**Clinic Logo Here**

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| [***YOUR CLINIC NAME HERE], a department of Hospital Name Here (if PBRHC)*** |
| Provider Based Rural Health Clinic |
| POLICY AND PROCEDURE MANUAL |
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| *Created: Month/Year*  *Updated: Month/Year* |

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# INTRODUCTION

This policy manual is specific to the operations of Clinic Name Here, a Provider Based Rural Health Clinic (PBRHC) owned and operated by Hospital Name Here, a Critical Access Hospital.

Your Clinic Name Here Hospital Name Here

Clinic Address Here Hospital Address Here

Town, OR Zip Code Town, OR Zip Code

Phone Phone

The Clinic Manager is responsible for the day-to-day direction and operation of the PBRHC and the Medical Director is responsible for the clinical direction and oversight of the PBRHC.

* Clinic Manager: Your Clinic Managers Name Here
* Medical Director: Your Medical Director Name Here, MD

A sustained and substantial effort is made to keep the PBRHC in full compliance with applicable State and Federal laws and this policy manual is one of the tools that helps ensure compliance of the PBRHC. This policy manual only addresses the items specific to our PBRHC and does not address other areas that are more appropriately addressed in other forms of guidance.

These other resources include:

* Hospital Name Here Policy and Procedures (Human Resources, Infection Control, Safety, etc.)
* Nursing Policy & Procedure Manual
* Business Office Policy & Procedure Manual

If at any time, the guidance in this PBRHC manual is found to conflict with or defer from guidance in some other policy manual, the specific guidance should be brought to the attention of Your Clinic Name Here’s Clinic Manager who will resolve the conflict through appropriate channels based on the specific situation.

This manual will be reviewed on an annual basis by an Annual Evaluation Committee; consisting of the following members:

Clinic Manager, Mid-Level Medical Provider, Medical Director, Business Office Supervisor, A representative from the clinic nursing department and Consultant Name (if applicable), a consultant from Consultant’s Company Name.

# MISSION STATEMENT

It is the intent of the healthcare providers, staff and administration of Hospital Name Here and Your Clinic Name Here to make available and provide exceptional medical care to the citizens of Your County.

As the main entry point for general healthcare services in Your County and as a Provider Based Rural Health Clinic, it is our goal to establish, maintain, and operate suitable facilities to provide quality primary medical care for persons in need.

In addition, we pledge:

* To administer healthcare of the highest quality to all patients, to practice disease prevention and health maintenance.
* To provide comprehensive care by making available a wide range of healthcare services.
* To maintain continuity of care by designing and maintaining a fully functional electronic Health Record and Practice Management System that meets federal meaningful use guidelines.
* To educate patients regarding disease process, the treatment program and appropriate interventions for potential problem situations.
* To allow the Physician(s) and Mid-Level Providers the flexibility to provide primary care to all citizens of Your County and surrounding areas.
* To provide a primary care program that encourages preventative care and health care education to citizens desiring those services, especially for those who have limited access to adequate medical care.
* To continually improve and expand the quality and comprehensiveness of services by placing the practice in the hands of qualified, responsible health care professionals who will work in cooperation with other public and private health resources.
* To develop and maintain medical care outcome standards which reflect the standards of national medical organizations, the laws, rule and regulation of the State of Oregon.
* To maintain an organization that can support quality medical care through the recruiting and retention of excellent medical care personnel.
* To continually improve quality and develop interventions to maintain and upgrade the quality of patient care.

# PATIENT NON DISCRIMINATION AND ADA POLICY

The services provided by the Your Clinic Name Here or any other operations it might in the future support, are available to all persons desiring those services regardless of race, color, national origin, religion, age, physical or mental handicap.

The following policies:

Non-Discrimination and Grievance Policy

ADA Policy for Hospital Name Here

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| --- | --- |
| Hospital Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Non-Discrimination and Grievance Procedure** | Origination Date: XXXXX |
| Department: Hospital Wide | Reviewed: XXXXX |

**Scope:** All visitors, customers, patients and employees of Hospital Name Here.

**Purpose:** To outline Hospital Name Here’s policy prohibiting discrimination of any kind, and to establish an internal grievance procedure to promptly investigate and resolve any allegations of discrimination.

**Policy Statement(s):** As a recipient of Federal financial assistance, Hospital Name Here does not exclude, deny benefits to, or otherwise discriminate against any person on the grounds of race, color, national origin, disability or age in the admission to, participation in, or receipt of the services and benefits of any of its programs and activities or in employment therein, whether carried out by Hospital Name Here directly or through a contractor or any other entity with whom Hospital Name Here arranges to carry out its programs and activities. Furthermore, Hospital Name Here has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging (1) violation of patient’s rights or (2) discrimination on the basis of handicap as prohibited by Section 504 of the Rehabilitation Act of 1973.

**Procedure(s):**

A. The foregoing policy statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975 and Regulations of the U.S. Department of Health and Human Services issued pursuant to the Acts, Title 45 Code of Federal Regulations, Parts 80, 84 and 91.

B. If there are questions concerning this policy or in the event of a desire to file a complaint alleging violations of this policy, please contact either Hospital Name Here Office of Administration, Enter Phone Number or: Office for Civil Rights, Region X, 2201 Sixth Avenue, Mail Stop RX-11, Seattle, WA. 98121, (206) 615-2290 -voice; (206) 615-2296-TDD

C. Section 504 states that "no otherwise qualified disabled individual ... shall, solely by reason of his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance..." The U.S. Department of Health and Human Services has issued regulations enforcing this law. These regulations may be examined in the Administrative offices of Hospital Name Here. The Hospital Administrator is responsible for coordinating the efforts of Hospital Name Here to comply with Section 504.

D. Grievance Procedure:

1. A grievance should be in writing, identify the complainant and briefly describe the alleged violation or discriminatory action.

2. The grievance should be filed in Administration at Hospital Name Here within a reasonable time after the complainant becomes aware of the alleged event.

3. The complainant may be represented by an attorney or other party.

4. The Administrator, or his designee, shall conduct a prompt and appropriate investigation of the grievance to determine its merits. These procedures contemplate an informal, but thorough investigation, affording all interested persons (or their representatives) an opportunity to submit relevant evidence.

5. The Administrator shall issue a written decision regarding the validity of the grievance no later than thirty (30) days after its filing.

6. Hospital Name Here shall maintain the files and records of the grievance, the investigation and the written decision.

7. The complainant's right to the prompt and equitable resolution of a grievance filed under these procedures shall not prevent the complainant from seeking other remedies, such as filing a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. A complainant does not have to use these procedures before seeking other remedies.

8. These procedures shall be liberally applied to protect the substantial rights of interested persons, to meet appropriate due process standards and to assure hospital compliance with Section 504 and the regulations. U.S. Department of Health and Human Services; Office of Civil Rights; 2201 Sixth Avenue; M/S RX-11, Seattle, WA. 98121, (206) 615-2290-voice, (206) 615-2296-TDD.

