Clinic Protocols for Quality and Risk Management
STATEMENT OF APPROVAL

COMMUNITY HEALTH CENTER
QUALITY IMPROVEMENT MANUAL
Plan Approval – FY 2015-2016

This signifies that the Quality Improvement Plan for Community Health Center was reviewed and approved by the Board of Directors as part of the overall annual grant application review process.

Approval Date: July 6, 2016

Medical Director: Danielle Darter, M.D.
QI Coordinator: Stephanie Bunch
Deputy Health Director/COO: Jennifer Greene, MPH
Health Director/CEO: Beth Lovette, RN, BSN, MPH

QI/QA Committee Board Members: Bob Edwards, Chairperson, Partners in Public Health
          Erin Torres, Patient Board Member, Partners in Public Health
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QUALITY IMPROVEMENT PLAN AND COMMITTEE DESCRIPTION

A. PURPOSE: To ensure quality of care and operations for the organization.

B. METHOD: A Quality Improvement Committee will oversee a comprehensive quality improvement plan, which will be developed with the input from all personnel and will be implemented by all personnel.

C. THE QUALITY IMPROVEMENT COMMITTEE: The QI committee will meet on a quarterly basis or as needed, and will be made up of permanent and rotating members. As much as is possible there will be a representative from each clinical site on the QI committee.

Permanent Members:
- Quality Improvement Coordinator (Chair)
- Medical Director (Vice-Chair)
- Director of Nursing
- Practice Administrator

Rotating Members, minimum composition:
- One nurse (MAs, LPNs, or dental assistant)
- One secretary

The rotating members will serve a two-year term with no more than five members rotating off in any given year. Other personnel may meet with the QI Committee as necessary when particular QI items are on the agenda. For example, a member of the dental staff may meet with the QI committee when a dental audit is presented. The rotating members will be personnel who have shown a commitment to quality patient care and will be chosen by the QI committee.

The Quality Improvement Coordinator is designated as chair, and Medical Director as Vice-Chair, of the QI committee and one of the two will report to the Board on a quarterly basis regarding QI activities.

D. QUALITY IMPROVEMENT PLAN: The QI plan will include QI items from the following areas in order to ensure comprehensive quality of care and operations:
   1. Clinical-Medical/Dental
   2. Credentialing/Continuing Medical Education
   3. Safety
   4. Ancillary services - laboratory, x-ray, EKG, etc.
   5. Administrative/Clerical
   6. Patient Satisfaction/Patient Rights & Responsibilities

E. AGENDA: The agenda of the QI committee will be determined by a schedule of audits and reviews that will occur throughout the year in the various areas that the QI committee oversees. On a yearly basis, the QI items will be reviewed by the QI committee and a plan for the coming year will be developed with new items inserted and old items deleted, based on the needs of the organization.
F. THE QUALITY IMPROVEMENT PROCESS: The QI committee is responsible for general oversight of the QI plan. Specifically, the QI committee makes sure that where there are deficiencies, corrective action is taken and the deficiencies are followed up. However, the responsibility for the actual implementation of the plan and implementation of corrective action will rest with personnel throughout the organization whose job description includes that area of responsibility. For example: Implementation and corrective action in clinical areas is the responsibility of the individual clinical supervisor, i.e., the physician or dentist for the particular site.

G. SCOPE OF SERVICE: Scope of Service for this organization is fully described in the annual grant application prepared for the Department of Health and Human Services. A list of required and optional services provided by this Corporation is attached. In general, AppHealth considers itself as a primary care organization. It is staffed by a provider base of a family practitioner and mid-level practitioners. The provision of medical care consists of a full range of primary and preventive care services to all patients. A list of these services is attached. Some centers provide more services than others, based on the availability of equipment and trained staff. The Chief Medical Officer has courtesy hospital privileges at Ashe Memorial Hospital, along with a formal arrangement in place where Hospitalists will admit and provide inpatient services for our patients.

H. QUALITY IMPROVEMENT METHODOLOGY

The Model for Improvement, developed by Associate in process Improvement provides a framework for developing, testing, and implementing change, and it is a powerful tool for accelerating improvement. The Model for Improvement is used to successfully improve care processes and outcomes.

What are we trying to accomplish? An organization’s response to this question helps to clarify which improvements it should target and their desired results.

How will we know that a change is an improvement? Actual improvement can only be proven through measurement. A measureable outcome that demonstrates movement toward the desired result is considered an improvement.

What changes can we make that will result in improvement? Improvement occurs only when a change is implemented, but not all changes result in improvement. One way to identify which change will result in improvement is to test the change before implementing it.
The Plan-Do-Study-Act (PDSA) cycle that tests and implements a change. The PDSA cycle tests a change by planning it, trying it, observing the results, and acting on what is learned. This is the scientific method used for action-oriented learning.

The PDSA Cycle starts at the **Plan** stage. When a QI team understands the nature of the current problem, the process that underpins the problem, and has specific ideas about what would mitigate the problem, it is ready to test changes to that process. The **Plan** stage helps the QI team to determine this by working through a set of questions. Before changes are tested, the team should secure the buy-in of those that will be affected. This ensures staff cooperation and results in an effective test of change. Testing the change occurs during the **Do** stage. The QI team tests the change and collects the required data to evaluate the change. In addition, any problems and observations during the test are documented. In the **Study** stage, the QI team learns all it can from the data collected during the **Do** and considers if the process was improved, objective for improvement and learning objectives. The responses derived from the **Study** stage define the QI team's tasks for the **Act** stage. The QI team may choose to start again with a new test cycle based on the analysis. If the problem is unsolved, the team may return to the **Plan** stage to consider new options.

For most system changes in health care, multiple small tests of change are needed to improve one system. The **Model for Improvement** is just one model that can be used to tailor the change to an organization's system until the predicted improvement is achieved. The PDSA cycle helps an organization to increase its ability to determine whether a change will have the desired outcome or if it should be abandoned. For example, a change might be tried in one area of the organization, with one or more individuals. As learning occurs, the test can be increased. If the test is successful, then the cycle is used as a framework for implementing knowledge into practice.

*Adapted from Institute for Healthcare Improvement*
1. QUALITY IMPROVEMENT STRUCTURE

- Board of Health
  - QI Council
  - QI 101 (Rapid QI Project Ends August 2015)
    - Environmental QI
    - WHCQI
  - Aim to increase billing accuracy for all services rendered at each family planning appointment

- Partners in Public Health
  - FQHC QI/QA
    - Patient population benchmarks/outcomes
      - Risk Management
      - Provider Peer Review

Commented [1]: Add Clinic QI to the FQHC block; also include a communication line to QI
Commented [2]: Makes sense
RISK MANAGEMENT POLICY

PURPOSE: The purpose of this policy statement is to declare the basics of a risk management policy for the organization to include those elements required for coverage of our clinicians under the Federal Tort Claims Act (FTCA). Furthermore, it is the intention of this document to identify an individual(s) involved in the risk management function(s) for this corporation, and to identify existing elements of a risk management plan.

EXISTING ELEMENTS OF THE RISK MANAGEMENT PROGRAM:

1. Quality Improvement Plan- a Quality Improvement Plan is in place, is annually reviewed, and a part of the on-going operations of this Corporation.
2. Quality Improvement Committee- a Quality Improvement Committee is in place, and is an integral part of the on-going operations of this Corporation.
3. Credentialing- credentialing of providers that are part of the clinical staff of this organization is accomplished in accordance with the appropriate sections of the Quality Improvement Plan.
4. Quality Improvement Coordinator- the Quality Improvement Coordinator is designated as the Chairperson of the Quality Improvement Committee and as such works closely with the Risk Manager to insure that the clinical aspects of the overall risk management program are properly accomplished.
5. Insurance Review- the Risk Manager is charged with the responsibility of insuring that the Corporation’s assets and individuals are properly insured on a continuing basis. This includes annual reviews of leases, annual equipment audits, and reviews of the overall insurance needs of all corporation personnel (from a business perspective).
6. Federal Tort Claims Act- The organization will apply to participate in the FTCA, in FY 16-17 following all procedures and meeting all requirements as requested.

CLINICAL STAFF SUPERVISION: Appalachian District Health Department has a formal clinical staff organization as identified in its organizational chart. The clinical staff is under the direction of a Medical Director. As such, the Medical Director is the supervisor of each member of the clinical staff. This includes all physicians, dentists, and mid-level practitioners. The Medical Director reports directly to the Executive Director/CEO.
MEDICAL RECORDS

GOAL: To maintain standardization and legibility of all AppHealth medical records. (Please see approved policies regarding medical records policy #204, electronic health record #578, internet usage policy #829)

METHODS:
A. A patient record (medical or dental) will be prepared for each patient served by this organization in Patagonia.
B. A standardized format will be used as noted below.
C. Periodic review of these records will be accomplished as part of the Quality Improvement program.
D. EMR- As available, staff providers are required to enter their notes directly into the Electronic Medical Record (EMR), in order to maintain them as organized and standardized as possible.
E. Compliance- Standardized, complete, and quality records are an integral portion of the requirements of the contracts of each provider in the organization. As such, performance is partially judged on these records.
F. All charts are standardized by the EMR, including the following sections:
   a. Current Problems (diagnoses list)
   b. Patient History (includes family history, patient history, social history and procedure history)
   c. Patient Prescriptions – Current Medications (medication list)
   d. Encounters – All (all visits, chart messages, emails, consults, some reports, past records)
   e. Allergies (current medicine and food allergies)
   f. Patient Flags (varied comments, not official part of medical record)
   g. Results (results from lab work and imaging procedures)
   h. Immunizations (found in NCIR)
G. Current Problems, Current Medications, History, Allergies and Immunizations will be reviewed and kept current.
H. As a minimum, every patient visit will have an EMR entry, with a nurse entry, at least one diagnosis regarding the current visit, and any medications prescribed.
I. Providers will finish notes within 72 hours of patient encounter.
J. Charts will be maintained continuously, with no charts left open and unsigned longer than 30 days.

CHART REVIEWS:
Charts are pulled randomly.
QI review - Annually - 10 charts per full-time provider, 5 charts per part-time provider.
Peer Review - every 6 months, 6 charts per provider.
CMO Reviews - 10% of all mid-level charts.

ACCEPTABLE RATE OF COMPLIANCE:
EMR entry for every patient: 95%
Minimum information per entry: 85%
Problems, medications, allergies and immunizations kept current: 90%
PROTOCOL FOR MID-LEVEL PROVIDERS

The following diagnoses or suspected diagnoses should be triaged to the physicians for evaluation. If the mid-level provider sees a patient that is suspected of having one of these conditions, then immediate consultation with a physician is required. Consult can be made in person or using phone, text or email as appropriate.

HEAD
- Headache, severe and acute with fever or neurologic changes
- Trauma with change in mental status or LOC

EYES
- Chemical Exposure
- Diplopia
- Eye Pain, acute or severe
- Foreign Body
- Loss of vision, sudden
- Trauma, severe

EARS
- Fever with bloody discharge
- Hearing Loss, sudden
- Trauma

NOSE
- Epistaxis, uncontrollable
- Foreign body

THROAT
- Inability to swallow
- Pharyngitis with abscess

PULMONARY SYSTEM
- Hemoptysis
- Respiratory distress, moderate or severe

CARDIOVASCULAR
- Abnormal pulse, symptomatic
- Chest pain, acute with risk factors
- Heart rate <40 or > 150
- Pulseless, cold extremity
- Syncope

GI
- Acute abdomen
- Choking
- GI Bleeding, acute
- Vomiting, protracted
GU
- Hernia, incarcerated
- Inability to void
- Priapism
- Scrotal pain, acute

GYN
- Amenorrhea with severe abdominal pain
- Ectopic pregnancy
- PID with fever
- Vaginal bleeding with pain or dizziness

MUSCULOSKELETAL
- Compartment syndrome
- Fracture or dislocation

NEUROLOGICAL
- CVA
  - Dementia or confusion, acute
  - Loss of Consciousness
  - Meningitis
  - Mental status change, acute
  - Seizure, active

PSYCHIATRIC
- Abuse, suspected
- Drug overdose

SKIN
- Cellulitis, extensive or severe

ENDOCRINE
- Hyperglycemia or hypoglycemia with symptoms
- Thyrotoxicosis

MISC
- Dehydration in pediatric patient or geriatric patient
- Sepsis
- Unstable patient
- Anaphylaxis
- Pain, severe
- Fever in child less than 3 months of age
- Site liability injury
PATIENT SATISFACTION

GOAL: To ensure that our patients needs and desires are met in a professional manner.

