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ADMINISTRATION

ABBREVIATIONS AND SYMBOLS; "DO NOT USE"
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The University of North Dakota Center for Family Medicine, Bismarck, is a fully accredited residency training program that has graduated over 150 physicians. The Center is administered by the University of North Dakota School of Medicine and Health Sciences. We are a three-year program and accept five first year residents annually through the NRMP Match.

Our program is sponsored by both hospitals in the community —Sanford Health and CHI - St. Alexius Medical Center — and enjoys the tremendous support of the local teaching faculty.

FACULTY:

Program Director: Jeff Hostetter, M.D.

Associate Program Director: Jackie Quisno, M.D.

Assistant Program Directors: Shannon Sauter, M.D.
Swami Gade, M.D.
Joseph Luger, M.D. (Dermatology)
Brynn Luger, MA, LPCC, NCC (Clinical Counselor)
Rhonda Schafer-McLean, M.D. (OBGYN)

PART-TIME FACULTY

Joan Connell, M.D. (Pediatrics)
Kristin Melby, FNP
Laura Schield, M.D. (Psychiatry)

Home

Mission Statement and Aims of the Program

The mission of the Center for Family Medicine is to train competent, caring family physicians who will exemplify the ideals and values of family medicine, and who will provide high-quality, safe, and effective medical care for North Dakota communities.

Educational Aims of the Program

The Program will:

1. Maintain a training program in the specialty of Family Medicine that is ACGME-accredited and focuses on the teaching of effective, evidence-based, high-quality and safe medical care.
2. Develop and employ a medical curriculum that aims for all graduates to pass the ABFM board examination on their first attempt.
3. Design learning activities to expose residents to diverse experiences including providing medical care in rural, under-served areas in ND, and in providing care to under-served demographic groups in ND.
4. Complete regular evaluations of individual resident physicians in order to individualize learning plans for resident physicians with the goal of bringing all learners to a high level of competence.
5. Provide continuous learning opportunities to faculty physicians in order to keep their medical knowledge and practices updated to current standards of care.
6. Provide faculty to serve as role models for high standards of professionalism and excellence in medical care.
7. Provide a learning and working environment that exemplifies and promotes inclusion, cultural and ethnic diversity, and safety to medical learners at all levels, staff, faculty, and patients.

The Resident physicians will:

1. Learn to gather essential and accurate information from patients by utilizing effective listening and communication methods in order to formulate comprehensive evidence-based management plans.
2. Learn to manage and treat the majority of medical problems encountered in clinical practice in all patient care settings including acute and chronic medical conditions.
3. Gain sufficient knowledge and technical skills to competently perform procedures within the scope of family medicine.
4. Learn strategies in providing disease prevention and health promotion.
5. Critique and appraise information for its validity and clinical usefulness, and be able to incorporate the best medical evidence into patient care.
6. Practice professionalism including respect, compassion, integrity, responsibility, and commitment to the ethical practice of medicine.
7. Demonstrate an ongoing commitment to personal and professional development and the need to participate in life-long learning and improvement.

8. Understand the importance of physician well-being and resilience including physical and emotional well-being.
9. Learn skills needed to provide health care in rural, under-served areas, and to under-served demographic groups.
10. Learn to function effectively within the larger health care system coordinating the provision of quality, cost-effective care as a member of the health care team and serving as advocates for patients.

Home

Paramedical/Ancillary Staff

The Center for Family Medicine is fortunate to have a dedicated and enthusiastic ancillary staff. The following is an abbreviated description of the duties for each classification of positions. The staff performs many other duties other than those described below; however, this information is to provide you with the basic function of each job classification.

Business Manager
The Business Manager is responsible for the overall supervision of the ancillary staff and ensures the efficient function of most aspects of the clinic. She/he is involved with the budget process (clinic operations and financial management), risk management, personnel administration/human resources (staff procurement), marketing and public relations, and ensures compliance with regulatory agencies. In addition to this, this person is in charge of coordinating the Practice Management/Management of Health Systems module rotation and training for the Residency Program and is involved in the Residency Recruitment process. The Business Managers at the UND-CFMs now have a direct reporting relationship on our Organizational Chart the Associate Dean of Administration & Finance at UND's School of Medicine & Health Sciences. The Business Manager is also a member of the UND-CFM's Oversight Committee.

Residency Coordinator
The Residency Coordinator is responsible for the overall scheduling of the Residents. He/ She coordinates Resident schedules with Community Preceptors, Director's schedules, and clinic Preceptor schedules. He/ She is responsible for the monthly calendars (call schedules and rotation schedules) as well as preparing evaluations for dissemination for all of the required residency rotations. The Admin Assistant also is responsible for maintaining Accreditation documents for the Residency Program and completes the Residency Billings that are invoiced to our sponsoring hospitals for GME reimbursement/reconciliation. This person is responsible for tracking the Resident's clinical and hospital encounters, rural rotations, and elective experiences.

Nursing Staff – Team
This department consists of clinic nursing staff (RNs & LPNs). In addition to this, we have a Geriatric Nurse Coordinator. Our nursing staff is efficient and knowledgeable. You will find that you can depend on them to serve you and your patients effectively. They prepare patients to be seen by the physicians, maintain the exam rooms for procedures, schedule appointments for your patients with other physicians and services based on your orders, keep the team pod stocked with supplies and medications, and prioritize patient messages.

Health Information/Medical Records
The Health Information/Medical Records department is responsible for all patient charts both electronic (EMR) and paper. Responsibilities include scanning of records into patient charts as well as destruction and retention schedules. This department is also in charge of HIPAA compliance as well as Release of Information.

Front Desk Receptionist/Schedulers
The receptionists are responsible for answering telephone calls that come into the clinic and maintaining the core switchboard, routing calls as appropriate. They are responsible for scheduling all patient appointments for physicians, nurses and ancillary support services. The receptionists are also responsible for collecting co-pays. The receptionists validate patient demographics and insurance information upon the patient's entry to the clinic system.

Radiology
The department is staffed with one full time registered and ND licensed radiologic technologist and a backup ND licensed certified Diagnostic Operator. Service is provided during regular clinic hours. Our department performs general diagnostic x-rays and is equipped with a computerized radiology system. Images are read by Sanford's radiologists by means of a PACS system. Radiology is cross-trained to do electrocardiograms, event monitors, pulmonary function tests and hearing screenings.

Laboratory
This department consists of laboratory scientists. Our in- house testing is broad and includes urinalysis, chemistry, hematology, microbiology, serology, and coagulation. What we are unable to do in house is sent to our reference

laboratory, Sanford Lab Bismarck. Turnaround time for most reference lab results is 12-24 hours. The lab is cross-trained to assist radiology staff with several ancillary testing procedures. The Laboratory Director/Supervisor acts as a lead team member on the UND-CFM's Risk Management Committee and Quality reporting.

Patient Accounts & Billing (Business Office)
This department consists of certified Professional Coders. The department is in charge of the clinic and hospital billing. They are responsible for maintaining proper billing procedures along with coding the charges with the correct ICD9 diagnosis and CPT Procedures. They make sure all insurance is filed and updated on any major insurance changes. They manage the accounts receivable for charges and collections and reconcile the daily deposit.

Pharmacy
This department consists of a PharmD. The department is in charge of assisting the residents/faculty with any medication/prescriptions needs. CFM Pharmacy is open Monday-Friday from 8am-5pm. The pharmacy offers a variety of over-the-counter medications, supplies, and prescriptions to our staff, residents, and patient populations. All pharmaceutical representatives report to the pharmacy for scheduling, displays, and drug samples where the samples are stored, inventoried, and dispensed to the patient (with a valid order from MD's).

Home

Clinic and University Websites:

Policy and Procedures can be accessed by all residents, faculty, and staff at the UND CFM Bismarck website which can be accessed by choosing the "Residency Program" link at the URL for the **UND Center for Family Medicine**. A hardcopy of the manual can be found in office of the Risk Management coordinator.

The URL for the **UND Center for Family Medicine Bismarck** is as follows:

http://www.cfmbismarck.und.edu

Direct patients and prospective residents to the site as necessary. Biographical sketches/photos are included on the site for all Faculty and Residents.

The URL for the **University of North Dakota's School of Medicine & Health Sciences** Home Page is as follows:

http://www.med.und.edu/

You can link back to UND Center for Family Medicine Bismarck by locating the Department's Academic tab.

The University of North Dakota's School of Medicine & Health Sciences **GME Residency Training Program** Home Page is located at

http://www.med.und.edu/residency

All UND residents and faculty Researches are required to complete the **UND Institutional Review Board's (IRB) Human Subjects Training Module**. The URL for this module is:

www.citiprogram.org

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RESIDENT DUTY HOURS POLICY

A. **Principles**
Physicians have a professional responsibility to appear for duty appropriately rested and fit to provide the services required by their patients.
The program is committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
The learning objectives of the program will be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events and must not be compromised by excessive reliance on residents to fulfill non-physician service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energy.

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

B. **Application**

This policy applies to all residents in UND residency programs.

C. **Definitions** Duty hours are defined as time spent in all clinical and academic activities related to the program. Specifically, this includes time spent in patient care (both inpatient and outpatient), administrative duties related to patient care, the provision of transfer of patient care, time spent in-house during call activities, and scheduled educational activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

D. **Policy**
1. Duty hours must be limited to a maximum of 80 hours per week, averaged over any four-week period, inclusive of all in-house call activities and all moonlighting.
2. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
3. Duty periods of PGY-1 residents must not exceed 16 hours in duration.
4. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours continuous duty in the hospital. Residents are encouraged to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00PM and 8:00AM is strongly suggested. Residents may be allowed to remain on-site in order to accomplish effective transitions in care for no longer than an additional four hours.
5. For emergency medicine assignments, duty periods must not exceed 12 hours in duration.
6. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled duty period to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must appropriately hand over the care of all other patients to the team responsible for their continuing care; and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director will review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
7. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
8. PGY-1 residents and intermediate level residents (as defined by the Review Committee) should have 10 hours, and must have 8 hours free of duty between scheduled duty periods. Intermediate level residents must have at least 14 hours free of duty after 24 hours of in-house duty.
9. It is desirable for residents in the final years of education (as defined by the Review Committee) to have eight hours free of duty between scheduled duty periods. There may be circumstances (as defined by the Review Committee) when these residents must stay on duty to care for their patients or return the hospital with fewer than eight hours free of duty. These circumstances must be monitored by the Program Director.

10. Residents will not be scheduled for more than six consecutive nights of night float.
11. PGY-2 and above residents will not be scheduled for in-house call more frequently than every third night (when averaged over any four-week period).
12. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Time spent in the hospital by residents on at-home call counts as duty hours.

Resident Recruitment Criteria

Purpose: To provide the UND Center for Family Medicine Bismarck with qualified candidates for residency selection.

Policy: The UND Center for Family Medicine Bismarck will use the following guidelines for resident selection:

1. All applicants must hold a doctor of medicine or doctor of osteopathic degree from a medical school approved by the North Dakota Board of Medical Examiners with the date of graduation to be five years or less from start of residency.
2. All applicants must have completed USMLE Step I and Step II, with a passing score.
3. All applicants must meet the requirements set forth by the North Dakota Board of Medical Examiners to be licensed in the state of North Dakota.
4. All applicants must submit two letters of recommendation from a US clinic/hospital or US practicing physician.
5. If an applicant does not meet the above criteria, they can be considered only if they successfully completed an observership at the UND Center for Family Medicine Bismarck.

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CFM Clinic Responsibilities

1. Clinic has priority over rotational responsibilities.

2. Notify the office manager and/or your nurse at the earliest possible time if you will be late/absent from clinic.

3. Morning clinic schedules ***begin promptly at 8:30 a.m.***

4. Afternoon clinic schedules daily, with the exception of Tuesday's begin promptly at 1:00 p.m.

5. Tuesday afternoon schedules begin after the resident business meeting (1:30 p.m.)

6. A maximum number of six physicians are scheduled per one-half day. No more than four residents per one-half day, unless a second preceptor is available.

7. Effective May 1st of each year, third year residents *may possibly* drop to two half days per week until graduation. (During the last five clinic days in June, third year residents are scheduled to work ½ day). This is contingent upon having adequate clinic numbers. Residents are required to see 1650 total patients for the three years.

