of skill/time).
4	Advanced Beginner (occasional guidance): Student performs the task under occasional guidance of the preceptor (for <25% of skill/time).
5	Independent (level of safe beginning provider): Student performs the task safely and effectively using own judgment without supporting cues.

Expectations should be contextualized by student's clinical exposure.

Expectations:

IP Q1 Novice-Intermediate
IP Q2 Intermediate- Adv Beginner
IP Q3 Adv Beginner-Competent

AMB Q1 Basic-Novice
AMB Q2 Novice-Intermediate
AMB Q3 Intermediate- Adv Beginner
AMB Q4 Intermediate- Adv Beginner
AMB Q5 Adv Beginner-Competent

Appendix C. Evaluation of Preceptor

Midwifery/WHNP: Student Evaluation of Preceptor

Instructions:

Thank you for completing this evaluation of your clinical preceptor. We encourage students to complete one evaluation per quarter for every preceptor that you work with.

The clinical course FOR reviews evaluations quarterly and the student names is visible to them on the evaluation. FORs may follow up with students based on evaluation feedback.

Evaluations will only be shared with the preceptor in an aggregated format, when three or more evaluations are available. Student names are not tied to the aggregated data.

1. Number of clinical sessions with this preceptor (dropdown)
2. When you first began shifts at this site with this clinical preceptor, did this clinical preceptor offer a complete orientation? y/n or n/a
3. What did you appreciate most about working with this preceptor? (free text)

	N/A	1-rarely or never	2-sometimes	3-most of the time	4-consistently
4. Demonstrates current knowledge and clinical competency.					
5. Models patient-centered care.					
6. Provides supportive learning environment: Incorporates the student into the health care team and makes the student feel welcome.					
7. Provides supportive learning environment: Plans learning experiences (e.g. patient selection) and goals with the student to facilitate achieving individual needs and overall course objectives.					
8. Provides supportive learning environment: Facilitates independent student decision making.					
9. Approachability and accessibility: Is readily available to the student for consultation as needed.					
10. Provides feedback: Provides formal and informal feedback in a clear and timely manner.					
11. Provides feedback: Identifies and builds on the student's strengths.					
12. Provides feedback: Identifies the student's areas for growth and suggests strategies for improvement.					
13. Provides feedback: Encourages the student to overcome challenges and make progress in growing into the provider role; invested in the student's success.					
14. Seeks to improve precepting skills: actively solicits and incorporates student feedback about effective precepting style.					
15. Employs self-awareness regarding the ways in which their identities and unconscious biases impact interactions with students and/or patients.					
16. Addresses the impact of racism and/or other structural oppression in health care.					
17. I was treated with respect by this individual.					
18. I observed others being treated with respect by this individual (patients, staff).					

19. Additional comments (required if score #1 or #2 above) [Free text]

Appendix D. Evaluation of Clinical Site

Midwifery/WHNP: Student Evaluation of Preceptor

Instructions:
Thank you for completing this evaluation of your clinical preceptor. We encourage students to complete one evaluation per quarter for every preceptor that you work with.

The clinical course FOR reviews evaluations quarterly and the student names is visible to them on the evaluation. FORs may follow up with students based on evaluation feedback.

Evaluations will only be shared with the preceptor in an aggregated format, when three or more evaluations are available. Student names are not tied to the aggregated data.

1. Number of clinical sessions with this preceptor (dropdown)
2. When you first began shifts at this site with this clinical preceptor, did this clinical preceptor offer a complete orientation? y/n or n/a
3. What did you appreciate most about working with this preceptor? (free text)

	N/A	1-rarely or never	2-sometimes	3-most of the time	4-consistently
4. Demonstrates current knowledge and clinical competency.					
5. Models patient-centered care.					
6. Provides supportive learning environment: Incorporates the student into the health care team and makes the student feel welcome.					
7. Provides supportive learning environment: Plans learning experiences (e.g. patient selection) and goals with the student to facilitate achieving individual needs and overall course objectives.					
8. Provides supportive learning environment: Facilitates independent student decision making.					
9. Approachability and accessibility: Is readily available to the student for consultation as needed.					
10. Provides feedback: Provides formal and informal feedback in a clear and timely manner.					
11. Provides feedback: Identifies and builds on the student's strengths.					