METHODS:
1. Patient Satisfaction Surveys are prepared by the Quality Improvement Committee to be utilized as scheduled by the Committee. A sample is attached.
2. Patients will be encouraged to complete a survey with each office visit.
3. Results will be tallied by the individual centers and compiled by the Chair of the Quality Improvement Committee for evaluation by the committee.

HOW OFTEN TO AUDIT: Ongoing, with monthly trending.

HOW MANY PATIENTS TO SURVEY: all patients
2016 AppHealthCare Patient Satisfaction Survey

1. Are you:
   - [ ] A new patient
   - [x] A returning patient (Go to Question #2)

Welcome. We are glad you are here. Please tell us your opinion about the service that you received today. Your feedback will help us improve our services. Your responses will be kept confidential. Thank you for your help.

2. How did you hear about our services?
   - [ ] Referred by a friend
   - [ ] Referred by another practice
   - [ ] Social Media (Facebook, Twitter, etc.)
   - [ ] Newspaper, magazine or any other printed material
   - [ ] Other (please specify):


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Welcome back! We are glad you are here. Please tell us your opinion about the service that you received today. Your feedback will help us improve our services. Your responses will be kept confidential.

Thank you for your help.

3. How long have you been a patient with us?
   - [ ] Less than 1 year
   - [ ] 1-2 years
   - [ ] 3-5 years
   - [ ] More than 5 years
   - [ ] Other (please specify)

   Please rate your visit today (Excellent, Good, Fair, Poor):

4. Your visit today:

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Does not apply</th>
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<tbody>
<tr>
<td>Ease of making my appointment</td>
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<td>Availability of appointments</td>
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<tr>
<td>The check-in process</td>
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<td>Waiting time in the lobby</td>
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<tr>
<td>Waiting time in the exam room</td>
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<tr>
<td>The check-out process</td>
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### 2016 AppHealthCare Patient Satisfaction Survey

5. Our communication with you:

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<th>Excellent</th>
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<th>Fair</th>
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<th>Does not apply</th>
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<tr>
<td>The friendliness of the</td>
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<td>receptionist</td>
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<td>Your phone calls</td>
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<tr>
<td>answered promptly</td>
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<td>The helpfulness of the</td>
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<td>medical staff (including</td>
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<td>nursing/medical assistant(s)</td>
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<tr>
<td>Explanation of your care</td>
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6. Your visit with the provider (Doctor, Physician’s Assistant, Nurse Practitioner):

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<th></th>
<th>Excellent</th>
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<th>Fair</th>
<th>Poor</th>
<th>Does not apply</th>
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<tr>
<td>Willingness to listen to you</td>
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<td>Taking time to answer your</td>
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<td>questions</td>
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<td>Amount of time spent with you</td>
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<td>Explaining things in a way you</td>
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<td>can understand</td>
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<td>Advice given to you on ways to</td>
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<td>stay healthy</td>
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7. Our facility:

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<th>Excellent</th>
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<th>Poor</th>
<th>Does not apply</th>
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<tr>
<td>Feeling welcome and</td>
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<tr>
<td>comfortable in our facility</td>
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<tr>
<td>Adequate parking</td>
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<td>Signage and directions</td>
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<td>are easy to follow</td>
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2016 AppHealthCare Patient Satisfaction Survey

8. Your overall satisfaction with:

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<tr>
<th></th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Does not apply</th>
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</thead>
<tbody>
<tr>
<td>Our practice</td>
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<tr>
<td>The quality of your visit</td>
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<tr>
<td>The care you received</td>
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<tr>
<td>Making your appointment today</td>
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9. AppHealthCare is open Monday through Friday 8:00am-4:45pm. Do these hours meet your needs?

☐ Yes
☐ No

10. Please check the hours below that would best meet your needs.

☐ 7:00am-8:00a
☐ 4:45pm-6:45pm
☐ Weekend hours
☐ Other (please specify)

11. Were you provided outstanding service today? If so, who or how?


12. How can we improve our services?


21
13. Please tell us the reason for your visit today. Choose all that apply.
   - Adult Health (sick visit, medication refills, CDL, physical)
   - Sick Child Visit
   - BCCCP (Breast and Cervical Cancer Control Programs)
   - Well-child Visit (age 20 and under physical)
   - Colposcopy
   - Family Planning (Birth Control)
   - General Clinic (pregnancy test, immunizations, TB, PPD, Depo)
   - Maternity Clinic
   - Nutrition Services
   - Sexually Transmitted Disease Clinic
   - WIC (Women, Infant, and Children)
   - Prefer not to identify service
   - Other (please specify)

14. Which of our locations did you visit today?
   - Alleghany County
   - Ashe County
   - Watauga County

Thank you for completing this survey. Please be sure to talk to the receptionist about our after-hours line.
Do not forget to visit our website for important updates: www.apphealth.com.
PERINATAL LOG

**Problem:** Failure of pregnant patients to obtain adequate prenatal care as reflected by entering into care within the first trimester results in higher rates of infant mortality. Follow-up after delivery with a newborn visit is an important tool in health education and disease prevention. A 6-8 week post-partum visit allows screening for post-partum depression as well as an opportunity to start birth control.

**Goal:** To reduce preventable causes of death during infancy by providing adequate prenatal care and appropriate newborn follow-up.

**Methods:**

1. Document pregnancy with a UCG when indicated. Positive results will be recorded in the perinatal log.
2. Explain to the patient the importance of early prenatal care. Check with patient to see where she would like to have OB care and explain the alternatives available. Within two weeks, make an appointment for initial OB visit as soon as possible.
3. Indigent patients should be referred to the local health department where they can receive information on WIC and Medicaid applications and free prenatal care.
4. Record in the prenatal log the date, Estimated Date of Confinement (EDC), Gs & Ps, and any risk factors identified at intake.
5. Check the log monthly to verify and update documented information.
6. From patient where she plans to have her baby followed for health care after delivery and record in log. This information may not be known at the initial visit, but should be entered in the log at least two months before the EDC.
7. Arrange to have OB send verification of delivery and record date in log. If verification is not received within three weeks after the EDC, contact patient.
8. After delivery is confirmed, record infant birth weight and send a reminder to the patient to have baby evaluated within four weeks. Premature infants and infants that are breast feeding should be evaluated in one week. Verify that newborn appointment has been kept with designated provider indicated in log and record information in log.
9. After delivery is confirmed, verify post-partum appointment is scheduled and has been kept and record in log.

**How Often to Audit:** Annually

**How to Audit:** Review the perinatal log since last audit to ensure completeness of all entries to include date, EDC, Problem list, verification of delivery, planned pediatric visit with confirmation that appointment kept. Any failures of patient compliance need documentation of attempt to correct the deficiency.

**Acceptable Level of Compliance:**

1. All entries in the log shall be up to date in 75% of the patients
2. Initial entry into OB care within the first trimester will be indicated in 50% of diagnosed pregnancies.
3. Newborn follow-up within one week will be done in 50% of patients.
4. Post-partum follow-up within 2 weeks will be done in 50% of patients.
<table>
<thead>
<tr>
<th>COUNTY</th>
<th>HIGH OR LOW RISK</th>
<th>DATE UPDATED</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME/DOB</td>
<td>TM</td>
<td>PARITY</td>
</tr>
<tr>
<td>PERSON 1</td>
<td>GB49H81</td>
<td>5/4/2016</td>
</tr>
<tr>
<td>PERSON 2</td>
<td>G3P0</td>
<td>6/27/2016</td>
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<tr>
<td>PERSON 3</td>
<td>G5P5</td>
<td>7/13/2016</td>
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<td>PERSON 4</td>
<td>GB49H81</td>
<td>9/13/2016</td>
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<tr>
<td>PERSON 5</td>
<td>G35P81</td>
<td>10/2/2016</td>
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24
IMMUNIZATIONS

**Purpose:** To reduce morbidity and mortality from diseases that are preventable by immunizations, namely: diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, H. influenza, influenza, varicella, pneumococcal pneumonia and hepatitis. Influenza infection and pneumococcal pneumonia are also important public health problems for adults in our service area. Over 80% of the excess deaths from pneumonia and influenza in the United States occur in persons 65 years or older, and a majority of these patients are not properly immunized. Additionally, two thirds of all cases of tetanus each year occur in people over the age of 50. Thus, vaccination against influenza, pneumococcal pneumonia and tetanus are an important part of primary prevention for our adult patients, as well.

**Goal:** To provide or document adequate immunization for all pediatric, adolescent and adult patients of AppHealth, according to the recommended schedule published by the CDC.

**Method:**
1. Provide on-site the following vaccines: DTaP, Hib, HepA, HepB, influenza, IPV, MMR, Td, Tdap, meningococcal, varicella virus vaccine and pneumococcal vaccine.
2. Administer immunizations by the appropriate schedule as recommended by the CDC for children, adolescents and adults.
3. Track all patients receiving primary immunizations at AppHealth for the intervals determined by their age and immunization status at time of first AppHealth immunization. Document that immunizations are received, or offered and refused, if patient is deficient in immunizations.
4. Document immunization status of all patients who are active users, but select to receive their immunizations elsewhere.
5. Verify pediatric patients’ immunization status at 12 months, 24 months, and 6 years old. Those children who are found to be delinquent will have their immunization status rechecked in 6 months.
6. Check adolescent and adult patients’ immunization status annually, or at next visit if more than one year has passed, based on the following:
   - Pneumococcal pneumonia vaccine: One time at 65 years or older, or re-vaccination if first dose was 5 or more years ago, at age <65.
   - Influenza vaccine: Age 50 years or older, yearly from October – January.
   - Tetanus: Once at 11-12 years, then once every ten years.
7. Have in place a management plan to catch up on immunizations, if needed.
8. All vaccines are maintained in NCIR.

**How Often to Audit:** Annually

**How Many Charts to Audit:** 10 per FTE provider

**Identify Charts:** Random for ages 19-35 months, ages 11-18 years and age 65+. Patients will have been seen within the last 6 months, had at least 3 visits to the office, and have been patients for at least three months.

**Acceptable Level of Compliance:**
Immunizations up to date for 19-35 month-old patients, or a management plan in place if not up to date: 85%
Immunizations up to date (HepB, MMR, Td) for 11-18 year old patients: 80%
Pneumococcal vaccine documented for patients age 65+: 80%
Influenza vaccine documented for patients age 50+: 80%
PEDIATRIC DENTAL HYGIENE

**Problem:** There is a high incidence of poor dental hygiene among children as reflected in numerous referrals to the dental clinic.

**Goal:** To reduce dental decay in children

**Methods:**
1. Patient is identified as pediatric
2. Patient receives counseling re: the recommendation to refrain from giving a bottle at time of bed, regular teeth brushing from the eruption of the first tooth and to supplement fluoride as appropriate.
3. Counseling occurs at Well Child Care (WCC) visits, acute visits, or at intervals not to exceed 6 months until the age of two.
4. If the child lives in a non-fluoridated area, the water supply should be tested and then fluoride supplementation should proceed as follows, based on concentration of fluoride contained in the water:

<table>
<thead>
<tr>
<th>Age of Child</th>
<th>&lt;0.3ppm</th>
<th>0.3-0.6ppm</th>
<th>&gt;0.6ppm</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 6 months</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>6 months to 3 years</td>
<td>0.25 mg/d</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>3 to 6 years</td>
<td>0.50 mg/d</td>
<td>0.25 mg/d</td>
<td>None</td>
</tr>
<tr>
<td>6 to 16 years</td>
<td>1.0 mg/d</td>
<td>0.50 mg/d</td>
<td>None</td>
</tr>
</tbody>
</table>

5. All parents are encouraged to have the child’s first dental appointment soon after first birthday.
6. Moderate to high risk patients will be referred directly to dentist, if possible.
7. Document that above recommendations are made. Use of EMR template item is adequate.
8. Apply fluoride varnish to all teeth surfaces when applicable. The purpose of applying fluoride varnish is to prevent, retard, arrest, and/or reverse the process of cavity formation in Infants and children with a moderate or high risk of developing cavities. Dental fluoride varnish is start at 6 months and continues until age 3.5 every 6 months.

