MARK TWAIN
HEALTH CARE DISTRICT

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Meeting of the Board of Directors
Wed. March 25, 2020
9:30 am
Mark Twain Medical Center Classroom 5
768 Mountain Ranch Rd,
San Andreas, CA

Tele-Conference Meeting

Conference Call Information

(605) 475-2875

Code 4864697

Agenda

Mark Twain Health Care District Mission Statement

"Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides high quality, professional and compassionate health care".

1. **Call to order:**
2. **Roll Call:**
3. **Approval of Agenda:** Public Comment - Action
4. **Public Comment on matters not listed on the Agenda:**

   The purpose of this section of the agenda is to allow comments and input from the public on matters within the jurisdiction of the Mark Twain Health Care District not listed on the Agenda. (The public may also comment on any item listed on the Agenda prior to Board action on such item.) **Limit of 3 minutes per speaker**. The Board appreciates your comments however it will not discuss and cannot act on items not on the agenda.

5. VS H&W Center – Draft Policies and Forms: Public Comment – Action……..…Dr. Smart

- Policies - Valley Springs Health & Wellness Center:

  Punctuation & Grammar Changes – Please Submit to District Office Staff.

1. Revised - Abnormal Vital Signs
2. Revised - Adverse Drug Reaction
3. Revised - After Hours Telephone Management
4. Revised - Alternate Communications in an Emergency Situation
5. Revised - Appointment Scheduling
6. Revised - Bioterrorism Threat
7. Revised - Co-Signature of Mid-Level Practitioner Medical Records
8. Revised - Conflict of Interest
9. Revised - Critical Value Notification
10. Revised - Demonstrated Competency
11. Revised - Earthquake or Weather Emergency
12. Revised - EKG
13. Revised - Emergency Ambulance Transfer
14. Revised - Emergency Medications and Supplies
15. Revised - Equipment Management
16. Revised - Exam Table and Exam Room Cleaning and Disinfecting
17. Revised - Exposure Control Plan
18. Revised - Fluoride Varnish for Medical Pediatric Patients
19. Revised - Formulary
20. Revised - Laboratory Electrical Safety
21. Revised - Late Arriving Patients
22. Revised - Laundry and Linen
23. Revised - Liquid Nitrogen
24. Revised - Management of Referral Requests
25. Revised - On Call Program
26. Revised - Processing X-Ray Requests
27. Revised - Radiation Safety and Protection Program
28. Draft - Reference Resources
29. Revised - Registering Patient Complaints
30. Revised - Staff Meetings
31. Revised - Standardized Procedure for Physical Examination
32. Revised - Sterile Field
33. Revised - Storage, Handling, and Delivery of Medications
34. Revised - Transfer of a Patient to a Hospital
35. Revised - Waived Testing Blood Glucose
36. Draft - Waived Testing Fecal Occult Stool
37. Revised - Waived Testing Hemoglobin
38. Revised - Waived Testing Hemoglobin A1C
39. Revised - Waived Testing Influenza A and B (pending review)

40. Revised - Waived Testing LeadCare II
41. Revised - Waived Testing Urinalysis Using Siemens Analyzer
42. Revised - Incident Reports 021820
43. Revised - Waived Testing Strep A Direct Rapid Testing 022120
44. Revised - Policy Manual Signature Page
45. Organization Chart

6. Next Meeting:

A. The next meeting will be Wednesday April 22, 2020 starting at 9am.

7. Adjournment: Public Comment – Action

Mar 17, 2020.

California Gov. Gavin Newsom issued Executive Order (N-29-20), which, in part, supersedes Paragraph 11 of Executive Order (N-25-20) issued on Thursday. The new Executive Order excuses a legislative body, under the Ralph M. Brown Act, from providing a physical location for the public to observe and comment if certain conditions are met. A physical location does not need to be provided if the legislative body:

1. [H]olds a meeting via teleconferencing and allows members of the public to observe and address the meeting telephonically or otherwise electronically;"
2. Implements a procedure for receiving and "swiftly resolving" requests for reasonable modification or accommodations from individuals with disabilities, consistent with the Americans with Disabilities Act, and resolving any doubt in favor of accessibility.
3. Gives advance notice of the public meeting and posts agendas according to the timeframes and procedures already prescribed by the Brown Act (i.e. 72 hours for regular meetings and 24 hours for special meetings) and
4. Gives notice of the means by which members of the public may observe the meeting and offer public comment, in each instance where notice or agendas are posted.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Abnormal Vital Signs	REVIEWED: 11/11/18; 9/14/19; 3/5/20
SECTION: Clinical	REVISED: 9/14/19; 3/5/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR

Deleted: 10/23/19

Subject: Abnormal Vital Signs

Objective: To assess the patient at risk for severe disease or complications.

Response Rating: Minimal to Severe

Required Equipment: Gloves.

Procedure

1. All patients in the Clinic will have a complete set of vital signs.

2. All children should be evaluated for severe respiratory distress as indicated by rapid breathing, retractions, or cyanosis (blue/purple lips) and brought in immediately for evaluation by the practitioner.

   a. In children under age 3, pulse, respiratory rate, temperature (oral or temporal artery thermometer), weight and pulse oximetry, if indicated.
   b. In children (3 years and above) and adults, add blood pressure.
   c. In children (regardless of age) who present as ill or in distress, ensure all vital signs are taken and recorded in the medical record.

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3. For pulse: notify the practitioner if less than 60 or greater than 100 in adults or if the patient shows visible signs of distress. The normal range for children will vary by age, but generally is faster. Review the pediatric vital signs reference posted in the nurses' workstation for guidance.

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4. For respiration: notify the practitioner if the rate is greater than 24 times per minute, or if there is any difficulty breathing or the patient shows visible signs of distress. Review the pediatric vital signs reference posted in the nurses' workstation for guidance.

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5. For blood pressure: in adults, notify the physician if systolic is >160 or less than 90, or if diastolic is over 100 or under 60.

6. For temperature: notify the practitioner if over 102 degrees.

7. For pulse oximetry: notify the practitioner if less than 95%.

8. In all cases, document the vital signs clearly in the medical record and notate if any are abnormal.

9. All abnormal vital signs and oximetry will be addressed by the practitioner during the visit.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Adverse Drug Reaction	REVIEWED: 2/1/19; 3/10/20
SECTION: Patient Care	REVISED: 3/10/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 2/27/19

Subject: Adverse Drug Reaction

Objective: To establish guidelines in the event of an adverse medication reaction

Acuity Rating: Mild to Severe

Procedure:

1. When a patient reports or a staff member observes signs of a medication reaction, staff will follow clinic protocol for medication reactions. The ordering practitioner will be notified immediately and will give the instructions for the patient regarding the prescribed medication. The patient will be instructed by the practitioner or nursing staff of the plan of care.
    a. If the patient is a dental patient, call the dentist immediately.
    b. If the dentist is unavailable, treat the problem as a medical problem.

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2. It is the practitioner's responsibility to educate the patient to any expected or potential side effects of any medication being ordered.

3. The practitioner and nurse/medical assistant who is administering the medication will ensure the patient's understanding of the benefits, expected or potential side effects of the medication.

4. The patient will be advised and expected to report any side effects to the practitioner, nurse, or medical assistant.

5. Adverse drug reactions are considered noxious and generally unintended and include undesired effects, allergic reactions, and idiosyncratic reactions.

6. Reactions may be exaggerated but otherwise normal pharmacological action of drug at usual dose. They may be an aberrant effect not expected at usual therapeutic doses.

7. Withhold any further administration of the medication.

8. Notify the practitioner immediately and obtain written orders for treatment.

9. Advise patient and/or family of plan of care.

Documentation:

1. Documentation of all medication reactions/adverse effects will be recorded in the patient's record. For medical only patients, utilize the EMR. For dental only patients, document in Dentrix. For patients who are seen in the practice for both medical and dental issues, document in both systems.

    a. Symptoms
    b. Time the practitioner was notified and what orders were given.
    c. Patient notification and response.
    d. Any follow up care or instructions given.
    e. Record allergy in allergy section of patient record
    f. Refer to clinical questions and guidance as posted in the nurses' station.

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Reporting:

1. In the case of adverse reactions to medications, the practitioner or designee will report the data to MedWatch at https://www.fda.gov/Safety/MedWatch/default.html.

2. In the case of adverse reactions to vaccinations, the practitioner or designee will report the data to VAERS at VAERS.hhs.gov.

Notify Pharmacy

If patient is reporting a reaction that occurred from a medication that was filled at a pharmacy, the pharmacist at the pharmacy will be notified of the patient's reaction.

Medication Administered in the Clinic

1. If an adverse/reaction of medication occurs from medication given to the patient in the Clinic, the attending staff member will complete an incident report.

2. A copy of the patient's visit note will be attached to the incident report and it will be sent to the Clinic Director.

3. The Clinic Director will review the report with the Medical Director and it will be reviewed at the Quality Improvement Meeting and/or with the Medical Staff.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: After Hours Telephone Management	REVIEWED: 1/2/19; 3/10/20
SECTION: Operations	REVISED: 3/10/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: After Hours Telephone Management

Objective: To ensure after hours calls placed by patients are answered and appropriate guidance is provided to callers, after the end of the business day, the Clinic will activate the after-hours on-call service.

Response Rating:

Required Equipment:

Procedure:

1. At the end of the business day, the Clinic Manager or designee will access the phone system and activate call forwarding.

2. At the start of the Clinic day, the Clinic Manager or designee will deactivate the call forwarding so that incoming calls may be answered by Clinic staff.

3. The practitioner schedule for coverage of the on-call service is managed by the Medical Staff Office and implemented with the approval of the Medical Director.

4. If the patient is seen in the practice for dental care and their issue is dental in nature, the practitioner covering the on-call service will contact the dentist after speaking with the patient and provide the patient's demographics, contact information, and information regarding the patient's complaint/concern.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Alternate Communications in Emergency Situations	DATE: 9/1/19; 2/25/20
SECTION: Safety and Emergency Planning	REVISED: 2/25/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR

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Subject: Alternate communications in emergency situations

Objective: To ensure personnel are able to communicate amongst themselves and with emergency services in the event of a clinic/community telephone/internet failure.

Response Rating: Mandatory

Required Equipment:

Procedure

1. Personnel will be provided with a confidential list of personnel (including provider personnel) so as to maintain those contacts in their personal cell phone for access when Clinic telephone service malfunctions. The list will be updated monthly and the content will not be shared with persons not employed or under contract with the Clinic.

2. The personnel list (with phone numbers) will be available in the Clinic at the following locations:

   a. Front of the "Staff Huddle Binder"
   b. At the receptionist desk
   c. The nurses' station
   d. Radiology department workstation
   e. Incident Command Binder

3. The Clinic will purchase and maintain a minimum of the following emergency communications equipment:

   a. Dual band (VHF/UHF) two way radios
   b. Active and supplemental batteries for said radios

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4. Staff will be oriented to the use of the radios as part of their Emergency Preparedness training.

5. Batteries will be charged and radios tested monthly.

6. Radios, batteries and chargers will be stored in the clinic in an accessible location.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Appointment Scheduling	REVIEWED: 11/12/18; 2/12/20; 3/5/20
SECTION: Admitting	REVISED: 2/12/20; 3/5/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Appointment Scheduling

Objective: Patient appointments will be scheduled in an effort to manage/decrease patient waiting time, increase patient satisfaction, and manage clinic workflow.

Response Rating:

Required Equipment: EHR

Procedure:

1. Patients will be encouraged to schedule appointments in order to decrease wait time and improve workflow in the Clinic.
2. Medical patients will be scheduled in 20-minute intervals, unless otherwise indicated by the practitioner, the visit type, or the patient's acuity.

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3. Dental patients will be scheduled in 30 minutes intervals for emergency/urgent care and 60 minute intervals for other appointment types.
3. When scheduling an appointment, staff will confirm the patient's address and telephone number as it is recorded in the scheduling system and remind the patient that any co-payment required will be due.
4. If the patient has not been seen in the Clinic previously, staff will capture all patient demographic information, if time permits.
5. New patients will be asked to arrive at the Clinic before their scheduled appointment time, so that their demographic record and signed new patient documents may be entered into the system.
    a. Patients who will bring completed paperwork with them should be asked to arrive 15 minutes before their scheduled appointment time.
    b. Patients who will not bring completed paperwork with them should be asked to arrive 30 minutes before their scheduled appointment time.
6. Patients will be pre-registered the day before their appointment.

7. Patients that arrive late for their appointment (10 minutes or more) will be treated as walk-in patients and will be seen as patient volume allows. Patients will be advised of this change from scheduled to walk-in status upon their arrival at the Clinic.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Bioterrorism Threat	REVIEWED: 8/29/19; 2/25/20
SECTION: Safety and Emergency Planning	REVISED: 2/25/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Bioterrorism Threat

Objective: A bioterrorism threat is the accidental exposure or deliberate release of viruses, bacteria, and/or other agents that cause illness or death in people, animals, or plants. Biological agents can be spread through the air, water, or food. They can be extremely hard to detect and may not cause illness for several hours or days. Some agents, like smallpox, can spread from person to person. Other agents, such as anthrax, are not spread person to person.