12. Provides feedback: Identifies the student's areas for growth and suggests strategies for improvement.					
13. Provides feedback: Encourages the student to overcome challenges and make progress in growing into the provider role; invested in the student's success.					
14. Seeks to improve precepting skills: actively solicits and incorporates student feedback about effective precepting style.					
15. Employs self-awareness regarding the ways in which their identities and unconscious biases impact interactions with students and/or patients.					
16. Addresses the impact of racism and/or other structural oppression in health care.					
17. I was treated with respect by this individual.					
18. I observed others being treated with respect by this individual (patients, staff).					

19. Additional comments (required if score #1 or #2 above) [Free text]

Appendix E. Centering Pregnancy Objectives, Expectations and Feedback

Centering Pregnancy Objectives:

1. Apply knowledge of antepartum theory to clinical care of pregnant people including data collection,
2. assessment, management and evaluation.
3. Facilitate discussion of prenatal topics in the group setting.
4. Participates fully as a member of the group
5. Participates in Facilitation of Centering Topics by session 3
6. Uses facilitative model as opposed to didactic model in group sessions
7. Mange normal antepartum presentations as well as antepartum complications per AP objectives.
8. Prescribe medications commonly used in the antepartum setting.
9. Utilize concepts of shared decision making and patient centered care in clinical practice.
10. Communicate in both written and verbal forms with an interdisciplinary health care team.
11. Evaluate the effectiveness of plans of care and formulate and implement alternative plans when needed.
12. Demonstrate professional accountability

Student Expectations for Centering Pregnancy

1. The student should contact the preceptor at least 2 weeks before the group begins to set up a time
2. and place for meeting for the first session.
3. Students will review all of the centering materials before group begins.
4. The student should come to group about 1 to 1.5 hours early to prep charts and discuss the group with
5. the preceptor
    a. This may need to be modified (as always some may need more or less time) and certain groups need more prep time related to anticipated lab results etc.
6. Students are expected to participate fully as a member of the group
7. Students should be doing about one-third of the mat visits (belly checks) by the mid-point and around half of the mat visits by the end of the rotation.
8. Students will use the format of each site to record, RN & CNM follow-up, mat issues etc (your
9. preceptor will orient you to this).
10. Facilitation: Students may begin facilitating topics as early as group 2, but the expectation is that
11. they will not be ready until maybe group 3.
12. The student should receive a list of topics from their preceptor.
13. At the end of each centering session the CNM & SNM will discuss the topics (including openings and closings) for the following session and decide what topics the SNM will facilitate.
14. Students may wish to review the topic that they will facilitate with the preceptor before group to boost their confidence and ask for tips.

Evaluation/Feedback for Centering Pregnancy

1. Feedback should be given at the end of each group
2. Bring your Goal sheet to each group to set plans and goals for the following group and review your previous goals and your preceptors' goals for you

InPlace Logs for Centering Pregnancy

1. Log each patient individually in InPlace: the only difference is that for each visit you note that it was a group appointment.
2. Do not log the entire group as a single visit
3. Log patients who you saw on the mat or you had a significant discussion with the preceptor about the plan of care.

Appendix F. Prenatal Care Management Clinical Expectations/Objectives for students:

I. Obtains all necessary data for complete evaluation of the patient.

A. Reviews previous data when available.

B. Interviews patient appropriately obtaining complete and relevant historical information.
1. Elicits information for data base at initial visit.
a. Identifies purpose of visit
b. Family history

c. Medical-surgical history
d. Obstetrical/gynecological history (including menstrual, sexual, contraceptive)
e. Presence of symptoms of pregnancy prn
f. Present obstetrical course
g. Social history, including substance use, relationship/support, stressors
h. Nutrition

2. Obtains complete and relevant information on return prenatal visits.
a. Common discomforts of pregnancy
b. Warning signs-bleeding, cramping, fever, h/a, visual disturbances, decrease fetal movement, frequency, urgency, dysuria, vaginal discharge.
c. Progress and status of pregnancy
d. Emotional well-being
e. Impact of pregnancy on family/significant others
f. Nutrition/diet history

3. Assesses psychosocial, emotional needs and coping abilities.
a. Observes for verbal and non-verbal clues to anxieties and fears.
b. Elicits the patient's concerns regarding their pregnancy and upcoming birth process.
c. Assesses patient's and significant other's level of understanding of pregnancy and upcoming birth.
d. Observes patient's ability to respond to support persons.
e. Assesses use and need for community resources and referrals
e. Elicits pregnant person and significant other's feelings about sexuality

4. Obtains information about structural and cultural factors influencing patient's health considering the structural vulnerability assessment tool, Appendix F.