**How Often to Audit:** Annually

**How Many Charts to Audit:** 10 per provider

**Identify Charts:** Random screen of active patients aged 0-3 years (screen from time 0-2 years)

**Acceptable Level of Compliance:**
- Documented counseling regarding BBTC and dental hygiene: 75%
- Patients age 6 months to 16 years with fluoride assessment documented in the last year: 80%
- Patients age 12 to 36 months with 1 or more documented fluoride varnish applications in the last year: 70%
GROWTH, DEVELOPMENT, AND ANEMIA SCREENING PROTOCOL

**Goal:** To adequately assess growth, nutrition, and development in pediatric population.

**Objective:** To identify, document, and manage problems with growth or developmental progress through appropriately timed visits and screenings.

**Screening Protocol:** All children should be seen on a regular basis for the purposes of monitoring growth and development and providing age appropriate screenings, immunizations, and anticipatory guidance. All children seen for a well child visit should have:

1. Height, weight, BMI and head circumference (< 3 years of age) measured. This will be plotted on a standardized growth chart in EMR.
2. Anemia screening once between the ages of 6 to 18 months.
3. Developmental assessment with evaluation of language, social, gross and fine motor development using center tools (ASQ, MCHAT, HEADS, CRAFT, PHQ9)

**Management Protocols:**

1. **Weight Assessment and Counseling** - All children and adolescents aged 3 to 17 will have a BMI percentile and counseling on nutrition and physical activity documented for the current year.

2. **Growth problem** - Any child noted to have an abnormal growth pattern (<5% or >95% height or weight, head circumference crossing 2 allobars) must have that growth pattern noted in the chart and a management plan outlined. The management plan should be appropriate for the abnormal pattern and may include dietary history, assessment of parental growth patterns, social service evaluation, and nutritionist evaluation, referral to pediatrician or special evaluation clinic. Monitoring of growth over time should also be evident.

3. **Anemia** - All children screened between 9 and 12 months. Children receive further screening through WIC. Children with a hematocrit <31% or hemoglobin <10.5g/dL should be identified as anemic and a management plan should be outlined. Presumptive therapy with an appropriate dose of supplemental iron and adequate follow-up should be instituted if dietary history or blood smear support the diagnosis of iron-deficiency. Further evaluation should be outlined if iron deficiency is not suggested by history or if no improvement is noted within two months of iron replacement.

4. **Developmental Delay** - Children with delayed development, suggested on the basis of screenings, should be further evaluated per the center's protocol and available resources. Options for further evaluation include referral to a pediatrician; developmental specialist or developmental evaluation clinic; the local school district and/or CDSA. All children with abnormalities in growth and development should have close follow-up and tracking as part of the management plan.

**Acceptable Level of Compliance:** 80% of charts audited will be in compliance

Charts will be considered in compliance if:

1. There are adequate and regular measurements of height, weight, BMI and head circumference (<3 years of age).
2. BMI percentile and counseling on nutrition and physical activity are documented for the current year.
3. A hematocrit or hemoglobin is recorded in the chart.
4. Developmental screening is completed in the well child history and physical section of the note.
5. A management plan must be in place for any abnormalities noted above.

**Identify Charts:** Randomized sampling of 5 charts per provider of pediatric patients who are age 18-24 months at the time of the review. Patients will have been seen within the last 6 months, had at least 3 visits to the office, and have been patients for at least three months. They will have had at least one well child visit. Charts audited for immunizations may be used.

**How Often to Audit:** Once annually if the threshold is met. Repeat in 3-6 months if the threshold is not met.
CERVICAL CANCER SCREEN PROTOCOL

**Goal:** To reduce the incidence of mortality secondary to undetected or delayed detection of cervical cancer.

**Objective:** To promote women’s gynecological health and reduce the risk of mortality secondary to undetected cervical carcinoma through implementation of Pap smear screening protocols.

**Screening Protocol:**
1. Regular Pap tests and gynecological exams recommended for all women starting at age 21.
2. Pap tests should be performed at an interval of every 3 years until age 30. If, at that point, there are no risk factors for cervical cancer and the patient has had three consecutive normal pap smears, then the test could be performed at an interval of every three to five years. Risk factors for cervical cancer include:
   a) Early onset of sexual intercourse
   b) History of multiple sexual partners or partners with multiple partners
   c) Low socioeconomic status
   d) History of HPV genital infection
   e) Previous cervical dysplasia or cancer
   f) Tobacco use
3. Pap smears may be discontinued after age 65 years if patient has had two normal consecutive Pap smears at least one year apart and chooses not to continue cervical cancer screening.
4. Women who have had complete hysterectomies, (other than for cancer or cervical sparing), do not need Pap tests but should have yearly breast exams and pelvic exams per the provider’s recommendations.

**Management Protocols:** Pap smears, HPV testing and follow up studies/referrals will be done following the ASCCP Algorithms. Abnormal Pap smears, including those requiring colposcopy, should be recorded and dated in the patient history and on the Problem List.

**Acceptable Level of Compliance:**
Documentation of a Pap smear in all females ages 21 years to 64 years per ASCCP guideline, unless documented that the patient has had a hysterectomy or declines exam: 85%

The following will also be reviewed for compliance rate of 65%:
1. Pap smear is reviewed/signed by the provider.
2. Follow up of abnormal Pap smears is per protocol.
3. Diagnoses from abnormal Pap smears that require increased surveillance, colposcopy, and/or referral are listed in the Patient History and on the Problem List.
4. If a patient refuses to have a Pap smear and this is documented, the chart shall be considered in compliance.
5. If the patient receives Pap smears elsewhere and this fact is documented with the date of the last Pap smear recorded, the chart will be considered in compliance.

**Identify Charts:** Randomized sampling of 5 charts per provider of adult female patients seen within the previous six months who are between the ages of 21 and 64 years. Patients will have had at least 3 visits to the office and have been patients for at least 3 months.

**How Often to Audit:** Once annually if the threshold is met. Repeat in 3-6 months if the threshold is not met.
DIABETES PROTOCOL

Goal: To reduce unnecessary death and disability from diabetes.

Methods:
Newly Diagnosed people with diabetes will be seen by MD after initial diagnosis

1. Should have a complete physical examination and lab work-up to include a urinalysis, urine microalbumin, complete metabolic profile, fasting lipid panel and EKG if over 40 years of age.
2. Dietary and lifestyle education, including self-management goals, should be given and documented.
3. Refer to Diabetes Self Management Program/ Medical Nutrition Therapy.
4. Refer for a diabetic eye exam.
5. Should be started on a low dose ACE/ARB unless clinically contra-indicated
6. Follow-ups should be at least at 3 month intervals until glucose is stable, and should include A1C if not done in past 3 months.

Established people with diabetes

1. Office visits every three to six months with a review of home blood sugar log. More frequent visits if patient is symptomatic or abnormalities exist in lab tests.
2. Document foot exam and education of patient to do daily foot exam every routine visit.
3. All patients with diabetes will be on an ACE/ARB unless contraindicated.
5. Yearly microalbumin urine, repeat in 3 months if abnormal. Any patient with persistently abnormal urine microalbumin will be referred to nephrology for further evaluation. If possible, stop any diuretics after first abnormal microalbumin.
6. HgbA1C done every 3-6 months depending on how well diabetes is controlled.
7. Exercise and diet education, including self-management goals, at least annually.
8. Target blood pressure to be less than 140/90
9. LDL level will be less than 100mg/dL; consider statin for all patients with diabetes. Check fasting lipid profile at least once a year.

How Often to Audit: Annually

How Many Charts to Audit: 10 per FTE

Identify Charts: Random screen of people with diabetes who are active users.

Acceptable Level of Compliance:
Diabetes on Problem list: 90%.
Average HgbA1C <7%: 50%
Documented self-management counseling within the last year: 50%
BP controlled <140/90: 50%
LDL less than 100mg/dL: 50%
Yearly microalbumin: 50%
Dilated eye exam in past year: 50%
Comprehensive foot exam documented at all routine follow up appointments: 85%
HYPERTENSION PROTOCOL

**Goal:** To reduce unnecessary death and disability from uncontrolled high blood pressure.

**Methods:**

New Hypertensive Patients
1. Blood pressure measurement is made with a properly calibrated and validated instrument with patient seated quietly for at least 5 minutes in a chair, with feet on the floor, and arm supported at heart level. At least two measurements should be made. Two readings on separate days of greater than 150/90 constitute diagnosis of hypertension.
2. Assess risk factors for CAD (family history, DM, cholesterol, smoking, obesity, exercise, alcohol).
3. Document education including low salt diet, weight loss, and exercise.
4. If patient is to be treated with medicines, document that hematocrit, creatinine, cholesterol, urinalysis have been ordered or done within the last year.
5. Ensure that an EKG has been done within the last five years (if over 40 years of age).
6. If diuretics are to be used, document uric acid, potassium and glucose levels checked within the previous year.
7. Reduce blood pressure to less than 150/90 for 70% of all patients within 3 months of initial visit.
8. If initial diastolic pressure is greater than 100, consider medical therapy at that time.

Chronic Hypertensive Patients:
1. If on medicines and stable 150/90 or less check blood pressure every 6 months with MD visit.
2. If not on medicines, check blood pressure at least yearly with MD visit.
3. Yearly urinalysis, creatinine, cholesterol (and potassium if on diuretic).
4. EKG every 5 years and fundoscopic exam at least every 2 years (if over 40 years of age).
5. Document patient education for every routine visit.

**How Often to Audit:** Annually

**How Many Charts to Audit:** 10 per provider

**Identify Charts:** Random screen of hypertensive patients who are active users.

**Acceptable Level of Compliance:**
Control of blood pressure 150/90 or less: 70%
Two blood pressure readings recorded in the last year: 90%
Document patient education with the last year: 70%
Use of aspirin or other antithrombotic agent if not contraindicated: 70%
ASTHMA

**Goal:** To reduce unnecessary morbidity and disability from uncontrolled asthma.

**Methods:**
1. Every asthma patient will be classified with the Classification of Asthma Severity scale, or the Levels of Asthma Control scale.
2. Any patient that is classified with persistent asthma or uncontrolled will be put on the appropriate anti-inflammatory medication to help prevent inflammation and asthma attacks.
3. Patients will be continually counseled on use of maintenance medications for persistent control of symptoms vs. use of short-acting rescue medications for acute symptom relief.
4. Patients will be encouraged to notice, and further avoid environmental triggers like cigarette smoke and other irritants.

**How Often to Audit:** Annually

**How Many Charts to Audit:** 10 per provider

**Identify Charts:** Random screen of asthma patients who are active users.

**Acceptable Level of Compliance:**
Percent of patients with severity and/or level of control assessment at last contact (phone or visit): 70%
Percent of patients with NHLBI classification of persistent asthma on anti-inflammatory medication: 70%
Documented self-management counseling within the last year: 70%
Number of symptom-free days in the past 2 weeks (14 – days (24hrs) of symptoms in last 2 weeks): >10 days: 70%
<table>
<thead>
<tr>
<th>Classification*</th>
<th>Symptoms†</th>
<th>Night symptoms</th>
<th>Lung function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: mild intermittent asthma</td>
<td>Symptoms occurring twice a week or less No symptoms and normal PEF between exacerbations Brief exacerbations (lasting a few hours to days) with variable intensity</td>
<td>Symptoms occurring no more than twice a month</td>
<td>FEV₁/FVC is 80% or more of predicted PEF variability of less than 20%</td>
</tr>
<tr>
<td>Step 2: mild persistent asthma</td>
<td>Symptoms occurring more than twice a week Exacerbations may affect activity</td>
<td>Symptoms occurring more than twice a month</td>
<td>FEV₁/FVC is 80% or more of predicted PEF variability of 20 to 30%</td>
</tr>
<tr>
<td>Step 3: moderate persistent asthma</td>
<td>Daily symptoms Daily use of inhaled short-acting beta agonist Exacerbations affect activity Exacerbations occur more than twice a week and may last for days</td>
<td>Symptoms occurring more than once a week</td>
<td>FEV₁/FVC is greater than 60% but less than 80% of predicted PEF variability of greater than 30%</td>
</tr>
<tr>
<td>Step 4: severe persistent asthma</td>
<td>Continual symptoms Limited physical activity Frequent exacerbations</td>
<td>Frequent symptoms</td>
<td>FEV₁/FVC is 60% or less of predicted PEF variability of greater than 30%</td>
</tr>
</tbody>
</table>

*The initial classification is based on the presence of certain clinical features before treatment. The presence of one of the features of severity is sufficient to place a patient in that category. A patient should be assigned to the most severe grade in which any feature occurs. The characteristics noted in this classification are general and may overlap because asthma is highly variable. Furthermore, a patient’s classification may change over time.