**Reference(s):** 12.1.10; 12.1.11

|  |  |
| --- | --- |
| Hospital Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Americans With Disabilities Act (ADA)** | Origination Date: XXXXX |
| Department: Hospital Wide | Reviewed: XXXXX |

**Scope:** All visitors, customers, patients and employees of Hospital Name Here.

**Purpose:**

Establish an organization-wide policy to prevent discrimination against individuals with disabilities in the employment process at the Your County Health District, doing business as Hospital Name Here (the District). The focus of this policy is the requirements under Title I, the employment section of the Americans with Disabilities Act (ADA). The District is a covered employer under the ADA.

**Policy Statement:**

It is the policy of the District to take specific steps to ensure that individuals with disabilities do not experience discrimination in the employment process. Threatening, coercing, intimidating or otherwise interfering with someone’s rights under the ADA is prohibited. The ADA specifically protects from retaliation individuals who oppose any act made unlawful by the ADA. In addition, any employee who makes a charge, testifies, or participates in any investigation covered under the ADA is protected from retaliation, intimidation and harassment.

Additionally, the District shall not deny access to public programs, activities or services to an individual with a covered disability. All supervisors of the District will become familiar with the provisions of the ADA and are expected to adhere to it when making employment decisions.

*Definition of Disability:*

Disability under the ADA is defined as: 1) A physical or mental impairment that substantially limits a major life activity; 2) A record of impairment; or, 3) Being regarded as having a covered impairment. Under this definition, a physical or mental impairment is not a disability unless its severity is to the extent that it substantially limits one or more major life activities, such as walking, seeing, hearing, speaking, working, etc. Also included in the definition is anyone who has a record of or has been misclassified as having a mental or physical impairment, which substantially limits one or more major life activities. The final inclusion under the term disability is those individuals who are regarded as having a covered impairment. This means that the impairment itself may not substantially affect a major life activity; however, if others view the impairment as substantially affecting a major life activity, the person is covered.

The ADA specifically excludes an individual who currently uses illegal drugs from coverage. However, someone who has successfully completed a supervised drug rehabilitation program or has otherwise been rehabilitated and no longer uses illegal drugs may be covered under the ADA.

**Procedures:**

A. Reasonable Accommodation: As an employer, the District has an obligation to make reasonable accommodations. The District will not base an employment decision on an individual’s need for reasonable accommodation. Reasonable accommodation includes such things as making physical modifications to the facilities; providing equipment to assist in the performance of job duties; job restructuring; modifying work schedules; and reassignment to vacant positions. If an applicant or employee discloses a disability and requests accommodation, a dialogue should take place with the applicant/employee to determine what would be an appropriate and reasonable accommodation. The accommodation may not cause an undue hardship on the District. If two or more options for reasonable accommodation are available, it is the District’s right to choose the least expensive option. However, advancement of the person on the job and future needs as the person develops in the position should be taken into consideration when determining what is an appropriate and reasonable accommodation. The accommodations made should not limit an employee’s opportunities for advancement.

B. Employment Related Physical and Psychological Examinations: Under the ADA, any pre-offer physical or psychological examination is prohibited. A job offer can be made on the condition that the applicant pass a physical and/or psychological examination if all entering employees in the same job category are subject to such an examination and/or inquiry regardless of disability. The job offer must first be made and it is essential to clearly state that the offer is contingent on the results of the exam. Under any circumstances, an examination must meet the test of job relatedness and be consistent with business necessity. This would also be the criteria for any post-employment exams.

C. Determination of Essential Job Functions: Determining essential job functions requires an analysis of the position to determine what functions are essential as a matter of business necessity. The supervisor will conduct this analysis under the direction of the Human Resources Department. Essential functions of each position will be determined before any recruitment is opened for a position. Essential job functions will be documented on job descriptions, recruitment matrixes, job announcements, etc.

E. Determination of Physical and Mental Requirements for the Job: Determining the physical and mental requirements of a job requires an analysis of the position to determine the physical and mental requirements of the various job duties and responsibilities. The supervisor will conduct this analysis under the direction of the Human Resources Department. These requirements will be determined before any recruitment is opened for a position. Physical and mental requirements will be documented on the ADA – Physical Activity Requirements (Attachment A) and ADA – Mental Activity Requirements (Attachment B) forms.

F. Pre-Employment Inquiries: The District may inquire as to an applicant’s ability to perform essential job related functions. Further, the District may ask an applicant to describe or demonstrate how, with or without reasonable accommodation, the applicant will be able to perform essential job related functions.

G. Alcohol and Illegal Drug Usage:Current use of an illegal substance is not considered a disability under the ADA. However if someone currently uses illegal drugs and has another covered disability, that person would be covered under the ADA based on the other covered disability. As permitted by the ADA, the District prohibits employees from being under the influence of alcohol or illegal drugs at the work place. A drug or alcohol user will be held to the same qualification standards for employment or job performance and behavior standards as other employees. If an employee’s substandard work performance or behavior is related to alcohol or illegal drug usage, that employee may be disciplined for the work performance and held to the same standards as other employees.

H. Positions Involving Food Handling: The ADA recognizes that persons with certain communicable diseases should not be employed in positions involving food handling. The Secretary of Health and Human Services has the responsibility for maintaining a list of diseases, which are transmitted through the handling of food. The District may refuse to assign or may discontinue assigning an individual with such a disease, to a job, which includes food handling.

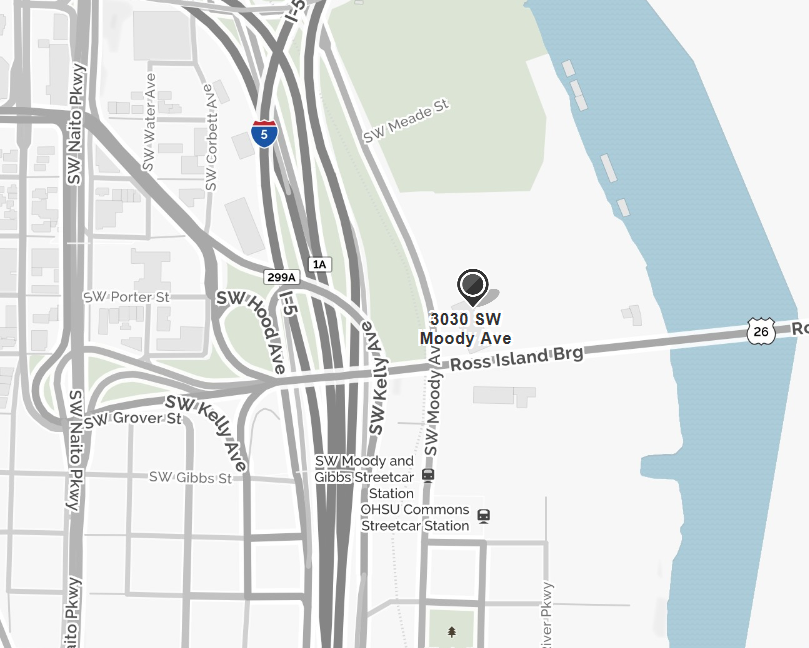
I. Filing, Investigating and Resolving Complaints: The steps for filing, investigating and resolving a complaint under this policy will be the same as found in Hospital Name Here Policy # HR 3.2, Equal Employment Opportunity.