Response Rating:

Required Equipment:

Procedure:

1. In the case of a biological threat:
   a. Notice of a biological event may come from the California Department of Public Health (CDPH) and/or the Calaveras County Public Health Office/Officer.
   b. Directions may be received from CDPH and/or the County Public Health Office/Officer on how to proceed.
   c. Patients that present to the Clinic during a bioterrorism threat and who indicate they have a potential exposure will be assessed by Clinic personnel who have donned personal protective equipment. These patients will be segregated and treated in the exam rooms closest to the exit doors with registration occurring in the exam room.
   d. Patients with symptoms that may be the result of a biological exposure will be reported according to current policy for the reporting of diseases as outlined by the CDC, the State of California, and the County.
   e. The Clinic may be directed by CDPH and/or the County Public Health Office/Officer to give information to patients regarding the biological event.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Co-Signature of Mid-Level Medical Records	REVIEWED: 7/1/19; 2/23/20
SECTION: Medical Staff	REVISED: 2/23/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Co-Signature of Mid-Level Practitioner Medical Records

Objective: To ensure compliance with current State of California regulations regarding the supervision of Nurse Practitioners and Physician Assistants; to ensure compliance with Peer Review standards in the Clinic: clinic notes completed by the mid-level practitioner (nurse practitioner, physician assistant, certified nurse midwife, LCSW) will be reviewed by the Physician Supervisor(s) for the timely review and co-signature of a minimum of 10% of the mid-level practitioners' clinic notes.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. A list of the patients treated by each mid-level practitioner will be developed at the end of each clinic month.
2. The Supervising Physician(s) will be presented with the list no later than the tenth day of the following month.
3. The Supervising Physician(s) will review the clinic note for a random 10% of patients listed, ensuring proper care was rendered and that said care was appropriately documented. This review will be documented.
4. Should the Supervising Physician(s) determine that the care rendered to the patient was not appropriate and/or sufficient:
   a. They will counsel the mid-level practitioner(s) to ensure they contact the patient and supplement their treatment per the direction of the Supervising Physician(s).
   b. Document on a peer review form that the mid-level practitioner(s) was counseled regarding their patient care.
5. The co-signature logs will be stored digitally, to ensure both HIPAA compliance and privacy relative to any personnel action documented.
6. The co-signature logs will be considered when the performance evaluation of the mid-level practitioner(s) are completed.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Conflict Of Interest	REVIEWED: 8/12/19; 2/24/20
SECTION: District	REVISED: 2/24/20
EFFECTIVE: March Board Meeting	EXECUTIVE DIRECTOR:

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Subject: Conflict of Interest

Objective: The purpose of this policy is to protect Mark Twain Health Care District's interest when it contemplates entering into a transaction or arrangement that might benefit the private interest of an employee.

This policy is intended to supplement, but not replace, any applicable state or federal laws governing conflicts of interest applicable to nonprofit organizations.

Response Rating: Mandatory

1. **Definitions:**

   a. *Conflict of Interest* - occurs when a covered person solicit or accepts gifts, does business with the District and/or engages in prohibited employment or business relationships, accepts unauthorized compensation, misuses their position, or discloses or uses certain information.

   b. *Covered Person* - Any employee.

   c. Contract - means and includes any written agreement.

   d. *District* - the Mark Twain Health Care District and its affiliated entities including, but not limited to Valley Springs Health and Wellness Center.

   e. *Exempt Employee* - an employed executive, administrative, professional, computer, or outside sales position and is not subject to the minimum wage and overtime provisions

   f. *Gift* - something which is paid or given by a person or entity to a Covered Person, directly or indirectly. This may include, but not limited to; real property, a preferential rate or terms on a loan, debt, goods or services, food or beverages, membership dues, entrance fees, admission fees, tickets to events, performances, facilities, parking or lodging.

      i. Gifts may not exceed $25.00 per gift and/or $500.00 per year.

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2. **Procedure:**

a. Duty to Disclose- In connection with any actual or possible conflict of Interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the CEO.

b. Recusal of Self - Any employee may recuse himself or herself at any time for involvement in any decision or discussion in which the employee believes he or she or may have a conflict of interest, without going through the process of determining whether a conflict of interest exists.

c. Determining Whether a Conflict of Interest Exists - After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he/she shall leave the meeting with the CEO while consideration of a conflict of interest is discussed and determined.

d. Procedure for addressing the Conflict of Interest - An interested person may make a presentation to the CEO, but after the presentations, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest. The CEO shall, if appropriate, appoint a disinterested person to investigate alternatives to the proposed transaction or arrangement.

3. **Violations of the Conflict of Interest Policy:**

a. Violations include, but are not limited to: bribery, payments for appointments to offices, willful or corrupt misconduct in office, embezzlement, misuse of public funds, prohibited political activities, conviction of a crime.

b. If the CEO has reasonable cause to believe an employee has failed to disclose actual or possible conflicts of interest, it shall inform the employee of the basis for such belief and afford the employee an opportunity to explain the alleged failure to disclose.

c. If after hearing the employee's response, the CEO still determines the employee has failed to disclose an actual or possible conflict of interest, they shall take appropriate disciplinary and corrective action.

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Resources:

http://www.fppc.ca.gov/Form700.html

FPPC Form 700 Reference Pamphlet (2015/2016)

Special District Board Member/Trustee Handbook

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Critical Alert Value Notification	REVIEWED: 2/1/19; 2/23/20
SECTION: Patient Care	REVISED: 2/23/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Critical alert value notification

Objective: To define policy and procedure to identify and report critical and alert test values.

Response Rating: Mandatory

Required Equipment:

Definition:

Critical: potential to be imminently life threatening
Alert: vital to patient management but not imminently life threatening

Procedure:

1. All point-of-care (waived) laboratory testing performed in the Clinic will be immediately reviewed by the attending and ordering practitioner at the time of the patient's visit.

2. All laboratory specimens that are sent to an outside lab will be reported via electronic transmission, with results populating the EMR. The practitioner will review results in the EMR in a timely manner.

3. If a test is sent out and a critical lab value results, the outside lab will contact the Clinic Manager via telephone to report the critical value. This will be read back and the Clinic Manager will contact the provider or Medical Director for further orders/action.

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4. The Clinic Manager will document receipt of the results and their communication with the provider/Medical Director in a patient case in the EMR.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Demonstrated Competency	REVIEWED: 3/1/19; 2/23/20
SECTION: Workforce	REVISED: 2/23/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Demonstrated Competency

Objective: To ensure personnel are capable of performing the tasks required by their position, competency will be demonstrated at the time of on-boarding and annually thereafter, in accordance with the Demonstrated Competency Checklist(s) in place at the time.

Response Rating: Mandatory

Required Equipment:

Definitions:

Demonstrated Competency: The ability to perform a work role or task to a demonstrated defined standard. To meet a competency standard, the activity is performed under specified conditions to the specified standard of performance.

Procedure:

1. Prior to assuming duties without direct supervision, all personnel will demonstrate competency according to the Demonstrated Competency Checklist currently approved for their job description.
2. Annually, all personnel will demonstrate competency according to the Demonstrated Competency Checklist currently approved for their job description.
3. Upon addition of new patient care equipment, patient care procedures, and/or waived testing kits in the Clinic, personnel will participate in orientation/education and then demonstrate their competency.
   a. Training will be documented with educational materials and documentation of personnel participation retained.
   b. After training is completed, competency will be demonstrated, documented and added to the current Demonstrated Competency Checklist as a "write-in".
4. Annually, the Demonstrated Competency Checklist will be reviewed to ensure it accurately reflects the processes, equipment, techniques that are pertinent to the Clinic environment with new processes, equipment, and techniques added and unnecessary elements deleted.

5. The Medical Director will complete Demonstrated Competency evaluation and documentation for Nurse Practitioners and Physician Assistants.

6. The Dentist will complete Demonstrated Competency evaluation and documentation for Registered Dental Assistants and Dental Hygienists.

7. A Registered Nurse will complete Demonstrated Competency evaluation and documentation for the Medical Assistants and Licensed Vocational Nurses.

8. Registered Nurse and/or Nurse Practitioners will complete Demonstrated Competency evaluation and documentation for the Registered Nurse(s).

9. The Radiologist will complete Demonstrated Competency evaluation and documentation for the clinic work performed by the Radiology Technicians. The Office Manager or their administrative designee will complete Demonstrated Competency evaluation and documentation for any administrative responsibilities of the Radioilogy Technicians.

10. The administrative designee will complete Demonstrated Competency evaluation and documentation for Front Office personnel and any persons assigned responsibilities for billing and coding functions.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Earthquake Or Weather Emergency	REVIEWED: 8/30/19; 2/25/20
SECTION: Safety and Emergency Planning	REVISED: 2/25/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Earthquake or weather emergency response/management

Objective: To ensure the safety of patient, personnel, and visitors in the event of an earthquake or weather-related disaster.

Response Rating: Mandatory

Required Equipment:

Procedure:

In the event of a fire or weather-related disaster:

1. Patients and visitors will be moved to the safest location(s) within the Clinic, as follows:

   A. Earthquake

      i. Structurally strong interior spaces, excluding doorways.

      ii. Away from objects on shelves that may fall and cause injury

      iii. Exterior areas which are not under trees, near power poles, or other tall structures (parking lot, as designated in Emergency Preparedness Plan)

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   B. Weather-related disaster

      i. In the case of a high wind storm/tornado, persons will be moved to interior rooms without windows. (See Shelter in Place Policy)

      ii. In the case of a rainstorm causing flooding, persons will be moved to rooms that are dry and/or have furniture that will allow the person to be up and away from the water.

      iii. The Clinic Manager or designee will ensure that a census of the patients and visitors is developed, with any special needs noted (requirement for oxygen, medication, additional supervision, aided support) and addressed as quickly as possible and documented in a medical record.

      iv. If required, utilities will be terminated at the source:

Service Type	Source Location
Natural gas	Exterior of building
Electrical service	Electrical panel
Water	Exterior of building

v. Clinic Manager or designee will contact 911 if assistance is required to evacuate or render care to patients, visitors and/or personnel.

vi. Clinic Manager or designee will contact the Administrator to advise emergency situation and request support, if required.

vii. Clinic Manager or designee will meet emergency personnel when they arrive.

viii. Clinic Manager or designee will record all actions taken and include that information in their Incident Report.

ix. Clinic Manager will prepare a thorough incident report and forward that report to the Administrator.

x. Clinic Manager will contact the Chief Executive Officer for assistance in identifying damage to the premises and to coordinate arrangements for the repair and replacement of damaged facilities and equipment.

xi. The Chief Executive Officer will notify Licensing and Certification, as well as any other appropriate agencies. Notification will specifically indicate whether the Clinic is safe for continue use, and if not, what alternate arrangements have been made so that care of the patients may continue.

2. Clinic staff should prepare to receive additional patients that may result from the situation.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: EKG	REVIEWED: 2/1/19; 10/28/19; 2/23/20
SECTION: Patient Care	REVISED: 10/28/19; 2/23/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: EKG

Objective: To obtain a clinical picture of cardiac rhythm and activity.

Response Rating: Moderate to Severe

Required Equipment: EKG Machine, computer (EMR) access

Procedure:

Prepare the patient:

The quality of an EKG/ECG is dependent on the preparation and resistance between the skin and the electrode. To ensure a good quality EKG/ECG and minimize the skin/electrode resistance the following must be completed:

1. Explain the procedure to the patient. Obtain the patient's height, weight, blood pressure, pulse, and current medications. Document in the EMR.

2. Direct the patient to remove all clothing from the waist up and put a gown on with the opening to the front.

3. Direct the patient to lie in a recumbent position. Ensure the patient is warm and relaxed and advise to be as still as possible and not to talk during the procedure.

4. Shave electrode areas if indicated using a disposable razor.

5. If patient is perspiring or has applied any lotions or creams, clean area with an alcohol swab.

6. Attach the electrodes to the patient's limbs and chest as labeled. The leads are coded and numbered:

    a. RA = Right Arm
    b. LA = Left Arm
    c. RL = Right Leg
    d. LL = Left Leg

e. C = Chest - (6 leads attached in sequence)

Connect the EKG to the laptop computer while the EMR program is open to the patient's record:

1. Plug the EKG machine into the laptop computer.
2. Follow the instructions as displayed on the computer screen.
3. Capture the image and print the results.

   a. All EKG results will be read by the ordering practitioner and over-read by an internist on the Clinic Medical Staff.

In the event of a borderline abnormal reading, excluding obvious and definitive Myocardial Infarction:

1. Practitioner will check the lead placement to assure proper lead placement by the MA/Nurse was performed.
2. Adjust the leads and repeat ECG may be indicated upon order from the treating practitioner.

Documentation of findings:

1. The Internal Medicine physician will document their findings on the EKG image using written text.
2. The annotated image will be returned to the ordering practitioner, attached to a patient case, sending the annotated and signed image to the Clinical Inbox.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Emergency Ambulance Transfer	REVIEWED: 9/11/19; 2/23/20
SECTION: Patient Care	REVISED: 2/23/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Emergency Ambulance Transfer documentation preparation

Objective: To assist the Clinic staff in the transfer of a patient, via ambulance, to a higher level of care.

Response Rating:

Required Equipment:

Procedure:

1. When notified that a patient will be transferred to a higher level of care, the Medical Assistant will assist by printing two sets of insurance cards, patient demographic sheets and the Patient Care Summary from the EMR..
2. One set of the copies will be sent with the medics.
3. The second set of copies will be provided to the responding medics for use by the ambulance company.
4. Both sets of copies will be given to the nurse or medical assistant, who will be responsible for giving them to the ambulance team.
5. The provider or nurse will provide the documents and report to the medic(s).
6. The practitioner will document the medical record by selecting procedure code "MISCOUT AMB". This code will ensure the patient's departure by ambulance will be captured for reporting purposes.
7. For minor patients, the practitioner should speak with the parent(s)/caregiver(s) regarding:
   i. The reason for the transfer
   ii. Location of transfer
   iii. Directors to the transfer location
8. The provider should call the receiving facility emergency department to provide a report to the provider at that location.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Emergency Medications and Supplies	REVIEWED: 7/24/19; 9/11/19; 2/19/20
SECTION: Patient Care	REVISED: 9/22/19; 2/19/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Emergency Medications and Supplies

Objective: To ensure appropriate and rapid response to medical emergencies in the Clinic that require medications.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. Under the supervision and approval of the Medical Director, the Clinic will maintain emergency medications, which will be stored in the crash cart.
2. At a minimum, these medications will include:
   a. Benadryl Injectible 50mg/1ml (prepared syringe) (generic)
   b. Epinephrine 1:1000 Injectible 1ml
3. Current medication inventory includes;
   a. Adenosine
   b. Oral Glucose Gel
   c. Solu-Medrol
   d. Diphenhydramine HCL
   e. Amiodarone HCl
   f. Atropine Sulfate
   g. Naloxone HCl
   h. Epinephrine

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i. Glucose Tablets

j. Aspirin (chewable)

k. Narcan (nasal spray)

l. Nitroglycerin Sublingual

4. The drawer will be clearly labeled "Emergency Medications".

5. Easily accessible and clearly legible in the drawer will be a dosage chart that takes into account the Clinic's patient population.