8. For the first 6 months of the academic year, all PGY-1 clinic patient encounters need to be precepted by a CFM faculty member **BEFORE** the patient leaves the clinic. After this time, a minimum of every third clinic patient encounters needs to be precepted.

9. For PGY-2 and PGY-3 residents, a minimum of every third clinic patient encounters needs to be precepted by a CFM faculty member.

10. All Medicare patient encounters need to be precepted by a CFM faculty member. All Medicare patients provided Level 4 or 5 care must be seen and examined by a precepting faculty. Also, a faculty member must be physically present and actively participate for all procedures on Medicare patients. The precepting faculty must write a brief note in the patient chart for all Medicare visits.

11. Resident clinic notes will be audited/reviewed by CFM faculty preceptors.

12. It is mandatory for all OB visits seen by a Resident to be precepted with the Attending Physician **BEFORE** the patient leaves the clinic.

13. Clinic session will be scheduled as follows:
    a. 1 full day for PGY-1 residents.
    b. 2 full days for PGY-2 and PGY-3 residents.
    c. Whenever possible, clinic sessions will be FULL days in clinic opposed to 2 or 4 half days.
    d. Exceptions: NICU, ICU, FMTS and OB will not have full days, but rather half day sessions only

14. The current clinic preceptor will not be allowed to see scheduled patient visits during that clinic day unless it is a patient emergency.

Home

Clinic Chief Resident Responsibilities

Meetings and Conferences:

1. A. Chair the resident weekly business meeting or arrange for another Resident to do so.
   1) Coordinate questions or problems that need to be discussed at the business meeting.
   2) Inform residents of policies and/or policy changes.
   3) Take and dictate minutes of the meeting.

   B. Represent Center for Family Medicine at meetings as assigned or required.

   C. Follow guidelines of Conference Attendance Policy-please see policy for details.

2. Clinical:

   A. Act as back-up physician in clinic for: medical students, interns, physicians on extended vacations/leave and walk-in patients.

   B. Arrange medical student orientation and work/call schedule as well as be involved in overseeing their clinical education.

   C. Act as liaison between the residents and the CFM Clinical Staff.

   D. Screen telephone calls requested by receptionists and other staff.

   E. Attend all Center for Family Medicine deliveries as able.

   F. From 8:00 a.m. to 5:00 p.m., assist in taking telephone questions from Nursing Homes regarding UND's Nursing Home patients when the primary care physician cannot be reached. The Geriatric Nurse, Chris, can be very helpful when these situations arise.

3. Other duties as required or assigned:

   A. Promote educational activities.

   B. Receive and handle items referred by the program coordinator, nursing staff, and/or other clinical staff.

   C. Act as back-up to interns for the FMTS.

   D. Coordinate orientation of new interns to various departments.

   E. Escort prospective residents on date of interview.

I acknowledge that I have read and understand the above responsibilities.

_____ _____

Name Date

Home

FMTS Intern Responsibilities

1. Interns are expected to, under the direction of the Senior resident, utilize every opportunity to gain experience in the Emergency Room or the Inpatient ward.

2. As directed by the Senior resident, Interns will be responsible for admitting patients and completing consultations for the Family Medicine Teaching Service (FMTS), performing daily rounds on FMTS patients, and finding patient information among other duties as necessary for patient care.

3. The Senior resident is expected to give the Intern requested guidance and teaching regarding patient care, so ask for help.

4. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

_____ _____

Name Date

Home

FMTS Senior Resident Responsibilities

1. Senior residents are responsible for admitting all UND Center for Family Medicine (CFM) faculty patients, patients transferred from outlying communities and facilities as well as all "unassigned" patients that are admitted to the Family Medicine Teaching Service (FMTS).
   A. If the Senior resident admits a CFM patient that has been previously admitted and cared for by another CFM resident or another CFM resident is that patient's primary care physician, the care is transferred to the other resident the following working day at 8:00 a.m. This is contingent upon the patient's request (priority #1) and mutual understanding between the physicians involved
   B. The Senior resident is responsible for keeping the "Handoff List" for all patients on the FMTS up to date to facilitate sign out and team member changes.

2. The attending physician must be notified of all acute status changes (i.e. ICU admissions, emergent surgeries, marked clinical deterioration, etc.) on patients on the FMTS.

3. Emergency Room Responsibilities.
   The Senior resident may be called for all CFM patients seen at both Emergency Rooms. The Emergency Room physician may call the CFM resident (s) on call at his/her discretion for the care of CFM patients and assistance with the Emergency Room workload. No patient may be discharge from the Emergency Room without being seen and the chart signed by a licensed physician.

4. The Senior resident is responsible for responding to CFM patient telephone calls after regular clinic hours.

5. Senior residents are responsible for supervising and teaching PGY-1 residents assigned to the FMTS. Specifically,
   A. The Senior resident is responsible for promptly reviewing (in person) all admissions done and consultations done by the PGY-1 resident to the FMTS.
   B. The Senior resident is responsible to give the PGY-1 resident requested guidance regarding patient care.

6. Senior residents should assign case topics to residents and medical students based on interesting cases from clinic or inpatient experience or as needed.

7. Follow guidelines of Conference Attendance Policy – please see policy for details.

I acknowledge that I have read and understand the above responsibilities.

_____ _____

Name Date

Home

Conference Attendance Policy

Purpose:
Didactic conferences are a significant portion of the learning residents receive, and are essential for board preparation and future practice. Thus attending as many of these sessions as possible is of high priority. This policy delineates

Policy:
1. Mandatory Conferences/Events will be published on the monthly calendar by the Residency Coordinator.

2. Residents are required to attend 75% of conferences.
   A. The attendance requirement can be met in two ways: 1) live attendance at the conference, or 2) viewing the recording of the conference on the internet.
   B. If the conference recording is viewed, the resident must send an email to the Residency Coordinator answering the questions at the end of this policy in order to receive credit for viewing.
   C. No more than 25% of conference attendance can be done by viewing recordings.
   D. Residents are excused from attendance if they are on vacation, CME, personal days, sick leave, or out-of-town rotations.
   E. Residents on night FMTS rotations are expected to view the conference recordings and are NOT excused from the requirement.

3. Attendance reports will be distributed monthly.

4. Deficient residents must make up their deficiency in the next semester.

5. Consequences for deficient attendance:

   A. Residents may not use ANY of their vacation time if they are below the 75% attendance mark. This includes time for family events and elective doctor's appointments. Residency Coordinator will keep track of the percentage on a daily basis and notify resident and faculty when the 75% mark is met.

   B. If the resident is out of vacation time, the resident will be required to view recorded conferences during their continuity clinic time. They will not be able to see patients until the 75% mark is met.

* Answer these questions via email to Residency Coordinator after viewing a recorded conference in order to receive credit for the conference.

Name:
Title of presentation:
Date and time watched online:
1) One thing I learned from the presentation:
2) One change I will make in my practice from watching the presentation:

Home

Goals and Objectives Policy

1. Residents are required to review the Goals and Objectives for each rotation with their preceptor no later than the end of the first week of the rotation.

2. Residents are required to have the preceptor sign the Goals and Objectives, and then turn them into the Program Coordinator by the Monday after the end of the first week of the rotation.

3. If the resident fails to turn in the signed Goals and Objectives form, the resident can be placed on vacation until the form is turned in. They can also be taken out of their continuity clinic until the form is turned in.

4. Goals and Objectives for all rotations can be downloaded from the residency website by following the link below.

   https://med.und.edu/center-for-family-medicine-bismarck/bismarck-goals-objectives.html

Home

Criteria for Advancement to Senior Resident Level

Purpose:
To ensure that a senior resident is qualified to supervise first year residents.

Policy:
The following criteria must be met in order for a resident to assume Second Call duties:

1. The USMLE Step 3 must be taken by June 30th of the calendar year; i.e. by the end of the PGY-1 year.
2. Faculty must confirm that the resident is qualified to provide PGY-1 supervision in a manner that is safe for patients.
3. If the USMLE Step 3 is failed, whether the resident may continue on Second Call will be determined on an individual basis. Criteria considered by faculty in this situation will include, but not be limited to:
    A. In-Service Training Exam scores
    B. Academic standing documented on evaluations
    C. Number of rotations passed during the PGY-1 year

In-Training Exam (ITE) Performance

Introduction:
The American Board of Family Medicine (ABFM) In-Training Examination (ITE) is a nationally standardized instrument administered to all family medicine residents enrolled in ACGME postgraduate training programs given annually during the last week of October. The ITE has been shown to be a useful predictor of future success on the ABFM specialty examination. All residents are required to take the ABFM specialty examination in April or May of the PGY-3 year.

The ITE exam tests core knowledge and patient management skills in eight major areas: Internal Medicine, Surgery, Obstetrics, Community Medicine, Pediatrics, Psychiatry and Behavioral Sciences, Geriatrics and Gynecology.

All residents are released from other responsibilities in order to be present for the ITE examination, and no vacation or elective time off is allowed during the week of the exam. The examinations are scored by the ABFM and the results reported to the Program Director.

Purpose:
To encourage lifelong learning; to ensure residents attain and retain the requisite knowledge to safely advance through the residency program; and to achieve a 100% pass rate for first time takers of the ABFM specialty examination at the end of residency training.

Definition:
Using the Bayesian score predictor provided with the ITE, residents are expected to score at a level that is equal to or greater than 90% prediction of passing the certification exam. Residents who attain scores below this level for their training year have a significantly poor prediction for passing the ABFM exam.

Procedure:
A resident with low ITE performance will be identified by the program director and the resident's faculty mentor following the receipt of the ITE examination results.

PGY 1 - The first year resident will meet monthly with the advisor to review progress. The resident and mentor will develop an individualized strategy to prepare them for the next year's ITE. This may include:

- Reviewing the ITE exam results to identify areas needing improvement
- Going through all the ITE exam Qs/As in those identified areas and reviewing
- Reading the twice monthly American Family Physician journal and completing the AFP CME quizzes

- Complete 25 AAFP board review questions weekly; focus on topic areas for board questions based on ITE performance areas that were suboptimal
- Take practice quizzes from the ABFM app

PGY 2 – The second year resident will meet with the advisor. A strategy will be developed, which likely will may include:

- Those items listed under PGY 1 remediation above
- Completing the AAFP Family Medicine Board Review Self-Study course (available through the UND CFM residency).
- Enrolling in an additional Q-bank

PGY 3 – The third year resident will meet with the advisor. A strategy will be developed, and will include

- Taking a 1-month elective dedicated to board review which will include an "away" **live** board review course; the resident would be required to pay for this course out of pocket, unless they have remaining CME dollars available to use

Policy for Unsuccessful Remediation:
If remediation is unsuccessful and the resident fails to meet the standard set for performance in the remediation process ***and on the follow-up examination***, the resident may be placed on academic probation. Subsequent arrangements will vary and may include a second remediation program to dismissal from the program. The resident's duration of training could be extended by the time necessary to successfully complete the subsequent remediation.

RESOURCES

American Family Physician (AFP) journal quizzes
AAFP website: www.aafp.org
Log in with your own username and password to obtain appropriate CME credit
Sign into the AFP CME quizzes
Complete the quiz twice monthly
Report CME from quiz completion on your AAFP CME site
Print a copy of your transcript from the AAFP website to place in portfolio for biannual review

AAFP Board Review questions
Enter AAFP website as above using your username and password
Sign into Board Review Questions
Complete 10 board review questions weekly; focus on topic areas for board questions based on ITE performance areas that were suboptimal
Print a copy of your transcript as above for your portfolio for biannual review

ABFM app
Free to download
Take practice quizzes; choose topic areas to focus on topic areas based on ITE performance as above

Healthtracks

This scheduled clinic (every Monday except Holidays that land on a Monday) is the responsibility of senior residents on a rotating basis. Similar to call, this scheduled responsibility may be traded between senior residents.

Weekly Time Records for Residents

Purpose:
To insure compliance with all duty hour time regulations stipulated by the ACGME.

Policy:
1. All residents will daily log their duty hours using the **Medhub** website or app.
2. If the duty hours are not submitted by the end of the third day of the week, the resident will be contacted by the Program Coordinator; then, the Program Director will recall the resident from their assigned duties and may place them on vacation time until they submit their duty hours. This will likely have a negative impact on the evaluation for their current rotation.

Resident Procedure Data Base Instructions

All residents are required to maintain a listing of their procedures during their time spent at the UND Center for Family Medicine. These records will be used to obtain hospital privileges at the hospital when you have completed residency.