**Reference:**

The Americans with Disabilities Act

Include: any other pertinent /existing policies

# CLINIC LOCATION AND HOURS OF OPERATION

Your Clinic Name Here is located at: Your Physical Address Here, in Your County, Oregon. Place a map showing YOUR location here:

Telephone: Your phone

Fax: Your fax

Website: [www.yourwebsite.com](http://www.yourwebsite.com)

**Your Clinic Name Here Office Hours:**

Monday 8:00 – 5:00

Tuesday 8:00 – 5:00

Wednesday 7:00 – 5:00

Thursday 7:00 – 5:00

Friday 7:00 – 5:00

Saturday 8:00 – 4:30

Sunday Closed

**After Hours:**

In the event of a medical emergency after regular clinic hours, patients seeking either urgent or emergent medical care will be instructed via Your Clinic Name Here’s recorded phone message to contact Hospital Name Here at enter phone number or dial 911. Emergency care is available at Hospital Name Here 365 days per year 24 hours per day.

**Clinic Holidays / Closures:**

Notifications of clinic closures will be posted one week prior to the closure. Your Clinic Name Here is closed if any of the following dates / holidays fall on a day that Your Clinic Name Here would routinely be opened on:

Christmas Eve - December 24th Close at 3:00pm

Christmas – December 25th Full Day

New Year’s Day – January 1st Full Day

Fourth of July – July 4th Full Day

Memorial Day Full Day

Labor Day Full Day

Thanksgiving Full Day

# COMPLIANCE WITH RURAL HEALTH CLINIC GUIDELINES

Consultant Name (if one is used), Consultant with Consultants Business Name will perform an annual evaluation of the program, which will include utilization of clinic services, review of services, policy and procedure review and updates, medical record review of active and inactive patient records and quality review of records.

The purpose of the annual review is to determine whether utilization of services is appropriate, that policies are accurate and followed and to determine if any changes are warranted. Upon completion of the annual review, the findings will be reviewed and appropriate corrective actions, if necessary, will be taken.

Whenever possible the RHC annual evaluation will be performed in conjunction with the annual evaluation committee that will include the Medical Director, a Mid-Level Practitioner, Clinic Manager, Business Office Supervisor, Clinic Nursing Department Representative, and a nonmember of Your Clinic Name Here direct staff. The Annual Evaluation Committee is comprised of the following people:

Medical Director Name Here, MD

Mid-Level Provider Name, PA-C

Your Clinic Managers Name Here, Clinic Manger

Other Annual Evaluation Committee Member Name, LPN, Care Manager

Other Annual Evaluation Committee Member Name, LPN

Consultant Name (if one is used), Consultant Business Name

**Required Documentation (refer to Appendix A for documentation)**

* Letter from the State Department of Health: clinic is eligible for certification.
* Medically Underserved Area and/or Health Professional Shortage Area designation documentation.
* Letter from CMS certifying Your Clinic Name Here as a Provider Based RHC.
* Final Accreditation Letter (from State Surveyor or other accredited organization that performed your site visit).
* The documentation for the underserved status of the area can be obtained by calling or writing:

Primary Care Office: Oregon Health Policy & Research  
1225 Ferry Street SE, 1st Floor  
Salem, OR 97301  
Phone:  (503) 373-1779 |Fax:  (503) 378-5511  
PCO Director: [Marc Overbeck](mailto:marc.overbeck@state.or.us) – (541) 287-0098  
HPSA and NHSC Contact: [Meadow Martell](mailto:meadowm@frontiernet.net) – (541) 287-0098

# STAFF ORGANIZATION AND RESPONSIBILITIES

The following lines of authority have been established:

**Ownership:**

1. Your Clinic Name Here is a department of Hospital Name Here, a Critical Access Hospital.
2. See Organizational Chart(s) located on the following pages.

**Staffing:**

1. Your Clinic Name Here has a health care staff, which includes one or more full-time physician and one or more full-time mid-level providers that are present for at least 50% of the time the clinic is operating. The staff also includes the necessary ancillary personnel that are sufficient at all times to provide the services essential to the operation of the clinic.
2. Refer to Appendix B of this manual for job descriptions for the RHC personnel.

**Medical Director Responsibilities:**

1. Provides medical direction for the clinic health care activities.
2. In conjunction with the physician assistant, participates in developing, executing and periodically reviewing the clinic policies and services provided to Federal program patients.
3. Provides medical care service to the patients of the clinic.
4. The physician is present for sufficient periods of time to provide medical direction, medical care services, consultation and communication for consultation, assistance with medical emergencies, and patient referral. Any extraordinary circumstances are documented in the records of the clinic.
5. Refer to Appendix B for copy of job description for the Medical Director.

**Hospital Name Here Organizational Flow Chart:**

Insert Your Hospitals’ Org Chart Here

**Your Clinic Name Here Organizational Chart**

**Your** County Community

**Your** County Health District Board of Directors

Physicians

Hospital Chief Executive Officer

Physician and

Mid-Level Providers

(Clinical

Direction & Oversight)

Your Clinic Name Here

Director Primary Care

**YOUR Hospital Name** Administration Team

(COO, CNO CFO, HR, Dev. & Recruitment,

Chief of Medical Staff, Director Primary Care)

RHC Medical Director (Clinical Oversight Only)

Mental/Behavioral Health

Mid-Level Providers

Your Clinic Name Here

Clinic Manager

Supervisor Clinical Support

Care Manager

Clinic Medical Office Clerks

Clinic Medical Office Specialists

Clinical Support Department (LPN’s, MA’)

Patient Services

Clinic Patient Financial Services

Administrative Assistant

**Professionally Licensed Employees of Your Clinic Name Here:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Title** | **License**  **Number** | **Expiration**  **Date** |
| Medical Director Name | MD | MDXXXXX | XX/XX/XXXX |
| Additional Physician Name | MD | MDXXXXX | XX/XX/XXXX |
| Mid-Level Provider Name | PA-C | PAXXXXX | XX/XX/XXXX |
| Mid-Level Provider Name | FNP | FNPXXXXX | XX/XX/XXXX |
| RN Name | RN | RNXXXXX | XX/XX/XXXX |
| LPN Name | LPN | LPNXXXX | XX/XX/XXXX |
| CNA Name | CNA | CNAXXXX | XX/XX/XXXX |
| CMA Name | CMA | CMAXXXX | XX/XX/XXXX |
| LCSW Name | LCSW | LCSWXXX | XX/XX/XXXX |
|  |  |  |  |
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The following documentation for each of the above physicians and mid-level providers is located behind the Professional Licensure Tab located in the providers credentialing file located in the business office of Your Clinic Name Here:

* State License
* Diploma
* Curriculum Vitae
* Drug Enforcement Authority Prescriptive Permit
* Certificate of Liability Insurance
* Hospital Privilege Documentation (if applicable)
* Certifications

Copies of CPR Certifications, continuing education certificates and if applicable, Licensure status (for MA’s and LPN’s) are located in the clinic staff personnel files.