6. The kit will be checked to ensure the contents are in-date. This inspection will take place on a monthly basis and will be documented on the Crash Cart log. The inspector will document their findings and sign the log upon completion of the inspection.

7. Medications which are used or removed due to outdate will be replaced immediately. Replacement of medications will be documented on the log.

8. Emergency supplies will include, but not be limited to:

a. Oxygen tank with regulator, tubing, and nasal cannula/mask

b. Airways in sizes consistent with the patient population served.

c. Ambu bags in sizes consistent with the patient population served.

d. Blood pressure cuff(s) and stethoscope

e. EKG machine

f. AED

g. Pediatric backboard

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Equipment Management	REVIEWED: 11/12/18; 2/18/20
SECTION: Operations	REVISED: 2/18/20
EFFECTIVE: March Board Report	MEDICAL DIRECTOR:

Deleted: 1/30/19

Subject: Equipment Management

Objective: Designated equipment in service for the care and treatment of patients will be inspected, tagged, and in good working order. The Clinic will maintain a current inventory of all equipment and will interface with an appropriate biomedical vendor to provide a Preventative Maintenance program that will ensure all equipment used in the diagnosis, treatment, and therapy of patients is properly maintained and will meet the standards required by Title 22 and community standards.

Response Rating:

Required Equipment:

Procedure:

1. All equipment in the Clinic will be evaluated for inclusion in a Preventative Maintenance program that will:
   a. Prolong the life or improve the operation of the device.
   b. Identify a failure or discrepancy not readily apparent to the normal user.
   c. Assure that the items in electrical-sensitive patient locations meet the requirements of ANSI/AAMI, safe current limit stands, as specified by California Title 22.
   d. Provide management reporting of equipment history reports and failure modes.

2. A current accurate inventory of all diagnostic and therapeutic equipment utilized within the facility will be available and updated when new equipment is delivered and used equipment is retired.

3. New equipment delivered to the Clinic may not be placed until it has received a Bio-Medical Inspection and sticker and is cleared for use. Where required, staff will be trained and competency documented before the equipment is placed into use.

4. Preventative Maintenance will be performed for all patient care equipment that is available to the Clinic. Inspections will be performed consistent with manufacturer recommended specifications. If no manufacturer recommendations are made, inspections will occur annually.

4. All equipment service will be documented.

a. A copy of all service work paperwork will be kept in the Clinic in the Manager's office.

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b. A summary of service history will be provided periodically to help identify failure trends.

c. Repairs that may affect the calibration, operation, or electrical integrity of any device will have an inspection completed after the repair, and such will be documented.

5. Inspection and repair of equipment is the responsibility of the Clinic Manager and/or designee.

a. Defective equipment discovered by personnel is to be marked defective, removed from use and reported to the Clinic Manager.

b. A maintenance request form will be completed for each instance of equipment removed from use for malfunction. The maintenance form will be returned to the Clinic Manager upon completion of the repair with the completed form retained to demonstrate compliance with policy and procedure.

c. Equipment requiring service or repair will be assigned to personnel or vendor(s) with appropriate training and necessary credentials.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURE

POLICY: Exam Table And Exam Room Cleaning And Disinfection	REVIEWED: 3/1/19; 3/5/20
SECTION: Infection Control	REVISED: 3/5/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 3/27/19

Subject: Exam Table and Exam Room Cleaning and Disinfection

Objective: To reduce nosocomial infections to patients and staff, ALL non-autoclavable materials and surfaces will be sanitized and cleansed with approved agents that are used according to manufacturers' instructions.

Acuity Rating: Mandatory

Procedure:

1. Exam tables, dental treatment chairs, guest chairs, gurneys, and wheelchairs shall be cleaned between patients.
2. All table paper, pillow covers and dental equipment sleeves and shields will be changed between patients.

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3 All exam tables will be wiped with approved sanitizing wipes between patients and allowed to air dry.

4 Surfaces coming into direct contact with a patient or used during a treatment or procedure, will be wiped with sanitizing wipes and allowed to air dry.

5 Blood and body fluids must be thoroughly cleaned from all surfaces prior to disinfecting.

6 For large amounts of blood and/or body fluids, an approved spill kit will be used.

7 Allow moisture left on surface from cleaning products to air dry. DO NOT WIPE SURFACES TO DRY.

8. Wipes can be used once gross contamination is removed.

9. Disposable gloves and personal protective equipment (PPE) are to be used while cleaning and to prevent direct contact with blood, body fluids and any surface that may be contaminated by an infectious source.

10. When cleanup is finished, remove gloves and PPE and wash hands.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Exposure Control Plan	REVIEWED: 3/1/19; 2/18/20
SECTION: Infection Control	REVISED: 2/18/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 3/27/19

Subject: Exposure control plan

Objective: To ensure compliance with OSHA and FOSHA blood borne pathogen and universal precaution standards.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. Exposure determination

   a. OSHA requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials. The exposure determination is made without regard to the use of personal protective equipment (i.e. employees are considered to be exposed even if they wear personal protective equipment). This exposure determination is required to list all job classifications in which all employees may be expected to incur such occupational exposure, regardless of frequency. The job classifications in this category are nurse practitioners, physician assistants, registered nurses, licensed vocational nurses, medical assistants, radiology technicians.

2. Tasks and procedures that may expose employees to blood borne pathogens

   a. The scope of occupational tasks and procedures that may expose Clinic employees to blood borne pathogens is rapidly changing. This is intended to be a general guideline against which all tasks can be measured.

   b. Any tasks and procedures that could be reasonably anticipated to provide contact with the employee's skin, eye, mucous membrane, or blood with potential infectious materials are included. Potentially infectious material means:

      The following human body fluids: blood, semen, vaginal secretions, cerebrospinal fluid, synovial (joint) fluid, pleural (chest cavity) fluid, peritoneal (abdominal cavity) fluids, amniotic fluid,

saliva in dental procedures, any body fluid that is visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

- Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and
- HIV-containing cell or tissue cultures, organ cultures, and HIV-or HBV or HCV-containing culture medium.

3. Compliance methods

a. Universal precautions

i. Universal precautions shall be observed in order to prevent contact with blood or other potentially infectious materials. See universal precautions policy.

ii. All blood or other potentially infectious materials shall be considered infectious regardless of the perceived status of the source individual.

b. Engineering and work practice controls

i. Engineering and work practice controls shall be utilized to eliminate or minimize exposure to employees.

ii. Where occupational exposure remains after institution of these controls, personal protective equipment shall be utilized.

iii. The following engineering controls shall be utilized:

- Disposable sharps waste containers

iv. The above controls shall be examined and maintained on a regular schedule. The schedule for reviewing the effectiveness of the controls is as follows:

- Sharps containers shall be checked with each use and changed when three-quarters (3/4) full or every 90 days, whichever comes first.

c. Hand washing facilities

i. See hand washing and glove use policies.

ii. Hand washing facilities or hand sanitizers are available to the employees who incur exposure to blood or other potentially infectious materials. These facilities shall be readily accessible after incurring exposure and are located in each patient care area.

d. Eyewash station

i. The eyewash station will be easily accessible and unobstructed for ease of use to employees who are performing those tasks that may result in splashes of hazardous chemicals to the eye.

ii. The employee will be able to access the eyewash station within 10 seconds of exposure. The eyewash station will operate with a one-hand movement to initiate water flow. Hot water will not be available to the station. Once water flow has been initiated, the station will operate hands free with water flowing from both sides to the face and with sufficient force for the water to meet in the middle.

iii. The employee will flush eyes for 15 minutes holding both eyelids open.

iv. The eyewash station will be inspected weekly for ease of access, one hand movement water flow initiation, and hands free operation. The inspection will last no less than 3 minutes.

e. Needles

i. Contaminated needles and other contaminated sharps shall not be bent, recapped, removed, sheared, or purposely broken. They shall be immediately discarded into a labeled sharps container easily accessible to personnel and close to the area of their use. The containers shall comply with OSHA regulations.

ii. OSHA allows an exception if the procedure would require that the contaminated needle be recapped or removed and no alternative is feasible and the action is required by the medical procedure. If such action is required, then recapping or removal of the needle must be done by the use of a mechanical device or a one-handed technique.

f. Containers for reusable sharps

i. Contaminated sharps that are reusable are to be placed immediately, or as soon as possible, after use into appropriate, hard-sided containers for the purpose of moving the item(s) from the patient care area to the designated sterilization area.

ii. Those containers should be sealable, puncture resistant, labeled with a biohazard label, and leak proof. The containers shall comply with OSHA regulations.

g. Work area restrictions

i. In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees are not to eat, drink, apply cosmetics or lip balm, smoke, handle contact lenses. Food and beverages are not to be kept in refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials are present.

ii. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

iii. All procedures shall be conducted in a manner that minimizes splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials.

h. Specimens

i. Specimens of blood or other potentially infectious materials shall be placed in a container that prevents leakage during the collection, handling, processing, storage, and transport of the specimens.

ii. The container used for this purpose shall be labeled or color-coded in accordance with the requirements of the OSHA universal precautions.

iii. Primary containers that contain specimens which could puncture the container or are contaminated shall be placed within a secondary container which is puncture resistant and prevents leakage during the handling, processing, storage, transport, or shipping.

iv. Refrigerators or other storage areas where specimens are kept shall not contain food or drink. They shall be labeled in compliance with the OSHA universal precautions.

i. Contaminated equipment

i. Equipment that has been contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping.

ii. Decontamination shall be performed as necessary unless the decontamination of the equipment is not feasible.

j. Personal protective equipment

i. All personal protective equipment used at this facility shall be provided without cost to employees.

ii. Personal protective equipment shall be chosen based on the anticipated exposure to blood or other potentially infectious materials. The protective equipment shall be considered appropriate only if it does not permit blood or other potentially infectious

materials to pass through or reach the employees' clothing, skin, eyes, mouth, or other mucous membranes under normal conditions and for the duration of time, which the protective equipment shall be used.

iii. Protective clothing shall be provided to employees within the work area where exposure is reasonably expected to potentially infectious materials.

iv. All personal protective equipment shall be cleaned, laundered, and disposed by of by the employer at no cost to employees. The employer at no cost to employees shall make all repairs and replacements.

v. All garments, which are penetrated by blood, shall be removed immediately or as soon as feasible. All personal protective equipment shall be removed prior to leaving the work area.

vi. Gloves shall be worn where it is reasonably anticipated that employees shall have contact with blood, other potentially infectious materials, non-intact skin, and mucous membranes. Gloves shall be available in every patient care area. Specialized gloves, powderless or hypoallergenic gloves shall be made available to any employee requesting them. They shall be kept in an area central to the employee's workspace.

vii. Disposable gloves are not to be washed or decontaminated for reuse and are to be replaced as soon as practical when they become contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised. Utility gloves may be decontaminated for re-use provided that the integrity of the glove is not compromised. Utility gloves shall be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

viii. Masks in combination with eye protection devices, such as goggles or glasses with solid side shield, or chin length face shields, are required to be worn whenever splashes, spray, splatter, or droplets of blood or other potentially infectious materials may be generated and eye/nose, or mouth contamination can reasonably be anticipated. This shall include work procedures that require pouring of potentially infectious liquids.

ix. Appropriate protective clothing, such as gowns, aprons, or similar outer garments that are impervious to liquids are to be worn whenever splashes, spray, splatter or droplets of blood or other potentially infectious materials may be generated and skin or clothing contamination can be reasonably anticipated.

k. Contaminated work surfaces, containers, and glass

i. All contaminated work surfaces shall be decontaminated after completion of procedures and immediately, or as soon as feasible, after any spill of blood or other potentially

infectious materials, as well as at the end of the day if the surface may have become contaminated since the last cleaning.

ii. All bins, pails, can, and similar receptacles shall be inspected and decontaminated monthly and as needed when there is evidence of leakage of waste onto the surface of the container. The Clinic staff shall assume responsibility and documentation of this shall be maintained.

iii. Any broken glassware, which may be contaminated, shall not be picked up directly with their hands. Broken glass clean up shall be accomplished using a broom and dustpan.

l. Regulated waste disposal

i. All contaminated sharps shall be discarded as soon as feasible in a sharps container. Sharps containers are located in each area in which sharps are used with potentially infectious materials.

m. Waste handling

i. Waste that contains blood or other potentially infectious materials shall be placed in bags that confirm to the OSHA universal precautions in construction and color coding or labeling. They shall not be compressed and shall be collected and disposed in a manner consistent with the hazardous waste regulations of the state and federal government.

n. Hepatitis B vaccine

i. All employees who have been identified as having exposure to blood or other potentially infectious materials shall be offered the Hepatitis B vaccine, at no cost to the employee.

ii. The vaccine shall be offered within 10 working days of their initial assignment to work involving the potential for occupational exposure to blood or other potentially infectious materials unless the employee has previously had the vaccine or wishes to submit to antibody testing which shows the employee to have sufficient immunity.

o. Employee tuberculosis protocol

i. Employee training

a. Upon employment all employees will be trained about TB transmission, symptoms, medical surveillance, and therapy.

ii. Employee surveillance

a. Upon employment, the Clinic offers PPD skin test at no charge to employees

- The PPD skin test is also immediately offered to any employee who is exposed to known or suspected TB patients.
- The PPD skin test is administered to any employee that presents with TB symptoms.
- The PPD skin tests are administered once as an initial baseline screen, annually for all employees, every six months for workers with known exposure.
- The physician/nurse practitioner will promptly evaluate any employee who has a positive PPD test.
- Any employee that has active TB will be placed under the care of a physician, local health department or physician of employee's choice (as circumstances dictate). The medical director will remain informed of the employee's TB status through frequent updates provided by the selected healthcare provider.
- Document exposures on the OSHA form 300, 300A, and 301.

b. Unless under the care of a providing physician, all TB test results should be CONFIDENTIALLY returned to the Human Resources Director.