†–Patients at any level of severity can have mild, moderate or severe exacerbations. Some patients with intermittent asthma have severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.
## Classification of Asthma Control

<table>
<thead>
<tr>
<th>Components of Control</th>
<th>Classification of Asthma Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Well-Controlled</td>
</tr>
<tr>
<td><strong>Impairment</strong></td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>Nighttime awakening</td>
<td>≤1x/month</td>
</tr>
<tr>
<td>Interference with normal activity</td>
<td>None</td>
</tr>
<tr>
<td>Short-acting beta2-agonist use for symptom control (not prevention of EIB)</td>
<td>≤2 days/week</td>
</tr>
<tr>
<td>FEV1 or peak flow</td>
<td>&gt;80% predicted/personal best</td>
</tr>
<tr>
<td>FEV1/FVC</td>
<td>&gt;80%</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td></td>
</tr>
<tr>
<td>Exacerbations</td>
<td>0−1/year</td>
</tr>
<tr>
<td>Progressive loss of lung function</td>
<td>Consider severity and interval since last exacerbation</td>
</tr>
<tr>
<td>Treatment-related adverse effects</td>
<td>Evaluation requires long-term followup care</td>
</tr>
<tr>
<td>Medication side effects</td>
<td>Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.</td>
</tr>
</tbody>
</table>


*ACQ values of 0.76–1.4 are indeterminate regarding well-controlled asthma.

Key: EIB, exercise-induced bronchospasm; FEV1, forced expiratory volume in 1 second.

**Notes:**

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by caregiver’s recall of previous 2–4 weeks. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient’s asthma is better or worse since the last visit.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year...
may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with persistent asthma.

DEPRESSION

Problem: Depression is a very common and debilitating problem, seen in 5-13% of patient visits to primary care providers.

Goal: To better identify and treat AppHealth patients who suffer from clinically significant depression (CSD).

Methods:
1. All patients 13 years and older will be screened for depression with two simple questions (PHQ-2):
   - Have you lost interest or pleasure in things you usually like to do?
   - Have you felt sad, low, down, depressed or hopeless?
   Yes to either question triggers completion of a PHQ-9 form and a more detailed investigation.
2. Recognize individuals at high risk for depression
   - Chronic insomnia or fatigue
   - Chronic pain
   - Multiple or unexplained somatic complaints, “thick charts”
   - Chronic medical illnesses (e.g., diabetes, arthritis)
   - Acute cardiovascular events (myocardial infarction, stroke)
   - Recent psychological or physical trauma
   - Other psychiatric disorders
   - Family history of mood disorder
3. Each patient with a PHQ 2 score > 0 will receive the Patient Health Questionnaire (PHQ-9), when possible. The PHQ-9 score will be obtained and documented.
4. Once depression is diagnosed, therapy can be initiated, whether it consists of psychotherapy, medications, counseling or all three.
5. Suicide risk will be assessed regularly throughout the course of treatment, including consultation with family and friends where appropriate. Agitation and suicide risk may increase early in treatment. The following will be used to screen for suicide risk:
   - Ask all depressed patients if they have thoughts of death or suicide, or if they feel hopeless and feel that life is not worth living. Also ask if they have previously attempted suicide.
   - If the answer is yes, ask about plans for suicide. How much have they thought about suicide? Have they thought about a method? Do they have access to material required for suicide? Have they said goodbyes, written a note or given away things? What specific conditions would precipitate suicide? What is stopping them from suicide?
   - Assess risk factors for suicide:
     - Psychosocial - indigenuous, male, advanced age, single or living alone
     - History - Prior suicide attempt, Family history of suicide, Family history of substance abuse, history of abuse/neglect
     - Clinical/Diagnostic – hopelessness, psychosis, medical illness, substance abuse
   - Consider emergency psychiatric consultation and treatment if:
     - Suicidal thoughts are persistent
     - The patient has a prior history of a suicide attempt or a current plan, or
     - The patient has several risk factors for suicide
6. Patient will be seen in close follow-up (2-4 weeks) for re-evaluation.
7. Target length to be on antidepressant is 12 months, to minimize possibility of relapse.
How Often to Audit: Annually.

How Many Charts to Audit: 10 per provider

Identify Charts: Random screen of patients who are active users.

Acceptable Level of Compliance:
Percent of patients screened with PHQ-2: 70%
Percent of patients with positive PHQ-2 that have completed PHQ-9: 70%
Patient Health Questionnaire – PHQ-9

PATIENT NAME

DATE

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all (0)</th>
<th>Several days (1)</th>
<th>More than half (2)</th>
<th>Nearly every day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Little interest or pleasure in things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b) Feeling down, depressed, or hopeless.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c) Trouble falling asleep, sleeping too much.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d) Feeling tired, or having little energy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e) Poor appetite or overeating.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) Feeling bad about yourself or that you are a failure, or have let yourself or your family down.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g) Trouble concentrating on things, such as reading the newspaper or watching TV.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>h) Moving or speaking so slowly that other people could have noticed; or the opposite: being so fidgety or restless that you have been moving around more than usual.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i) Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

□ Not difficult at all □ Somewhat difficult □ Very difficult □ Extremely difficult

TOTAL SCORE:
Instructions – How to Score the PHQ-9

Major depressive disorder is suggested if:
- Of the 9 items, 5 or more are checked as at least ‘more than half the days’
- Either item a. or b. is positive, that is, at least ‘more than half the days’

Other depressive syndrome is suggested if:
- Of the 9 items, a., b. or c. is checked as at least ‘more than half the days’
- Either item a. or b. is positive, that is, at least ‘more than half the days’

Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all=0, several days=1, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

<table>
<thead>
<tr>
<th>Score</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>The score suggests the patient may not need depression treatment</td>
</tr>
<tr>
<td>5-14</td>
<td>Mild major depressive disorder. Physician uses clinical judgment about treatment, based on patient’s duration of symptoms and functional impairment.</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderate major depressive disorder. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.</td>
</tr>
<tr>
<td>20 or higher</td>
<td>Severe major depressive disorder. Warrants treatment with antidepressant, with or without psychotherapy; follow frequently.</td>
</tr>
</tbody>
</table>

Functional Health Assessment
The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient’s functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

For further information on the PHQ-9:
CARDIOVASCULAR DISEASE

**Goal:** To decrease morbidity and mortality associated with cardiovascular disease.

**Objective:** To identify and document cardiac risk factors, and initiate management as necessary to prevent occurrence or recurrence of cardiac disease and injury.

**Methods:**

1. All adult patients (ages 20-64) should have in their chart documentation of a cardiovascular risk assessment performed within the last four years. The assessment shall include the following:
   - Family history (parents and siblings) of coronary artery disease.
   - Screening question will be if any blood relative died suddenly from unexpected disease or had a heart attack before the age of 55.
   - Tobacco use
   - Hypertension (BP>150/90 for 2 readings)
   - Diabetes Mellitus
   - Elevated lipid levels, according to ATP III guidelines:
     - LDL<100 for CAD or CAD-equivalent
     - LDL<130 for 2 or more risk factors
     - LDL<160 for 1 or less risk factors
     - Risk factors: smoking, hypertension, diabetes, HDL<40, FH of significant CAD, men over 45, women over 55
   - Obesity - BMI>=30 (BMI = 705 x weight in pounds/height in inches squared)

2. Any positive answer for tobacco use, hypertension, diabetes, elevated cholesterol, or obesity should be noted on the problem list.

3. Management plan will be documented for each of the identified risks as follows:
   - Cholesterol not known - advise to test
   - Hypercholesterolemia- diet instructions initially and consideration of medical treatment if LDL is not adequately controlled after 3 months of lifestyle changes.
   - Diabetes - evaluate and treat per diabetes protocol
   - Obesity- diet and exercise program and dietitian referral
   - Hypertension- low salt diet and treatment per hypertension protocol
   - Smoking- counseled to stop smoking with or without withdrawal therapy
   - Inactivity- exercise program and instructions
   - Family history- N/A
   - Presence of CVD – aspirin therapy - 81mg to 325mg daily, blood pressure control, lipid levels controlled, weight reduction
     - 2 or more risk factors - if no contraindications, initiate aspirin therapy 81mg daily.

**How Often to Audit:** Annually.

**How Many Charts to Audit:** 10 per provider

**Identify Charts:** Random screen of adult patients who are active users.

**Acceptable Level of Compliance:**
- Control of blood pressure under 150/90: 70%
- Documented patient education and counseling within the last 4 years: 70%
- Use of aspirin or other antithrombotic agent for patients with CVD or at risk for CVD: 90%
- Documented lipid panel in last year: 80%
LDL controlled to appropriate levels, as stated above: 60%
Weight reduction in last year (maximum weight in last 12 months minus last measured weight) for patients with BMI>25: 30%
CORONARY ARTERY DISEASE: LIPID THERAPY

**Goal:** To decrease morbidity and mortality associated with coronary artery disease.

**Objective:** To identify patients with abnormal lipids and initiate interventions of lifestyle changes, diet, exercise, weight loss and lipid lowering medication if indicated.

**Methods:**
1. All patients with documented Coronary Artery Disease should be on lipid therapy unless contraindicated.
2. All adult patients should have annual lipid testing.
3. If lab values are abnormal, dyslipidemia will be noted in problem list, other CVD risk factors will be re-evaluated, patient education and counseling will be documented annually.
4. If lifestyle changes do not result in adequate lowering of lipids, statin therapy will be initiated.

**How Often to Audit:** Annually

**How Many Charts to Audit:** 10 per provider

**Identify Charts:** Random screen of adult patients who are active users.

**Acceptable Level of Compliance:**
- Percent of patients with Coronary Artery Disease on lipid therapy unless contraindicated: 70%
- Percent of adult patients with annual lipid testing: 70%
- Percent of adult patients with LDL > 100 with lifestyle counseling documented in the last year: 80%
- Percent of adult patients with LDL > 100 despite lifestyle counseling on a statin: 70%
ADULT WEIGHT SCREENING

**Goal:** To identify adult patients who are overweight and have a written follow-up plan to address unhealthy weights. Obesity in adults increases risks for many other chronic diseases including diabetes, hypertension, dyslipidemia and coronary artery disease. A 5 to 10% reduction in weight can greatly diminish rate of morbidity and mortality associated with obesity.

**Methods:**
1. All adult patients will have a BMI documented at each visit.
2. Adult patients identified with elevated BMI’s will be counselled about the importance of diet, exercise, and weight loss.
3. Adult patients identified with obesity will have this diagnosis added to their problem list and be referred for Medical Nutritional Therapy if appropriate.
4. Adult patients with obesity will have a follow-up plan documented.

**How Often to Audit:** Annually

**How Many Charts to Audit:** 10 per provider

**Identify Charts:** Random screen of all adult patients.

**Acceptable Levels of Compliance:**
- Percent of adult patients with BMI documented each visit: 90%
- Percent of adult patients with elevated BMI with documented counseling: 70%
- Percent of adult patients identified as obese have diagnosis added to their problem list: 70%
- Percent of adult patients diagnosed with Obesity have documented follow up plan: 70%
TOBACCO USE SCREENING AND CESSATION INTERVENTION

**Goal:** To reduce morbidity and mortality from tobacco use. Tobacco use is the leading preventable cause of death in the US. Stopping tobacco use can drastically improve outcomes in all diseases, including COPD, heart disease, and ischemic vascular disease. Stopping smoking also decreases health risks for maternity patients and children.

**Methods:**
1. All adult patients will be screened for tobacco use one or more times per year.
2. All adult patients who use tobacco will receive cessation counseling and be offered referral to NC QUIT and medication.
3. All adult patients identified as using tobacco will have tobacco abuse added to their problem list.

**How Often to Audit:** Annually

**How Many Charts to Audit:** 10 per provider

**Identity Charts:** Random screen of all adult patients.

**Acceptable Level of Compliance:**
- Percent of patients who have tobacco use updated in history: 70%
- Percent of patients identified as using tobacco that received cessation counseling in the past year: 70%
- Percent of patients identified as using tobacco that have tobacco abuse on their problem list: 70%
Goal: Colorectal cancer almost always develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can find precancerous polyps, so that they can be removed before they turn into cancer. Screening tests can also find colorectal cancer early, when treatment works best.