# SERVICES

Your Clinic Name Here provides outpatient medical services to patients of all ages, including obstetric care to expectant mothers. The services that are provided by Your Clinic Name Here include, but are not limited to the following:

**Basic Scope of Service:**

* Acute Care
* Geriatric Care
* Preventative (Women’s Health, Men’s Health and Well Child Care)
* Obstetrics
* Chronic Disease Management and Education
* Illness Prevention and Education
* Immunization (Adult and Childhood)
* Minor Procedures (circumcision, vasectomy, removals, minor wound repair)
* Tele-Psychiatry Services
* Integrated Behavioral Health Services

**Diagnostic laboratory procedures, including:**

* Urinalysis, by dipstick
* Hematocrit
* Blood sugar
* Examination of stool specimens for occult blood
* Pregnancy testing (urine)
* Primary culturing for transmittal to reference lab
* Group A strep - Rapid Test
* Pro-time / INR

The basic scope of services includes those diagnostic and therapeutic services and supplies that are commonly furnished in a medical practice or at the entry point into the health care delivery system. This is accomplished by the following direct services:

* Prevention of illness and promotion of health through obtaining medical history, physical exams, assessing health status, treatment of various medical conditions, providing annual check-ups, well child care and patient education.
* Diagnosis of problems presented at the medical clinic by taking health histories, doing appropriate physical exams, lab tests, pap smears, pregnancy tests and other diagnostic testing and procedures.
* Treatment of immediate problems and chronic illnesses with drug prescriptions, injections, and other procedures as medically necessary.
* Acute care for minor injuries or illnesses.
* Counseling regarding questions or concerns that patients may have about their physical and / or mental health.
* Referral of patients to medical specialists, testing (imaging, etc.) public and private health and social services agencies.
* Referral and follow-up treatment to patients who require hospitalization, emergency room care, assisted living or home health care.
* Specimens requiring testing not available at Your Clinic Name Here are referred to one of the following laboratories:

Pathology Services: LabCorp, Inc. (Example)

John Doe, MD (Derma Pathologist)

All Other: Hospital Name Here Laboratory

# PRESENCE OF A MEDICAL PROVIDER DURING RHC HOURS OF OPERATION

**Scope:**

A medical provider shall be on the premises at all times that the RHC is open to the public.

**Purpose:**

Patient care shall be provided so long as there is a health care provider physically on the premises to ensure patient safety.

**Policy Statement:**

It is the policy of Your Clinic Name Here to have a medical provider on the clinic premises at all times that the RHC is open to the public.

The hours of operation of the RHC are as follows:

Monday 8:00 – 5:00

Tuesday 8:00 – 5:00

Wednesday 7:00 – 5:00

Thursday 7:00 – 5:00

Friday 7:00 – 5:00

Saturday 8:00 – 4:30

Sunday Closed

Should a patient arrive prior to the provider arriving on premises, the patient shall be allowed to wait in the front lobby. Business office services may be provided without a provider on the premises but no patient care shall be performed until the provider arrives. Patient care services include, but are not limited to: injections, Blood Pressure Checks, INR’s, Rooming a Patient, etc. In the event of an emergency, a clinic MA or LPN may triage a patient to the emergency room of Hospital Name.

For clinics held on Saturdays, when only one doctor may be present, in the event of a trauma, obstetrical delivery or other emergency that the doctor is called upon, clinic operations may need to cease until additional medical providers can be called in to cover or until the event is complete and the original provider can return to the clinic. In the event that the clinic doctor is called out for such an event, the clinic administrator or the administrator on call should be notified. All reasonable measures should be exhausted to attempt to find alternative coverage in this type of event. Patients shall be notified according to policy and rescheduled or asked to come in at an alternative time.

# MEDICAL RECORDS MAINTENANCE AND DOCUMENTATION

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Medical Records Maintenance and Documentation** | Origination Date: XXXXX |
| Department: Department Name | Reviewed: XXXXX |

**Policy Statement:**

It is the policy of Your Clinic Name Here to maintain complete medical records on each patient seen by way of thorough documentation in RHC’s electronic medical records (EMR).

**Procedures:**

A. Confidentiality

* Patients as well as the clinic staff will be made aware that the electronic medical record and the information contained within are to be held in strict confidence. This will be done by providing a written privacy policy to all patients (or their legal guardian) and posting the privacy policy in a public area within Your Clinic Name Here. HIPAA training upon hire and ongoing annual HIPAA refreshers will make the clinic staff aware of this.
* A patient must give written permission for the release of medical information from their chart. A parent or legal guardian must supply this permission for a minor. The only exception to this is when records are released from provider-to-provider for continuing medical care for the patient.

B. Responsibility: At the PBRHC, maintenance, accessibility and systematic organization of medical records will be the responsibility of the Clinic Manager.

C. Development of Medical Records:

* Each patient will have an individual electronic medical record.
* Clinic visit notes will be recorded within the patient electronic medical record on the date that the visit takes place.
* A Medical Assistant, CNA or LPN will record height, weight, blood pressure, pulse, temperature, respirations, drug allergies (including severity level and symptoms of allergic reaction) and Chief Complaint when appropriate.
* Assessment of each visit will include either a presumptive or definitive diagnosis.
* Each clinic visit alone will include the following: date of exam, chief complaint, history, review of systems, medication list, problem list, laboratory or imaging orders and results if available and appropriate, diagnosis and treatment plan, including new prescriptions, patient education and instructions and return appointment if needed.

D. Personal Data Base:

* Each patient will be required to complete a new patient registration packet prior to his or her first provider visit. Thereafter, patient shall be required to provide an updated registration annually or if any of the demographic or insurance information changes prior to that.
* If a patient is a minor or unable to supply the necessary information, a parent or guardian will be required to provide the registration data.

E. Obtaining Medical Records from Previous Medical Providers: If deemed appropriate by the clinic medical provider, it may be necessary to obtain information in the form of medical records from previous medical providers or hospitals. The patient (or their guardian) will be asked to sign a medical records release of information form so that the records can be requested.

F. Referrals: If the medical provider deems it necessary that a patient undergo further testing, such as imaging, EKG, sleep study, etc. or if the patient needs to see a specialty doctor, a flag or electronic order will be sent to the Patient Services Representative to obtain proper authorization based on the patients insurance requirements and to schedule the test for the patient. Refer to specific policies and procedures for referral initiation, process and tracking for more information.

G. Miscellaneous Procedures:

* All electronic medical charts have a flow sheet where all laboratories, immunization, injections and various tests are recorded.
* Upon completion of an office visit, an electronic order shall be submitted to the billing/coding department to submit electronic filing to insurance company.
* Payments shall be electronically recorded in patient’s electronic billing account. This account shall provide an accounting of any payments towards charges, contractual and/or bad debt write offs along with any balance due and payable by the patient.