4. Post-exposure evaluation and follow-up

A. Post-exposure evaluation

1. When the employee incurs an exposure incident, it shall be reported to the physician who shall ensure that a personal accident/incident form and OSHA forms 300, 301A, and 301 are completed and that the physician or nurse practitioner sees the employee immediately. The following information must be included on the OSHA forms:

- Name and SSN of employee
- Date and description of incident
- Type of PPE worn (or not worn)

2. All employees who incur an exposure incident shall be offered post-exposure evaluation and follow-up in accordance with the OSHA standards.

3. Testing should occur as soon as possible. The employee will be tested for HBV, HCV, HIV/AIDS. If the employee declines to be tested they must sign a statement indicating their refusal to be tested and their serum should be saved for 90 days.

B. Interaction with health care professionals

1. The physician shall provide a written opinion for the following post-exposure instances:

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- When the employee is sent to obtain the Hepatitis B vaccine.
- Whenever the employee is sent to a health care professional following an exposure incident.

2. The written opinion shall be limited to:

   a. Documentation of the incident;

   b. Identification and documentation of the source, unless prohibited by law;

   c. Determination of need for the employee to receive the Hepatitis B vaccine and if the employee has received the vaccine;

   d. That the employee has been informed of the results of the evaluation; and

   e. Instruction that should be given to the employee regarding any medical conditions that could result from exposure to blood and/or other potentially infectious materials.

3. The employee shall be provided a copy of this written opinion within 15 days of the completion of the evaluation.

C. Training

1. Training for all employee shall be conducted prior to initial assignment to tasks where occupational exposure may occur and annually thereafter.

2. Training shall include the following explanation of:

   - The OSHA universal precautions for blood borne pathogens
   - Epidemiology and symptomology of blood borne diseases
   - Modes of transmission of blood borne pathogens
   - This exposure control plan
   - Procedures that might cause exposure to blood or other potentially infectious materials at the Clinic
   - Personal protective equipment available at the Clinic
   - Who should be contacted, and follow-up procedures concerning an exposure incident; post-exposure evaluation
   - Signs and labels used at the facility
   - Hepatitis B vaccine program at the Clinic

3. The training shall provide an opportunity for interactive questions and answers by a person knowledgeable in the subject matter.

D. Record keeping

1. Medical records

    a. Shall contain requirements for documentation of incidents.
    b. Records cannot be disclosed without consent.
    c. Records must be maintained throughout employment plus thirty (30) years.

2. Training

    a. Dates, attendance, and SSN of attendees shall be documented.

    b. Records shall be maintained for a minimum of three (3) years.

5. Needlestick safety and prevention act

A. Annually, the Clinic will review the Exposure Control Plan to ensure that it reflects changes in technology that will help eliminate or reduce exposure to blood borne pathogens.

B. The Clinic will involve non-managerial workers in evaluating and selecting safety engineered devices.

1. Sharps evaluation procedure

    a. The Medical Director will:

        i. Determine which products are to be evaluated and provide at least four or more test samples for each individual evaluating the product. (Each evaluator should have enough samples to disassemble and examine the design thoroughly.) Employees chosen for the sharps evaluation procedure should currently use a similar category of product in the Clinic.

        ii. Provide visual instructions and demonstrate the proper use of each device. Be sure testers can evaluate products in a simulated patient environment.

        iii. Review the instructions and rating system with each evaluator.

        iv. Require each evaluator to complete an evaluation form.

        v. Review responses on evaluation forms; make conclusions, and recommendations.

    b. The evaluators will:

i. Re-enact all steps of intended or possible procedures performed with the device.

ii. Attempt to misuse the device and circumvent or disable the safety feature.

iii. Answer each question on the evaluation form including any short answer sections at the end. If you do not understand a question, the evaluator will write their comments directly on the sheets.

C. The Clinic will maintain a sharps injury log that ensures employee privacy and contain, at a minimum, the type and brand of device involved in the incident, if known; the location of the incident; and a description of the incident.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Fluoride Varnish for Medical Pediatric Patients	REVIEWED: 7/8/19; 3/5/20
SECTION: Patient Care	REVISED: 3/5/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR

Deleted: 7/31/19

Subject: Fluoride varnish use for pediatric patients

Objective: To define the appropriate use and application of oral fluoride varnish for pediatric patients.

Response Rating:

Required Equipment: Single use fluoride varnish packets, gloves

Procedure for Medical Clinic

1. Screening requirements for patients – infants through age 5

    a. An inspection of the mouth, teeth, and gums must be performed at every health assessment visit. Dental caries are classified according to treatment needs, from routine dental referrals to referrals for emergency (immediate) treatment.
    b. Document findings as required by the California PM 160 Dental Guide.
    c. Assess risk for dental caries in accordance with relevant, reliable resources such as:
    - American Academy of Pediatrics - Preventive Oral Health Intervention for Pediatricians
    - American Academy of Pediatrics - Oral Health Risk Assessment Tool
    -National Maternal & Child Oral Health Resource Center – Bright Futures in Practice: Oral Health--Pocket Guide 2nd edition
    d. Provide anticipatory guidance.
        i. For prevention of caries and gum disease, key topics to emphasize include establishing a dental home, parents'/caregivers' oral health, transmissibility of caries-causing bacteria, proper oral hygiene practices, fluorides, and dental sealants.
        ii. Other important areas to stress include dental injuries (especially related to sports), tobacco use and oral cancer, eating disorders, and oral piercing. See Table 2 Anticipatory Guidance for Oral Health, which contains age specific messages.

2. Fluoride varnish application

    a. Practitioners and Clinic staff will be trained in the application of fluoride varnish and that training will be documented prior to the implementation of the fluoride varnish program.
    b. Practitioners will provide a written order for the application of fluoride varnish, where it is

determined such a service is appropriate for the pediatric patient. (Patients age 5 and less, no more than four times per year)

c. Apply the varnish according to the manufacturer's guidelines.

3. Post-application guidance for parents

a. Child may drink water after application of fluoride varnish
b. Child should not eat any foods that are hard, crunchy, or chewy for the rest of the day
c. Do not brush or floss the child's teeth today or tonight
d. Brush and floss teeth beginning the next day
e. After application of the fluoride varnish, teeth will appear to have a yellowish coating. This yellowish coating will go away after the teeth are brushed.

Resources:
California Department of Health Care Services, Systems of Care Division
Child Health and Disability Prevention Program, Health Assessment Guidelines
March 2016

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Formulary	REVIEWED: 4/1/19; 3/2/20
SECTION: Medication Management	REVISED: 3/2/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: : 4/24/19

Subject: Formulary

Objective: A formulary for the Clinics will be developed, followed and updated.

Response Rating:

Required Equipment:

Procedure

1. A Clinic formulary will be developed, followed and updated after consultation with the Medical Director, Dental Director, Clinic practitioners, and other appropriate personnel, as required.
2. Additions, deletions, revisions to the formulary will be managed through the use of a chargemaster management form, as required by policy. At a minimum, the form will document who requested the change, item details, CPT code, charges, addition to chargemaster, staff training.
3. Clinic formulary will be approved by the Medical Director.
4. Strengths of medications will be limited to the smallest number of variations required to appropriately address patient needs.
5. Additions, deletions, and other changes to the Formulary will be discussed at the Clinic Medical Director meeting(s).
6. A copy of the current formulary will be available in the Clinic for review by practitioners, at their request.
7. A copy of the current formulary will be available in the Clinic in the medication management area.
8. Monthly Medication Management surveys of the Clinic will include inventory review using the Formulary as a resource.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Laboratory Electrical Safety	REVIEWED: 11/12/18; 2/18/20
SECTION: Operations	REVISED: 2/18/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 1/30/19

Subject: Laboratory Electrical Safety

Objective: To present an overview of the Laboratory electrical safety policy.

Response Rating: Mandatory

Required Equipment:

Procedure:

All employees will be educated in and follow these guidelines for electrical safety:

- All electrical equipment will be regularly inspected and serviced per the Clinic's preventive maintenance program.
- All employees will be trained in the proper handling and operation of equipment prior to use.
- All electrical equipment will be inspected prior to use. If any damage is noted to the electrical cords, junction, or casing, do not use.
- Never use electrical equipment on wet surfaces.
- Never yank electrical cords from outlets.
- Never leave electrical cords across walkways or door openings.
- Never use electrical equipment that does not have a grounded plug.
- All laboratory instruments and appliances are adequately grounded and checked for current leakage before initial use, after repair or modification and when a problem is suspected. If a new instrument is installed or initially checked by the manufacturer, the laboratory will have the required check performed at the next preventive maintenance cycle.
- Charging cords will not be left in the outlet with an exposed connector.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Late Arriving Unscheduled Patients	REVIEWED: 4/28/19; 2/19/20
SECTION: Operations	REVISED: 3/27/17; 7/10/18; 2/19/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Late Arriving Patients

Objective: To ensure effective operation of the Clinic and to reduce unnecessary overtime costs, the Clinic will not schedule patient appointments after 4:30pm and will not register patients for care after 4:30pm unless the patient has a medical emergency. Patients will be expected to arrive at the Clinic promptly relative to their appointment time.

Response Rating: Mandatory

Required Equipment: None

Procedure:

1. The Clinic electronic scheduling module will support the scheduling of physical examinations, appointments for acute illness, follow-up, and health maintenance visits.

2. Patients will be expected to arrive promptly for their appointments.
   a. If a patient arrives more than 10 minutes late for their appointment, they will be treated as a walk-in patient and worked in to the schedule.
   b. Patients will be advised that tardiness will be tracked and, if habitual, will affect the patient's ability to schedule appointments in the future.

2. Adult and Child comprehensive physical examinations will not be scheduled after 4:00pm. Sports physicals may be performed after 4:00pm with confirmation from the practitioner.

3. Patients arriving at the Clinic without an appointment after 4:30pm with an acute complaint will be assessed by the registered nurse or provider on duty, who will:

   a. Assess chief complaint

   b. Take and document vitals signs, if indicated.

   In absence of a registered nurse or provider, the licensed vocational nurse or medical assistant will document chief complaint and vital signs.

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4. The registered nurse, licensed vocational nurse, or medical assistant will consult with the practitioner and present chief complaint and vital signs information.

5. Patients with urgent medical complaints will be seen by a medical practitioner:

   a. Acute chest pain

   b Acute abdominal pain

   c. Active labor

   d. Disabling headache

   e. Fever

      i. Temp >100 in an infant younger than 2 months
      ii. Temp >101 for any patient
      iii. Temperatures in infants younger than 4 months should be obtained rectally.

   f. Uncontrollable vomiting

   g. Uncontrollable bleeding

   h. Possible fracture

   i. Head trauma

   j. Shortness of breath

   k. Altered mental status

   l. Critical values on vital signs

   m. Dental abscess/pain

6. Patients with urgent dental complaints will be seen by the dentist:

   a. Dental abscess/pain

   b. Broken tooth

   c. Facial swelling

   d. Facial pain

   If the dentist is not present, schedule a same day appointment with a medical practitioner.

7. Patients whose complaints are not deemed medically urgent will be scheduled for an appointment on the following day.

8. Patients requesting medication refills will be scheduled for an appointment on the following day.

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9. Patients requesting physician “school notes” will have their medical record researched to determine whether they were seen by a Clinic practitioner during the timeframe in question. If the patient was seen, the previously provided note will be re-printed. If the patient was not seen, the Clinic will decline to provide a “school note”.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Laundry and Linen	REVIEWED: 11/12/18; 2/18/20
SECTION: Operations	REVISED: 2/18/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 1/30/19

Subject: Laundry and linen

Objective: To ensure use of sanitary gowns, drapes, and other laundry/linen, wherever possible disposable patient gowns, drapes, and sheets will be utilized.

Response Rating:

Required Equipment:

Procedure

1. Disposable patient gowns will be available in a variety of sizes, consistent with the patients served in the Clinic.
2. Disposable drapes will be available in a variety of sizes, consistent with the procedures performed in the Clinic.
3. Disposable table paper will be utilized to cover examination tables/chairs and will be replaced between patients.
4. Disposable will be utilized to cover any gurney located in the Clinic and will be replaced between patients.
5. Should cloth sheets be utilized, soiled sheets will be placed in a covered soiled laundry bin which will be located in the locked housekeeping closet.

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7.→When the patient no longer requires the blanket, the used blanket will be placed in the covered soiled →laundry bin located in the locked housekeeping closet.¶
8.→Linen/laundry service vendor will replace any used blankets and sheets once a week.¶

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Liquid Nitrogen	REVIEWED: 3/2/20
SECTION: Patient Care	REVISED:
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Liquid Nitrogen

Objective: Safe use of Liquid Nitrogen in the Clinic for medical procedures.

Response Rating: Mandatory

Required Equipment: Safety gloves, eye protection, Dewar's dipper

Procedure:

The safe handling and use of liquid nitrogen in liquid nitrogen Dewar's requires knowledge of the potential hazards. The safety precautions as outlined must be followed to avoid potential injury or damage. Do not attempt to handle liquid nitrogen until you have been thoroughly trained and understand the potential hazards, their consequences, and the related safety precautions.