Methods:
1. Adult patients age 50 to 74 years of age will have appropriate screening for colorectal cancer.
2. Appropriate screening for colorectal cancer will include either fecal occult blood test within 1 year or colonoscopy within 10 years.

How Often to Audit: Annually

How Many Charts to Audit: 10 per provider

Identify Charts: Random screen of patients ages 50 to 74.

Acceptable Level of Compliance: 50%
EMERGENCY PLANS AND PROCEDURES

Emergency Codes
Overhead paged emergency color codes will be used to alert staff of situational emergencies that occur in the agency.

<table>
<thead>
<tr>
<th>Page</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red</td>
<td>Fire</td>
</tr>
<tr>
<td>Blue</td>
<td>Medical Emergency</td>
</tr>
<tr>
<td>Grey</td>
<td>Violence/Security Alert</td>
</tr>
<tr>
<td>Brown</td>
<td>Severe Weather</td>
</tr>
<tr>
<td>Pink</td>
<td>Child Missing</td>
</tr>
<tr>
<td>Black</td>
<td>Bomb Threat</td>
</tr>
<tr>
<td>Orange</td>
<td>Hazardous Material</td>
</tr>
<tr>
<td></td>
<td>Event/Bioterrorism</td>
</tr>
</tbody>
</table>

**Bomb Threat**

All bomb threats should be taken seriously.

When a bomb threat is called in, perform the following procedures:

- Remain calm
- Attempt to keep the caller on the line as long as possible. Ask him/her to repeat the message. Record every word spoken by the person and use the bomb threat report to ask the necessary questions of the caller. See Appendix A.
- Immediately after the caller hangs up, notify the immediate supervisor and make the appropriate page for evacuation for a bomb threat.
  - Code Black
    - Make the page 3 times slowly and clearly.
      - Code Black, Code Black, I repeat this is a Code Black
    - Follow the evacuation procedures for fire response with the exception of the gathering location. Ashe Health Department staff will meet behind the old hospital building in front of Mt. Jefferson Child Development Center. Alleghany Health Department staff will meet at the Daymark Recovery building. Watauga Health Department staff will meet in front of the Department of Social Services Building.
- Employees should take all personal belongings with them. If a suspect item is found, the employee may not return to the building until it is found clear.
- Notify 9-1-1 after staff have evacuated the building. The person who took the bomb threat call should be the person to call 9-1-1 to give the operator the information you collected on the bomb threat report. Alleghany staff will call from inside the Daymark Recovery building. Ashe staff will call from inside the Mt. Jefferson Daycare Center building. Watauga staff will call from inside the Department of Social Services building. **Do not use cell phones or two way radios, as they may set off the suspect device.**
When a written threat is received, perform the following actions:

- Remain calm
- Avoid handling it unnecessarily in order to preserve possible fingerprint(s), handwriting or typewriting, paper and postal marks. These will prove essential in tracing the threat and identifying the writer.
- While written messages are usually associated with generalized threats and extortion attempts, a written warning of a specific device may occasionally be received; it should never be ignored.
- Immediately after the caller hangs up, notify the immediate supervisor and make the appropriate page for evacuation for a bomb threat.
  - Code Black
- Make the page 3 times slowly and clearly.
  - Code Black, Code Black, I repeat this is a Code Black
- Follow the evacuation procedures for fire response with the exception of the gathering location. Ashe Health Department staff will meet behind the old hospital building in front of Mt. Jefferson Child Development Center. Alleghany Health Department staff will meet at the Daymark Recovery building. Watauga Health Department staff will meet in front of the Department of Social Services Building.
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See Bomb Threat Report Form in Employee Safety Manual

**Fire Emergency Response**

Dry chemical Class ABC extinguishers are available in each health department building in all three counties. This type of extinguisher is appropriate for use against fires that are made up of ordinary combustibles (wood, paper textiles), flammable liquids and electrical equipment.

**Alarm System**

The Watauga County Health Department and Ashe School Based Health Center have alarm systems with alarm pull stations. The Ashe School Based Health Center’s alarm system is tied to the Ashe County Middle School’s alarm system. The Alleghany CAP-DA program is housed in the Blue Ridge Development Center (BDC) in Sparta, NC. The Blue Ridge Development Center has alarm pull stations. The Ashe County Health Department and Alleghany County Health Department does not have automatic alarm pull stations due to the age of the building. If a fire is seen or suspected in the Ashe or Alleghany County Health Departments, the lead secretary or back up secretary will go through the building blowing a whistle to alert staff and patients to evacuate the building. The Ashe Environmental Health building has smoke detectors.

**If you discover a fire (see flames or smoke).**

Use the RACE acronym as a reminder for a fire emergency response.

- **Rescue:** Remove anyone in immediate danger
- **Alarm:** Activate fire alarm pull station and dial 9-1-1 (If in Ashe or Alleghany, page “Code Red and the location of the fire”, “Code Red and the location of the fire”, “Code Red and the location of the fire” (THREE TIMES) over the intercom. If the intercom does not work, a whistle will be blown throughout the building.
- **contain:** Close doors to confine the fire
- **Extinguish:** Extinguish the fire, if safe to do so. Evacuate if instructed to do so.
Self-protective measures:
- If your clothes catch fire: Stop, Drop and Roll
- If the smoke is intense, drop to the floor and crawl
- If you are trapped in a room, place a wet towel or cloth under the door to prevent smoke from entering
- Move to a safe location and close doors after ensuring that rooms have been evacuated

If you hear a fire alarm:
- NEVER assume the alarm is "just a drill". Use every opportunity to practice and improve.
- Assist patients outside to the far end of the parking lot. Use the exit routes described later in this section for different parts of each building
- The lead secretary will account for all patients and staff members

Use the fire extinguisher to put out a fire ONLY:
- AFTER the fire department has been notified and
- IF you have a way out and
- You can fight the fire with your back to the exit and
- You have the proper extinguisher, in good working order and
- You know how to use it
  - To use a fire extinguisher, use the PASS acronym:
    - Pull the safety pin
    - Aim the stream at the base of the fire
    - Squeeze the trigger handle together.
    - Sweep the stream from side to side at the base of the fire.

If you are unsure of your ability to safely fight the fire or of the fire extinguisher’s capacity to contain the fire, then confine the fire and leave the area immediately.

Evacuation
All employees should evacuate out of the building as quickly as possible. Each supervisor will take roll call of each employee once everyone has evacuated the building.

All employees will follow the emergency exit diagrams in their current location for an exit route out of the building. This means the closest exit to your current location. All employees at the Ashe County Health Department and the Watauga County Health Department will meet in the front parking lot of each building furthest away from the building. Employees at the Alleghany County Health Department will meet in the side parking lot next to the health department. The Ashe School Based Health Center will follow the evacuation plan and exit routes for the Ashe County Middle School.

Alleghany County Health Department Fire Response
- When a fire is discovered, page "Code Red and the location of the fire", "Code Red and the location of the fire", "Code Red and the location of the fire." If the intercom does not work, a whistle will be blown throughout the building.
- All employees, patients and visitors will meet in the employee parking area for roll call.

Ashe County Health Department Fire Response
- When a fire is discovered, page "Code Red and the location of the fire", "Code Red and the location of the fire", "Code Red and the location of the fire." If the intercom does not work, a whistle will be blown throughout the building.
- All employees, patients and visitors will meet in the employee parking area for roll call.
Watauga County Health Department Fire Drill Instructions

- Whoever discovers the fire will activate the nearest pull station.
- All staff and visitors will meet in the employee parking area for roll call.

Fire Drills

Fire Drills will be performed quarterly for each county health department. The School Based Health Center will follow the schedule for the Ashe County Middle School. The Ashe Environmental Health office is designated as a business, therefore, fire drills are not required by fire code.

Watauga County Health Department Fire Drill Instructions

- Call Security Central for Creekside Electronics, Inc. and tell them you need to put the Watauga County Health Department’s fire alarm system on test. Tell them how long you expect the test to last: Approximately 30 minutes. The number is: 1-800-438-4171
  - Our account number is: 8120
  - The receiver number is: PY
  - The pass code is 1430
- Notify Boone dispatch that we are going to be doing a fire drill. The number is: (828) 262-4500
- Take the key from the system panel in the secretary’s office area, insert the key into a pull station, open the door and push down the black lever to sound the fire alarm.
- Evacuate the building, timing how long it takes everyone to get out. The evaluator will stay in the building about 3 minutes to make sure everyone is out.
- Reset the pull station by closing the door and turning the key.
- Go back to the Front Office area and insert the key in the panel box and turn the key. Press “Silence”. Press “Acknowledge”. Then press “Reset”.
- Call “All Clear” and allow everyone to re-enter the building.
- Call Security Central for Creekside Electronics to put the health department “back on-line”.
- Call Boone Dispatch to notify them the drill is over.

Ashe County Health Department Fire Drill Instructions

- The employee that leads the drill will notify dispatch that we are going to be doing a fire drill. The number is: (336) 846-5600
- The employee that leads the drill will then page “Code Red and the location of the fire”, “Code Red and the location of the fire”, “Code Red and the location of the fire.” If the intercom does not work, a whistle will be blown throughout the building.
- All employees, patients and visitors will meet in the employee parking area for roll call.
- Evacuate the building, timing how long it takes everyone to get out. The evaluator will stay in the building about 3 minutes to make sure everyone is out.
- Page and inform everyone “All Clear” and allow everyone to re-enter the building.
- Call dispatch to notify them the drill is over.

Alleghany County Health Department Fire Drill Instructions

- The employee that leads the drill will notify dispatch that we are going to be doing a fire drill. The number is: (336) 372-4455
- The employee that leads the drill will then page “Code Red and the location of the fire”, “Code Red and the location of the fire”, “Code Red and the location of the fire.” If the intercom does not work, a whistle will be blown throughout the building.
- All employees, patients and visitors will meet in the employee parking area for roll call.
- Evacuate the building, timing how long it takes everyone to get out. The evaluator will stay in the building about 3 minutes to make sure everyone is out.
- Page and inform everyone “All Clear” and allow everyone to re-enter the building.
- Call dispatch to notify them the drill is over.
Hurricane Plan and Sheltering In Place

A hurricane is a tropical storm with winds at a constant speed of at least 74 miles per hour. The storm itself can cover a circular area between 200 and 480 miles in diameter, last more than two weeks over open water, and travel across the entire length of the Eastern United States. Hurricane season is June 1 through November 30, with peak months being August and September. Unlike fires or tornadoes and other severe weather emergencies, hurricanes are tracked for weeks before they make landfall. This allows time to prepare for the storm.

Hurricane Plan Procedures

- Remain calm
- All employees and patients will be advised to shelter in place and gather in the center of the building on the first floor (not below ground floor), and close all doors and windows.
  - Page Code Brown and advise all employees, visitors and patients to shelter in place and gather in the center of the building on the first floor (not below ground floor), and close all doors and windows.
- Gather essential disaster supplies (e.g., nonperishable food, bottled water, battery-powered radios, first aid supplies, flashlights, batteries, duct tape, and plastic garbage bags if available) if there is time
- Stay away from windows and doors and stay indoors until the storm is over.

Shelter in Place Guidelines

Not all emergencies require the evacuation of your building. During certain emergencies, authorities may recommend citizens to “shelter in place”. This is a precaution aimed to keep you safe while remaining indoors. Most likely you will only need to shelter in place for a few hours. Shelter in place is not the same thing as going to a shelter in case of a storm.

- Shelter in place does not mean sealing off your entire office building or health care facility
- Shelter in place means taking refuge in your agency or whatever other building you are in. It is preferable to take refuge in interior rooms, with a water supply, but with no or few window. If you are told to shelter in place in your agency, follow the guidelines below.

In the event shelter in place is indicated, you should:

1. Notify your supervisor who will notify the Deputy Health Director.
2. The Deputy Health Director will give the ok to close the agency or parts of the agency. Close and lock all windows, exterior doors, and any other openings to the outside.
3. If you are told there is danger of explosion, close the window shades, blinds or curtains.
4. Select interior rooms above the ground floor with the fewest windows or vents.
5. Avoid rooms with mechanical equipment like ventilation blowers or pipes because this equipment may not be able to be sealed form the outside.