H. Filing of Records:

* Outside reports, records, test results shall be digitally indexed or scanned and electronically filed within the patient’s electronic medical record and routed to the primary care provider for review and final signature.
* Due to the electronic nature of the chart, medical records can never be deleted.
* Charts of patients who have not been seen for five or more years may be changed to inactive status within the electronic medical record. However, if the patient presents for care at a later date, they can be returned to active status.
* Deceased patient charts shall be marked as deceased and be placed in inactive status.

I. Review of Records: Every notation, record, office visit, prescription or entry in the electronic health record shall be electronically signed by the responsible party, that being the provider giving medical care, the primary care provider or staff member responsible for the document, etc.

# CONFIDENTIALITY OF PATIENT INFORMATION

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| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Confidentiality of Patient Information** | Origination Date: XXXXX |
| Department: Medical Records, Clinic Name | Reviewed: XXXXX |

**Purpose:**

Define proper protocol of Confidentially of Patient Information

**Policy Statement:**

Information known or contained in the patient’s medical record shall be treated as confidential and will be released only within the guidelines provided for by HIPAA.

**Procedures:**

A. All persons employed at Hospital Name Here and Your Clinic Name Here having access to information concerning patients, such as volunteers, hospital staff members, and physicians, must complete HIPAA training and hold all information in strict confidence.

B. No information concerning patients, physicians, staff members or volunteers is to be relayed to others. Information which may be ordinary facts and necessary for planning of specific care and services will be handled with professional discretion and on a “need to know” basis.

C. Requests for patient information will be to the Health Information Management Department. In the event that no Health Information Management Department personnel is available to fulfill an emergency request for release of information, appropriately trained personnel will release the information. The fulfillment of such requests will be in accordance with the hospital’s established policy and procedures for release of information.

D. At no time shall staff members, volunteers, or others associated with Hospital Name Here and Your Clinic Name Here, who have access to confidential patient or hospital information, speak with the news media, or others outside the hospital, without the prior approval from the hospital administration. All encounters with the news media should be directed to administration.

**Reference:**

http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/Downloads/HIPAALaw.pdf, Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 104th Congress

# PATIENT CARE POLICY & PROCEDURES

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Patient Care Policy & Procedures** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Policy Statement:**

The following policies were developed by the medical providers of Your Clinic Name Here. It is the policy of the Your Clinic Name Here to provide the best and most appropriate and medically necessary services to the members of Your County.

**Procedures:**

The RHC will provide the following direct services at the clinic site, making use of the services of both the physicians and the midlevel providers (refer to job descriptions).

A. Professional Services:

* Office Visits
* Physical Exams
* Preventive Exam and Services
* Patient Education and Counseling
* Blood Pressure Checks
* Immunizations / Injections

B. Clinical Procedures:

* Audiometry
* Catheterization (bladder)
* Ear Examinations
* Ear Piercing
* Cauterization
* Excision of Small and Large Skin Lesions
* Excision of Ingrown Toenail
* Foreign Body Removal (minor)
* Foreign body Removal (eye)
* Fracture Treatment and Follow-up Care
* Incision and Drainage (simple and uncomplicated)
* Laceration Repair
* TB Skin Test (or other)
* Visual Acuity Testing

C. Laboratory:

* Provide laboratory services appropriate to the medical needs of the patient, using the facilities located onsite or at Hospital Name Here.

D. Rural Health Clinic Laboratory:

* Basic laboratory procedures will be performed at Your Clinic Name Here that are applicable under the clinics CLIA Waived Laboratory Certificate (PPM).
* Appropriately trained clinic personnel will perform services.
* Laboratory services available on site are:
  + Urinalysis, by dipstick
  + Hematocrit
  + Blood sugar
  + Examination of stool specimens for occult blood
  + Pregnancy testing (urine)
  + Primary culturing for transmittal to reference lab
  + Group A strep - Rapid Test
  + Pro-time / INR
* Laboratory Services (collected on-site with off-site analysis)
  + Pap Smear
  + Punch Biopsy
  + Endometrial Biopsy
  + Urine Culture
  + Culture & Sensitivity
* Laboratory tests that are not available at the Your Clinic Name Here will be collected at the Hospital Name Here Lab.

E. Injections / Immunizations / Procedures offered at Your Clinic Name Here are:

* Allergy Injections
* Flu Shots (all ages)
* Pneumovax
* TB
* Childhood and Adult Vaccines, Including VFC
* Prescribed Injectable Medications (i.e. Depo)

F. Guidelines for Medical Management of Health Care Problems:

* All records entered into the Your Clinic Name Here electronic medical record are permanent. All healthcare records shall be well documented, containing sufficient data to correctly assess and respond to medical problems, which are reviewed.
* The physician or midlevel provider will make all consultations and referrals after consultations with the patient. Such consultation/referral will be documented in the patient record.
* Your Clinic Name Here’s Patient Services personnel shall coordinate referrals.

G. Off-Site Services: It is the policy of Your Clinic Name Here to provide the following services to the members of **Your** County off site:

* Home Visits and Assisted Living Visits when appropriate
* Inpatient and Outpatient Hospital Services and Procedures
* Obstetrical Procedures Including Deliveries and C-Sections
* Emergency Room Coverage

H. Security of Medications: Administration of all drugs and biologicals (if appropriate) will be performed by the physician, midlevel provider, or other appropriately trained personnel, upon the order of the physician or midlevel provider.

*These patient care policies and procedures shall be reviewed at least annually. Policies will be reviewed and approved by the Medical Director.*

# REFERRAL PROCESSING & AUTHORIZATION & TRACKING

**Referral Processing**

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Referral Processing** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Purpose:** This policy will outline the steps of the referral process, specifically: 1) tests, 2) referrals, and 3) prior authorization.

**Policy Statement:**

Your Clinic Name Here is committed to quality patient care, which includes processing referrals in a timely and efficient manner.

**Procedures:**

A. The Referral Process for Diagnostic Test:

* Order/flag is received from Primary Care Providers (PCP) via electronic medical record (EMR).
* If required the insurance company is contacted for pre-authorization of referral.
* If referral is an imaging procedure or test, Patient Service Representative will contact the Imaging Department to schedule test and patient is notified of date and time.
* If referral is an outpatient diagnostic procedure, such as colonoscopy, EGD, etc., the Patient Service Representative notifies Hospital Name Here outpatient scheduler. Patient is notified by the outpatient scheduler regarding date and time and instructions if appropriate.
* Documentation of prior authorization and appointment time / date and any other pertinent information is documented in the patient chart and signed by the Patient Services Representative via electronic signature and routed to ordering provider.