C. Performs review of systems and appropriate physical examination.
1. Performs physical examination systematically, completely, accurately, and with minimal physical and emotional discomfort initially and as appropriate.
2. Explains procedures appropriately in language patient can understand.
3. Routinely checks:
a. blood pressure
b. Weight status
d. Edema (pretibial, facial, pedal, digital)

4. Performs abdominal exam at each visit, noting when indicated appropriate to gestational age:
a. Size, shape, contour and presence of abdominal scars.
b. fundal height
c. Fetal heart tones
d. Fetal presentation, position, and lie using Leopold's maneuvers.
e. Estimated fetal weight
f. Contractions, abdominal tenderness, over-distension.

5. Performs pelvic exam at initial visit and when indicated, noting:
6. Performs the following procedures correctly and uses instruments appropriately:
a. Abdominal exam - Leopold's Maneuvers
b. Pelvimetry-if indicated
c. Vaginal speculum exam
d. Bimanual exam
e. Sterile speculum exam for nitrazine, ferning
f. Pap smear
g. GC/CT, GBS testing

h. Herpes culture
i. Wet mount/Microscopy
j. FHT's with Doppler and fetoscope (if available)
k. Limited OB ultrasound with direct supervision of preceptor after completion of ultrasound module.

D. Obtains and evaluates appropriate laboratory data
1. Reviews charts for previous lab data.

2. Obtains and evaluates routine initial prenatal laboratory tests.
3. Obtains and evaluates additional lab data according to clinical setting protocol and patient history.
    a. Utilizes appropriate technique
    b. Explains procedures and reasons for tests to patient
    c. Completes requisitions appropriately
4. Obtains or orders additional diagnostic tests as indicated for anemia, UTI, STIs, diabetes, thyroid disorders, size dates discrepancy, etc.

E. Organizes data for assessment and completes data base.
1. Clusters data appropriately.
2. Recognizes deviations from normal.
3. Identifies missing information.
4. Obtains additional data as necessary

II. Makes an accurate assessment re: the normalcy of findings identifying actual or potential problems and level of risk, based on correct interpretation of the data.
A. Identifies tentative diagnosis.
B. Interprets significant data from history, vital signs, physical exams and laboratory/diagnostic studies to identify complete problem list including:
1. Amniotic fluid disorders
2. Disorders of genital tract
3. Previous uterine surgery
4. Antepartal bleeding
5. Cardiopulmonary disorders
6. Endocrine disorders.
7. Fetal growth, size-dates discrepancies, position and pregnancy risk:
    a. Incompetent cervix
    b. Premature labor
    c. Post-term pregnancy
    d. Intrauterine growth retardation
    e. Macrosomia
    f. Fetal demise
    g. Multiple gestation
    h. Breech
8. Hematologic disorders
9. Hypertensive disorders
10. Urinary tract infections
11. Vaginitis
12. Exposure to or use of teratogenic substances
13. Other adverse medical/pyschosocial conditions which may affect outcome of pregnancy or the parturient/fetal well-being.
14. Psychosocial or substance use/abuse concerns

C. Corroborates complete problem list with patient.
1. Adapts approach to patient.
2. Communicates information in a manner patient can understand.

III. Assumes the appropriate management role in the planning and provision of care.
A. Collaborates with other health team member's prn.
B. Co-manages or transfer care as appropriate.