Keep People Safe

- If there are patients or visitors in the building, provide for their safety by asking them to stay, not leave.
- Gather essential disaster supplies (e.g., nonperishable food, bottled water, water filters, battery-powered radios, first aid supplies, flashlights, batteries, duct tape, and plastic garbage bags if available)
- Unless there is an imminent threat, ask staff, patients and visitors to call their emergency contact to let them know where they are and that they are safe.
- Turn on call-forwarding or alternative telephone answering systems or services. Change the recording to indicate that the office is closed.
- Continue listening to the radio or television until you are told all is safe or you are told to evacuate in specific areas at greatest risk in your community.

Tornado Plan
A tornado is a violent storm with spiraling high-speed winds. The noise of a tornado has been described as a roaring sound, like a train far away. Tornadoes often accompany severe thunderstorms and are only one of many thunderstorm hazards.

Severe Thunderstorm WARNING:
A warning is issued when the National Weather Service expects thunderstorms with large hail and/or damaging winds in excess of 57 miles per hour. Frequent lightening is likely and a tornado is possible.

Tornado WATCH:
A tornado watch is issued when the National Weather Service determines that the atmospheric conditions are favorable for tornadoes to form, although none have yet been sighted. A “watch” is intended to provide enough time, for those who need to set their plans in motion to do so.

Tornado WARNING:
A tornado warning is issued when a tornado has been sighted or is indicated by weather radar. Warnings advise of a threat to life or property. IMMEDIATELY TAKE COVER IN A SAFE AREA AWAY FROM OUTSIDE WINDOWS/DOORS, IN AN INTERIOR LOWEST LEVEL OF THE BUILDING.

Procedures if a Tornado Warning occurs:
- Remain calm
- All employees and patients will be advised to shelter in place and gather in the center of the building on the first floor (or a below ground floor if available) and protect your head.
  - Page Code Brown and advise all employees, visitors and patients to shelter in place and gather in the center of the building on the first floor and protect your head (Repeat three times).
- Follow the above mentions shelter in place guidelines.
- Gather essential disaster supplies (e.g., nonperishable food, bottled water, water filters, battery-powered radios, first aid supplies, flashlights, batteries, duct tape, and plastic garbage bags if available) if there is time
- Stay away from windows and doors and stay indoors until the storm is over.

Protocol for Weather Drills and Weather Responses

Tornado

Drill: To enact a tornado drill, the employee leading the drill will page “This is only a drill. Code Brown, all employees, visitors and patients should calmly shelter in place and gather in the center of the building on the first floor and protect your head. When all is clear another page will be made. This is only a drill.” (Repeat three times)

Response: To respond to a tornado warning page “Page Code Brown and advise all employees, visitors and patients to shelter in place and gather in the center of the building on the first floor and protect your head.” (Repeat three times)

Hurricane

Drill: To enact a Hurricane drill, the employee leading the drill will page “This is only a drill. Code Brown, all employees, visitors and patients should calmly shelter in place and gather in the center of the building on the first floor and protect your head. Stay away from windows and doors and stay inside until the all clear is given. This is only a drill.” (Repeat three times)
Response: To respond to a hurricane warning page “Page Code Brown and advise all employees, visitors and patients to shelter in place and gather in the center of the building on the first floor and protect your head. Stay away from windows and doors and stay inside until the all clear is given.” (Repeat three times)

Medical Emergencies

In the event of a medical emergency, use the Medical Emergency Code to alert other employees to help and to report to the area.

Policy: Although AppHealthCare does not operate emergency rooms, it is our policy to identify and respond to life threatening patient emergencies occurring in the office in a rapid, responsible and professional manner. Our purpose is to stabilize the emergency patient.

Procedure:
The following procedures will be used to implement this policy:

1. "Code Blue" will be announced by the clinical staff member who discovers a patient emergency has occurred. Patient will be placed flat on his/her back on the floor or on an exam table as available.

2. Management Support Clerical staff will be assigned the following duties during a "Code Blue":
   A. Notify EMS (911 or emergency number for each centers county) on Doctor or Nurse’s instruction, with patient information to include age, sex, condition, office address.
   B. If patient is in public area of office, management support clerk will escort other patients and family members away from the emergency scene.
   C. If a second Management Support staff member clerk is available, they are responsible for updating and assisting patient’s family. If the second Management Support staff member clerk is not available, the recorder will assist the family when possible.

3. First medical professional on the scene, either nursing staff or provider, will assess patient and begin BLS per protocol during a "Code Blue".

4. Other nursing or Management Support clerical duties during "Code Blue":
   A. The Management Support clerk or second nurse will open the chart and document emergency procedures to include patient history, code start time, medications administered, procedures performed and code end time. A copy of this report plus patient’s basic demographic information will be made available to EMS.
   B. Secondary nurse or Management Support clerk will assist with BLS.
   C. Secondary nurse will assist provider with advanced cardiac life support. As appropriate, run EKG, start IV, and administer meds, on provider instruction.
   D. Each site will determine who will be the recorder for their site. If the second nurse is the recorder, Management Support the clerk will assist the first nurse with BLS and the second nurse will record as well as assist the provider with ACLS. If Management Support the clerk is the recorder, the second nurse will assist with BLS and ACLS.
5. The following additional procedures will be followed to insure that the office is prepared in the event of a “Code Blue”:

   A. Nurses will monitor the crash box monthly for appropriate stocking and dating of medicines and to insure that equipment and oxygen are in working order. Medical Director will advise as to medicines and equipment necessary for the crash cart. The monthly crash box check will be documented. Any discrepancies or problems will be reported to the Director of Risk Management for action.

   B. Clinical staff will maintain current CPR certification (BLS). Clerical staff is encouraged to obtain CPR certification. Management will arrange and pay for classes each year. Providers are encouraged to obtain and maintain advanced cardiac life support certification (ACLS).

   C. Office manager phone numbers for each phone station to include numbers for EMS, police, poison control and fire department. All centers are covered by 911.

   D. The Director of Risk Management will arrange with each center staff a “Code Blue” drill to be conducted annually. This will include review of emergency/disaster plans & policies. This will be documented.

   E. All new employees will be trained in “Code Blue” policies/procedures. This will be documented also with emergency/disaster plans and policies.
ASSESSMENT OF PATIENTS POLICY

General: AppHealth assesses each incoming patient for his/her physical, psychological, social, nutritional, and functional status to determine the need for care or treatment. Information from other agencies or clinical settings is included in the initial patient assessment. Educational needs and the capacity for home care are assessed so the center staff may arrange for appropriate training and/or referrals.

The patient will be reassessed at each clinic visit for any changes from the initial assessment. Progress or other changes made from one visit to the next in terms of the patient's diagnosis, care setting, desire for care, and response to care is noted in the medical record. The assessor will complete or assist patient with completing the Health History Form during the first visit. When appropriate and with the patient's approval, data from family or caregiver will be included. Initial assessment includes review and integration of all available past medical history and records, if applicable. Any collaborative efforts between departments, agencies, or care facilities will be clearly documented and delineated in the medical record. The assessor will record relevant physical data that may include the following:

1. Laboratory findings
2. Allergies
3. Present medication usage
4. Activities of daily living
5. Nutritional status, if indicated
6. Patient mobility/functional status, if indicated
7. Alcohol and tobacco consumption
8. Past medical history and family medical history
9. Past hospitalizations/surgeries/invasive procedures
10. Review of systems
11. Wound location and duration
12. Temperature, pulse, respiration, blood pressure, BMI
13. Comfort level (pain threshold)
14. Evidence or suspicion of abuse

In the case of suspected abuse, staff is trained in the legal and procedural actions that must be taken under such circumstances. Victims of alleged or suspected abuse and neglect are assessed with the informed consent of the patient. All relevant staff is also trained in the federal, state, and/or local statutes that apply to the collection of evidentiary material and the notification of authorities in suspected abuse cases. Staff is familiar with local resources for referral of patient and family, to be utilized as appropriate.

Non-physical assessment data include:

1. Patient diagnosis
2. Patient care setting
3. Patient's desire for care
4. Patient's response to care/care plan
5. Patient's need for follow-up care

If a need for follow-up care is identified, the appropriate clinical staff develops a care plan, and follow-up visits are scheduled. Center staff takes measures to communicate to the patient the importance of keeping follow-up appointments.

Diagnostic Testing: The center provides for diagnostic testing as part of the patient assessment process. When a center has X-ray, laboratory, and other diagnostic services on-site, these facilities are sufficient
for patient assessments, and are utilized as appropriate. If any or all of these facilities are not on-site, contractual and procedural agreements with off-site laboratories and/or radiology providers are established in writing, and the center provides the use of these services as part of patient assessment.

The results of diagnostic tests are interpreted in a timely manner by qualified professionals, who may be part of the center staff, or who are provided to the center by means of established and written contract. Pathology examinations of tissue samples are reported to the center staff quickly and without delay. All results of diagnostic testing are recorded in the patient medical record.

If the center maintains on-site laboratory facilities, these facilities are in compliance with federal regulations, (CLIA-88). Documentation of compliance with federal regulations, and documentation that testing provides the quality and accuracy to support clinical and medical decisions, is supplied by all in-house or contracted referent facilities. See Lab Manual for details.

Assessment of Child and Adolescent Patients: Assessment of child or adolescent patients will be highly individualized and will include evaluation during Well-Child visits and as indicated during sick visits of the following:

1. Growth and development
2. Emotional needs
3. Cognitive status
4. Educational needs
5. Social needs
6. Daily activity needs

In addition, this center recognizes the need to be alert to suspicion or signs of abuse of its child and adolescent patients. All staff members are trained in heightened alertness to vulnerable populations, the recognition of signs of abuse, the criteria for identifying a victim of abuse, and the legal and procedural actions which must be taken under such circumstances. Victims of alleged or suspected abuse and neglect are assessed with the informed consent of the patient, parent, or legal guardian or otherwise as provided by law. All relevant staff is also trained in the federal, state, and/or local statutes that apply to the collection of evidentiary material and the notification of authorities in suspected abuse cases. Staff is familiar with local resources for referral of patient and family, to be utilized as appropriate.

Prenatal and Postpartum Assessment: Prenatal and postpartum patients are seen and treated per ACOG guidelines for prenatal and postpartum care. Care is transferred to the delivering physician at 37 weeks, sooner if patient is deemed beyond the scope of this practice.

Reassessment: Each patient will be reassessed at each clinic visit to determine appropriate progress, and identify any changes from the initial assessment. If indicated, reassessment includes evaluation of the patient’s:

1. Diagnosis
2. Response to treatment
3. Knowledge of previous visit instruction
4. Areas of knowledge deficit
5. New illness/disease state
6. Wound condition, dressing usage and care needs
7. Signs and symptoms of complications
8. Continuing care needs
9. Nutritional status and needs
10. Comfort level
11. Compliance with treatment/care plan
If a significant change in the patient’s condition is detected upon reassessment, care plans are adjusted accordingly, and timely reassessments are arranged. Mechanisms and policies are established and utilized within the center to assure that care decisions are coordinated and appropriate throughout the patient’s contact with the health center.

Potential Victims of Abuse and Neglect:

1. **General**
   All health care providers have a responsibility to be alert to the indications given by patients that they may be potentially victims of abuse or neglect. This responsibility embraces all patients, that is: infants, children, victims of sexual assault, victims of spousal or partner abuse, and geriatric patients.

2. **Criteria**
   The criterion listed below is a representative, but not exclusive list of indications that health care provider should be alert to patient abuse systems.
   
   ● **Child Abuse:**
     
     **Physical Indications:**
     - Lacerations
     - Bruises
     - Unexplained swelling
     - Unexplained broken bones
     - Significant unexplained weight loss

     **Behavioral Cues:**
     - Nervous or inappropriate laughing or smiling
     - Crying
     - Sighing
     - Anxiety
     - Defensiveness, Anger
     - Lack of eye contact, or fearful eye contact
     - Minimizes seriousness of injuries
     - Reluctance to speak in the presence of a potential abuser

     **Verbal Cues**
     - Talks about a "friend" who has been abused
     - Refers to a partner’s "anger" or "temper"
     - Responds affirmatively to any of the following questions:
       - Have you been hit or harmed any time in the past year?
       - Have your parents ever destroyed things you cared about?