B. The Referral Process for Referrals for Service:

* The doctor will send the Patient Service Representative an order/flag for referral via electronic medical record (EMR).
* If required the insurance company is contacted for pre-authorization of referral.
* Once authorization is received or in cases where pre-authorization is not required, the applicable patient records sent to the providers office:
  + Demographics
  + Chart notes
  + Provider order
  + Prior authorization form, if applicable
  + Diagnostic test related to the referral to include imaging, labs, etc.

C. The referred service’s office contacts the patient directly to schedule the appointment.

D. Documentation of the above steps are documented along with any other pertinent information in the patient’s chart and signed via electronic signature.

**Referral Authorization**

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Referral Authorization** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Procedures:**

A. Process for Prior Authorization for Diagnostic Tests:

* Order/flag is received from Primary Care Providers (PCP) via electronic medical record (EMR).
* Verify the patient’s insurance company to determine the appropriate process to obtain the prior authorization in a timely manner. (Medicare does not require prior authorization).
* The most commonly used prior authorization process is using AIM. The AIM website processes prior authorizations for the majority of the carriers that Your Clinic Name Here patients have coverage through. Since AIM is the most commonly used prior authorization process the following is what takes place:
  + Access AIM Provider Portal via internet.
  + Choose the appropriate insurance (if insurance company is not on this list they must be called directly).
  + Enter patient data
  + Enter specific diagnostic test ordered by PCP
  + Enter chief complaint
  + Enter location where test will be performed.
  + Notice of authorization decision will be sent via email or fax to patient service representative.
  + Document the authorization information into patient chart and on the order that is submitted to the facility performing the test.
  + Notify patient of the date, time and instructions if necessary of the scheduled test or appointment.
  + If the insurance requires contacting the carrier directly, then telephone access will be made and steps vi-viii above will be taken.

**Referral Tracking and Follow Up**

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Referral Tracking and Follow Up** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Purpose:** To outline the steps of the referral tracking and follow-up process.

**Policy Statement:** It is the policy ofYour Clinic Name Here that referrals are processed and tracked to ensure that the patient receives the testing or care that is recommended by their medical provider.

**Procedures:**

A. Tracking:

* Patient Service Representative will receive faxes of patient’s scheduled appointments from various specialists and will document the dates/times of scheduled appointments in the patient chart.
* Bi-monthly, the Patient Service Representative utilizes a referral tracking report within the electronic medical record (EMR).Each referral is verified by:
  + Receipt of referred provider’s chart notes or if chart note or appointment time is not present, the patient service representative calls the referred provider to obtain chart notes, via fax.
* Once notes are scanned into the EMR, the referral is marked as completed by the Patient Service Representative.

B. Follow-up:

* The Patient Service Representative initiates follow-up when a flag is received from the Primary Care Provider (PCP), or when documentation of the appointment is not received within 30-45 days from the referral, which is verified during Tracking (above).
* The Patient Service Representative follows up if a patient call is received, stating they have not heard from the referred provider.
* The Patient Service Representative monitors compliance/attendance when instructed by the PCP for some patients that may need additional assistance in the referral process.

C. Declined or missed appointments: Declined or missed appointments will be documented in the patient chart and routed to the ordering provider to determine what action, if any, to take.

**Desired Patient Outcomes:**

* Patients will receive appropriate referral in a timely manner.
* Patient’s insurance will be notified for pre-authorization.
* Patients will be notified of scheduled diagnostic test by patient services representative**.**
* The referred healthcare professional’s office will contact the patient regarding appointment and scheduling.

# MOST COMMONLY USED SPECIALISTS

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Most Commonly Used Specialists** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Purpose:** This policy will outline the most commonly used specialist. The PCP will determine the type of provider and specialty based on the individual patient needs such as diagnosis.

**Policy Statement:** Your Clinic Name Here is committed to quality patient care, which includes the referral to additional medical professionals, services, and care.

**Procedures:**

A. When possible, a referral will be made to a specialist who visits the RHC to save the patient from long distance travel. However, should the need for the referral be sooner than the next specialist visit, a referral to the specialist in their city may be needed. In addition, the patient may wish to travel to see the specialist and the PCP shall take that into consideration when placing the referral.

B. The list of specialists below are the most commonly used, however there may be others that a referral may be made to depending on the patients needs.

C. Whenever possible, a referral will be made to a provider/organization that is participating with the patient’s insurance plan, however this cannot always be guaranteed and ultimately, it is the patient’s responsibility to determine if the specialist is in network or out of network.

Insert list of most commonly used providers – Name, specialty and telephone number.

*Your Clinic Name Here maintains an updated list of visiting specialist who serve patients locally on the Clinic X-Drive.*

**Insert a Letter from your Hospital (even if PBRHC) stating that they will accept the RHC’s referrals. Sample wording below:**

Dear RHC Medical Staff,

This letter is to notify you that HOSPITAL NAME HERE will gladly accept your referrals for inpatient, outpatient, surgical and emergent services that you, as a medical provider, deem necessary and appropriate for the patients you treat.

Services are offered through the following departments of HOSPITAL NAME HERE:

* Emergency Care
* Surgical Services (including infusion therapy)
* Anesthesia (including pain management)
* Laboratory
* Imaging
* Sleep Lab
* Nursing
* EMS
* Dietary Services
* Outreach

Should you have any questions or concerns regardign any of the services we offer, please do not hesitatet o contact the Department Supervisor or any member of the Administratove Team.

Sincerely,

XXXXXXX

CEO

HOSPITAL NAME HERE

# EMERGENCY CARE POLICY:

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Code Blue Protocol & Definitions** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Scope:** Your Clinic Name’s Providers and staff

**Purpose:**

* To provide guidelines on initiating Advanced Cardiac Life Support (ACLS) according to the measures provided by the American Heart Association (AHA) to a patient with no palpable pulse and/or no discernible respirations.
* To provide definitions of terms used in reference to a patient’s code

**Policy Statements:**

* It is the policy of Your Clinic Name Here to provide accurate and up to date guidelines on BLS and ACLS protocol for clinic staff.
* Full Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS) will automatically be implemented for every patient at Your Clinic Name Here Clinic unless there is a DNR on file in their chart.

**Procedures:**

A. In those instances where a patient is found to have no palpable pulse and/or no discernible respirations, the individual noting the patient’s condition will start Basic Life Support (BLS).

B. Your Clinic Name Here Providers will be alerted and activate the “Code Blue” process as indicated.

C. The Trauma/Code Blue team at Hospital Name Here may be activated for cardiac or respiratory arrest by calling 5\*\*9 on one of the land line phones. A staff member will direct the team from the front lobby to the patient.

D. Basic airway management shall be maintained by a BLS certified staff member.

E. ACLS protocols will be followed per the trauma/code team from Hospital Name Here. The procedures to follow will be dictated by the outcome of the code.

F. The patient will be transferred to Hospital Name Here Emergency Department as soon as stable enough to move accompanied by a Your Clinic Name Here Provider, and will then be handed off to the Physician covering the Emergency Room.

G. A staff person from Your Clinic Name Here will stay with the patient’s family if available to answer questions and provide support.