All procedures are to be entered in the **MedHub** data base using the website or the app.

This information will be included on your semi-annual evaluation and ACGME Milestone assessment.

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Miscellaneous Hospital Policies

The following is a general overview of Hospital Issues. Please refer to the Medical Staff Policy Manuals for both Sanford Health Systems and St. Alexius Medical Center for details.

1. All Admissions, Discharge Summaries, and Procedures need to be done under the name of an attending physician. It is important to write the name of the attending physician on **all** orders and to specifically mention the name of the attending physician on **all** notes.

2. Family Medicine Residents are not responsible for coverage of any area of either hospital except at outlined in the section titled Residents and as assigned by rotational preceptors. This means that residents are NOT solely responsible for running CODES or coverage of the ER; however, it is expected that residents will participate in these activities.

3. It is expected that ALL documentation will be timely, written or dictated clearly, concisely and with completeness. Use **only** well recognized and approved abbreviations.

4. Services available to residents at either hospital at no charge include: Lab coats, Meals at St. Alexius, Library services, and Parking.

5. Although there is no specific dress code at the CFM or at either hospital, it is required that physicians dress in a professional and responsible manner. Scrubs are discouraged when seeing patients in continuity clinic, and are allowed to be worn only when residents are FMTS, Obstetrics, and Surgery.

6. Family Medicine residents do not have Active Staff clinical privileges at either hospital. Clinical privileges for residents are determined by the clinical privileges of their attending physicians. The level of supervision of residents is determined by level of training of the resident and level of comfort of the attending physician.

Home

RESIDENT SUPERVISION POLICY- Bismarck/Hettinger, Minot/Williston

Purpose:
The purpose of this policy is to ensure that the program will provide sufficient support, mentorship, and guidance in the supervision of physicians-in-training to facilitate education and the provision of safe and excellent patient care, while providing sufficient autonomy for residents to develop into independent practitioners

Policy:
1. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each ACGME Review Committee) who is ultimately responsible for that patient's care.

A. This information should be available to residents, faculty members, and patients.
B. Residents and faculty members should inform patients of their respective roles in each patient's care.

2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients. Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident- delivered care with feedback as to the appropriateness of that care.

3. **Levels of Supervision**. To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

A. **Direct Supervision** – the supervising physician is physically present with the resident and patient.
B. **Indirect Supervision with direct supervision immediately available** – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.:
C. **Indirect Supervision with direct supervision available** – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
D. **Oversight** – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

A. The program director must evaluate each resident's abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
B. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
c. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

5. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

7. The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

8. **The guidelines and protocols for common circumstances requiring faculty involvement such as care of complex patients, ICU transfer, DNR decisions, etc:**

A. Inpatient FMTS service

When issues arise where there is need for 1) increased supervision of care, 2) expert consultation on the complex patient, 3) overwhelming volume of patient care, or 4) any other situation where the resident does not feel comfortable making decisions, the following protocol should be followed:

a. Contact the attending physician – explain situation and ask for guidance.
*The attending physician is responsible for determining the course of action.
b. If unable to contact the attending, contact the Program Director.
c. If the resident on the FMTS is ill, they should contact the attending physician who will adjust staffing and patient load as they deem necessary to ensure balance between service and educational obligations.
d. The FMTS has a cap of 20 patients.

B. Outpatient continuity clinic

When issues arise where there is need for acute patient care outside the scope of the clinic setting, the following protocol should be followed:

a. Contact the precepting physician – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.

C. Nursing home or other long-term care facility:

When issues arise where there is need for higher level of care or any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.
b. During the night, contact the FMTS attending physician – explain situation and ask for guidance.
*The FMTS attending physician is responsible for determining the course of action.
c. If unable to contact the precepting or attending physicians, contact the Program Director.

D. Patient phone calls

When issues arise where there are any questions regarding the most appropriate course of action for patient care, the following protocol should be followed:

a. During the day, contact the precepting physician at the clinic – explain situation and ask for guidance.
*The precepting physician is responsible for determining the course of action.
b. During the night, contact the FMTS attending physician – explain situation and ask for guidance.
*The FMTS attending physician is responsible for determining the course of action.
c. If unable to contact the precepting or attending physicians, contact the Program Director.

Hospital Admission Responsibilities

1. All patients are to be admitted by FMTS residents.
2. When a clinic patient is admitted to the hospital by other than the primary care resident, the patient is transferred to the primary care resident or FMTS resident as soon as possible. The admitting resident is responsible for the orders and the history and physical.
3. Unassigned patients admitted through the ER are admitted by the FMTS residents.

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Admission Order Signature Policy

Purpose:

1. To ensure admission orders are accurate and that patient safety is maximized.
2. To maximize the amount of learning experienced for PGY-1 residents on the UND FMTS from each hospital admission.

Policy:

1. All admission orders written by PGY-1 residents are to be reviewed and approved by a PGY-2 or PGY-3 resident BEFORE they are submitted to be implemented.

2. This only applies to the initial set of admission orders, not to orders for ongoing care.

Fatigue Mitigation

The UND and the program will provide all residents with educational activities to teach strategies that may be used to mitigate fatigue including, but are not limited to, strategic napping; the judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue, and self-monitoring performance and/or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

2. The program, in partnership with Sanford Health, CHI St. Alexius, and WRHS, will provide adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

3. If a resident is too fatigued to safely return home, they may take the following actions as they prefer:
   - A. Sleep in call rooms that are available at the hospitals or at the Bismarck CFM.
   - B. Ask attending to arrange a ride home for them
     1. This may be provided by faculty or CFM/hospital staff.
   - C. Obtain a ride home using Uber, Lyft, or taxi.
     1. The resident is to inform the inpatient service attending or site director that they will be doing so BEFORE they leave the hospital.
     2. The program will reimburse the resident for the expense of the ride once they submit the receipt for the ride per UND policies and procedures.

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Patient Scheduling

1. First year residents are scheduled 3-6 patients per clinic session; half an hour per patient. Please discuss with a faculty member if more time per patient is needed or if more patients can be scheduled.

2. Schedules can be checked in Epic.

3. Except in emergencies or special arrangements, patients are seen by appointment; however, walk-ins are welcome.

4. If a physician asks an unscheduled patient to come to the clinic, the physician must notify the front desk and nursing staff so the that preparations can be made before the patient is seen. If a patient comes in for an exam and is to return for lab work the nurse must be notified.

5. Residents that have morning clinic are expected to arrive at 8:30 AM. Those with afternoon clinic hours are expected to arrive at 1:00 PM and remain in the clinic until 5:00 PM to cover walk-ins and/or late scheduled patients.

6. If a physician is delayed for a scheduled appointment at the clinic, they must always notify the appointment desk personnel.

OB Scheduling

1. OB patients will be scheduled with a specific resident if they so request.

2. If the patient does not have a preference or does not request a physician, the patient is scheduled with residents on a rotating basis.

3. If a patient requests a pregnancy test but does not have a physician, the test is ordered under the clinic preceptor. If the test is positive the nurse will instruct the patient to see a physician as soon as possible. If the patient wishes to continue with the CFM and asks whom they should see, the patient is told to check with the reception staff to see which physicians are available.

Home

Rural Rotations

1. Rural rotations may be conducted in a community office outside of the Bismarck-Mandan area for a period of not less than two weeks and a maximum of eight weeks during the second and third years of residency.

2. The Program Director or designee will coordinate, negotiate, and approve all rural rotations.

3. Rural rotations during the last two weeks of June and the first two weeks of July will not be granted.

Inpatient Pediatrics

Purpose:
Provide adequate funding for the required inpatient pediatrics rotation.

Policy:
1.All residents will be required to do a one-month rotation at the University of Colorado Children's Hospital.
2. In addition to the regular monthly salary that the resident will continue to receive while in Denver, the UND Center for Family Medicine will refund the resident mileage to and from Denver at the current state rate as well as provide housing during the rotation.

Medical Coverage for Sporting Events

Purpose:
To delineate the procedures for insuring adequate medical coverage when residents and faculty are providing medical coverage for sporting events.

Policy:
1. Either a faculty member or a PGY-2 or PGY-3 resident will be allowed to provide medical coverage at sporting events in the community.

2. If a resident is providing coverage, a faculty member must be either concurrently present at the event or be available by phone to provide immediate consultation. The resident is responsible for establishing the consulting coverage arrangements BEFORE the start of the sporting event.

3. Medical care will be provided by either the faculty or resident physician based on the policies, procedures and medical releases/permissions of the team.

Moonlighting

Moonlighting activities must not interfere with the resident's clinic, hospital, or rotational responsibilities.

2. Moonlighting must **NOT** take priority over the resident's clinic schedule. Clinic or rotation responsibilities will not be shortened for moonlighting purposes.

3. Residents must log moonlighting hours in **MedHub**.

4. Refer to the "Moonlighting Policy For Residents" at the UND SMHS GME policies website.
https://med.und.edu/policies/_files/docs/gme-moonlighting.pdf

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Effects of Leave on Completion of Residency - Bismarck/Hettinger

1. Purpose of Policy

This policy elucidates the details of the amounts of leave available to residents and the consequences of exceeding the amount of leave allowed in the completion date of all UND Family Medicine residencies.

2. Background

There are two entities that control resident time off: the ABFM and the UND. They both have separate rules and they do not match.

A. Per the ABFM, residents get 21 weekdays off per year for any reason.

Vacation, Illness, and Other Short-Term Absences Residents are expected to perform their duties as resident physicians for a minimum period of eleven months each calendar year. Therefore, absence from the program for vacation, illness, personal business, leave, etc., must not exceed a combined total of one month per academic year. The ABFM defines one month as 21 working days or 30 calendar days.

https://www.theabfm.org/become-certified/residency-training-guidelines

B. Additionally, the ABFM specifies a leave category called "Family Leave" which can be taken for certain situations including:

1) The birth and care of a newborn, adopted, or foster child, including both birth- and non-birth parents of a newborn.
2) The care of a family member* with a serious health condition, including end of life care
3) A resident's own serious health condition requiring prolonged evaluation and treatment

The Family Leave policy specifies time can be taken for these situations without extending residency per the following guidelines:

"Family Leave Within a Training Year: *ABFM will allow up to (12) weeks away from the program in a given academic year without requiring an extension of training, as long as the Program Director and CCC agree that the resident is ready for advancement, and ultimately for autonomous practice. This includes up to (8) weeks total attributable to Family Leave, with any remaining time up to (4) weeks for Other Leave as allowed by the program.*
There is no longer a requirement to show 12 months in each PGY-year for the resident to be board-eligible; however, by virtue of the allowable time, a resident must have at least 40 weeks of formal training in the year in which they take Family Leave. This policy also supplants the previous 30-day limit per year for resident time away from the program.

Total Time Away Across Training: *A resident may take up to a maximum of 20 weeks of leave over the three years of residency without requiring an extension of training. Generally speaking, 9-12 weeks (3-4 weeks per year) of this leave will be from institutional allowances for time off for all residents; programs will continue to follow their own institutional or programmatic leave policies for this.*
If a resident's leave exceeds either 12 weeks away from the program in a given year, and/or a maximum of 20 weeks total, (e.g. second pregnancy, extended or recurrent personal or family leave) extension of the resident's training will be necessary to cover the duration of time that the individual was away from the program in excess of 20 weeks."

https://www.theabfm.org/sites/default/files/PDF/ABFM%20Family%20Leave%20Policy-5-21-2020.pdf

C. Per the UND residents get:

1) Vacation: Residents/Fellows shall receive 3 weeks (21 calendar days =15 weekdays + 6 weekend days) of paid vacation annually to be taken in periods of time mutually agreed upon by resident/fellow, training site, and Program Director. Vacation is non-cumulative from one year to the next.
2) Meetings: Residents/Fellows may receive up to 7 calendar days (5 weekday + 2 weekend days) of paid leave for professional meetings, annually and non-cumulatively. Leave taken under this section *does not* count towards the thirty (30) days of allowable leave in Section 7 below.
3) Sick Leave: Residents/Fellows will be given 12 calendar days of paid sick leave per calendar year for personal and dependent illness. Sick leave is noncumulative from one year to the next. Residents/Fellows are responsible for notifying their program director of any absence because of illness. Residents/Fellows shall provide medical verification for absences due to illness when requested. Residents/Fellows who use all allotted sick leave may not meet ACGME or certification board requirements. Refer to Section 7 below. If incapacity results in more than 3 days, the UND Long-Term Medical and Family Leave Policy will be followed.

http://med.und.edu/policies/_files/docs/gme-leave.pdf

D. **Clarifications/FAQs**

1) Days off for interviews count as vacation days.
2) "Professional days" in resident contracts are for meetings. The leave for "Meetings" that the UND allows DOES NOT count toward the ABFM total days off.
3) Time off for community service count as vacation days.
4) There is no category for "personal days". Absence for "personal business" (ABFM) count toward "vacation" days UNLESS they are "sick" days (UND).
5) There are more sick days allowed by the UND than the ABFM allows. If you use more than 6 sick days per year, you will have to extend your residency.
6) Days missed to take board exams DO NOT count toward any category since they are required duty assignments.
7) Time off for religious activities count as vacation days.
8) Per ABFM policy, unused days do not transfer to the next year; "use it or lose it" on July 1st.
9) Sick leave may be used for illness or other health related issues, maternity/paternity leave, funerals, or family emergencies.
10) Time off for religious activities or community service count as vacation days.
11) FMLA leave (different than ABFM Family Leave!) is available for qualifying situations. This is unpaid leave and can be taken for time off over and above the above limits.