IV. Develops a comprehensive plan of management.
- A. Identifies patient and family learning needs
- B. Identifies patients and/or babies at risk
  1. Confirms anticipated problems and identification of "at risk" patients and/or babies with instructor or physician an appropriate.
  2. Identifies the possible effect on outcome of pregnancy for patients with problem.
  3. Identifies possible treatment plans and consequences of each.
  4. Selects most appropriate therapeutic plan based on valid rationale.
- C. Identifies and utilizes appropriate consultation for evaluation and validation of management plan and/or referral.
- D. Uses shared decision making to determine patient preferences for anticipated procedures including informing patient of options, rationale, risks, sequelae, and limitations of therapeutic milieu.
- F. Identifies need for appropriate additional lab or diagnostic tests.
- G. Plans for subsequent assessment at appropriate intervals and determines appropriate time for return visit/consult.
- H. Refers as needed for nutrition, social services, health education, medical consultation or management.
- I. Demonstrates respect for patient's right to make decisions concerning personal health care.

V. Implements/directs management plan.
- A. Records data accurately and concisely, using appropriate medical terminology.
  1. Completes patient record and writes progress notes according to clinical setting protocol.
  2. Includes all clinically relevant material in written record.
  3. Uses appropriate amount of time for charting.
  4. Is organized and concise in verbal reporting.
  5. Completes appropriate lab or radiology requisitions and consulting forms.

VI. Evaluates effectiveness of plan of care.
  1. Follows implementation of plans made by all members of the healthcare team and institutes appropriate mechanism for follow-up with team providers prn.
  2. Reviews outcome of plan with patient.
  3. Formulates and implements alternative plan of care as needed

VII. Demonstrates Professional Accountability.
- A. Dependable, reliable, punctual, trustworthy.
- B. Maintains integrity with preceptors & staff.
- C. Demonstrates accountability for own learning.
- D. Accepts limitations & lack of knowledge.
- E. Evaluates own performance objectively.
- F. Sees self realistically.

VIII. Communication.
- A. Keeps preceptor advised of patient's status.
- B. Maintains written documentation - concise, complete.
- C. Asks for help appropriately.
- D. Establishes effective rapport with patient

Appendix G.

Clinical Management Expectations/Objectives of Students for the patient seeking gynecologic, sexual, and reproductive health care (GSRH):

1. GSRH includes but is not limited to assessment, diagnosis and management or referral of the following conditions:
    a. Sexually transmitted infections, including partner evaluation and treatment or referral
    b. Treatment of condyloma
    c. Urinary tract infections
    d. Reproductive life planning and contraceptive needs
    e. Reproductive cancers screening and detection
    f. Menstrual function (including fertility cycles) and disorders
    g. Infertility
    h. Sexual function and dysfunction
    i. Genetic risks related to GSRH
    j. Preconception counseling and assessment
    k. Unintended pregnancy management, including:
        i. Decisional assessment
        ii. Pregnancy options counseling
        iii. Referral for abortion care, adoption or prenatal services
    l. Pregnancy diagnosis and dating
    m. Miscarriage management
    n. Provision of medication abortion
    o. Medical management of ectopic pregnancy
    p. GSRH care for lesbian, gay, transgender and gender non-conforming persons
    q. Screening, counseling and referral for sexual assault/abuse, intimate partner violence, and reproductive coercion
    r. Sexual assault examination, treatment and counseling
    s. Perimenopause, menopause and post-menopause health care needs
    t. Pelvic floor function/dysfunction and urinary continence disorders
    u. Other disorders of the reproductive system
    v. Vulvar and vaginal conditions
    w. Nutritional needs in regards to GSRH health

2. The student is expected to demonstrate skill in the following processes
Assessment and diagnosis:
    a. Investigate by obtaining all necessary data for the complete evaluation of the patient, including comprehensive or problem-oriented health history and physical exam related to GSRH and non-GSRH health conditions that may impact GSRH, and identify deviations from normal
    b. Screen for health risks, health promotion needs and psycho/social/cultural/genetic/lifestyle factors that may impact health, including but not limited to sexual assault and abuse, intimate partner violence, and reproductive coercion
    c. Identify deviations from normal in the history and physical exam
    d. Order or perform GSRH screening and diagnostic tests based on age and risk factors, including but not limited to screening for sexually transmitted infections and reproductive cancers
    e. Identify problems or diagnoses and health care needs based on correct interpretation of

the subjective and objective data.

f. Interpret screening and diagnostic tests
g. Develop and analyze differential diagnoses on the bases of clinical and laboratory data
h. Diagnose GSRH problems, diagnoses and health care needs based on correct interpretation of the data.
    i. Identify and/or diagnose non-gynecologic, genetic and psychological factors that may impact GSRH
    ii. Anticipate other potential problems or diagnoses that may be expected based on the identified problems or diagnoses.