H. Efforts shall be made to contact the family at the first available opportunity. The attending provider shall inform the family of the patient’s status.

I. The patient’s provider will complete appropriate documentation.

**Code Blue Definitions:**

Cardiopulmonary Resuscitation (CPR) is defined as artificial respiration accompanied by external cardiac compressions. This is considered an extraordinary resuscitative measure.

* CPR is defined as Cardio Pulmonary Resuscitation
* ACLS is defined as Advance Cardiac Life Support
* DNR is defined as Do Not Resuscitate.
* DNI is defined as Do Not Intubate.

**Definition of Code Status:**

Full Code CPR initiated, ACLS started until a physician is present and assumes control of the code situation.

NO Code (DNR) No CPR, no intubation, no medications, no arrhythmia treatment, no defibrillation. Oxygen and suctioning are not considered extraordinary.

# PATIENT COMMUNICATION POLICIES

**Persons with Limited English Proficiency (LEP)**

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| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Persons with Limited English Proficiency (LEP)** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Policy Statements:**

Clinic Name Here will take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. Our policy is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment.  The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

Language assistance will be provided through use of contracts with organizations providing interpretation or translation services, or technology and telephonic interpretation services. All staff will be provided notice of this policy and procedure, and staff that may have direct contact with LEP individuals will be trained in the use of an interpreter and TTY/TDD services.

**Procedures:**

A. Identifying LEP persons and their language needs: Clinic Name Here will promptly identify the language and communication needs of the LEP person.  If necessary, staff will use a language identification card (or “I speak cards,” available online at www.lep.gov) or posters to determine the language.  In addition, when records are kept of past interactions with patients (clients/residents) or family members, the language used to communicate with the LEP person will be included as part of the record.

B. Interpreter: The Compliance Coordinator is responsible for:

* Maintaining an accurate and current list showing the name, language, phone number and hours of availability of bilingual staff (see attached list);
* Contacting the appropriate bilingual staff member to interpret, in the event that an interpreter is needed, if an employee who speaks the needed language is available and is qualified to interpret; and
* Obtaining an outside interpreter if a bilingual staff or staff interpreter is not available or does not speak the needed language.

*Certified Language Interpreters* have/has agreed to provide qualified interpreter services. The agency’s telephone number is **1-800-225-5254** and the hours of availability are 24 hours a day seven days a week.

Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP person will not be used as interpreters unless specifically requested by that individual and **after** the LEP person has understood that an offer of *Certified Language Interpreters* at no charge to the person has been offered by the facility. Such an offer and the response will be documented in the person’s file. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, *Certified Language Interpreters* services will be provided to the LEP person.

Children and other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

C. Providing Written Translations: When translation of vital documents is needed, Clinic Name Here will:

* Submit documents for translation into frequently encountered languages to *Certified Language Interpreters*. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.
* Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.
* Clinic Name Here will set benchmarks for translation of vital documents into additional languages over time.

D. Providing notice to LEP persons: Clinic Name Here will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand.  At a minimum, notices and signs will be posted and provided in intake areas and other points of entry, including but not limited to the emergency room, outpatient areas, etc.    

E. Monitoring language needs and implementation: On an ongoing basis, Clinic Name Here will assess changes in demographics, types of services or other needs that may require reevaluation of this policy and its procedures. In addition, Clinic Name Here will regularly assess the efficacy of these procedures, including but not limited to mechanisms for securing interpreter services, equipment used for the delivery of language assistance, complaints filed by LEP persons, feedback from patients and community organizations.

**Persons who are Deaf, hard of hearing or blind**

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| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Persons who are Deaf, hard of hearing or blind** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Policy Statement:**

Clinic Name Here will take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits.  The procedures outlined below are intended to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. All necessary auxiliary aids and services shall be provided without cost to the person being served.

**Procedures:**

A. Identification and assessment of need: Clinic Name Here provides notice of the availability of and procedure for requesting auxiliary aids and services through posted notices. When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, Clinic Name Here staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

B. Provision of Auxiliary Aids and Services: Clinic Name Here shall provide the following services or aids to achieve effective communication with persons with disabilities:

* **For Persons Who Are Deaf or Hard of Hearing:**
  + For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, the on duty nursing staff is responsible for providing effective interpretation or arranging for a qualified interpreter when needed.
  + *American Sign Language Video Interpreters* are available through Language Line Solutions (LLS). This service is only accessible via the Telemedicine Unit labeled Language Line Solutions. This is a 24/7 service. The system must be plugged into one of the active network ports in order to place a call. Using the remote control go the system directory and select Language Line Solutions. The system will dial though and a representative from LLS will respond.
  + Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter.  However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and *after* an offer of an interpreter at no charge to the person has been made by the facility.  Such an offer and the response will be documented in the person’s file.  If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be considered.  If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

**NOTE: Children and other residents will not be used to interpret, in order to ensure confidentiality of information and accurate communication.**

* + Communication by Telephone with Persons Who Are Deaf or Hard Of Hearing:
    - A twenty-four hour (24) telecommunication device (TTY/TDD) which can connect the caller to all extensions within the facility and/or portable (TTY/TDD) units, for use by persons who are deaf, hard of hearing, or speech impaired is also available free of charge. The TTY/TDD device is located in the Emergency Department, room 1. The phone number to this device is Insert phone number. The patient may dial XXX from this device, which connects to Oregon Relay Service who will dial the number the patient is trying to call and they will relay the patient’s message to the caller. Those assisting the patient may also call XXX (Oregon Relay Service) for additional assistance in placing a call, if needed.
* **For Persons Who are Blind or Who Have Low Vision:**
  + Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
  + Qualified readers; reformatting into large print; taping or recording of print materials not available in alternate format; or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision. In addition, staff is available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.
* **For Persons with Speech Impairments:**
  + To ensure effective communication with persons with speech impairments, staff will contact the Speech Therapist at: (insert phone number),who is responsible to provide the aids and services in a timely manner:
  + Writing materials; computers; flashcards; alphabet boards; communication boards; and other communication aids.
* **For Persons with Manual Impairments:**
  + Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following:
    - Note-takers; speakerphones; or other effective methods that help to ensure effective communication by individuals with manual impairments.

# DRUG STORAGE AND SECURITY

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Drug Storage and Security** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Policy Statement:**

It is the policy of Your Clinic Name Here to ensure safe and secure handling and storage of all drugs used in the facility for direct patient care.

**Procedures:**

The following is an outline of how drug storage and monitoring will take place at Your Clinic Name Here:

A. Security: All medications stored on the premises of Your Clinic Name Here will be stored in cabinets or a refrigerator. All controlled medications will be stored in a locked, storage cabinet.

B. Expiration Dates: All drug storage areas will be inspected and inventoried at least every two months by the Clinic Name Here Pharmacy Department who will maintain a medication log. All medications will be disposed of properly when their expiration date has passed.