Liquid Nitrogen will be kept in a container, secured to the wall, and with a vented lid in the Biohazard room. A designated metal dipper will be kept near the container for the transfer of liquid nitrogen by staff from the storage vessel to the portable Dewar's container.

The Liquid Nitrogen unit will only be refilled by the contracted vendor.

Handling Liquid Nitrogen: Contact with liquid nitrogen with the skin or eyes may cause serious freezing (frostbite) injury. It is always important to protect your hands and eyes when working with liquid nitrogen. ALWAYS use Cryo-gloves and the approved eye protection. The Cryo-gloves should fit loosely, so that they can be thrown off quickly if liquid should splash into them. Always wear the specific cryo-eye protection provided (safety glasses without side shields do not give adequate protection). These are located next to the Liquid Nitrogen.

Long pants (which should be cuff-less if possible) should be worn outside the shoes. Any kind of canvas shoes should be avoided because a liquid nitrogen spill can be taken up by the canvas resulting in a far more severe burn. **Handle liquid nitrogen carefully. Never allow any unprotected part of your body to touch objects cooled by liquid nitrogen.** Such objects may stick fast to the skin and tear the flesh when you attempt to free yourself. Use tongs, preferably with insulated handles, to withdraw objects immersed in the liquid, and handle the object carefully.

Maintenance: Always keep the unit clean and dry. Do not store it in wet, dirty areas. Moisture, animal waste, chemicals, strong cleaning agents and other substances which could promote corrosion should be removed promptly. Use water or mild detergent for cleaning and dry the surface thoroughly. Do not use strong alkaline or acid cleaners that could damage the finish and corrode the metal shell. Always keep unit upright. **Rough handling can cause serious damage to Dewar's.**

Use only containers designed for low-temperature liquids: Cryogenic containers are specifically designed and made of materials that can withstand the rapid changes and extreme temperature differences encountered in working with liquid nitrogen. Even these special containers should be filled slowly to minimize the internal stresses that occur when any material is cooled. Excessive internal stresses can damage the container. Do not ever cover or plug the entrance opening of any liquid nitrogen Dewar. Do not use any stopper or other device that would interfere with venting of gas. These cryogenic liquid containers are generally designed to operate with little or no internal pressure. Inadequate venting can result in excessive gas pressure which could damage or burst the container. Use only the loose-fitting neck tube core supplied for closing the neck tube. Check the unit periodically to be sure that venting is not restricted by accumulated ice or frost.

Use proper transfer equipment. Only use the solid metal dipper to transfer the liquid nitrogen from the tank to the Dewar.

Nitrogen gas can cause suffocation without warning. Store and use liquid nitrogen only in a well - ventilated place: As the liquid evaporates, the resulting gas tends to displace the normal air from the area. In closed areas, excessive amounts of nitrogen gas reduce the concentration of oxygen and can result in asphyxiation. Because nitrogen gas is colorless, odorless and tasteless, it cannot be detected by the human senses and will be breathed as if it were air. Breathing an atmosphere that contains less than 19 percent oxygen can cause dizziness and quickly result in unconsciousness and death.

Note: The cloudy vapor that appears when liquid nitrogen is exposed to the air is condensed moisture, not the gas itself. The gas causing the condensation and freezing is completely invisible.

Never dispose of liquid nitrogen in confined areas or places where others may enter. Disposal of liquid nitrogen should be done outdoors in a safe place. Pour the liquid slowly on gravel or bare earth where it can evaporate without causing damage. Do not pour the liquid on the pavement.

First Aid Notice: If a person seems to become dizzy or loses consciousness while working with liquid nitrogen, move to a well-ventilated area immediately. If breathing has stopped, apply artificial respiration. If breathing is difficult, give oxygen. Call a physician. Keep warm and at rest. If exposed to liquid or cold gas, restore tissue to normal body temperature 98.6°F (37°C) as rapidly as possible, followed by protection of the injured tissue from further damage and infection. Remove or loosen clothing that may constrict blood circulation to the frozen area. Call a physician. Rapid warming of the affected part is best achieved by using water at 108°F/42°C). Under no circumstances should the water be over 112°F/44°C, nor should the frozen part be rubbed either before or after rewarming. The patient should neither smoke, nor drink alcohol. Liquid nitrogen burns could be treated as frostbite.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Management Of Referral Requests	REVIEWED: 11/12/18; 2/18/20
SECTION: Admitting	REVISED: 2/18/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Management of referral requests

Objective: To ensure prompt attention is paid to referral orders and to ensure the process is completed timely.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. A system is set-up to track and manage the referral process.
2. Upon determining that a referral is required, the provider will document same in the medical record and will provide the necessary details in the form of an order:
   a. Service type (consultation, imaging study, etc.)
   b. Provider preferred (if appropriate)
   c. Purpose of referral
   d. Time frame (number of days/weeks/months) before reminder will appear
3. Upon completion of the order, staff will log receipt of the referral and start the authorization and referral process.
4. The Referral Clerk or Medical Assistant assigned will have primary responsibility for obtaining authorization for referral services and will follow through with the insurance carriers to obtain authorization and will document same in the medical record.
5. Delays in obtaining authorization will be documented in the medical record and communicated to the provider and the patient.

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6. If the authorization is denied, the denial will be documented in the EMR and the provider will follow-up with the patient.

7. If the authorization is given, the designated staff member will work with the referral provider and the patient to schedule the necessary appointment and will document appointment details in the EMR.

    a. Should the patient prefer to schedule their own appointment directly with the referral provider, they will be empowered to do so.

    b. Staff will function relative to the patient's preference and will document same in the EMR.

8. The referral provider's report will be received at the Clinic and will be scanned into the EMR.

    a. If the document is sent via USPS, it will be faxed (use Athena Net front and back fax pages) for inclusion in the patient's EMR.

    b. If the document is sent via fax, it will be "intercepted" by Athena Net and included in the patient's EMR.

9. Should there be a delay in receipt of the report, designated staff member will follow up with phone calls to the referral provider's office. EMR flags will alert to the absence of the report.

10. A task will appear on the provider's worklist to indicate the referral report has been received. After the provider has reviewed the report and documented next steps, the task will appear as complete.

11. Staff will be notified, via the EMR tasks functionality, if the provider wishes the patient to return to the Clinic to discuss the referral appointment/report.

12. If no appointment is necessary and communication via telephone or patient portal is sufficient, provider will complete that/those tasks and document same in the EMR.

12. The EMR tickler system will notify both provider and staff if the processing of an authorization, scheduling of an appointment, or completion by the patient of the appointment is not completed by the previously designed time frame.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: On-Call Program	REVIEWED: 11/12/18; 2/19/20
SECTION: Operations	REVISED: 2/19/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: On Call Program

Objective: To ensure the development and operation of an after-hours on-call program in compliance with contractual obligations and to meet patient need.

Response Rating: Mandatory

Required Equipment:

Procedure:

1. The Medical Director, with the support of the Clinic Manager will be responsible for establishing the schedule to staff the On-Call Program.
2. Medical staff members (Physicians and Mid-level providers) will participate in the On-Call Program, with staffing determined based first, upon volunteer's availability; and, then assignments made by the Medical Director to cover any open slots.
3. Maintenance of the calendar is the responsibility of the Medical Director.
   a. The on-call "shift-day" schedule template will be as follows:
      i. Monday 1700 – Tuesday 0800
      ii. Tuesday 1700 – Wednesday 0800
      iii. Wednesday 1700 – Thursday 0800
      iv. Thursday 1700 – Friday 0800
      v. Friday 1700 – Monday 0800
4. Maintenance of the on-call schedule with the practitioners assigned to each day is the responsibility of the Medical Director

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5. A relationship will be established with a local answering service who will respond to after hours calls in the manner outlined by the practice, which may be revised from time to time.

6. Content of the message patients will hear when they contact the clinic after hours is the responsibility of the Clinic Manager, who will ensure the message is current and accurately reflects how the practice wants after hours contacts managed.
   a. Message content will include:
      a. Statement that the Clinic is closed
      b. Statement that the message is available in English and Spanish
      c. A Reminder that if the patient is calling to report a medical emergency they must hang up and contact 911 immediately
      d. Statement that Anthem and California Health and Wellness patients may call the appropriate 24 hour Nurses Line for advice
      e. Options to schedule an appointment by phone, leave a message for someone, or contact the practitioner on-call.
7. Practitioners will be expected to be available to cover the on-call schedule a minimum of one shift/day a month, unless otherwise notified by the Medical Director. The Medical Director will then assign shifts/days; first, on a volunteer basis; and, then as required in rotation to ensure fairness. Holiday shifts/days will be rotated as necessary.
8. Practitioners on-call will be required to respond to patient outreach within a 30 minute timeframe. Compliance will be confirmed by daily reports from the answering service.
9. Practitioners will document their interaction with the patient using the EMR based upon the complexity of care and whether any orders (ie medications) are given to ensure the patient's medical record is accurately updated.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Processing X-Ray Requisitions	REVIEWED: 2/1/19; 3/1/20
SECTION: Patient Care	REVISED: 3/1/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Processing X-Ray Requisitions

Objective: To ensure efficient and timely processing of radiology orders and the subsequent access to newly available images.

Response Rating:

Required Equipment:

Procedure:

1. Confirm that patient has been registered at the registration desk.
2. Confirm and Identify correct patient
3. Upon receipt of any x-ray request/order, log the request into the Radiology Department PACS system at the x-ray console.
4. Enter required information into the Viztec DR machine.
5. Take images as ordered then transfer the images to Novarad PACS.
6. For Clinic patients, after images have been taken:
   a. Track exams in the EMR (click on x-ray check exam complete)
   b. Notify provider that the x-rays are ready on the patient (specify)
7. All x-ray requests are scanned into PACS for radiologist reference.
8. Copy of completed order is given to billing for confirmation purposes.
9. Upon reading, report is taken from PACS and scanned into the EMR for review by the ordering provider.
10. Retain requisition and printed report for six months with stamped confirmation of being scanned into PACS and EMR.

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→a.→Enter charges for exam taken into Athena EMR.¶
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→b.→Attach fax transmission receipt to requisition(s).¶
→c.→Place all requisitions, with attached fax transmission receipts in the document bin for retention.¶
8.→Retain requisition/fax transmission receipt daily packets for six months.
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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Radiology Safety	REVIEWED: 4/1/19; 3/1/20
SECTION: Operations	REVISED: 3/1/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Radiation Safety

Objective: Safety of personnel and patients in Radiology Department

Response Rating: Mandatory

Procedure: Radiation Safety and Protection Program

Organization and Administration

1. Senior Radiological Technician will be responsible for the implementation and enforcement of all Radiation Safety and Protection procedures.

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ALARA Program

1. The radiology department shall use, to the extent practicable, procedures and engineering controls based upon sound radiation protection principles to achieve occupational doses and doses to members of the public that are as low as is reasonably achievable (ALARA).

2. All technicians working in the radiology department will be required to use tested and approved techniques posted at the x-ray console in the radiology department to achieve the principles of the ALARA program.

Dosimetry Program

1. All technicians will be required to wear approved film badges that will monitor their doses of radiation while working within the radiology department.

a. Film badges will be left in the radiology office upon end of shift. Badges are NOT to be taken out of the radiology department.

b. A Control film badge will be kept in the radiology department at all times conspicuously located in the designated drawer.

2. Film badges will be monitored, checked, and documentation will be provided on a quarterly basis.

3. Radiation dosimetry reports will be reviewed and initialed by the Clinic Manager on a quarterly basis. Copies of these reports will be made available to all technicians involved in the dosimetry program.

4. Technicians will be instructed on the proper use of individual monitoring devices including consequences of over exposure to radiation.

Radiological Controls

1. Entry and Exit Controls

   a. The two doors entering the radiology department will be closed at all times when an exam is in progress.

2. Posting Requirements

   a. The two doors entering the radiology department will be posted with a sign indicating a radiologic exam is in progress and to Not Enter

   b. A current copy of Department Form RH-2364 (Notice to Employees) will be posted in the radiology department office for all employees to read.

   c. A copy of the CCR 17 (California Code of Regulations) with a copy of operating and emergency procedures applicable to work will be available to employees in the radiology department for review.

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Disposal of Equipment

1. Any sale, transfer, or discontinuance of use of any reportable source of radiation will be reported in writing to the Department.

Other Controls

1. Positioning aids, gonadal shielding, and protective aprons are available within the radiology department for shielding patients from over exposure to radiation.

    a. These aids will be tested annually and logged to ensure the integrity of the devices.
    b. Protective aids will be placed on the x-ray table and an x-ray image will be taken to ensure efficacy of the protective devices

Record Keeping and Reporting

1. Supervision of all record keeping will be the responsibility of the Senior Radiologic Technician.

2. Records kept on hand are in the Radiology Department and will be scanned into the shared drive:

    a. Daily log of patients and exams
    b. Records release forms (disc's of digital images for patients)
    c. Radiation Dosimetry Reports
    d. Digest of new regulations to CCR 17
    e. Log of testing of Radiation Protection devices

Training

1. Operating and Safety Procedures: Safety Procedures for radiology equipment are delineated in the Operational Manual provided by the equipment manufacturer. These procedures are located in the Radiology Department.

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2. On a quarterly basis all radiological technicians will be instructed in the health protection problems associated with exposure to radiation, in precautions or procedures to minimize exposure, instruct such individuals in, and instruct them to observe, to the extent within their control, the applicable provisions of Department regulations for the protection of personnel from exposures to radiation occurring in the radiology room.

    a. These training sessions will be documented and that documentation will be kept in the radiology department office.

3. Technicians will be reminded of their responsibility to report promptly to the administrative staff of the Health Care District any condition that may lead to or cause a violation of department regulations or unnecessary exposure to radiation.