3. Policy

If residents exceed more than 21 weekdays off per year for any reason other than for ABFM-approved Family Leave, their residency end date will be extended to allow them to be in compliance with ABFM policies on absence.

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Vacation/Leave Requests

Policy:

1. Leave requests should be presented as far in advance as possible and must be approved by the Vacation Committee. The Vacation Committee is made up of the three faculty members. It will meet every two weeks to review leave requests.

2. The committee will use the following guidelines for approving leave:
   A. First come, first served.
   B. No leave allowed if resident is on **OB**, **Inpatient Peds**, **NICU**, or **FMTS** rotations.
   C. No leave allowed the last week of June and first week of July.
   D. For a two week rotation, only is 2 days of leave allowed. For a month rotation, only 5 days of leave is allowed.
   E. If more than two residents from a given year of training (PGY-1, PGY-2, PGY-3) request vacation for the same period, approval shall be subject to availability to cover clinic and hospital patient services.

Procedure:

a) Arrange clinical coverage for the days off requested.
b) Submit request at least two weeks in advance by completing a Vacation Request in **MedHub**.
c) For situations involving emergency, health, family problems, or other special circumstances, please include an explanation requesting variance from the above policies to the leave request.
*Special circumstances will be considered, but are not a guarantee that approval will be granted.

CME Funds

1. Residents receive an allotted amount of funding to be used for CME activities**.**

2. The funds can be used during any year of residency.

3. All CME activities must be approved by the Program Director before the CME activity is attended. They will be approved based on how the CME furthers the professional goals of the resident beyond what is available in the local curriculum.

4. CME funds MAY be used to pay for the following expenses:
   a) expenses associated with live CME events including registration, travel expenses, and per diem.
   b) registration for online CME events
   c) USMLE Step 3 and/or ABFM board exam fees.

5. CME funds MAY NOT be used to purchase any "durable materials" like books, computers, software, or courses on disk, flash drive, or other media.

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Annual Program and Faculty Evaluation Surveys

Introduction:
1) The ACGME requires that all residents and faculty be given the opportunity to formally evaluate the program at least once a year.

2) The UND Statement of Resident Responsibilities (https://med.und.edu/policies/_files/docs/gme-resident-responsibilities-policy.pdf) states that resident must "Participate in the evaluation of the program and its faculty".

3) The ACGME and the UND are committed to making sure that evaluations can be done in an anonymous fashion to ensure that there is no possible retaliation against people completing evaluations.

4) UND SMHS Family Medicine residencies have received citations from the ACGME for not having policies and procedures to ensure that residents have the opportunity to evaluate the residency programs.

Purpose:
To ensure that the residents and faculty are given the opportunity to evaluate the program yearly, and that residents are given the opportunity to evaluate the faculty yearly.

Procedure:
1) The UND SMHS Family and Community Medicine Department will send electronic surveys annually (in the month of May) to all residency core faculty and resident physicians.

2) The residents will receive evaluation surveys of each core faculty member, and of the program.

3) The core faculty will receive evaluation surveys of the program.

4) The UND SMHS Family and Community Medicine Department will inform the program coordinator that the surveys have been sent.

5) The UND SMHS Family and Community Medicine Department will provide weekly reports for 4 weeks to the program coordinator of survey recipients who have not completed the surveys.

6) The program coordinator will remind these recipients to complete the survey.

7) After 4 weeks, the survey will close and results will be compiled and de-identified by the UND SMHS Department Family and Community Medicine non-residency faculty member.

8) The UND SMHS Family and Community Medicine Department will send reports of the surveys to the department chair within 2 weeks of the survey closure date and, once approved by the department chair, to the program directors.

Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about the individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is important element contributing to high quality care.

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The documentation of each patient should include:
    A. Reason for the encounter and relevant history, physical examination findings and prior diagnostic results;
    B. Assessment, clinical impression or diagnosis;
    C. Plan for care;

2. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

3. Past and present diagnoses should be accessible to the treating and/or consulting physician

4. Appropriate health risk factors should be identified.

5. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

6. The CPT and ICD-10 CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record

Home

Dictation Time Limits

Purpose:
To keep our clinic chart dictations as up to date to ensure the best possible patient care and safety.

Procedure:
1. All physician and APP's will have 7 days after the date of visit to have a note for the visit dictated.

2. All documentation must be verified and signed by the provider within ten days of the clinic visit.

3. If documentation is delinquent, the medical records staff will inform the Program Director and the following will apply:

A. No additional patient visits will be scheduled beyond what is already on the provider's schedule.

B. Additional patient visits will not be scheduled until the provider has completed all delinquent documentation.

4. If dictation is delinquent for greater than 1 year from date of service, the note will be locked by Medical Records staff with the following statement added to the note.

> "This note has not been completed by the provider. It cannot be submitted for billing, and any additional information added by the provider would likely be inaccurate. Thus the note is being signed by clinic staff as an incomplete note in order to expedite administrative processes."

5. Although providers are strongly encouraged to complete and sign all documentation before going on vacation, the above time limits can be interrupted by vacation time without penalty. For example, if a provider goes on vacation five days after seeing a patient they will have an additional 2 days to complete their documentation upon returning to work.

Notification of Diagnostic Report Results

1. Notification of diagnostic results to patients is to be monitored to ensure that physicians are reviewing patient results and patients are receiving their diagnostic test results in a timely manner.

A. Routine reports will be communicated with the patient within 48 hours of receiving the report

B. Critical reports will be communicated ASAP from when the report was received.

2. Internal tracking of diagnostic tests will be done periodically by risk management (lab, xray, EKG, audiograms, Pap, biopsy). Providers will be reminded of outstanding reports are present in their Epic in-basket.

3. Notification and reading of results can be documented in Epic through the in-basket in the "Results" folder. Choose to notify either by telephone call, letter, result note, or MyChart notification. Mark "Done" after patient has been notified.

4. All paper diagnostic reports faxed or mailed to the clinic will be tagged for review and signature. Once signed return to medical records to be scanned into patient's chart. Then can complete notification steps as needed.

Home

Consent for Treatment

Informed Consent

I. Purpose:

A. The informed consent process is viewed as being integral to the physician/patient relationship and to the practice of medicine. Informed consent is not simply a signature on a preprinted form; instead, it is a process of information exchange and an opportunity to educate the patient about recommended treatment. Anytime a "material risk" is associated with a procedure, informed consent should be obtained. The attending physician is responsible for obtaining the informed consent from the patient or legal guardian of a minor.

B. Basic consent entails letting the patient know what you would like to do and asking if it is alright to proceed. Basic consent is important and valid in regard to noninvasive and routine procedures such as x-rays and venipunctures.

C. The physician, may exercise "therapeutic privilege" and not inform a patient of a particular risk if the physician can document that explanation of such risk would affect the patient's ability to make a rational decision or cause harm that would exceed the risk itself.

D. The patient's consent should only be "presumed" rather than obtained, in emergency life threatening situations, when the patient is unconscious, or incompetent and no surrogate decision maker is available.

1. Procedure:

A. The informed consent process should be obtained for the following:

1. Minor surgery which involves entry into the body
2. Non-surgical procedures involving more than a slight risk or harm to the patient, or involving a risk of change in the patient's body structure.
3. Experimental procedures
4. Patient photographs (involving medical care)
5. Procedures in which the medical staff determines that a specific explanation to the patient is required.

B. The consent for diagnostic and/or surgical procedure form should be obtained for the following:

1. Any minor surgical procedure
2. Colposcopy
3. Colonoscopy
4. Laryngoscopy
5. Endometrial biopsy
6. HIV testing
7. Nexplanon Insertion
8. Novasure
9. IUD
10. LEEP

C. The physician will explain and discuss the proposed procedure with the patient and/or legal guardian.

D. The diagnostic and/or surgical procedure consent form will be executed, and the physician will obtain informed consent to include the following:

1. A description of the procedure to be performed in terms understandable to the patient.

2. A statement of the possible risks, complications and the alternative methods of treatment.
3. The identity of the physician who will perform or order the procedure.
4. A statement that indicates that the patient has read and understands the consent form.

5. A statement that indicates that the patient has had an opportunity to ask questions and has had those questions answered in terms understandable to the patient.
6. The patient or legal guardian's signature, the date and time the consent was signed.
7. The signature of a witness, (may be a physician), and the date signed.

E. Special consent forms should be obtained for the following:
   1. Against medical advice
   2. Sterilization – Tubal ligation and Vasectomy
   3. Stress test
   4. Botox
   5. Pulse Light Therapy
   6. Colonoscopy

F. For Medicaid (female) sterilization procedures:

1. The attending physician is responsible for obtaining the informed consent from the patient, but the physician or the nurse may need to read the contents of the consent form to the patient before instructing the patient to read and sign it.
2. Thirty days must elapse after the date of the patient's signature on the consent form, before the sterilization procedure may be performed.
3. One week in advance of the procedure, the nurse will send the completed form to the physician performing the sterilization procedure, one copy to the hospital, and one copy is retained in the patient's medical record.
4. The physician's statement on the consent form is to be signed by the physician at the time of the hospital admission or shortly before the sterilization procedure.
5. Refer to the Department of Health Information for Women packet.

2. Documentation

In all cases the physician is responsible to document in the progress note or procedure note that the essential elements of informed consent were discussed. At a minimum this should include:
1. Treatment options
2. The risks and complications of the procedure
3. The opportunity for the patient to ask questions

3. Incapacitated persons

Informed consent for health care for a minor patient or a patient who is determined by a physician to be an incapacitated person and unable to consent may be obtained from a person authorized to consent on behalf of the patient. The following is in order of priority that may provide consent to health care on behalf of the patient.
1. The individual to whom the patient has given a durable power of attorney that gives them the authority to make health care decisions for that patient.
2. The appointed guardian of custodian of the patient.
3. The patient's spouse who has maintained significant contacts with the incapacitated person.
4. Children of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person.
5. Parents of the patient, including a stepparent who has maintained significant contacts with the incapacitated person.

6. Adult brothers and sisters of the patient who have maintained significant contacts with the incapacitated person.

7. Grandparents of the patient who have maintained significant contacts with the incapacitated person.
8. Grandchildren of the patient who are at least eighteen years of age and who have maintained significant contacts with the incapacitated person or
9. A close relative or friend of the patient who is at least eighteen years of age and who has maintained significant contacts with the incapacitated person.

Informed consent for health care for a minor patient or a patient who is an incapacitated person must make reasonable efforts to locate and obtain authorization for the health care from a competent person.

Before any person authorized to provide informed consent, the person must first determine in good faith that the patient, if not incapacitated, would consent to the health care.

No person authorized to provide informed consent pursuant to this section may provide consent for sterilization, abortion, or psychosurgery or for admission to a state mental health facility for a period of more than forty-five days without a mental health evaluation or other court order.

4. Minors

A general rule, a minor cannot consent to their own treatment and the consent of a parent or legal guardian is required to treat the minor for non-urgent matters.

Written consent, **Consent for Minors Medical Care and Information**, is required when someone other than parent/guardian will accompany the minor patient to the appointment if anticipated that the parent/guardian will not be present for the appointment.