C. Drug Shelf Life: All multiple-use vials must be disposed of 30 days after the date of first use. The date of the first use will be written on the vial. Upon locking the medication cabinet, an inventory will take place daily to ensure that no open vials have reached the 30-day period. If a vial is found to have reached the 30-day expiration date, it will be discarded, even if the expiration date of the drug has not yet been reached. Medications that must be mixed will be labeled with the date when it was mixed and when it must be discarded. Such medications shall be discarded per the manufacturer recommendations but no more than 24 hours after the drug is mixed.

D. Administration of Drugs:

* Injections of medications will not be administered by a NA/CNA/MA/LPN unless a physician, physician assistant or nurse practitioner is on the premises.
* All injections or medications will only be administered under the direction of a medical provider.

E. Prescribing: All prescriptions, including controlled substances, will only be prescribed by the physician, physician assistant or nurse practitioner, in accordance to their DEA licensure. All prescriptions will be documented in the patients chart indicating the drug name, strength, duration and diagnosis and date prescribed.

# EQUIPMENT INSPECTION

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| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Equipment Inspection** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Policy Statement:**

All medical equipment on premises of Clinic Name must be inspected for safety, operation, and reliability.

**Procedures:**

A. Equipment coveredunder the scope of work for (Name of Hospital or Facility that does your Biomedical inspections) XXXXXXXX shall be inspected and logged on six-month intervals, usually occurring in Month and Month.

B. Upon discovery of an equipment problem, the equipment will be assessed by biomedical staff and Clinic Name facilities staff to determine how to proceed. From there the equipment will be removed from service and either repaired in house, sent to biomedical services office, or sent out to the manufacturer/ third party.

C. Facility services will track the repair until it has either been repaired and returned to service, or deemed not suitable for repair at which point it will be disposed of.

D. Non biomedical equipment shall be inspected by Clinic Name staff or third party inspector if required. Equipment shall be inspected upon acquisition, annually and as per manufacture recommendation.

E. Repairs and inspections done on all medical equipment shall be logged and records kept by facility staff.

# HEALTH AND SAFETY - GENERAL

|  |  |
| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Health and Safety** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Purpose:**

Establish an employee health and safety program and expectations of employees of the Your County Health District, doing business as Clinic Name Here (the District), regarding safety and health issues.

**Policy Statements:**

It is the policy of the District to provide employees with a safe and healthful work environment. To accomplish this goal, the District will maintain an active Safety Committee to assist in developing and implementing safety rules and regulations.

Supervisors and managers also make diligent efforts to promote safety. Employees are expected to follow all safety rules and regulations, including the use of appropriate protective clothing and equipment, attending all training sessions related to their job, and following directions of warning signs, signals, and/or directions of supervisory personnel. Employees will immediately report all job-related injuries and illnesses to their supervisor.

Safety rules and regulations will be effective immediately upon communication. Rules and regulations will be distributed to each department and posted on employee bulletin boards. Supervisor will ensure safety rules and regulations are communicated to their employees.

In conformance with Chapter 656 of the Oregon Revised Statutes, the District will obtain and maintain Workers’ Compensation insurance coverage.

**Procedures:**

A. All job-related injuries or illnesses will be reported per Clinic Name Here Policy # XXXX, regardless of severity. A “near-miss” will be reported using an Incident Report.

B. When an employee identifies a safety problem, they and any other employees at the scene are expected to:

1. Safely eliminate the hazard and obtain necessary assistance.
2. Safely control the hazard by enclosure or guard.
3. Employ avoidance procedures.
4. Use personal protective equipment or clothing as appropriate.

C. When an injury occurs, employees are expected to:

1. Take remedial first aid actions.
2. Report the injury as soon as possible.
3. Seek emergency care if necessary.
4. Fill out the accident form.
5. Provide their supervisor with a medical release from a doctor if medical care is provided.
6. Review the incident with the Human Resources Department.

D. Employees are expected to give their full skill and attention to the performance of their duties, using the highest standard of care and good judgment. Employees are expected to report any unsafe condition or action to their supervisor and warn co-workers of the unsafe act or condition. Employees will also refrain from “horseplay” at all times.

E. Safety Committee: Senior management and the Board fully support efforts to create a safe and healthful work environment. In order to provide such an environment, the District will maintain a pro-active District Safety Committee.

The District Safety Committee shall consist of five (5) employee representatives and five (5) management representatives. The Committee will meet on a monthly basis and meetings are open to anyone. The Safety Committee bears responsibility to perform its assigned duties and assure the District maintains a safe work environment. The goals of the Safety Committee are:

* To establish and maintain appropriate safety training practices for all employees, including necessary policies and procedures.
* To review training records and safety policies to ensure compliance and to recommend improvements.
* To perform workplace safety inspections/evaluations.
* To review and/or investigate all occupational injuries and illnesses and near-miss incidents.
* To get employees involved achieving and maintaining a safe, healthful workplace.
* To identify and eliminate hazards and unsafe practices.
* To keep accurate records of Committee activities and recommendations.
* To periodically evaluating the Committee’s strengths and weaknesses.
* To receive written or verbal suggestions from employees for improvement in safety policies and/or practices and to take action as appropriate.

The Safety Committee will develop and maintain By-laws for Committee operating needs and to achieve the above goals. By-laws and revisions thereto, will be approved by the Director of Human Resources.

**References:**

Clinic Name Here Policy # X

Oregon Revised Statutes 654.010, 654.176 and Chapter 656

Safety Committee By-laws

**Facility Evacuation Map:**

Insert a picture of your facility’s evacuation map here.

# EMPLOYEE VACCINATION AND TB TESTING

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| --- | --- |
| Clinic Name Here | Policy Number: XXXXXXX |
| Policy Subject: **Employee Vaccination and TB Testing** | Origination Date: XXXXX |
| Department: Department Name Here | Reviewed: XXXXX |

**Purpose:**

Establish a program to ensure the health and safety of employees at Your County Health District, doing business as Clinic Name Here (the District), by requiring TB testing of all employees and certain vaccinations be given to employees based upon their position/occupational exposure risk.

**Policy Statement:**

It is the Policy of the District to provide a safe, healthful work environment for its employees. In order to achieve this goal, the District may require employees to undergo TB testing and receive certain other vaccinations as a condition of employment.

**Procedure:**

A. All employees will undergo TB testing at hire and as necessary when a potential exposure is suspected.

B. Dietary personnel will be offered the hepatitis “A” vaccine at the time of hire.

C. Employees will be offered the flu vaccine as long as there are sufficient supplies of the vaccine.

D. If the District believes an employee will have a reasonably anticipated occupational exposure to hepatitis “B”, the employee will receive appropriate training and will be offered the hepatitis “B” vaccination series and any boosters as recommended. Taking the hepatitis “B” series is not mandatory, nor is it a bona fide occupational qualification. Employees may decline the hepatitis “B” series initially and later change their mind and receive the series. All costs associated with this policy will be borne by the District.

**Reference:**

Oregon Administrative Rules 333-012-0330, 333-01900405, 333-026-0010, & 333-520-0020

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