4. Technicians will be instructed in the appropriate response to warnings made in the event of any unusual occurrence or malfunction that may involve exposure to radiation and advise them as to the radiation exposure reports which they may request.

Quality Assurance Programs

1. Every six (6) months the radiology equipment will be subjected to a preventative maintenance inspection by qualified radiological maintenance personnel.

    a. Any repairs necessary to maintain the safety and functionality of the equipment will be documented and that documentation will be kept in the radiology department office for later review.

    b. It will be the responsibility of the Clinic Manager to keep and maintain these records.

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Internal Audit Procedures

1. This procedure will be reviewed on an annual basis.

    a. The procedure will be reviewed by the Senior Radiologic Technician.

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b. All Radiologic Technicians in the Radiology Department will review and sign the procedure after each annual review.

2. A copy of this procedure will be available in the Radiology Department for review by personnel.

3. This procedure will also be placed in the Policy and Procedures manual of the Mark Twain Health Care District.

Reference: California Code Regulations, Title 17

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Reference Resources	REVIEWED: 1/30/20; 3/5/20
SECTION: Medical Staff	REVISED: 3/5/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Medical Staff Reference Resources List

Objective: The Medical and Dental Staff, under direction of the Medical and Dental Directors, will maintain a list of approved medical reference resources. This list will be included in both the Policy and Procedure Manual and as a part of the Standardized Procedure Mid-Level Practitioners and will be reviewed and updated according to the Policy Development and Review policy.

Response Rating: Required

Required Equipment:

Procedure:

1. In-house protocols
    a. List of scheduled drugs (as a part of the formulary)
    b. Schedule II Patient Specific Protocol for Acute Conditions; Chronic, Acute, Recurring, and Persistent Limited Conditions; Severe Pain, Attention Deficit Hyperactivity Disorder

2. Examples of References
    a. Up-to-Date (online resource, quick link on all computers)
    b. Epocrates (embedded in athenaHealth EMR, quick link on all computers)
    c. Taber's Cyclopedic Medical Dictionary
    d. The 5 Minute Clinical Consult (29th Edition 2020)
    e. Epidemiology and Prevention of Vaccine Preventable Diseases (13th Edition)
    f. The Harriet Lane Handbook (app downloaded to smart phone of NP/PA and interested MD)
    g. Drug Information Handbook for Dentistry
    h. CDT-2020 (Current Dental Terminology)
    i. SDS sheets for all medications and supplies where available

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Registering Patient Complaints	REVIEWED: 2/1/19; 12/26/19; 2/14/20; 3/5/20
SECTION: Operations	REVISED: 12/26/19; 2/14/20; 3/5/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Patient complaints

Objective: To give consideration of all complaints and concerns and correct processes that are problematic, all patient complaints and concerns will be addressed in a timely manner.

Response Rating:

Required Equipment: Clinic patient complaint form; patient complaint forms provided by payor groups

Procedure:

1. Patient complaint regarding billing
    a. Patients will be given access to the appropriate patient complaint forms and advised/assisted in the completion and submission of said form.
    b. The registration staff will explain the charges and insurance billing procedure.
    c. If patient concerns are not resolved to the patient's satisfaction, the patient will be referred to the Biller(s) for further breakdown of charges.
        i. If the Biller(s) is not available, the Clinic Manager will speak with the patient.
    d. If patient concerns are not resolved to the patient's satisfaction, the patient will be referred to the Chief Executive Office for problem resolution.

2. Patient complaint regarding services rendered
    a. Patients will be given access to the appropriate patient complaint forms and advised/assisted in the completion and submission of said form.
    b. The registration staff will refer patient and complaint to the Clinic Manager who will review and explain services rendered and attempt to resolve the patient's complaint.

c. If the patient is not satisfied with the Clinic Manager's explanation, the patient and their complaint will be referred to the attending physician, dentist, or mid-level provider for review and recommendation for resolution.

d. If the patient is not satisfied with this explanation, the patient will be referred to the Executive Director for further discussion.

e. All patient complaints are to be routed to the Clinic Manager, regardless of their resolution status, so that the Clinic Manager can review complaints and determine whether changes in clinic operations are required.

f. Complaints will be included in the QAPI meeting agenda and addressed in that venue.

3. Patient complaint regarding Section 504 issues

   a. Refer to Section 504 Grievance policy

4. Patients will have access to the Patient Grievance forms specific to their insurance carrier. Upon request, these forms will be provided to the patient.

5. Patient grievances will be analyzed and trends identified as part of the Clinic Annual Review process with findings and recommendations shared with the leadership team.

6. Patients are requested to contact Clinic Manager, the Clinic's accreditation agency should they have a complaint or grievance. Clinic Manager can be reach by telephone at 209-772-7070 or via the internet via https://www.mthcd.org/valley-springs-health-wellness-center.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Staff Meetings	REVIEWED: 2/1/19; 3/5/20
SECTION: Operations	REVISED: 3/5/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Staff meetings

Objective: To ensure timely communication, knowledge-sharing, and issue resolution amongst all Clinic personnel in a leadership managed setting, mandatory, scheduled, agenda-driven staff meetings will be conducted on a regular basis, with advance notice to staff members, ensuring maximum participation**.**

Response Rating:

Required Equipment:

Procedure

1. Staff meetings will be scheduled on a routine basis, typically the first Wednesday of each month, at at the same time as the Medical Staff meeting so as not to interrupt the Clinic's patient care schedule.

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2. An agenda will be prepared in advance of each meeting, comprised of old business (not resolved at previous meetings) and new business.

3. Attendance will be taken at each meeting.

   a. Employees may be absent from a meeting if they are ill, on a leave of absence, or vacation.
   b. Employees not able to attend for one of the reasons noted above will review meeting minutes and sign-off.
   c. Employees must attend a minimum of 10 mandatory meetings each year.

4. Minutes will be prepared during each meeting and made available to staff for their reference and for review if the staff member was absent from the meeting.

5. Staff is encouraged to offer agenda items to the Clinic Manager for inclusion on the meeting agenda.

6. Staff is encouraged to actively participate in each meeting, offering insight and recommendations.

7. Meetings may contain educational components relative to Clinic operations, new programs or devices, software, and/or technology.

8. The agenda may include outside speakers/presenters in additional to Clinic personnel.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Standardized Procedure for Physical Examinations	REVIEWED: 6/1/19; 2/20/20
SECTION: Standardized Procedures	REVISED: 2/20/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Standardized orders for physical examinations (sports physical, post-offer physical, annual wellness exam).

Objective: To define and clarify procedures and tests that may be performed by a qualified clinical nursing/medical assistant for a physical examination.

Response Rating:

Required Equipment:

Procedure:

After completion of training and documentation of demonstrated competency, the Nursing/Medical Assistants employed in the Clinic are authorized by the Medical Staff to perform components of physical examinations as found on the physical examination forms utilized in the Clinic. This includes:

*Vital signs (height/length, weight, blood pressure, respiration, temperature, body mass index, head circumference)

*Sensory screening (Snellen eye test, audiometry, Ishihara test for color blindness)

*Procedure/Test (capillary specimen collection for hemoglobin and/or blood glucose, capillary specimen collection for Blood Lead, testing of urine via approved urinalysis processes)

*Risk assessment/anticipatory guidance questionnaires (Tuberculosis, Lead, Tobacco, Nutritional, and Psychosocial-Behavioral), as well as completion of the age-range specific Staying Healthy Assessment (SHA) tool

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Sterile Field	REVIEWED: 2/1/19; 3/10/20
SECTION: Patient Care	REVISED: 3/10/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 2/27/19

Subject: Sterile Field

Objective: To provide sterile procedure field in the effort to prevent infection.

Response Rating:

Required Equipment:

Procedure:

1. A sterile drape is to be placed over a Mayo stand.
2. Do not place non-sterile items on the sterile drape sheet.
3. The Nurse, Medical Assistant, or Dental Assistant will consult with the practitioner as to which items are needed.
4. Requested items will be placed in their non-sterile package wrapping on the counter.
5. The practitioner will set up their own sterile field after donning sterile gloves.
6. Staff may be asked to assist with the opening of packages and other ancillary tasks in support of the practitioner.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Storage, Handling, and Delivery of Medications	REVIEWED: 7/1/19; 2/18/20
SECTION: Medication Management	REVISED: 2/18/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 7/31/19

Subject: Storage, handling, and delivery of medications

Objective: To ensure the safe storage and management of medication in the Clinic.

Response Rating: Mandatory

Required Equipment:

Definitions:

Procedure:

Storage and Control

1. All pharmaceuticals are stored according to the manufacturer's recommendations or, in the absence of such recommendations, according to a pharmacist's instructions.
2. All pharmaceuticals are stored under proper environmental conditions (i.e., proper temperature, light, humidity, conditions of sanitation and segregation).
3. Storage areas must be secure, fixtures and equipment used to store drugs will be constructed to limit access only to designated and authorized personnel.
4. Proper consideration is given to the safe storage of poisons and flammable compounds.
5. Internal medications are stored separately from external medications.
6. Non-medications and flammables are not to be stored in medication refrigerators.
7. Room Temperature – Room temperature, as it applies to medication storage shall be between 15°C (59°F) and 30°C (86°F). Medication rooms and drug storage area temperatures will be maintained within this range. A log will be maintained for each medication room to document the temperature daily. Clinic Manager and/or Designee will be notified immediately if the temperature in the storage area falls below or is above this specified range. Medications will be relocated to another storage area until the problem is corrected. The Clinic Manager will be consulted to insure proper relocation.

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8. Refrigerator Temperature - Refrigerator temperature, as it applies to medication storage shall be between 2.0°C (36°F) and 8.0°C (46°F). Medication refrigerator temperatures will be maintained within this range.
9. If the temperature is not within the specified range, the Clinic Manager will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. Action(s) taken will be documented either directly on the Refrigerator Temperature Log.

a. Freezer Temperature - Freezer temperature, as it applies to medication storage shall be below -20°C (- 4°F). Medication freezer temperatures will be maintained within this range. A log will be maintained for each medication freezer to document the temperature daily. If the temperature is not within the specified range, the Clinic Manager and/or Designee will be notified immediately. Medications will be relocated to another storage area until the problem is corrected. The manufacturer will be consulted to insure the proper relocation of medications. Action(s) taken will be documented either directly on the Freezer Temperature Log or through a Plant Maintenance Work order or an Incident Form.

Note: *Only freezers rated for cryogenic temperatures (below -20°C) are acceptable for medication storage. Freezer compartments of refrigerators are not acceptable for medication storage.*

11. Each refrigerator/freezer will have a serviceable temperature-recording device capable of monitoring temperatures within the range required.

a. For all medication refrigerators and freezers within the organization, it is the responsibility of the Clinic Manager or designee to check and document the temperature twice daily.

b. Medication Rooms – Medication room(s) are to remain locked at all times. Only authorized personnel will have access to medication room(s). Authorized personnel will include, but are not limited to Providers, Registered Nurses, Licensed Vocational Nurses, and Medical Assistants. Other employees needing access to a medication room must be given authorization by Clinic leadership.

c. Med Dispense – Lockable medication cabinets are used to store unit-of-use medications in the patient medication dose system. These medication cabinets will be locked when not attended. Access to medication cabinets will be limited to designated clinical staff. The Med Dispense cabinets maintain control and storage of medications and keeps specific documentation of all transactions in regards to distribution and administration.

Medical Sales Representatives

1. Medical Sales Representatives are restricted from any non-prior approved activities at the Clinic. All representatives MUST sign-in with the Clinic Manager and are allowed ONLY to the Clinic if approved by the Clinic Manager and/or Medical Director. Medical Sales Representatives are restricted from promoting their products and/or services anywhere within Clinic without PRIOR approval from the Medical Director.

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Distribution of Medications

1. The Clinic will obtain all drugs in single unit of use (unit dose) packaging whenever practical.
    a. Medications are contained in, and administered from, single unit or unit dose packages.
2. Medications are dispensed in ready-to-administer form to the extent possible.
3. For most medications, not more than a 14 days supply of doses is provided to or available at any time.

Ordering to Meet Par Level Minimums

1. The Clinic will maintain a formulary that is approved by Medical Staff.
2. Clinic Leadership, in cooperation with the Medical Director, will establish par levels for each medication listed on the formulary.
3. After placement of the initial order, re-orders will be achieved by obtaining use data from the Medication Management System machine and refilling inventory based on use as identified by the Medication Management System report.
4. During regular pharmacy inspections/audits of the Clinic, inventory will be audited to insure counts are accurate based upon use/waste of medications.

Emergency Medications

1. Based on a list developed and approved by the Medical Staff, an inventory of emergency medications will be maintained in both the adult and pediatric crash carts
2. In keeping with Clinic policy, Crash Carts will be checked for inventory status and outdates on a monthly basis and after each use of the cart, with each inventory check documented and the documentation retained as a part of the active Quality Assurance/Performance Improvement program.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Transfer Of Patient To A Hospital	REVIEWED: 3/1/19; 2/25/20
SECTION: Safety and Emergency Planning	REVISED: 2/25/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 3/27/19

Subject: Transfer of the Patient to a Hospital

Objective: To ensure safe transport of a patient to the hospital with copies of all medical documentation.

Response Rating: Severe

Required Equipment: Patient chart, labs, pertinent paperwork, x-rays, Transfer Form, etc.

Policy: Patients requiring transport to the hospital should be informed of this decision by the practitioner. The practitioner will determine the appropriate mode of transportation based on patient condition.

The following guidelines should be followed prior to transport:

1. Call 911 as ordered by the practitioner.
2. All attempts to stabilize the patient prior to transport will be made by the practitioner and staff, in collaboration with EMS.
3. The practitioner will decide if the patient may be transported by private vehicle or ambulance.
4. Patients are to be properly prepared for transport with valuables given to family members or charge member of the ambulance.
5. AMA form will be completed and signed by patient or family member if the patient declines to go to the emergency room via the recommended transport or if they decline to go at all.
6. Copies of all test results and medical records should be made and given to the patient or charge member of the ambulance. If x-ray copying services are available, a copy of the film should be given to the patient. Original films should not be given out.
7. If being transferred by ambulance, the practitioner will provide the transport team with a verbal status report of the patient's condition.