Parents/guardian can sign the **Authorization of Release of Information form** for information to go to another person approved by the parent/guardian.

A provider seeking consent for a minor patient must make reasonable efforts to locate and receive authorization for the health care from a parent/guardian.

If written consent cannot be obtained from the parent/guardian, attempt to contact the parent/guardian to discuss the office visit findings and treatment plan, unless law permits the minor patient to obtain treatment without parental consent or the minor has requested a visit without parental/guardian consent. State of ND explains a minor to be ≥ 14 years and < 18 years of age for the following exceptions that can be treated without parental consent. The minor will need to sign the **Minor's Consent to Services** form.

1. Treatment of Minor for sexually transmitted disease
2. Emergency Care
3. Blood donations
4. Prenatal Care and other pregnancy care services
5. Unaccompanied homeless minor

A minor who has been deemed emancipated by a court of law may also consent for his or her own treatment.

The HIPAA rules provide an exception to protecting a minor patient's PHI when that minor patient seeks treatment without parental consent. If the Provider's professional judgment deems it in the best interest of the minor patient to inform the parent/guardian of the minor patient's visit, the provider may do so.

5. Refusal to be Informed

An exception to the informed consent process occurs when a patient refuse to be informed about a treatment or procedure. There could be many reasons for this and it is the responsibility of the physician to attempt to find out why the patient is refusing to be informed before a treatment or procedure is done. Another option is to see if the patient will allow the physician to provide this information to a relative or friend.

Documentation necessary in the event of Refusal to be Informed:

1. Information that was given to the patient before they refused further information, and that the patient refused to be informed.
2. Plan of care.

6. Refusal of Treatment

A mentally competent patient may refuse any medical treatment. In order to satisfy the requirements of the informed consent process, it is important that patients are provided with the risks associated with not undergoing a treatment.

When informing a patient who is refusing a treatment do and document the following:

1. Evaluate the patient's capacity to make decisions.
2. Assess the patient's overall understanding of the information provided.
   Re-educate the patient when necessary.
3. Document
   a) diagnosis and recommended treatment,
   b) risks and benefits of the recommended treatment,
   c) alternative treatments if available
   d) risks and consequences of not having the recommended treatment, and reasons for refusal.

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Transitions of Care/Hand off Policy

Purpose:
This policy establishes standards for transitions of care for Residents training in Accreditation Council for Graduate Medical Education (ACGME)-accredited Graduate Medical Education (GME) programs at all UND Family Medicine residencies

Definitions:
Resident: Any physician in an ACGME-accredited graduate medical education program, including residents and fellows.

Transitions of Care: the hand-off of responsibility for patient care from one provider to another, most commonly at the time of check-out to on-call teams, but also applicable in other transitional settings, including transfers between one clinical care setting to another or the scheduled change of providers (e.g. end-of-month team switches).

Hand-off: Transfer of essential information and the responsibility for care of the patient from one health care provider to another.

Patient Safety Practices: Habits and routines that reduce the risk of adverse events related to exposure to medical care across a range of diagnoses or conditions.

HIPAA: Health Insurance Portability and Accountability Act, a 1996 federal law that restricts access to an individual's private medical information.

EHR: Electronic Health Record.

Policy:

All residents and faculty members must demonstrate responsiveness to patient needs and recognize that these supersede self-interest. This includes the recognitions that under certain circumstances the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider.

The following key Patient Safety Practices are critical to effective Transitions of Care:

- Interruptions must be limited
- Current, minimum content must be conveyed
- The opportunity to ask and respond to questions must be provided
- Hand-off documents must be HIPAA compliant.

A. Hand-off Participant Responsibilities:

1. **Minimize Interruptions:** Participate in hand-off communication only when both parties can focus attention on the patient-specific information (i.e. quite space).
2. **Current, Minimum Content:** Hand-off communication must include the following information:
   a. Patient name, location and a second chart-based identified (e.g. Date of Birth [DOB] or Medical Record Number [MRN]).
   b. Identification of primary team or attending physician
   c. Pertinent medical history including:
      1) Diagnosis
      2) Current condition
      3) Pertinent labs
      4) DNR status
3. **Anticipated Changes in Condition or Treatment:** Hand-offs should include:
   a. Suggested actions to take in the event of a change in clinical conditions (i.e. "if-then" discussion).
   b. Any elements that the receiving provider must perform (i.e. a "to-do" list).

4. **Opportunity to Ask and Respond to Questions:** Allow adequate time for hand-off communication and maximize opportunities for face-to-face of verbal hand-offs:
   a. In-person, face-to face hand-offs are preferred
   b. If not possible, telephone verbal hand-offs may occur
   c. In either case, a hand-off document (written or electronic) must be available to the receiving provider
   d. Then hand-off must include an opportunity for the participants to ask and respond to questions.
5. **HIPAA Compliant Hand-Over Documents**
   a. All written or electronic hand-off documents must be compliant with HIPAA and local hospital policies.
   b. Each residency site is responsible to develop its own hand-off document in cooperation with resident and attending input.

Home

Patient Education

Purpose:

To provide accurate, evidence-based, culturally proficient, and meaningful patient education to the patient.

Patient education is given to a patient to provide help in solving his/her health problem. It should be incorporated in to routine office visits for all patients. Effective patient education ensures that patients have a sufficient level of knowledge and understanding, which allows them to make informed decisions regarding their care.
Patient education is selected to recognize the education level, literacy and language needs of patients. Select education materials that are written at a 5th to 8th grade level. Materials should be appropriate for the reading and comprehension levels and the cultural and ethnic diversity of the patient population. Education materials need to support education provided and not take place of provider education.

When selecting materials:

- The type of resources that a patient or support person responds to varies from person to person. Using a mixed media approach often works best.
- Keep your assessment of the patient in mind. Consider factors such as literacy, numeracy, and culture as you develop a plan.
- Avoid fear tactics. Focus instead on the benefits of education. Tell your patient what to pay special attention to.
- Be sure to review any materials you plan to use before sharing them with the patient. Keep in mind that no resource is a substitute for one-on-one patient teaching.

Approved patient materials to provide education to patients can be found in EPIC. If other patient materials are to be given to patients the provider will review them for accuracy and relevant to the patient's needs

Interpreters:

Pacific Interpreters Service-Nursing will be trained in how to access these services when needed.
Microsoft Office Word Document Language Translation

Documentation Guidelines:

1. Evaluation of the patient's ability to comprehend the information provided.
2. The content name and source of patient education materials that were provided to the patient. Remember to include all education used-verbal, audio, written. There is NO need to include a copy of the handout in the medical record.
3. Evaluation of the patient's understanding of the information provided. (e.g., teach back, repeat back)
4. Interpreters-Document use of and service (ex. telephone). Document name of the interpreter services, name of the interpreter, and description of the information provided, patient's stated level of understanding of the information, signature of nurse of medical provider making the entry.
5. Nursing must have approval of the provider for all education given. List source and handout given per physician.

Home

Geriatric Education

Nursing Home Rounds:

1. **Objectives**
   a) Identify aspects of the aging process.
   b) Gain an awareness and sensitivity to the medical, emotional, social, economic and physical needs of the elderly.
   c) Enhance perceptions and attitudes toward the elderly.
   d) Develop an insight into the continuity of care of the elderly in a long-term health care center.
   e) Gain knowledge regarding the role of the physician caring for the elderly patient in a long-term health care center.

2. **Protocol**
   a) There will be an assigned "nursing home week," where each physician will see their nursing home patient. To meet the Medicare guidelines, this visit will be at least every 30 days on a new admission to the nursing home facility for the first 90 days and at least every 60 days thereafter.
   b) Nursing home teaching rounds will be held one time per month, after the above completed nursing home week.
   c) At the nursing home teaching rounds, all residents will meet along with the geriatric nurse and a preceptor.
   d) One assigned resident will present a short lecture on an assigned geriatric topic.
   e) Each resident physician will present his or her patient to the group. This will give the resident an opportunity to discuss their patient's care with a preceptor and other residents.
   f) One or two residents will be assigned to go on walking rounds with the preceptor and the geriatric nurse. This is where we will see each patient and sign the appropriate forms.

Geriatric Home Visits:

1. **Objectives**
   a) Demonstrate the informational value of a home visit.
   b) Develop and maintain observational skills.
   c) Learn about cultural, social and environmental habits of the patient.
   d) Increase understanding of family dynamics.
   e) Aid the resident in developing a more holistic approach to geriatric care, utilizing the information obtained on the home visit.

2. **Protocol**
   a) The resident is responsible for selecting an appropriate patient for a home visit. The geriatric nurse or preceptor may also suggest patients.
   b) Geriatric team members that will attend the home visit will include the preceptor, resident physician, geriatric nurse and social worker when possible.
   c) Each resident will participate in a minimum of one geriatric team home visit per year.
   d) The geriatric nurse will schedule home visits.
   e) The geriatric team visit will be brief (30-60 minutes), and by appointment. The geriatric nurse will have the billing sheet, the patient data base, and chart when available. The nurse will also obtain the patient's vital signs, when appropriate. The geriatric nurse is available to perform venous blood draws, if needed, but this needs to be discussed in advance.
   f) Following the home visit, the resident physician will dictate findings and follow-up plans of treatment.

Other components and duties:

1) Select a patient for a home visit, and complete a minimum of one home visit per year.
2) Attend all nursing home care conferences for your nursing home patients
3) Communicate to the geriatric nurse any potential or new nursing home patients.
4) Promptly sign orders from nursing homes that are sent to residents at the clinic, and place them into the outgoing mail bin.
5) Communicate to the geriatric nurse when you are not able to attend any of the above-mentioned assignments.

Home

Graduation Requirements

Criteria for receiving a certificate of completion at the end of residency:

1. Successfully complete all required rotations.
2. All completed rotations have a filled-out evaluation form from the preceptor.
3. All required procedures logged in **MedHub**.
    a. Must have 30 vaginal deliveries and an additional 10 continuity deliveries
    b. ABG 10 procedures
    c. Foley Cath 10 procedures
    d. Pap Smear 10 procedures
4. Complete all ACGME patient visit requirements.
    a. 1,650 total continuity clinic patient visits
    b. 165 continuity clinic patient visits for patient under 10 years old
    c. 165 continuity clinic patient visits for patient over 60 years old
    d. 75 pediatric (<18 years old) ER visits
    e. 75 pediatric (<18 years old) hospital visits
    f. 40 newborn hospital visits
    g. 250 total pediatric (<18 years old) ER and hospital visits **combined**
    h. 750 adult (>18 years old) hospital visits
5. Have all clinic notes completed.
6. Pay all late Resident Dues
7. Have completed the Residency to Reality Series

To be turned in on last working day of work:

1. Practice Management Book Club Book
2. Key to clinic key
3. Beeper
4. Practice and Contact Address including new email

Reminder:

Apply for your own Medicaid ID number

Home

Attending Physician's CFM Clinic Responsibilities

1. Attending Physician's need to be available at the clinic during the hours that they are assigned as Preceptor.
2. *It is mandatory that the preceptor for the clinic is stationed in the preceptor office ("Fish Bowl") at all times during their assigned times unless they are precepting procedures or have other duties associated with precepting patients in the clinic.*
3. It is mandatory for all OB visits seen by a Resident be precepted with the Attending Physician.

Home

Confidentiality and Disclosure of Concern Cards

Purpose:
To delineate the procedures for insuring confidentiality of Concern Cards submitted to Program Director or Site Director.

Policy:
1. Concern Cards submitted to the Program Director or Site Director via **MedHub** will be kept strictly confidential by the Program Director or Site Director and the Program Coordinator.

2. If the PD deems that patient safety is in jeopardy from the information on the Concern Card, the Program Director or Site Director may choose to intervene immediately in such a way that anonymity of the content of the Concern Card cannot be maintained. However, the actual Concern Card itself will not be shared with the person who is the subject of the report.

3. The Program Director or Site Director may use general information from Concern Cards to shape resident or faculty feedback. However, every attempt to maintain the anonymity of the author of the Concern Card will be made.

Home

Event Reporting

Purpose:
An event is an occurrence that is inconsistent with the routine operation of the clinic or the routine care of a patient. The event may or may not result in an injury or harm to a patient or visitor. IF no harm occurred, the event is considered a near miss. Near misses are important in event reporting because the potential for harm is present and needs to be addressed to prevent a similar occurrence which may lead to harm.