Management:

a. In partnership with the client develop a plan of care based on assessment findings and diagnoses:
    - Provide anticipatory guidance, health promotion education /counseling
    - Prescribe pharmacologic therapies.
    - Initiate non-pharmacologic therapies including complementary and alternative therapies
    - Guide patients in development of a reproductive life plan.
    - Identify the need for collaboration with other members of the health care team (consultation collaborative management or referral) in meeting identified health needs in regards to GSRH conditions or non-gynecologic conditions that may impact or be impacted by GSRH.
b. Participate in care coordination for clients with complex GSRH needs.
    - Identifies and collaborates with other community agencies in developing this plan and in providing a continuum of care.
c. Assesses health, environmental, cultural, and interpersonal resources of patients and their families.
d. Advocate for informed choice, shared decision making and the right to self determination
e. Assume responsibility for the safe and efficient implementation of a plan of care.
f. Evaluate the effectiveness of the care given recycling appropriately through the management process for any aspect of care that has been ineffective.
g. Provide care to "low-risk" or "moderate-risk" patients safely, equitably, respectfully, accurately, professionally and completely.
h. Communicate effectively in written and verbal forms with an interdisciplinary health care team.

3. Procedures that may be performed by students with the preceptor's direct supervision after they have received didactic instruction in class, skills lab or via module include:
    a. placement of intrauterine devices and contraceptive implants after the student has received a hands-on training in these skills at the School of Nursing.
    b. Endometrial biopsies, endocervical curettage, vulvar biopsy.
    c. Placement of pessaries, and pelvic floor biofeedback.
    d. Cervical cap and diaphragm fitting and instruction
    e. Placement of cervical dilators
    f. Limited OB ultrasound for dating pregnancy

Appendix H: GYN order of report and sample report

GYN Order of Report for use by Midwifery Students

SNM's: Please individualize the report to the needs of your site but do give a formal report on each patient.

This is__*XX*_ pronouns: [_/_] a_____year old G__P__ who is here today for_____.[pronoun] current sexual history is_____
XX has/has not had unprotected intercourse since their last period
XX's contraceptive method is_____
Other problems that are current/relevant to today's visit are: _____
Menstrual history: _____
Significant pregnancy history_____ GYN history: _____
Medical history: _____
Family history (*if significant)*_____
Social History (*habits, lifestyle, work …if significant)*_____

Physical exam and Pelvic exam findings:
Assessment: (a complete current problem list and differential prn)
Plan:
(include diagnostic, therapeutic/treatment, education/teaching, follow-up and any referrals)

Sample GYN Report:

This is a 23-year-old G3P0030 who is here for an annual exam. Pronouns are: she/her
Other problems that are current or relevant to today's visit are:

- Ovarian cyst
- Painful intercourse
- Vaginal irritation

Their **current sexual history** is: one steady partner, no condom use with that partner. Two other partners inpast 3 months, uses condoms with them. Reports painful intercourse for the past two weeks, the pain is external, on the skin, not deep. Also reports an itchy, generalized vaginal irritation for the past week. No use of used any new soaps or perfumed products.

The **birth control method** is:_____. Happy/unhappy with this method/ uses it consistently (or not)
The **menstrual hx i**s WNL. LMP was _____
Pregnancy hx is significant for three TABs in the past three years, most recent 6 mo. ago
GYN history is significant for ovarian cyst diagnosed at SFGH three months ago, no follow-up done
The **medical history** is noncontributory
(ask your preceptor if they want the family history, pregnancy history be routinely included? Whatabout habits and lifestyle?)