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Note: It is against Clinic policy for staff members to transport patients in private vehicles. If transport is non-emergency and all other alternatives for travel exhausted, the patient should be transported to the hospital by a taxi or other commercial mode.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Waived Testing Blood Glucose	REVIEWED: 8/28/19; 2/21/20
SECTION: Waived Testing	REVISED: 2/21/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Deleted: 11/19/19

Subject: Waived Testing using the Quintet AC device

Objective: Testing of blood specimens for the purpose of determining the patient's blood glucose level will be performed in the Clinic using approved waived testing technologies and techniques, specifically a Quintet AC device.

Response Rating: Mandatory

Required Equipment: Quintet AC, test strip, lancet, gloves, cotton ball/gauze 2x2, dot bandaid

Procedure:

1. Upon receipt of a written order or by Standardized procedure, a capillary blood specimen will be collected and tested to determine the patient's blood glucose level.

   a. Ensure machine has batteries installed.

   b. Turn machine on so that you may insert the test strip. Alternatively, machine turns on when the test strip is inserted.

   c. Don gloves.

   d. Assemble lancet, test strip (confirm in date), bandaid, cotton ball or gauze.

   e. Warm patient's finger and press finger at or below first joint.

   f. Use alcohol prep pad to wipe fingertip.

   g. Allow fingertip to air dry or use clean gauze to dry fingertip.

   h. Use lancet to obtain specimen on patient's fingertip, along side of finger.

   i. Squeeze fingertip to express drop of blood and wipe away first drop of blood before collection.

   j. Squeeze fingertip to express drop of blood and fill test strip with blood and ensure capture area is full.

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l. Results should appear in 5 seconds.

m. Record results in EMR.

n. Remove test strip and dispose of in sharps container.

2. Alert the ordering practitioner is the patient's results (in between patient encounters) if the test is abnormal (>126mg% fasting, > 140mg% non-fasting).

3. To clean machine

a. Turn machine off.

b. Wipe exterior of machine with germicidal wipe.

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→ l. → Insert test strip in machine and start measurement as soon as possible. ¶

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→ b. → Wipe table with alcohol swab.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Waived Testing - Fecal Occult Stool	REVIEWED: 2/20/20
SECTION: Clinical	REVISED:
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Occult Stool, waived test

Objective: To ensure accurate waived test processed and resulting

Response Rating:

Required Equipment:

Procedure:

1. Upon receipt of written order from the provider, give the patient the hemoccult packet that contains instructions on how to prepare for the test, such as diet and medication to take or not before performing the test, along with the specimen collection tool.

2. If the patient will be taking the kit home to collect the specimen, instruct the patient to bring the card back to the Clinic when specimen collection is completed, if the patient is sent home to perform the test.

3. Once completed, the nurse or medical assistant will don PPE and then place two drops of hemoccult developer on the backside (opposite side of the collected specimen) of the card along with one drop on the control dots. A positive result should appear blue/purple in color. Upon seeing this result, the test must be repeated.

4. The result must be read within one minute of applying the developer to the card.

5. The control performance monitor should be read within ten seconds of applying the developer on the control dot.

6. Document the results in the patient's medical record.

7. When the test is done in the Clinic during the course of a clinic visit, place the stool specimen on the card on the front specimen side.

8. Let the specimen dry on the card for three to five minutes before applying the developer as noted above and record the results in the EMR.

9. Complete the result as noted above.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Waived Testing Hemoglobin	REVIEWED: 8/28/19; 2/20/20
SECTION: Waived Testing	REVISED: 2/20/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Waived Testing using the Consult Diagnostics Hemoglobin Analyzer

Objective: Testing of blood specimens for the purpose of determining the patient's Hemoglobin level will be performed in the Clinic using approved waived testing technologies and techniques, specifically a Consult Diagnostics device.

Response Rating: Mandatory

Required Equipment: Consult Hemoglobin Analyzer, lancet, microcuvette, gloves, cotton ball/gauze 2x2, dot bandaid

Procedure:

1. Upon receipt of a written order or by Standardized procedure, a capillary blood specimen will be collected and tested to determine the patient's Hemoglobin level.
   a. Ensure machine is plugged into the wall.
   b. Turn machine on.
   c. Don gloves.
   d. Assemble microcuvette (confirm in date), bandaid, cotton ball or gauze.
   e. Warm patient's finger and press finger at or below first joint.
   f. Use alcohol prep pad to wipe fingertip.
   g. Allow fingertip to air dry or use clean gauze to dry fingertip.
   h. Use lancet to obtain specimen on patient's fingertip, along side of finger. Lancet to sharps container.
   i. Squeeze fingertip to express drop of blood and wipe specimen 3 times before collection

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j. Squeeze fingertip to express drop of blood and fill microcuvette with blood and ensure capture area is full.

k. Wipe excess blood from microcuvette before inserting in machine.

l. Look for air bubbles in the filled microcuvette. If present, take a new sample. Small bubbles around the edge can be ignored.

m. Insert microcuvette in machine and press down. Result displays within seconds. Remove microcuvette immediately after results are displayed.

n. Record results in EMR.

o. Dispose of microcuvette in the biohazardous waste container.

2. To clean machine

a. Turn machine off.

b. Wipe exterior of machine with germicidal wipe.

3. If error message EO3 displays on machine it means that the microcuvette has been left in the machine too long or was removed too slowly.

a. Turn machine off.

b. Remove table.

c. Using red handled cleaning tool thoroughly wipe inside of machine.

d. Wait 15 minutes

e. Insert table into machine, click to engage, and close.

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→m.→Close table and wait for results, approximately 1 minute.

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→b.→Remove table from machine.¶

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→e.→Insert table into machine, click to engage, and close.

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Waived Testing Hemoglobin A1C	REVIEWED: 12/27/19; 2/20/20
SECTION: Waived Testing	REVISED: 2/20/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Waived Testing using the A1C Now Professional for Hemoglobin A1C

Objective: Testing of blood specimens for the purpose of determining the patient's Hemoglobin A1C level will be performed in the Clinic using approved waived testing technologies and techniques, a A1C Now Professional analyzer.

Response Rating: Mandatory

Required Equipment: A1C Now Analyzer, A1C Now Hemoglobin A1C Reagent Kit, lint-free tissue, gloves, cotton ball/gauze 2x2, dot bandaid,

Procedure:

1. Store the kits in temperatures below 122 degrees F in the designated laboratory up to four (4) months prior to use.
   a. If the temperature label, place on the outside of every kit, is exposed to a temperature in excess of 122 degrees F the dot on the label will turn red and the product should not be used.
   b. Run the rest with all parts of the test kit at the same temperature within the specified range.
   c. If the kit has recently been at high temperatures (above 82 degrees F) or in the refrigerator, keep the kit at room temperature for at least one hour before use.
   d. Avoid running the test in direct sunlight, on hot or cold surfaces, or near sources of heat or cold.
   e. Quality control materials should be used to confirm the test kit is working properly. Refer to the product insert for information on when to run controls.
      i. Quality control is run automatically with each test.
      ii. Completed quality control will show QCOK on the device's display window.
   f. Use analyzer only with the materials included in the original kit. The analyzer will expire after the programmed number of tests have been run. If another test cartridge is inserted, the analyzer will display "00TL".

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2. Upon receipt of a written order or by Standardized procedure, a capillary blood specimen will be collected and tested to determine the patient's Hemoglobin A1C level.

   a. Open plastic shaker pouch by tearing plastic pouch open at the perforation line.

b. Collect blood using the fingerstick method and available lancets, then utilize the blood collector and fill just to the top of the collection tube.

c. Fully insert the blood collector into the shaker body. You may use a twisting motion.

d. Mix the specimen by shaking the shaker body vigorously 6-8 times which will mix the blood with the testing solution. Stand the shaker on the counter while preparing the cartridge.

e. Open the foil cartridge pouch by tearing at the notches on the sides.
DO NOT OPEN the pouch until you are ready to use it immediately. Use within 2 minutes of opening. If the foil pouch is damaged, do not use.

f. Insert the cartridge by clicking the test cartridge into place. The analyzer and test cartridge codes must match. If codes do not match, call Customer Service at 1-877-870-5610.

g. Prepare the shaker base by removing it from the package. Wait for SMPL to display. This indicates the shaker base is ready for the shaker.

h. Dispense the sample into the cartridge. Ensure the analyzer is on a level surface. Push down completely to dispense the diluted sample. Then remove quickly. DO NOT handle the analyzer again until the test is complete.

i. Results will display in five (5) minutes. The display counts down. The result cycle remains displayed for 15 minutes or until the next test cartridge is inserted.

j. Dispose of the cartridge in an approved biohazard bin.

k. Record results in the patient's medical record.

3. Between uses, the analyzer may be sanitized using a Super Sani Wipe.

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→a.→With each new shipment¶
→b.→With each new lot¶
→c.→Whenever problems are identified (storage, operator, instrument, or other)¶
d.→To ensure that storage conditions have not affected the product, run a control sample before running a patient sample if the test kit has been stored for more than a month and it has been at least a month since the last control testing.¶

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Influenza A and B Test - Waived	REVIEWED: 12/27/19; 2/20/20
SECTION: Waived Testing	REVISED: 2/20/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Influenza A and B testing using OSOM Ultra Flu A & B waived testing kit

Objective: Accurate, timely point-of-care testing to determine patient's Influenza A and B status

Response Rating:

Required Equipment: Gloves, Influenza A and B test kit, timer

Procedure:

1. Follow test kit components according to manufacturer requirements
   a. Store test sticks and extraction reagent at room temperature (59 – 80 degrees F)
   b. Do not freeze any of the test kit components.
   c. Do not use test sticks and reagents after expiration date.
   e. Test sticks that have been outside of the desiccated container for more than 1 hour should be discarded.
2. Don gloves.
3. Collect a specimen.
   a. Only nasal swabs can be used with this test.
   b. Insert the test swab into the nostril that appears to have the most secretion. Using a gentle rotation, push the swab until resistance is met at the level of the turbinates (at least one inch into the nostril). Rotate the swab a few times against the nasal wall.
   c. Use only the swabs supplies in the OSOM Influenza A & B Test kit. Swabs from other suppliers have not been validated for use. Do not use swabs that have cotton, rayon, or polyester or wooden shafts.

d. Test the swab as soon as possible after collecting the specimen. If swabs cannot be processed immediately, specimens may be held at room temperature for no longer than eight (8) hours. Swabs may also be stored at 36-46 degrees F for up to 24 hours.

e. To transport patient samples place swab in clean, dry container such as a plastic or glass tube.

f. If a culture result is desired, a separate swab must be collected for the culture.

g. The test performance depends on the quality of the sample obtained as well as the handling and transport of the sample. Negative results can occur from inadequate specimen collection and/or handling.

4. Perform the test

a. Add extraction buffer

1. Tear the top off the Extraction Reagent Capsule and dispense entire contents into the Extraction Well.

b. Insert the specimen swab in the Swab Stand

1. Spin swab three (3) times to mix the specimen
2. Let stand one (1) minute
3. Spin swab three (3) times again

c. Discard the swab in the biohazardous waste container.

1. Raise the device upright and let stand 1-2 seconds
2. Gently tap device to ensure the liquid flows into the hole
3. Lay the device back down

d. Set the timer for ten (10) minutes

e. Read results

1. Read the results in 10-15 minutes
2. Confirm negative results at 15 minutes
2. Refer to Result Interpretation Guide or stick diagram in the OSOM literature for help in reading the test stick.
3. Discard used test components in suitable biohazardous waste container.

g. Record results in EMR and advise the ordering provider that results are available.

5. In the event the usual OSOM waived testing kit is not available, review and follow the directions provided by the manufacturer.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Waived Testing - LeadCare II	REVIEWED: 8/29/19; k2/20/20
SECTION: Waived Testing	REVISED: 3/11/18; 2/20/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Waived Testing using the Leadcare II device

Objective: To screen and identify children with elevated BBLs for appropriate treatment, education, and elimination of lead exposure.

Response Rating: Mandatory

Required Equipment: Leadcare II, treatment reagent tube, capillary tube, plunger, lead sensor, dropper, label, powder-free gloves, lancet, cotton ball/gauze 2x2, dot bandaid. Equipment needs to be stored in a clean box with a cover.

Definitions: BBL: Blood Lead Level
Reference Level / Elevated BBL: > 5 ug/dL

Procedure:

Specimen Collection and Testing

1. As a part of the pediatric patient's physical examination. Risk assessment and frequency of screening to be determined by the provider in conjunction with the American Academy of Pediatrics recommendations for preventive pediatric health care located on the periodicity schedule.

   a. Risk assessment to be performed with appropriate action to follow if positive at 6 months, 9 months, 12 months, 18 months, 24 months, 3 years, 4 years, 5 years, 6 years.
   b. Screening or risk assessment is to be performed at 12 months and 24 months.
   c. If the screening or risk assessment is not performed per the recommended periodicity schedule, document in the EMR the reason.

2. Upon receipt of a written order a capillary blood specimen will be collected and tested to determine the patient's blood lead level.

   a. Ensure machine is plugged into the wall and/or batteries installed.

   b. Don gloves.