Policy:
For reporting system to be successful, it is important that a culture of safety is in place, recognizing that the patient safety is the top priority and encouraging staff member to report errors and near misses. It should not contain subjective narrative or attach blame to others.

Staff members should report all events on an incident form within 24 hours of the event. Event incident forms will be sent to the risk manager/business manager upon completion, and copies of the reports will not be included in the patient's medical record or personnel files.

Proper investigation of events is critical to understanding the cause(s) and to identifying areas for improvement. The report, which contains factual information around the event, will be used to initiate the investigation of the event. For serious events that cause injury, harm or additional medical intervention and treatment, a root cause analysis (RCA) will be performed. This process allows those involved in the event and others to participate in an analysis by reviewing the event, what led up to it, and the aftermath.

Tracking and trending reported information will assist the risk management committee to evaluate processes and care patterns within the clinic. Incident and complaint forms will be evaluated periodically and trends reported to the Business Manager and the Medical Director.

Event reporting is considered a quality improvement or peer review activity, and will follow state guidelines to protect the information in all the documents included in the reporting and investigation.

Statement of Confidentiality:
Data, records and knowledge, including minutes, collected for or by individuals to committees assigned peer review functions are confidential, not public records, and are not available for court subpoena in accordance with North Dakota NDCC 23-34.

Examples of Event Reporting opportunities:

- Near Miss
- Allergic Reactions
- Lack of adequate follow-up
- Surgical or procedural events
- Falls (any incident of an employee injury)
- Equipment failures or improper use of equipment resulting in injury
- Workplace Violence
- Improper Consent
- Procedures performed without informed consent
- Refusal of Treatment
- Refusal to be informed
- Lost or broken valuables
- Sanford Security called
- Patient leaving or signing out against medical advice-noncompliance
- Unanticipated patient outcome
- Missed or delayed diagnosis
- Specimen Labeling errors
- Critical results not communicated to the Provider
- Patient Complaints
- Complications following Treatment
- Wrong patient treated or wrong procedure performed.
- Medication-related occurrences (including near-misses)

Visitor events (for example, falls) should be reported to ensure that the important information is captured at the time of the event. If possible, tactfully take pictures of the fall area.

Document all patient involved events using the UND incident Report(link below) Forms are available from your Supervisor or Risk Management Coordinator. All in clinic and off site incidence will need to be reported by staff.

Employee Injury events will be recorded by following the guidelines from the University of North Dakota Safety website. The forms will include
https://campus.und.edu/safety/_files/docs/incident-reporting-form-persons.pdf

https://campus.und.edu/safety/_files/docs/incident-investigation-form-part-one.pdf

https://campus.und.edu/safety/_files/docs/incident-investigation-form-part-two

Home

Complaint Management

The Risk Management Team of UND Center for Family Medicine will manage the risk associated with minor and non-critical events per their organizational policies. Complaints regarding resident performance will be managed by the Program Director or Site Director.

Purpose:
Complaints or concerns received by clinic staff reflect patient perceptions and expectations. Feedback, solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service.

Procedure:
All clinic and administrative staff will be responsible for receiving complaints. Complaints related to a specific department will be forwarded to the department supervisor. Complaints related to physicians will be forwarded either to the Business Manager or the Program Director.

1. The patient complaint is received either verbally or in writing by any staff person.
2. A complaint form will be completed by the person receiving the complaint.
3. If the complaint can be resolved at this level, the staff member receiving the complaint will:
    A. Resolve complaint
    B. Complete complaint form including signature and date
    C. Completed form will be forwarded onto the Business Manager to be reviewed and original to be filed with the assigned CFM Risk Management Representative. A copy will be sent to the Risk Management Division of the State of ND if warranted.
4. If the complaint cannot be immediately resolved, the complaint form will be forwarded to the Business Manager, Program Director, or Site Director. An investigation will be initiated and a timely review of the events surrounding the complaint will be done. Documentation will be made on the complaint form.
5. Changes will be made in policy/process in a timely manner and communicated to all staff as appropriate.

Home

Patient Satisfaction Survey

Purpose:
Patient Satisfaction Surveys reflect patient perceptions and expectations. Feedback, either solicited or unsolicited, presents an opportunity to identify issues and implement systematic processes to improve care and/or service. In making UND Center for Family Medicine the healthcare facility of choice, we are committed to maintain the trust our customers have in UND and our Residency Program, and to insure we exceed our customers' expectations in the event dissatisfaction with service occurs. The patient satisfaction surveys will help us to create individual relationships with our customers and build a service recovery culture within our organization.

Procedure:
1. Each patient will be sent a survey, typically within 24 hours of their appointment.
2. Results of the survey will be shared with Residents during their semi-annual evaluations.

Home

Electronic Communications

Purpose:
To assure the appropriate use of electronic communication within the UND Center for Family Medicine in addition to the general UND Computing and Network Usage Policy.

Procedure
1. Password Protection:
   a. All assigned to or created passwords by an employee are private and should not be shared with others. All electronic devices and applications shall be password protected. Passwords need to be changed frequently using a unique password.

   b. Only use a program under your personal login information. Do not use a program accessed by another employee. Log employee out and then log in with your information.

2. Facsimile:
   a. Practice reasonable safeguards to avoid a misdirected fax by ensuring the correct fax number is used. Protect PHI by using fax machines that are located in secure places and using a cover letter every time a fax is sent.

   b. If documents including PHI are faxed to the incorrect fax number, a breach has occurred. Contact the HIPAA officer or Supervisor. Refer to UND CFM's Faxing policy for the complete guidelines to send and receive facsimile that include PHI.

3. E-mail:
   a. When using the University of North Dakota's e-mail system, the individual user must understand that it is an unsecure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect against a HIPAA breach.

   b. E-mail is used within the clinic appropriately by staff using the University assigned email address for an employee. By State of North Dakota law, university email content is considered public record, and thus may be open and accessible for inspection.

   c. E-mail communication with patients shall be done with a secure system. Encryption is the only approved mechanism to electronically transmit PHI. The use of the EMR patient portal will provide a secure means to communicate with patients.

4. Personal Device:
   All personal devices are not required by staff to fulfill an employee's job requirements. By State of North Dakota law, all electronic communication records are public records, and thus may be open and accessible for inspection. The use of personal devices opens the employee to personal liability for discoverable electronic communication.

5. Texting:
   a. When using texting the individual user must understand that it is an secure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect confidential information.

   b. Texting should not replace a phone conversation in order to avoid miscommunication between you and the patient or employee. Texting should be avoided during patient care to prevent errors.

   c. Texting is not to be used for communication with patients.

6. Social Media:
   Social media is a means of communication using web-based and mobile technologies for the exchange of information. Social Media is not to be used for communication with patients about patients and/or their PHI. No health or medical related information that relates to official activities may be posted on social media.

7. Lost or Stolen Device:
   a. All lost or stolen devices need to be reported to the department supervisor as soon as possible. The mobile provider will need to be called to deactivate the phone. If a PHI breach is a concern the HIPAA officer will need to notified of the breach.

b. Applications are available for devices that can locate the lost device and the phone can be remotely locked or the information can be deleted from the phone. i.e. Find My iPhone. It is recommended that electronic mobile devices have this or a similar application.

8. Termination or Resignation of Employment:
All employee access to current software applications and devices will be deactivated.

***For complete UND policy see the office of Human resources and Payroll Services Annual Notification of Policies.**

Home

CLINICAL OBSERVER/SHADOWING POLICY

Purpose:
To establish a policy and procedure for short-term visiting residents (international or US medical graduates) who are not eligible to provide clinical services.

Policy:
Observers will not have any clinical responsibilities but must complete institutional documentation requirements in order to avoid liability and confidentiality issues. These are HIPAA requirements.

1. Observers are non-employees. An onsite observation agreement must be completed prior to the shadowing experience. The completed application must be kept on file.

2. Observers must complete UND CFM's HIPAA training. A copy of the HIPAA completion certification must be kept on file.

3. Observers are not eligible for computer access.

4. Observers will wear an observer name tag while in the facility.

5. Observers may:
   A. Watch, listen, and ask questions of medical students, residents, and attending physicians.
   B. Attend journal clubs and conferences.
   C. Touch a patient only with the permission of the patient and presence of an attending supervisor.

6. Observers must:
   A. Be introduced to each patient they observe.
   B. Have each patient sign the Patient Consent for Presence of Student Observer form.

7. Observers may not:
   A. Write anything in any patient chart.
   B. Write any prescriptions.
   C. Give any orders, either verbal or written, to any other health care provider or patient.

Home

Credentialing and Privileging of Faculty Providers

Faculty Providers upon hire will need to provide the following information to obtain privileges at UND Center for Family Medicine Clinic. Include all procedure(s) you would like to offer to your patients.

Verify competency to perform any or all of the following:

Bone Marrow Biopsy
Botox Injection
Colonoscopy
Circumcision
Echocardiography
EGD
EKG Stress Testing
Endometrial Biopsy
Holter Monitor Interpretation
Implanon/Nexplanon Insertion
IUD Placement
Larynogoscopy
Nuclear Stress Testing
Pulse-Light Therapy of Skin Lesions
Language Certification
Vasectomy

Provide evidence of competency by providing a list and number of each performed in the last 3 years certification of training. Current privileging documentation from the hospital or clinic where you practice would fulfill this requirement also. Provide the same for all procedures not listed that are outside your standard training for your specialty.

a. All current faculty as of the effective date of this policy who perform any of the above procedures will be grandfathered with privileges to continue to performing the procedure.

b. Any new faculty or any procedure not listed above will be required to document training by one or more of the following to receive privileges to perform the procedure:
   1) Certificate of training
   2) Evidence of competency

c. The faculty will meet to review both the proposed procedure and the documentation of training, and determine the conditions under which the provider may perform the procedure; i.e. the faculty will serve as a credentialing committee for the clinic. The provider requesting privileges will be disqualified from the final vote/decision of the committee.

1. The hospitals, St. Alexius and Sanford will provide documentation of the credentialing done for the physicians. The hospital will send a letter to the physician confirming credential status. A copy of the letter will be placed in a file and updated as required.

2. A copy of the credentialing process for each hospital is kept on file.

3. Background checks of a physician will be completed following the guidelines of the North Dakota Board of Medical Examiners.

4. Quality review of charts will be done annually to document outcome of procedures for each faculty member.

Each Faculty will provide the following documents to the Residency Coordinator.

Physicians

a. Current letter from hospital (Credentialing/Privileging)
b. Current State License
c. Current DEA
d. Current malpractice binder
e. Certification for PALS, ATLS and ACLS
f. List of Procedures performed by each physician.
g. Verification of Signature

Nurse Practitioner:

a. Current state license ND Board of Nursing
b. Current ANCC certification
c. List of Procedures performed by nurse practitioner
d. Verification of Signature

Language Certification

To deliver quality interpretation to a limited English proficient patient, we offer Language Line Academy through Pacific Interpreters for interested Physicians and Nurses.

A Bilingual Fluency Assessment for Clinicians testing is needed to assess the level of fluency in English and the second language in a healthcare context setting, as well as medical terminology before the second language is used for patient care at the clinic.

Contact the Clinic Business Manager for more information about this certification.

Home

Peer Review

Purpose:
The Peer Review process is designed to evaluate the quality and appropriateness of the diagnosis and treatment provided by members of the medical staff with clinical privileges. The peer review process documents recommended corrective action, if necessary, and creates a framework for remedial action for deficiencies found. It will also be used as a tool to determine competency in granting and renewing privileges.

Definition:
Peer Review is a process by which a physician investigates the medical care provided by other physicians, nurse practitioners, clinical counselors and CRNAs in order to assess the quality of health care delivered and to determine whether accepted standards of care have been met.

Policy:
Peer review will be completed on patient care records that reflect the practice of our providers.

Peer review is meant to provide medical opinions conducted by an objective physician and relevant medical staff. Review should occur by another individual who has comparable levels of training, credentials, and experience. Review of the care provided by nurse practitioners is evaluated by a physician. An individual physician cannot conduct a peer review of his or her own cases nor can a non-peer perform the peer review. This is not meant to be a performance appraisal. Although the peer review process is on-going, data is monitored quarterly.

Procedure:
1. A predetermined number of medical records will be selected from each of the following areas for each provider practicing in the clinic to be reviewed externally applicable to that provider.