   ● **Spousal or Partner Abuse:**
     
     **Physical Indications:**
     - Lacerations
     - Bruises

     **Injuries to the facial area**
     - Unexplained swelling
     - Unexplained broken bones
     - Significant unexplained weight loss

     **Behavioral Cues:**
Nervous or inappropriate laughing or smiling
Crying
Sighing
Anxiety
Defensiveness, Anger
Lack of eye contact, or fearful eye contact
Minimizes seriousness of injuries
Overly attentive, aggressive or defensive partner
Reluctance to speak in the presence of a potential abuser

Verbal Cues:
Talks about a "friend" who has been abused
Refers to a partner's "anger" or "temper"
Responds affirmatively to any of the following questions:
Have you been hit or harmed any time in the past year?
Are you in a relationship with someone who hurts or threatens you?
Has your partner ever destroyed things you cared about?
Has your partner ever forced you to have sex when you did not want to?

● Sexual Assault

Physical Indications:
Lacerations
Bruises
Injuries to the vaginal area

Behavioral Cues:
Nervous or inappropriate laughing or smiling
Crying
Sighing
Anxiety
Defensiveness, Anger
Lack of eye contact, or fearful eye contact
Minimizes seriousness of injuries

Verbal Cues:
Talks about a "friend" who has been abused
Refers to a partner's "anger" or "temper"
Responds affirmatively to any of the following questions:
Have you been hit or harmed any time in the past year?
Are you in a relationship with someone who hurts or threatens you?
Has your partner ever destroyed things you cared about?
Has your partner ever forced you to have sex when you did not want to?

● Elder Abuse

Physical Indications:
Lacerations
Bruises
Unexplained swelling
Unexplained broken bones
Significant unexplained weight loss
Any evidence of malnutrition

Behavioral Cues:
Nervous or inappropriate laughing or smiling
Crying
Sighing
Anxiety
Defensiveness, Anger
Lack of eye contact, or fearful eye contact
Minimizes seriousness of injuries
Overly attentive, aggressive or defensive partner
Reluctance to speak in the presence of a potential abuser

Verbal Cues
Talks about a “friend” who has been abused
Refers to an adult child’s “anger” or “temper”
Responds affirmatively to any of the following questions:
Have you been hit or harmed any time in the past year?
Are you ever hurt or threatened by a caregiver or close relative?
Has your caregiver ever destroyed things you cared about?

3. **Action**

In this healthcare organization all staff will be oriented to these criteria as part of the initial employee orientation. All staff directly involved in the provision of healthcare services will receive periodic updates regarding these criteria.

The reporting of abuse will be carried out in accordance with current law and regulation. The organization will maintain a current list of referral agencies to assist patients and healthcare providers in seeking appropriate assistance with issues of patient abuse or neglect.
CONTINUITY OF CARE PLAN

**General:** AppHealth Care provides general primary health care to members of the community. A description of the scope of health care services is set forth in the Patient Information Brochure available at the patient registration desk. The primary health care services are available for all age groups, for persons of either sex, and include assessment and diagnostic services, treatment of acute and episodic disorders, the management of chronic health conditions, referral for specialty health care services, and patient health care education.

**Initial assessment:** New patients of the AppHealth Care will receive a comprehensive initial assessment to ascertain the appropriateness of care available at the community health center.

The assessment of patient health care needs will include basic demographic information, individual and family health history, a physical assessment, and as appropriate, the assessment of nutritional needs, psycho-social needs, health education learning needs, and any other special needs relevant to the provision of quality health care services.

A new patient, presenting for the first time with an urgent or episodic health care need will have those factors assessed that are relevant to the immediate episode of care. By the third visit to the community health center the remaining elements of the comprehensive assessment will be completed, and a Health History Form initiated in the patient’s health record.

Demographic information will be used to determine the payment status, and the third party payers for the patient. It is the policy of the AppHealth Care that ability to pay will not be a factor in determining eligibility to receive care. A sliding fee scale is available to all patients with an annual household income at or below 200% of the federal poverty level.

The specific information to be obtained for all patients is described in the policies listed below:

- Demographic & Payment Status
- Financial Policies
- History & Physical Examination
- Assessment of Patients
- Nutritional, Psycho-Social, & Learning Needs
- Assessment of Patients
- Advance Directives
- Patient Rights

**Referrals from an outside organization:** Patients who are referred to AppHealth by an outside health care or social service organization will be regarded as new patients, with the initial assessment expectations those that are set forth above. With the written consent of the patient, relevant health and social history data will be requested from the referring organization.

**Referral to another health care organization:** Patients whose health care needs exceed those that can be provided by AppHealth Care, in terms of complexity and scope, will be referred to another health care organization whose scope of care meets the needs of the patient. When requested, and authorized in writing by the patient, the findings of any health care assessment performed at AppHealth will be made available to the organization to which the patient has been referred for care.
Criteria defining the appropriate care setting: The following elements will be utilized in making a determination regarding the most appropriate care setting for the patient:

2. The patient's specific health care needs.
3. Payment status will not be a determining factor.

Patients who are being cared for on a regular basis at another health care facility will not be eligible for limited health care services (such as laboratory tests only, or pharmacy services only), except in unusual circumstances, and then only with the approval of the Medical Director.

Referral Protocols: Clinical protocols that detail the referral process should be followed by staff. These include but are not limited to: AppHealthCare Referral Process; Policy 509 Referral Follow-Up Protocol; Policy 204 Patient Records Management; Policy 570 After Hours Calls

Patient Transfers: Patient transfers arise from urgent health care needs and are distinguished from routine referrals by the sense of medical urgency. Patient transfers are to be carried out in the following manner:

1. Transfer is to be made by ambulance or EMS vans.
2. The hospital to which the patient is being transferred will be notified prior to the patient's leaving AppHealth.
3. The patient's consent or the consent of an authorized patient surrogate will be obtained prior to the transfer.
4. All relevant medical information will be assembled and transported with the patient.
5. When not accompanied by family members, AppHealth will make every effort to reach family members and advise them of the transfer.
6. A follow-up telephone call will be made to confirm the patient's arrival at the hospital.

Referral Agreements: When referrals for specialty health care services, or any other related health care services, develop in such a manner that a regular pattern can be discerned, AppHealth will seek to establish a referral agreement with the other health care provider. Such an agreement will set forth the conditions for referral, the procedures to be followed in transferring patient information and for the return of information related to the relevant findings. In addition to the progress of treatment, the agreement may also set forth the arrangements for billing of the services, matters related to medical malpractice liability, and such matters related to quality of care or accreditation issues.

Denial of Care: Patients may be denied health care on the basis of several factors:

1. Patient care needs that are beyond the scope of services available at AppHealthCare (The Clinical Program Services Policy should serve as an additional reference for any concerns about patients with healthcare needs that require specialty care).
2. A pattern of significant non-compliance with health care instructions which, in the judgment of the primary health care provider, jeopardize the health of the patient.
3. Failure to abide by health and safety requirements of AppHealthCare (non-smoking policy, non-tolerance for verbal or physical abuse of staff and other patients, etc.)
4. Other factors which make the continued provision of health care services inappropriate.
5. All patients who are denied care have a right to appeal this decision to the CEO by making a request.

Patient Information Rack Cards and Welcome Letter: Patient Information is available at the registration desk at each of AppHealth Care facilities. The brochures contain information regarding the scope of services, the hours of operation and how to obtain assistance after hours, procedures for appointments,
applying for the sliding fee scale discount (including no one will be turned away for inability to pay) and for walk-in services. Patient information will be available in English and Spanish.
CARE OF PATIENTS POLICIES

**General:** This center operates according to an established and written set of patient care standards, which addresses all aspects of patient care. Patient care plans are developed and performed by qualified professionals in accordance with professional standards. All patients are monitored closely during and after procedures are performed.

**Determining Procedures:** Patient care procedures are determined in part by assessment of the patient as explicated in the Assessment of Patients policy. Also operative in determining appropriate procedures is the review of the procedure’s potential risks and benefits. Once determined, patient care is performed by a licensed, credentialed, and qualified professional as required by law and as stipulated by the governing body. Patient care is carried out under satisfactory environmental conditions, (as described in the Environment of Care Manual), and in accordance with Patient Rights and Organizational Ethics Policies.

There is a process for periodic assessment of the appropriateness of the medical care that this health center delivers. This process includes:

1. Professional peer review
2. Periodic chart audits
3. Patient satisfaction surveys
4. Review of Performance Improvement activities
5. Intensive assessment of significant negative outcomes

**Informed Consent:** Informed consent is the basis for a valid procedure permit. The physician will be responsible for discussing with the patient and family the nature of the procedure and potential benefits, risks, and potential complications. An informed consent form will be completed for all elective, invasive procedures to include lesion and tumor removals and destructions, skin, cervical and endometrial biopsies, placement of long acting reversible contraception, toenail removals and joint injections. As dictated by the patient history, it may become necessary to obtain medical information from other physicians or facilities. The medical record shall contain evidence of the patient's informed consent. See Informed Consent at the end of this policy.

**Medications/Pharmacy:**

**A. General:**

All medications are dispensed by a qualified professional with adequate credentialing and privileging as required by law. All medications are prescribed and dispensed according to applicable federal, state, and local laws.

Medications are selected, prescribed, and dispensed by qualified professionals according to organizational goals and in accordance with local, state, and federal law. Patient medication information is always considered when prescribing, ordering, or dispensing medication. Medication dispensing areas are kept clean and organized according to the policies described in Environment of Care Policy Manual. Medication storage areas are kept locked.

**B. Sample Medications -**

1. **SCOPE** - This policy addresses practices and procedures for all sample medications provided to patients of this organization. This includes any nutritional supplements provided to pediatric or geriatric patients since these supplements are issued by lot numbers, and are subject to recall.
2. **RESPONSIBILITY** - The Medical Director is responsible for all aspects of the sample medications program of this organization.

3. **CUSTODY** - Sample medications are in the custody of the physicians or other health providers to whom the pharmaceutical representatives have officially provided the samples in accordance with state law and regulation. The custody of the medication remains the responsibility of the physician to whom the medications were given.

4. **SECURITY** - All sample medications are stored in locked cabinets or closets. Keys to the sample medications locked areas are provided only to those individuals that are authorized to give the medications to patients on behalf of the physicians who have legal custody of the medications.

5. **INVENTORY** - Appropriate inventory controls will be conducted to assure proper security, storage, transportation and administration of sample medications. At least monthly, all sample medication lockers will be inventoried to remove all out-dated medications. Out of date medications will be discarded or disposed of in accordance with applicable state law and regulation.

6. **FORMULARY** - Each physician will determine which sample medications he/she will accept. The program will not accept medications solely on the preference of the pharmaceutical representative. Consideration for the benefit to the center’s patients will be made in the decision to accept sample medications. No narcotics or other controlled medications will be accepted.

7. **RECALL TRACKING** - All sample medications provided to patients will be recorded to include medication name, dosage and lot number. This will be done in the patient’s EMR chart, or on a sample log-out tracking sheet. The pharmaceutical representative is responsible for entering the name, lot number of the medications, expiration date and the date they were provided to the organization on the appropriate recall-tracking sheet. Recall tracking sheets will be maintained in each of the sample medication lockers.

8. **ADVERSE DRUG REACTIONS** - A record will be maintained of all adverse drug reactions that are reported to the health center by patients who have received medications from the health center. A summary of reported adverse drug reactions along with any corrective action taken by the health center’s medical staff will be reported to the Quality Improvement Committee.

C. Emergency Medications

Emergency medications are located in a secure and easily accessed location and/or on the emergency cart. Patient demographics determine the contents of emergency medication stores. The exterior of the emergency cart is inspected daily. The emergency cart is locked with a serially numbered breakaway lock. The number on this lock is inspected daily. A member of the nursing staff monthly inspects the interior contents of the emergency cart. All records of inspection are maintained.

D. Multiple dose vials

**Issue:** Staff needs clear and consistent guidance regarding the procedures used to expired biologicals contained in multiple dose vials.

**Policy:** To be followed as outlined below:

1. Appropriate sterile technique will be employed whenever multiple dose vials are entered.
2. Upon the initial draw from a multiple dose vial, the current date will be recorded on the vial label.

3. If the vial contains medications to be used for infant or pediatric immunizations, the vial will be considered expired 30 days after the date of the initial entry. The expired vial and its contents will be disposed of in accordance with current approved practice.

4. If the vial contains other medications, the vial will be considered expired on the expiration date given on the label by the manufacturer, provided there is no evidence of contamination.