The **pelvic exam** is:
(or if you haven't done the exam yet: "I plan to look for____on the pelvic exam, I plan to do a wetmount and take cultures for GC/CT…)
All WNL or
Multiple vesicular lesions
Generalized erythema with thick curdy discharge

My ASSESSMENT IS: (list all problems and/or differential PRN)
- vaginal candidiasis
- ovarian cyst without followup
- multiple TABs, explore desire for effective contraceptive method

My PLAN is:
- Diagnostic: ultrasound
- Therapeutic: OCP start as desired by patient; clotrimazole 1% vaginal gream 1 appl PV WHS x7
- Education: safer sex
- Follow-up/Referrals:

APPENDIX I:

Patient Confidentiality
When printing and using documentation for the purpose of learning the following HIPAA guideline must be followed:

The documented progress notes cannot contain any of the following 18 Identifiers and should not include any identifiers or any information that can later re-identify the patient.

1. Names;
2. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Phone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social Security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;

13. Device identifiers and serial numbers;
14. Web Universal Resource Locators (URLs);
15. Internet Protocol (IP) address numbers;
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code

Privacy and security guidelines can be reviewed at http://hipaa.ucsf.edu/student-training. Violations of patient privacy may be subject to disciplinary action

APPENDIX J

Structural Vulnerability Checklist

From: Bourgois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017). Structural Vulnerability. Academic dicine, 92(3), 299-307.

Domain	Screening questions and assessment probes[b]
Financial security	**Do you have enough money to live comfortably—pay rent, get food, pay utilities/telephone?** • How do you make money? Do you have a hard time doing this work? • Do you run out of money at the end of the month/week? • Do you receive any forms of government assistance? • Are there other ways you make money? • Do you depend on anyone else for income? • Have you ever been unable to pay for medical care or for medicines at the pharmacy?
Residence	**Do you have a safe, stable place to sleep and store your possessions?** • How long have you lived/stayed there? • Is the place where you live/stay clean/private/quiet/protected by a lease?
Risk environments	**Do the places where you spend your time each day feel safe and healthy?** • Are you worried about being injured while working/trying to earn money? • Are you exposed to any toxins or chemicals in your day-to-day environment? • Are you exposed to violence? Are you exposed regularly to drug use and criminal activity? • Are you scared to walk around your neighborhood at night/day? • Have you been attacked/mugged/beaten/chased?
Food access	**Do you have adequate nutrition and access to healthy food?** • What do you eat on most days? • What did you eat yesterday? • What are your favorite foods? • Do you have cooking facilities?
Social network	**Do you have friends, family, or other people who help you when you need it?** • Who are the members of your social network, family and friends? Do you feel this network is helpful or unhelpful to you? In what ways? • Is anyone trying to hurt you? • Do you have a primary care provider/other health professionals?
Legal status	**Do you have any legal problems?** • Are you scared of getting in trouble because of your legal status? • Are you scared the police might find you? • Are you eligible for public services? Do you need help accessing these services? • Have you ever been arrested and/or incarcerated?
Education	**Can you read?** • In what language(s)? What level of education have you reached? • Do you understand the documents and papers you must read and submit to obtain the services and resources you need?
Discrimination	***[Ask the patient]* Have you experienced discrimination?** • Have you experienced discrimination based on your skin color, your accent, or where you are from? • Have you experienced discrimination based on your gender or sexual orientation? • Have you experienced discrimination for any other reason? ***[Ask yourself silently]* May some service providers (including me) find it difficult to work with this patient?** • Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments? • Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care? • Is this patient likely to elicit distrust because of his/her behavior or appearance? • May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?

[a]This tool should be used along with common questions regarding intimate partner violence, alcohol/substance use, diet, and exercise.
[b]The questions in bold function as initial screens that could potentially be quantified. They are followed by assessment probes to elicit more detail and context.

APPENDIX K

UCSF University of California San Francisco

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

Allyship Means Action Tip Sheets

Department of Obstetrics, Gynecology and Reproductive Sciences

Providing Linguistically Appropriate Care

Reference Administrative Policy Number 9.05: Language Access Services.