- Medical
- Procedural
- Obstetrics
- Dermatology
- Counseling

2. In addition, clinical records will also be selected from the following categories:

- Anesthesia- These records will be reviewed externally by an outside CRNA.
- Reported care-related complaints

3. Any additional cases flagged for review will be reviewed by the Medical Director. If it is determined to be a case that needs to be reviewed, the provider will be contacted and made aware. The Provider will then have time to review the case.

4. A peer review tool criteria will be selected and approved by Medical Director.

5. When the review is completed will be shared with the provider. The provider will provide comments.

6. The peer review tool along with the provider responses will be reviewed by the Medical Director.

7. A report of peer review activities will be provided to the Medical Director.

8. External Peer Review Guidelines

Sample of charts will be reviewed by an external peer.

- 10 clinic visit charts per faculty/attending provider per year.
- 5 procedure visit chart per faculty/attending provider per year.
- 10 obstetric visit chart per faculty/attending provider per year if applicable.
- 10 anesthesia procedures per CRNA per year.
- 10 clinic visit charts per nurse practitioner provider per quarter.
- 10 counseling visit charts per counselor per year.

Home

Disclosure

POLICY:

To maintain transparency and integrity in all of the UND Center for Family Medicine functions. It is appropriate to disclose adverse events, errors and/or unanticipated outcomes that could affect a patient's emotional or physical health. Discussion of unanticipated outcomes is based on strong communication processes, both before and after treatment or procedures.

An outcome may be negative and/or unanticipated, but not necessarily be the result of an error. The informed consent process should address possible risks, complications and adverse outcomes. A discussion about an unanticipated outcome that was addressed as part of the informed consent process is a much different discussion than disclosing an error.

General Principles

A. **Events to be disclosed** — This includes adverse events, unanticipated outcomes, and occurrences in which patients are significantly harmed or have the potential to be significantly harmed.

B. **To whom disclosure will be made** — Make disclosure to the patient and, only when appropriate, to the patient's family, significant other or patient advocate.

C. **Timing of disclosure** — Disclose adverse events as soon as possible after the identification that an adverse event has occurred. If event analysis is incomplete within the first 24 hours, then sharing only partial factual information is more important than waiting until all details of the event have been factually ascertained. If the patient is not able to comprehend the information, it should be disclosed to the patient advocate, depending on the severity of the occurrence and his/her need to know the information.

D. **Honest disclosure** — Tell the patient the facts as known, and assure the patient that you are committed to obtaining and providing all available information as it becomes known. Consider the use of support services (e.g., social worker, mental health therapist), as appropriate.

E. **Cultural sensitivity** — Demonstrate respect for individual cultures and provide interpreters for non-English speaking or cognitively impaired patients.

F. **Who will disclose events** — Disclosing adverse events is primarily the attending physician's responsibility. When it is impractical or unreasonable for the physician to do so, a designee may be used. If the physician is uncertain regarding the event and/or the obligation to disclose or finds it difficult (is unable) to disclose the event to the patient, the physician will consult with the practice administrator and/or the office manager to determine who will disclose the events. The practice administrator and/or office manager, in consultation with the physician, may disclose the adverse event to a patient, if a physician cannot or does not inform the patient in a timely manner.

G. **Events for which disclosure may be discretionary** — Disclosure of certain events is a matter of clinical judgment. Errors that do not harm a patient and do not have the potential to do so may not require disclosure to patients.

H. **Mechanism to assist with the disclosure process** – The physician practice administrator and/or office manager may provide assistance to physicians regarding disclosure. These individuals have the authority to help clinicians make decisions about which adverse events need to be reported and disclosed and to help make decisions about disclosure when the most responsible clinician fails to do so or is unable.

I. **Beneficial consequences of disclosures (and error reporting)** –

1. Patients receive prompt care for injuries suffered and are fully informed to assist in further decision-making and treatment planning.
2. Errors are opportunities to learn how to improve patient safety.
3. Lessons learned from error reporting will serve to correct system problems.

IV. Procedure

A. Staff Member and Physician Actions

1. Take immediate actions to safeguard the patient, as needed.

2. If the adverse event is of a serious nature, notify the office manager and/or the physician as soon as possible. Complete an incident report and inform the patient's attending physician.

3. Document the event in an objective and factual manner in the patient's record as soon as possible after the event.

4. In consultation with risk management, discuss the factual details and sequence of what occurred with the healthcare team and attempt to reconcile any differing perceptions of what occurred.

5. Determine how the details of the event, the outcome and the treatment plan will be explained to the patient and his/her family members. Decide which member of the healthcare team (generally the physician) will discuss the event and with whom (patient and/or family member). Designate a family contact person.

6. Be accessible for questions. Repeated requests for an explanation of the event are a common reaction when patients and family members are informed of an adverse event or medical error.

7. If the event involved a medical device or piece of equipment, preserve these materials for investigation. Do not clean or alter the device or equipment in any way and contact the office manager and/or the physician. Do not return defective devices or equipment to a manufacturer.

8. Notify your malpractice insurance carrier of the event in a timely manner and obtain guidance, as applicable.

9. Defer to the office manager and/or the physician to determine when and if patient billing should occur. Follow compliance policies.

B. Communication Framework for Disclosure

1. Have the attending physician and/or a leadership staff member meet with the patient (and family members as appropriate) as promptly as other duties permit. Delays should be avoided.

2. Present the nature, severity and contributing cause (if known) of the adverse event in a straightforward and nonjudgmental manner.

3. Avoid attributing blame to yourself or to specific individuals or to the organization as a whole. Serious adverse events are rarely due to the sole action or inaction of one person. Do not criticize the care or response of another provider.

4. Disclosure is a process; be sure the disclosing medical providers avoid speculation and focus on what is known at the time of the discussion, what happened, what led to the event, and the recommended course of action.

5. To avoid the appearance of contradicting information, provide a caveat that as information becomes available, further discussion will take place.

6. If further treatment is necessary as a result of the adverse event, describe what can be done, if anything, to correct the consequences of the adverse event.

7. Identify someone (staff member or physician) to have ongoing communication with the patient and/or family members.

8. Convey empathy and use language that is understandable to the patient. Make eye contact and concentrate on presenting your body language in an open and caring manner.

9. Apologizing for the observed occurrence of the adverse event is appropriate. This aspect of communication is separate from discussing ascertained causes of the event. A sincere show of concern can increase the rapport between the patient and provider.

C. Withholding of Information

1. Sometimes the outcome information can put a patient at risk of harm either due to psychological trauma or exposure to physical harm. In such situations, clinical judgment regarding disclosure should be exercised.

2. If information is withheld, document the reasons for such. It may be appropriate to have a mental health provider conduct an assessment to determine concurrence.

D. Reporting and Accountability

Prompt and thorough reporting and disclosure of events by the physician and staff members will be managed by Risk Management and individual provider accountability. The practice will address patient safety concerns through the medical staff peer review process and/or human resource procedures when the investigation reveals a serious lack of provider knowledge, skill deficit, unawareness of the hazard, oversight, or negligent or reckless disregard for patient safety.

E. Documentation

1. Document facts objectively, completely and contemporaneously, including that a discussion of the unanticipated event took place.

2. Ensure that the documentation is dated, timed and signed at the time of the entry.

3. Avoid writing any information unrelated to the care of the patient (e.g., incident report filed or legal office notified) in the medical record.

4. Do not alter any prior documentation or insert backdated information.

5. Record the name and relationship of those present.

6. Include documentation of any questions posed by the patient/family members and indicate that answers were provided by the caregiver.

7. While an addendum to the record may be made, consider carefully whether this information is relevant to the patient's clinical management. Accepted reasons for an addendum are for the correction of facts (i.e., persons involved, time of event, sequence of events) and for the addition of facts or clarifying information.

If you participated in the care, but were unable to access the record until a later date, you may provide added information. Do not use an addendum to state your opinions, perceptions or defenses.

8. Assign the most involved and knowledgeable staff member(s) to record the factual statement of the event in the patient's record, as well as any follow-up needed or done as a result of the event.

Home

ABBREVIATIONS AND SYMBOLS; "DO NOT USE"

Resource: https://www.jointcommission.org/facts_about_do_not_use_list/

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Home

APPOINTMENT DESK

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Cash Receipts Handling Policy

All mail payments received are opened and sorted by the billing department.
Cash, checks and credit cards are taken at the reception counter and a receipt is printed out and given to patient. The checks are then restrictively endorsed with our stamp. The cash checks and credit cards are kept in the cash drawer at reception counter during the day. At the end of the day a deposit report is generated and the cash, checks and credit cards are balanced. Report, credit cards are placed in a folder to be delivered the next morning to the billing department. Cash and checks (with $100.00 till separated) are placed in deposit bag along with mail payments and log and placed in the safe in the pharmacy. The next day the billing supervisor prepares the deposit. All paperwork is given to the Residency Coordinator.

A receipt from the bank is returned to the Residency Coordinator for final verification of deposit. Verification of deposit accuracy is to be completed within 2 business days.

Patient Scheduling, Routine and Urgent Care

1. Patients are scheduled for appointments Monday-Friday from 8:30 am – 4:45 pm.
2. Except in emergencies or special arrangements, patients are seen by appointment; however, walk-ins are welcome.
3. A patient can be scheduled at 8 am to accommodate urgent needs of patients.
4. Patients who are 10 minutes late or more may be rescheduled. There may be exceptions based on circumstance and appointment availability.
5. If a physician asks an unscheduled patient to come to the clinic, the physician needs to notify the front desk.
6. If a physician is delayed for a scheduled appointment at the clinic, always notify the appointment desk personnel.
7. All appointments will be initiated, rescheduled or moved to another provider by the front desk and/or nursing staff.
8. OB Scheduling

    a) OB patients will be scheduled with a specific resident if they request so.
    b) If the patient does not have a preference or does not request a physician, the patient is scheduled with a resident on a rotating basis and schedule availability.
    c) If a resident notifies the receptionist not to schedule any more OB patients, the request is taken into consideration.
    d) If a resident notifies the receptionist to schedule more OB patients, the request is taken into consideration.
    e) If a patient requests a pregnancy test but does not have a physician, the patient must schedule with a physician.
    f) Our Urgent Care appointments provide diagnosis and treatment for: Acute upper respiratory infection, Allergies, Bites or stings, Bladder infection, Bronchitis, Cold or flu symptoms, Cough, Ear infection, Fevers, Foreign

object removal, Headaches, Minor allergic reactions, Minor burns or bruises, Minor fracture, Rash or poison ivy, Scrapes or minor cuts, Sinus infections, Sore throat, Sprains

i. Resident physicians will be scheduled before a faculty provider or nurse practitioner.

ii. Attending can be consulted to make decisions about scheduling conflicts and moving patients from provider to provider.

9. After hours, our physicians are also available to be called upon in the ER of both hospitals in Bismarck to triage clinic patients with urgent needs.
10. Resident Guidelines for scheduling

a) First year residents are scheduled 3-5 patients per afternoon; 60 minutes per patient for the first 6 months of residency, then 30 minutes per patient. Please contact the front desk if more time per patient is needed or if more patients can be scheduled.
b) Residents that have morning clinic are expected to arrive at 8:30 A.M. Those with afternoon clinic hours are expected to arrive at 1:00 P.M. and remain in the clinic until 5:00 P.M. to cover walk-ins and/or late scheduled patients.
c) PGY-1 residents are not to have Social Security Disability physicals scheduled with them until after January 1 of PGY-1 year. They are required to precept ALL Social Security Disability physicals with the preceptor BEFORE the patient leaves the clinic."

Home

Telephone Procedures

The telephone is answered electronically and the patients are given a menu to follow. The daily answering service is activated automatically at 7:30 a. m. through 5:00 p.m.

To change the recording on the answering machine, call Grand Forks at 701 777-4111 and inform them of the changes. The AHC voicemail is as follows:

Thank you for calling the Center for Family Medicine. The Center is closed at this time. If this is an emergency, dial 911. To find out what Doctor is on call, call St. Alexius Medical Center 530-7000 or Sanford at 323-6000. Clinic hours are Monday-Friday 8 a.m. to 5 p.m.

1. Identify they type of call and take action.

a. Emergency calls: Put through to the nurse or physician immediately.

b. Calls from patients: Transfer to the Phone Nurse.

c. Call from other physicians: If the call concerns a patient, secure chat to inform the provider of the call. The provider will decide whether to take the call or to call back.

d. Calls from nurses about hospitalized patients: Handled the same way as calls from provider. Message or secure chat provider, patient information from the hospital are never relayed through someone else other than the provider. Do not breach professional ethics.

e. Calls from pharmacists: Transfer to the Phone Nurse.

f. Personal/business calls: Route as instructed by provider.