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c. Label the treatment reagent tube with the patient ID using labels.

d. Wash patient's hands with soap and water and let air dry.

e. Warm patient's finger and press finger at or below first joint. Use alcohol prep pad to wipe fingertip.

f. Allow fingertip to air dry.

g. Use lancet to obtain specimen on patient's fingertip, alongside of finger.

h. Squeeze fingertip to express one drop of blood 2 or 3 times before collection.

i. Squeeze fingertip to express drop of blood and holding capillary tube almost horizontally with green band on top, fill the capillary to the black line.

j. Wipe excess blood from capillary tube with a clean wipe or gauze.

k. Look for air bubbles in the filled capillary tube. If present, take a new sample. Small bubbles around the edge can be ignored.

l. Place the capillary tube into the reagent tube. Insert a plunger into the top of the capillary tube and push down, ensuring entire volume of sample is dispensed into the treatment reagent.

m. Replace the reagent tube cap. Invert the tube 8 to 10 times.

n. Insert blood lead sensor into machine to turn it on.

o. Remove the cap from the reagent tube. Squeeze the walls of the dropper and insert into the sample. Release the pressure to draw some sample into the dropper.

p. Touch the dropper tip to the X on the sensor and squeeze to dispense the sample.

q. Wait 3 minutes until the test is done.

r. Record the test results in the ERM.

s. Remove used sensors from the analyzer as soon as the result is recorded.

3. To clean machine

a. Machine goes off automatically.

b. Clean analyzer with a damp cloth and warm, soapy water.

c. Disinfect with Cavi Wipes.

d. Do not leave any soap film on the analyzer. Do not allow liquid into the sensor connector. Do not wash the inside of the calibration button reader.

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Test Result Reporting

1. Report results on CDPH site https://eblr.cdph.ca.gov using the assigned clinic identifier and password.

2. The reportable range of the test is 3.3 to 65 µg/dL.

3. Capillary blood samples that generate a lead level of 5 ug/dL should be confirmed with a second test sample from a different site. However, if the result of the second sample is also above 5 µg/dL, the patient should be sent to a laboratory for a confirmation blood draw.

4. In cases where the capillary specimen demonstrates an elevated lead level but the confirmation venous sample does not, it is important to recognize that the child may live in a lead-contaminated environment that resulted in contamination of the fingertip. Efforts should be made to identify and eliminate the source of lead in these cases.

- "Low" is a blood leverl less than 3.3 ug/dL -- should be recorded as <3.3 ug/dL
- "High" in the display windows indicates a blood lead test result greater than 65 µg/dL. When this occurs, report the blood lead result as greater than (>) 65 µg/dL. "High" results on LeadCare II should be followed up immediately as an emergency laboratory test and Reported.
- Blood lead results ≥9.5 µg/dL must be electronically reported within 3 working days from the date of analysis.
- Blood lead results <9.4 µg/dL must be electronically reported within 30 calendar days from the date of analysis.

5. State Reporting

- Abnormal high results must be reported to the state and the receipt scanned into medical record the same day as performed.
- Normal results must be reported to the state at the end of each month.
- Results reported to the state electronically are given an Accession Reporting Number consisting of the Kit Lot# followed by test# (ex: 1234-1, 1234-2 etc). not using any public health information identifier.

6. Repeat Testing Guidelines

If blood lead level	Childs Age	Perform capillary re-test within
< 5 ug/dL	< 12 months	3 – 6 months
< 5 ug/dL	1 – 5 years	6 – 12 months

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If blood lead level	Childs Age	Perform capillary re-test within
5 – 14 ug/dL	1 – 5 years	1 - 3 months
If blood lead level	Childs Age	Perform capillary re-test within
15 -44 ug/dL	1 – 5 years	1 – 4 weeks
➢ 44 ug/dL	1 – 5 years	48 hours

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MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Waived Testing - Urinalysis Using Siemens Analyzer	REVIEWED: 8/29/19; 2/20/20
SECTION: Waived Testing	REVISED: 2/20/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

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Subject: Urinalysis using Siemens Analyzer

Testing of urine specimens will be performed in the Clinic using approved waived testing technologies and techniques.

Objective: Testing of urine specimens will be performed in the Clinic using approved waived testing technologies and techniques, specifically a Siemens Analyzer.

Response Rating: Minimal

Required Equipment: Urine container with patient specimen, gloves, urine dipstick and paper towel

Applies to: All personnel

Procedure

1. Obtain written order from provider or perform test per approved Standardized Procedure, as applicable.
2. Apply gloves.
3. Collect specimen from patient.
4. Testing is started from the main Select Screen.
5. On the screen, touch Strip Test to conduct urinalysis.
6. The next screen that appears is Prepare Test.
7. Make sure the test table insert has the reagent strip holder facing upward. Also, have the test strip, urine sample and paper towel ready.
8. Touch the Start button. The next screen that appears is another Prepare Test. This screen prompts you through the steps to prepare the test strip.

9. A timer displays how much time you have remaining to complete the steps.

10. You have 8 seconds to complete the following 4 steps:

    a. Dip the reagent strip into the urine sample, wetting all pads.
    b. Immediately remove the strip from the urine.
        i. NOTE: Do not dip the automatic band or color band in the urine sample. Blot by touching the edge of the strip into the paper towel to remove excess urine.
        ii. Place the reagent strip in the channel of the table with the test pads facing up. Slide strip to the end of the channel.
        iii. At the end of the 8 second countdown, the test table and strip will automatically be pulled into the analyzer.

11. The analyzer will print the result with date and time and test result.

12. Document the color and clarity of the urine on the results print out and in the EMR.

13. Enter results into the patient's EMR and advise provider testing is complete.

14. If provider orders the specimen to be sent to the laboratory for culture, draw up urine into Urine Culture tube, label the tube and place in laboratory pick up basket after ensuring the laboratory requisition is completed and signed by the provider

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→An asterisk will appear next to any abnormal results.¶

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Incident Reports	REVIEWED: 11/12/18; 2/18/20
SECTION: Operations	REVISED: 2/18/20
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Incident Reports

Objective: All unusual events shall be documented on an incident report form to provide proper documentation and follow-up and to support risk identification and trends.

Response Rating:

Required Equipment:

Procedure:

1. An incident report shall be completed promptly when any of the following events occur:

    a. Medication error
    b. Adverse drug reaction
    c. Non-reconcilable narcotic medication inventory error
    d. Patient accident
    e. Employee accident
    f. Visitor accident
    g. Cardiac or respiratory arrest
    h. Newborn delivery
    i. Death
    j. Hostile or threatening person
    k. Theft of Clinic, patient, or employee possessions
    l. Vandalism
    m. Any "out of the ordinary" events with possible risk management consequences

2. The completed Incident Report will be forwarded to the Executive Director as soon as possible after the event occurs, but no later than 24 hours after the event.

3. The problem description will be precise, concise, and accurate. It is not necessary to include details regarding any patient care treatment rendered. The description should include the result of action(s) taken and disposition(s).

4. All Incident Reports will be reviewed by both the Medical Director and Clinic Director. Follow-up action(s) shall be recorded in the Quality Assurance Performance Improvement meeting minutes.

5. The Incident Report is a confidential document and will be handled as such. Incident Reports are not part of the patient's medical record and will not be filed therein.

MARK TWAIN HEALTH CARE DISTRICT
RURAL HEALTH CLINICS
POLICY AND PROCEDURES

POLICY: Waived Testing - Strep A Direct Rapid Testing	REVIEWED: 8/29/19; 2/21/20
SECTION: Waived Testing	REVISED: 2/20/29
EFFECTIVE: March Board Meeting	MEDICAL DIRECTOR:

Subject: Strep A Direct Rapid Testing

Objective: To detect Strep A, using waived testing processes, for diagnosis and implementation of treatment plan.

Response Rating:

Required Equipment: Rapid Strep A testing kit

Procedure:

1. As per Standardized Procedure or upon receipt and review of a written order.
2. After applying gloves, retrieve two swabs from the test kit and one culture swab and swab the back of the patient's throat for a count of three (3) seconds. Avoid swabbing sides of the mouth or the tongue.
3. Uncap Reagent A and Reagent B. Holding bottle straight up with the tip pointing in the test tube, add four (4) drops of Reagent A, then add four (4) drops of Reagent B.
4. Rotate swab ten (10) times and let swab in reagent for one minute. Press swab against the side of the tube and squeeze the bottom of the tube while removing the swab so that most of the liquid stays in the tube.
5. Discard swab in biohazard bin.
6. Begin timer and read results in five (5) minutes.
7. Any shade of red in the "T" region should be considered positive.
8. Line only at "C" region is negative.
9. Line only at T test is invalid.
10. If the results are negative, advise the practitioner and request a laboratory requisition to allow you to process the second swab and send to the laboratory for confirmation testing.

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3. →Remove test device from foil pack.¶
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4. →Place the test device on a clean, dry, level surface. Make sure the device is in the closed position.¶
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8. →Hold device down on a flat surface. Open valve by twisting ribbed part of valve clockwise until it stops →in open valve position.¶
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11. Remove gloves and wash hands.

12. Record results in EMR and laboratory log.

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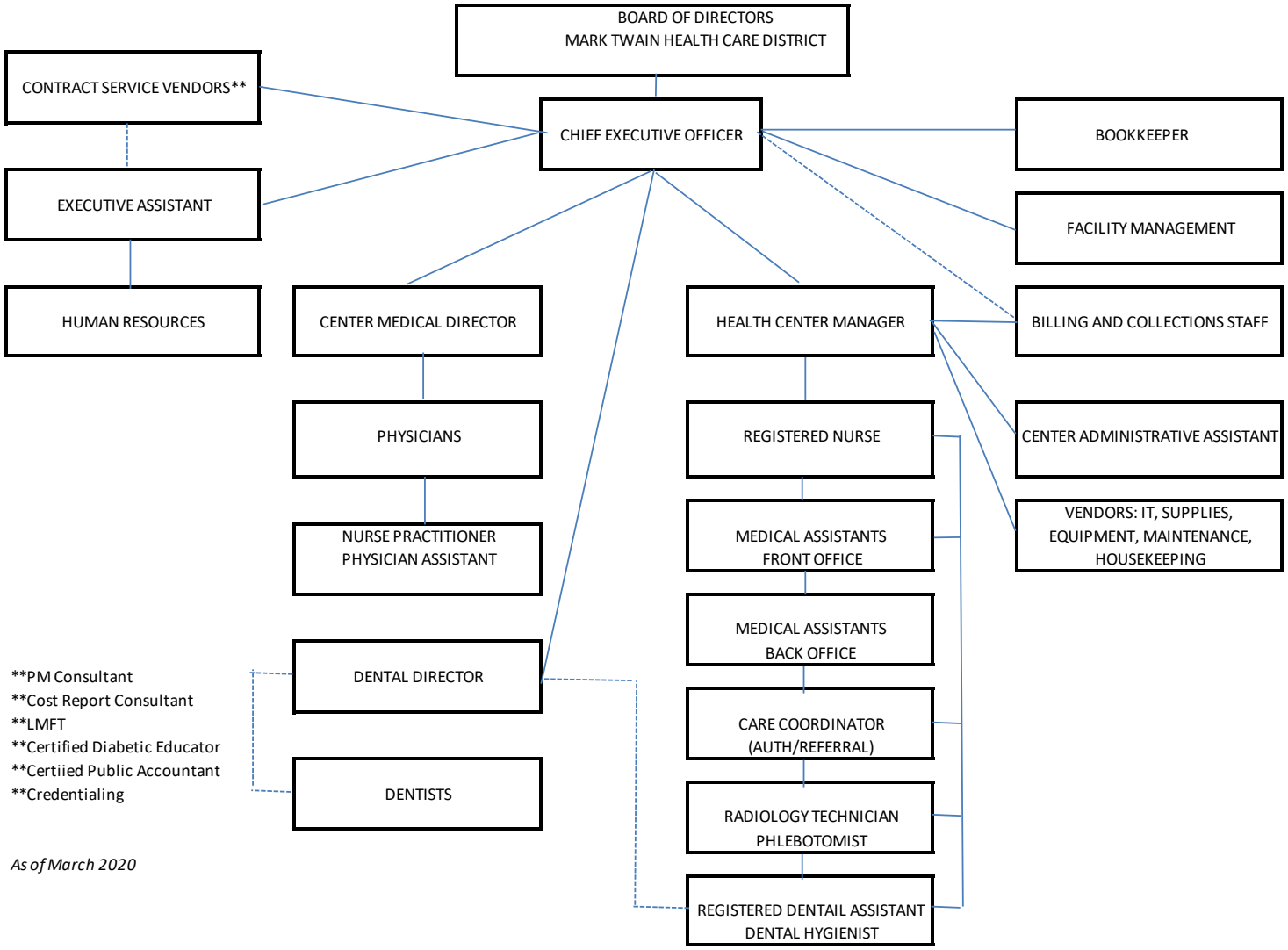
MARK TWAIN
HEALTH CARE DISTRICT

These policies and procedures are to be used by the Mark Twain Health Care District / Valley Springs Health and Wellness Center staff. The manual is reviewed and updated annually.

REVIEWED AND APPROVED:

Name and Title	Date
Lin Read, MBA, OTR/L – President, Mark Twain Health Care District	
Susan Atkinson, MSW – Treasurer, Mark Twain Health Care District	
Debbie Sellick, CMP - Member-at-Large, Mark Twain Health Care District	
Talibah Al-Rafiq - Member-at-Large, Mark Twain Health Care District	
Kathy Toepel – Member-at-Large, Mark Twain Health Care District	
Randy Smart, MD – Chief Executive Officer, Mark Twain Health Care District; Medical Director, Valley Springs Health and Wellness Center	
Brandi Gomez, FNP-C – Nurse Practitioner, Valley Springs Health and Wellness Center	
Tina Terradista, RN – Manager, Valley Springs Health and Wellness Center	
Cheryl Duncan – Consultant	

Valley Springs Health Wellness Center
51 Wellness Way, Valley Springs, CA 95252



**PM Consultant
**Cost Report Consultant
**LMFT
**Certified Diabetic Educator
**Certiied Public Accountant
**Credentialing

As of March 2020