- **Recognize that linguistically appropriate care is a fundamental component of equitable and safecare, and commit (as individuals and teams) to providing linguistically appropriate care to all patients.**
  - Promote self/team-awareness (and necessary action) about the factors which enhance and reduce capacity to meet this goal.
  - Include patients' language needs as a standard element of team communication.
  - Normalize "speaking up" by all team members as a means of advocating for linguistically and culturally appropriate care.

I'm concerned that the patient may not understand all of what we say (or that we do not understand the patient). Let's call a time-out to partner with an interpreter.

- **Effectively elicit patient's language preferences at the beginning of the encounter.**

Which language do you prefer? Or In which language do you prefer to receive your care?

Not *Do you speak English*? (Note that clarifying language preferences may require partnering with a Qualified Interpreter.)

- **For patients with limited English proficiency, regardless of whether they state English or another language as their preferred language, explicitly state that they are legally entitled tocommunication with the support of Qualified Interpreters.**

- **Collaborate effectively with Qualified Interpreters.**

  The clinician…
  - faces the patient, ideally at eye level.
  - speaks directly to the patient and uses active listening, including nonverbal cues such as eye contact.
  - negotiates a shared agenda with the patient that accounts for the time demands of an interpreted encounter.
  - builds rapport and trust with verbal and nonverbal expressions of empathy.
  - speaks briefly, allowing for the Qualified Interpreter to provide thorough interpretation.
  - provides timely clarification when requested by the Qualified Interpreter or patient.
  - uses teach-back to assess understanding, especially for key elements of the care plan.

- **For patients who decline a Qualified Interpreter (either to engage with a Certified Bilingual Clinician, Designated Bilingual Staff, Non-approved Bilingual Staff, or family member OR utilize English as a second language), explicitly invite ongoing feedback regarding the adequacy of communication.**
    - Consider that power dynamics inherent to the patient provider relationship may necessitate repeated check-ins before a patient feels empowered to request interpreter services.
    - Avoid relying on family members as interpreters, especially when discussing themes that may be heavily influenced by family dynamics or personal values, such as family planning, end of life care, or choosing between treatment options where the evidence does not clearly guide practice.
    - Recognize that partnering with a Qualified Interpreter may be necessary to provide safe care even when it is not the patient's preference.

  We are committed to communicating effectively with you. Throughout the encounter, we want you to understand and also feel understood. If at any time we are not meeting this goal, please let us know immediately.

  I'd like to check in with you about how the encounter is going. What can I do to improve our communication?

  I understand that you prefer to communicate with the help of your family member. At this time, I need for us to work with a Qualified Interpreter so that I can provide you with the best care.

- **Promptly identify "red flags" indicating the need for a Qualified Interpreter.**
  [excerpt from Regenstein M, Andres E, Wynia MK. Appropriate Use of Non-English Language Skills in Clinical Care.
  JAMA. 2013;309(2);145-146]

    - **Word finding**
      The clinician cannot think of a good word to describe a concept.
    - **Rephrasing**
      The patient displays lack of understanding during a teach-back communication, and the clinician cannot rephrase the concept or instruction in a different way.
    - **Emotional disconnect**
      The patient displays an emotional response that does not seem to match the content of the conversation.
    - **Patient editing**
      The patient needs to edit what she or he says or speak noticeably more slowly than normal. This may require exploration on the clinician's part to elicit.
    - **Novel topic or issue**
      The encounter turns to a subject that is unusual, novel, or something the clinician does not usually handle.
    - **Confusing answer**
      The patient's description or answer to a question does not make sense and requires

repeated clarification.

- **Confusing question**
  The patient asks a question that is confusing or seems to be out of context.

- Other potential red flags of a current or prior communication barrier:
  - The patient has no questions.
  - The patient chooses to speak English with English speakers and another languagewith staff fluent or proficient in that language.
  - Documentation about the patient's history is not consistent with current historyor the patient does not recognize elements of the history being reviewed.
  - The patient describes a previous clinical encounter very differently from how it isdocumented in the patient's chart.
  - The patient has numerous questions about a conversation had with a previous teammember.
  - The patient defers to a family member to ask and answer most of the questions,allowing that this may be culturally appropriate in some cases.

The encounter does not pass the "English-speaker equivalency test": *Would my counseling/education/treatment options have been the same (within culturallyappropriate norms) were this patient an English speaker*