5. If at any point appropriate sterile technique is compromised, the vial and its contents will be considered expired and disposed of.

6. Should there be any physical or visual evidence of contamination the vial and its contents will be considered expired and disposed of.

Pharmacy Services

Pharmacy services are provided by Halsey Drug located in Sparta and Peoples Drug located in West Jefferson. These pharmacies are staffed by appropriately credentialed and licensed pharmacists and staff, who follow all regulations and procedures as defined by local, state and federal law.

Laboratory Services

The following policies apply in the case of a laboratory which is designated by CLIA certification as a moderate complex laboratory solely equipped for the performance of routine laboratory testing or routine diagnostic laboratory testing.

Laboratory facilities will comply with CLIA-88 regulations and any state or local statutes that may apply. Procedures for infection control as outlined in the Environment of Care Policy Manual will be followed, and records of quality control and compliance shall be maintained.

Specimen collection and specimen preservation shall be performed according to infection control policies. Test performance shall be subject to quality control checks. Records of quality control shall be maintained. A record of scheduled and regular instrument calibration, equipment performance evaluation, and product quality control and evaluation are current and maintained.

All refrigerators which are used to contain specimens, reagents, and medicines are monitored daily for appropriate temperatures in accordance with CLIA standards, (34°–40°F).

The mission of AppHealth laboratory is to maintain high standards of patient testing through an on-going process designed to evaluate and monitor the quality of the total testing process, which includes general systems, pre-analytical, analytical, and post analytical. This includes patient preparation and specimen receipt, testing and test result reporting. Our Laboratory Quality Assessment program also includes interaction with the patients, doctors, clinics, state and local government agencies and other laboratories. The objective of this Quality Assessment Plan is to: Establish and follow written policies and procedures, Assure the integrity of the specimen sample, Assure the accurate, reliable and prompt reporting of test results, Monitor and evaluate quality control logs, Identify and correct problems, Identify needs, provide training and other resources required to maintain competency and improve the skills of testing personnel, Documentation of all aspects of quality assured services, and improve communication.

The Quality Assessment Plan is reviewed and updated annually by the Lab Manager, State Lab Technical Consultant, and all Laboratory Technicians.
Medical Records

Medical records are maintained for each patient. Records contain accurate recording of the following when indicated:

1. Physiological status
2. Mental status
3. Administered fluids, medications, and/or blood
4. Allergic reactions
5. Procedure complications
6. Pathology and laboratory results
7. Medications prescribed and/or administered
8. Any adverse effect of medications on patient
9. Dietary needs when applicable
10. Referrals and information from other agencies/providers/clinics
11. Informed consent to treatment

AppHealth uses an Electronic Medical Record (EMR), so that progressively less paper records are being produced. The EMR is secured by standard electronic security measures that include strong passwords, rotating passwords, locking screens requiring passwords to access, and security profiles for different members of the active staff. The paper-based medical records that remain are stored in locked cabinets, or in secure spaces such as locked rooms in order to assure the confidentiality of medical records, and also to protect them from loss, tampering, alteration, and destruction. During office hours staff secures records. All persons having access to the cabinet or to the secure spaces used for storing medical records, whether an employee of the center or a contracted service, are governed by written confidentiality pledges.

Data is entered into the medical record by the end of each clinic day. Active medical records are stored for a period of seven years, unless otherwise stipulated by state regulation (see Management of Information for details). Inactive medical records are retired in accordance to state regulation. The release of any information contained in the medical record may only be performed with the written consent of the patient.

Verbal orders for medications (orders received via telephone) may be initiated by authorized health care providers and executed by nurses under their direction. Any time verbal orders for medications are received; they will be entered into the patient record and countersigned by the healthcare provider initiating the order within 48 hours of the next day the provider is in the practice. Communication by email or other electronic means constitutes written orders, and as such, do not have to be signed in any way.

Rehabilitation Plans: A rehabilitation plan is developed by the appropriate primary care provider based on accepted professional standards, with the goal of restoring or improving the patient’s best level of independence and quality of life. The following criteria are assessed in the development of a rehabilitation plan:

1. Patient’s needs
   81717760. Patient’s ability
   81717761. Patient’s education
   81717762. Patient’s support system
   81717763. The treatment necessary to reach defined and reasonable goals
   81717764. Patient’s housing environment
   81717765. Patient’s vocational environment
   81717766. Patient’s social environment
A qualified professional implements rehabilitation plans. Planning for eventual discharge from rehabilitation programs is initiated early in the treatment process. Written discharge criteria determine a patient’s readiness to end rehabilitation services.
PATIENT SPECIFIC INFORMATION (MEDICAL RECORDS)

Goal: The goal of maintaining accurate and timely information for each patient is to promote the effective and efficient provision of healthcare services.

Customer Health Record: The organization at the first patient contact shall establish a patient health record. The record, as applicable, shall include the following documentation:

- patient demographic information (including but not limited to the patient’s name, gender, address, phone number, date of birth, height, weight, as well as the name, address, and phone number of any legally authorized representative
- legal status of patients receiving mental health services
- any findings and assessments
- conclusions and impressions drawn from medical history and physical examination
- the diagnosis or diagnostic impression
- evidence of known advance directives
- evidence of informed consent for procedures and treatments as appropriate
- diagnostic and therapeutic orders
- all diagnostic and therapeutic procedures, tests, and results
- all operative and other invasive procedures
- progress notes made by authorized individuals, including the date, staff person, and care or service provided
- all reassessments
- all consultant reports
- every medication prescribed
- every dose of medicine administered to the patient, including the strength, dose or rate of administration, administration devise used, access site or route, known drug allergies, adverse drug reactions, and patient’s response to medication (if known)
- all relevant diagnoses established during the course of care
- referrals or communications made to external or internal care providers and community agencies
- when appropriate and necessary, treatment summaries and other pertinent documents to promote continuity of care
- documentation of clinical research interventions, as appropriate, which are distinct from entries related to regular patient care.

When appropriate, information received from treatment of the patient from other providers of care will be included in the health record.

PRE & POST OPERATIVE DOCUMENTATION (This section does not generally apply to primary care practices but may apply to dental and some procedures performed.)

The customer health record shall thoroughly document operative and other procedures as well as the use of anesthesia. This documentation, if applicable, shall include:

- a preoperative diagnosis (documented prior to the procedure by the responsible licensed independent practitioner)
- operative reports which document the provider and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis
- authentication of the operative report in accordance with the organization’s timeliness policy
- postoperative documentation which records the patient’s vital signs, level of consciousness, medications (including intravenous fluids), and any unusual events or postoperative complications
• patient's discharge from post anesthesia care by a responsible licensed independent practitioner or according to discharge criteria: as well as the documentation of the licensed independent practitioner responsible for the discharge.

Please note that the organization does not have any approved discharge criteria. However, the organization reserves the right to develop such criteria in the future and such criteria will be strictly followed to determine the patient's readiness for discharge.

SUMMARY LIST (PROBLEM LIST)

A summary list including all significant diagnoses, special procedures, drug allergies, and medication lists will be produced in the health record as information is gathered and input into EMR. This will be as complete as possible by the third consecutive visit of a customer to the organization's facility.

URGENT CARE ACTIVITIES

In the event of an urgent or emergent issue, particularly when the patient is being transferred or rushed to another provider of care, it is the responsibility of the organization to provide information quickly to the provider of follow-up care within the constraints and limits of confidentiality. Additionally, the medical record should note:

- the time and means of arrival
- when a patient leaves against medical advice (AMA): as well as
- the conclusions at termination of treatment (including final disposition, condition, and instructions for follow-up care).

Finally, authorization for the transfer of the health record should be granted by the patient or the legally authorized representative before information can be released.

TIMELY MANAGEMENT & ACCESS TO HEALTH RECORD INFORMATION

Access to health record information should be on a timely basis. The timeliness of records is determined by the type of information and its use.

For example: documentation of assessment, care, and education provided on site should be complete and in the medical record generally within 24 hours and not later than three business days after the services are rendered. Outside laboratory and x-ray reports should normally be received from the vendors within 48 hours and no later than five business days from the date of the service. Finally, information provided to referral services should normally be received at least 24 hours prior to the delivery of services and no later than prior to the delivery of services.

Periodic assessments of the timeliness of medical record completeness will be a routine component of the organization's performance improvement activities. Any deviations from the standards of practice will be treated as incidents and will be tracked throughout the year. The results of this tracking will be shared with the relevant quality committees and the medical staff on at least an annual basis.

VERBAL ORDERS

The use of verbal orders is an acceptable practice in this organization. However, documentation and authentication of verbal orders shall comply with the timeliness policy of this organization or applicable law, whichever is the stricter requirement.
DATING AND AUTHENTICATION OF HEALTH RECORD ENTRIES

The organization shall maintain and update, as appropriate, a list of all those individuals authorized to make entries into the customer health record. The organization shall also have a standardized and approved method (including initial and signatures) for identifying and authenticating entries by authors.

Furthermore, unless approved by the Board of directors, the use of signature stamps is prohibited.

Those individual with signature stamps which are approved for use by the Board of Directors will sign a statement assuring that the signature stamp will be kept under tight controls and will only be used by them.
AGGREGATE DATA & INFORMATION

Goal: The goal of developing and utilizing aggregate data is to compile information regarding the processes and outcomes of an organization to make informed decisions to improve the provision of patient care.

Aggregation of Process and Outcomes Data: The organization will utilize a number of sources to aggregate and analyze process and outcomes data. These sources include, but are not limited to:

- internal and external financial reports (i.e. monthly and annual)
- internal and external utilization reports
- reports to external funding sources (i.e. UDS, Title 330 Grant, etc.)
- medical record and peer reviews: and
- clinical tracking systems (i.e. Clinical Outcomes Measures)

The scope of the aggregation will deliberately not be limited to allow management to track and trend any data it feels necessary for the effective management of the organization's processes.

Copies of the most recent of each of the above reports are included at the end of this section.
KNOWLEDGE BASED INFORMATION

**Goal:** The goal of maintaining knowledge based information is to ensure that the organization is managing itself and performing its processes utilizing the most effective, up to date methods and technology.

**Scope:** The scope of knowledge based information to be maintained shall include all staff within the organization. The scope may also involve informing the community about any changes or recent breakthroughs in the medical and other health related fields.

**Orientation and Training:** The organization has established an orientation program which is specific to the classification of the employee (See Personnel Policies). This program will ensure that the organization's employees are knowledgeable in the essential aspects of:

- their job responsibilities
- the organization's plan for managing its risks in the environment of care
- procedures for controlling nosocomial infections
- specific administrative rules and processes that the organization requires
- the scope of services provided by the organization, as well as
- other patient care related issues.

The objective of the orientation and training program will be to promote a learning culture within the organization which will develop the most informed and competent staff possible.

**Competence Assessment:** On-going competence assessments will further ensure that staff maintain their knowledge of clinical and operational issues as well as to ensure that their basic competencies (i.e. those covered during their initial orientation), have been maintained over time. Additionally, on-going competency assessments will ensure that the staff's knowledge has been updated as new knowledge and technologies become available.

Assessments of staff competence will be performed on a regular basis. Ideally this assessment would be performed annually, but the time between assessments should never exceed two years. These assessments, both individually and as aggregate data, will be used as the foundation for planning the organization's training and education program.

**Continuing Education:** Annually the organization approves, as part of its budget, several items relating to the continuing education of staff. These allocations can come in the form of a continuing education budget for individual medical providers and other staff.

**Library/Holding Area:** Where possible, the organization will develop a small holding area or library for these publications and will make them available to all staff. Additionally, every effort will be made to make computer based information sources such as “Epocrates” available to all providers.
COMPARATIVE DATA & INFORMATION

**Goal:** The goal of interpreting and utilizing comparative data is to develop baselines of organizational performance and using internal and external benchmarks, to evaluate and measure the organization’s effectiveness, as well as to identify priorities for performance improvement.

**Utilization and Contribution to External Databases:** The organization utilizes a number of external databases to evaluate itself and set priorities for improvement. These databases may include, but are not limited to:

- Clinical Outcomes Measures
- BCHDANET Report (Accumulation of UDS performance data)
- BPHC Benchmarks for performance (i.e. Program Expectations)

The organization contributes information to each of the databases identified above on an annual basis.

**Security and Confidentiality of Information:** When contributing to external agencies and databases every effort will be made to remove identifier information which could compromise confidentiality and security.