2. Providers will document After Hours calls in EPIC providing updated medical advice given to the patient.

Home

Missed Appointments

NO SHOW/CANCELLED/RESCHEDULED

Purpose:

Patients may fail to appreciate or comprehend the significance of a particular appointment to their ongoing care and treatment; all missed appointments are to be documented in the patient record and brought to the attention of the physician. A missed appointment is defined as any appointment that has been scheduled that does not occur for any number of reasons.

Policy:

1. Appointment Reminders are sent to all appointments with calls being made one business days before appointment.

2. Receptionist Staff will delete all NO SHOW and CANCELLED patients in EMR with an appropriate reason code.

3. Nursing receives a task for the appointment and will follow-up with the Provider.

4. A record of No Show, Rescheduled, or Canceled Appointments, whether initiated by the patient or the physician are kept within EMR indefinitely.

5. All Referred Appointments (i.e. Pre-op/Dermatology/Pediatric) to the clinic will be notified that the patient cancelled the referred appointment by calling or sending a letter to the Physician that made the referral.

6. Nursing review of No Show, Cancelled and Rescheduled appointments will be documented on progress notes. Include all copies of Missed Appointment Letter or dictated letter in the patient's chart. Although some patients may be difficult to contact, it is important to document that attempts were made.

   Nursing will direct review of chart to Physician as medically necessary. The following are examples of when to review chart with physician. This list is not all inclusive and will require open communication between Physician and Nurse.

   Hypertension
   Diabetes
   Medication Management
   Post Hospital Visit
   Abnormal Lab Values
   Colposcopy
   Pregnant Women
   Pain Management

   OB Patient's that haven't
   been seen >1 month

   Repeat Pap with history of
   Abnormal PAP

7. Physician review of No Show, Cancelled and Rescheduled appointments:

   a. It is the responsibility of the physician to determine the action to be taken based on a review of the patient record and the clinical needs of the patient at the time. Any contact with the patient, whether by telephone or written communication is to be documented in the patient's chart, any necessary follow-up with the patient should take place and be documented. Non-compliance by the patient will be documented in the chart.

   b. Although some patients may be difficult to contact, it is important to document that attempts were made.

   c. Physicians can decide to send the Missed Appointment (form) letter. Communication by personalized letter explaining the reasons and or risks of not keeping the appointment would be beneficial for those patients missing several appointments. A certified letter is only necessary if the patient is being terminated by the provider. A copy of the certified letter along with the receipt of delivery (if applicable) should be placed in the patient's medical record.

8. A reminder for follow up appointments for patients can be provided by the physicians.

   The INSTRUCTIONS FROM YOUR CLINIC VISIT form will be filled out during a patients visit to remind them of their at home instructions from their recent visit as well as any follow up appointments.

9. Follow up appointments will be monitored for patients, by using the following:
   a. Use of the Instructions from your clinic visit form.
   b. Prescription refills from patient or pharmacy phone calls.
   c. Reviewing all missed appointments.

10. Termination of patient from a physician's practice due to patient's noncompliance will be done following the Clinic's Termination policy.

Home

[Date]

[Patient Name]
[Address]
[City, State, Zip]

Dear [Patient Name]:

We noticed you were unable to make your recent clinic appointment. The physicians and staff here at the UND Center for Family Medicine are concerned about your health and encourage you to call our office at (701) 751-9500 or Toll-Free at 1-866-870-0464 as soon as possible to reschedule. We understand that life can get busy but also know that regular appointments with your doctor are a vital part of staying healthy.

You can call us any time prior to your appointment to cancel if you cannot make it, still a 24 hour notice is preferred. Your appointment can be rescheduled at that time as well. Please contact me if you have any questions.

Sincerely,

[Physician name, MD or DO]

Take Time for Your Health

Home

Credit card Handling Policy

Bismarck CFM will follow the Accepting Credit Cards and eChecks Policy set forth by the University of North Dakota's Finance department. This policy can be found http://und.edu/finance-operations/_files/docs/2-3-credit-cards-pci.pdf.

Cards will be accepted in person, over the phone, or by mail. Transactions will be processed immediately upon receipt of card information. Once the transaction is processed, the card holder data must be destroyed using a cross-shred method. Receipts will be kept for deposit and audit reasons. These receipts will contain no card holder data. Unless prior approval is given, card holder data is not to be stored. If transactions cannot be immediately processed, credit card information must be stored in a locked drawer with access limited to only those allowed to process the card. Card information must be kept confidential. If cardholder information is stored for reoccurring payments, the data must be stored in a locked cabinet with limited access. The reasoning for the storage must be approved by either the Business Manager or the Program Director. Management approval must also be given when determining a storage place or moving a storage place for the data. Cardholder data is to be stored in a restricted, protected area and away from public access. It must also be labeled as classified. A record log must be kept. Staff is required to complete an entry on the log whenever card data is accessed. CVV codes may not be retained/stored.

Credit card information cannot and will not be stored in an electronic format. Under no circumstances will transmission of data across an open public network be allowed. Cardholder data is restricted by business need to know basis.

Only front desk staff, pharmacy staff, and business office staff are allowed to process credit cards. No other employees need access to the credit card machine or the data used in transactions. Terminals will be kept in a secure location that limits access from unauthorized users. After business hours, terminals will be stored in a secure location where access is limited.

Sales will be reconciled on a daily basis. Staff will print the Daily Totals Report and the Daily Settlement Report. The Daily Totals Report will be submitted via the online department deposit form. A copy of Daily Totals Reports will also be kept on file with the daily deposit submission form and verifying email.. The Daily Settlement Report will also be retained with the daily deposits. Batch information does not contain card numbers. These batch reports are used to verify totals.

Monthly audits of the credit card terminals shall be performed to ensure the terminal has not been tampered. This process shall be completed by the Business Manager. The NDUS Physical Inspection Checklist will be compared to the PCI Terminal Characteristics Form. Any discrepancies will be questioned to the staff using the terminal. Any suspicious activity will be reported to the UND Controller immediately as well as the UND Police and Bismarck Police Department. Monthly inspection documentation will be kept on file in accordance with the appropriate retention schedule.

Any security incidents regarding credit cards should be brought to the attention of the business manager. The University of North Dakota Accounting Services office will also be notified. If necessary, the bank where the transactions are processed will be notified. An incident report will also be filed.

Credit card information must be destroyed when it is no longer needed for business or legal reasons.

This policy will be reviewed annually with staff.

Procedures for Credit Card Voids/Refunds

1. If an error is discovered immediately, the person performing the transaction must promptly void the transaction and re-run the card.

2. If an error is discovered at the end of the day processing, whoever verifies the charges for the day will process a void before batching out and the card must be re-run with the appropriate amount. Any other parties involved in the error must be informed of the problem.
3. If an error is discovered any time after a batch has been completed and closed, a refund to the credit card will be performed and the credit card will be re-run for the appropriate amount. Two employees must be present to ensure the card is refunded properly.
4. All batches that include voids or refunds must be reviewed and signed off by the Business Manager at the end of batching out.

Home

EMR Contingency

Purpose:

To provide a plan for each clinic department to follow when the computers and/or software are not working properly.

ALL DEPARTMENTS:

Retain copies all forms listed in this policy for use. Update forms on a yearly basis if applicable.

Front Reception

In the event of an unplanned downtime, first action is to call the Technology Support Center and contact local IT staff member. 1-877-949-4678

Contingency computer is located on the west wall of the front reception area. This computer must be left on and restarted weekly to keep files up to date. Daily schedules can be found in the Sanford Applications; One Chart Downtime Read only. Access is your EMR login. **TEST THIS MONTHLY, including PRINTING

1. All patients will complete the Downtime packet.
2. Photocopy insurance cards as needed.
3. Copy demographics to travel with patient to the nurse/provider.
4. Notify nurse of patient admitted to be seen by phone.
5. Keep a log of patients calling into make an appointment; call patients when it is possible to schedule in EPIC. Record patient's name, DOB and phone number.

Copayments will be kept on receipt books. A label will be placed on all copies of the receipts to include Name and DOB. Staple a copy of the receipt to the travel ticket.

NEED: Patient Registration Forms in Downtime Packet
Covid-19 Downtime Screening
COVID-19 Vaccine Documentation
Patient Telephone Encounter

Nursing/Physicians

Documentation of visit will be done on a Patient Office Visit Downtime Form for each visit to include the following information as needed: SOAP/progress notes, referrals, history, medications, immunizations, communication and nursing orders, patient education, lab/xray orders..

PRESCRIPTIONS: Hand written on prescription pads. Keep copy with the progress notes for the visit.

Lab/X-ray Orders
Fill out lab and x-ray requisitions completely as possible. Including name, DOB, chart #, ordering physician, dx codes. Place Orders in Lab/X-ray Stacker. Remember to mark WAITING or NOT-WAITING.

NEED: Patient Office Visit Downtime Form
Prescription Pads
Covid-19 Downtime Screening
COVID-19 Vaccine Documentation
ABN
Patient Office Visit
MRI Screening Form
Patient Telephone Encounter

LAB/Radiology

Lab/X-ray will watch at front desk for orders. Demographics and insurance information will travel with charge ticket. Waiting patients will be returned to their exam room by lab/xray. Not-waiting patients will leave the clinic.

NEED: Lab Requisition
X-ray Requisition

Medical Records

Nursing/Physician Chart Request-Call Ext 26754
Ask for the possibility of EMR records and updated access to EMR.

Business Office

Assist other departments as needed.

Residents/Faculty

Scheduling can be found on MedHub and at the front reception desk.

Post Computer Downtime

Master list of patients will be sent to Appointment, Nursing and Business Office Supervisors.

Return calls to patients that called wanting an appointment to schedule their appointment.

Add appointments to the DOS of schedule.

Physicians and Nurses will document the visit in the appropriate encounter. Complete the documentation from the Patient Office Visit Downtime Form. Medications, Orders and Referrals will be added to the patient's records as necessary.
Medical Records will audit chart for completion.

Home

Identity Theft Prevention Program

The purpose is to outline various measures to prevent, identify and mitigate medical identity theft.

The clinic is committed to protecting patient identification and health insurance information from theft and fraudulent use. All employees and medical staff are responsible for reporting actual and suspected patient medical identity theft and threats.

This clinic policy will follow the policies given by the University and expand to include specific procedures to follow with our patient accounts. University policy can be found at

http://www1.und.edu/finance-operations/associate-vp/identity-theft.cfm

Red Flags for health care providers may include:

1. A complaint or question from a patient based on the patient's receipt of:
    a. a bill for another individual
    b. a bill returned with incorrect address
    c. a bill for a product or service that the patient denies receiving
    d. a bill from a health care provider that the patient never patronized or
    e. a notice of insurance benefits (or Explanation of Benefits) for health care services never received.
    f. a collection notice from a bill collector.

2. Records showing medical treatment that is inconsistent with a physical examination or medical history as reported by the patient.

4. A patient or insurance company report that coverage for legitimate hospital stays are being denied because insurance benefits have been depleted, or that a lifetime cap has been reached.

5. A complaint or question from a patient about information added to a credit report by a health care provider or insurer.

6. A dispute of a bill by a patient who claims to be the victim of any type of identity theft.

7. A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance.

8. A notice or inquiry from an insurance fraud investigator for a private insurance company or law enforcement agency.

Prevention of Medical Identity Theft

1. Employee Background Check Procedures:
    a. Background checks will be conducted on all new employees that fall under the University's Criminal History Background Check policy.

2. Patient Identification Procedures:
    a. Reasonable efforts will be implemented to verify the patient's identity when new or existing patient account transactions occur.
    b. New Patient Accounts: Verify patient identification (e.g., name, date of birth, address, driver's license, government issued picture identification, insurance card). Scan insurance card(s) given by the patient into EMR.

c. Existing Patient Accounts: When applicable, verify patient identification (e.g., name, date of birth, address, driver's license, government issued picture identification, insurance card). Verify the validity of requests for change of billing address. Verify patient identification prior to providing personal information.
d. Unavailable Identification Card: Politely remind patient that we require identification and to bring it for their next appointment. Provide education to the patient that explains why the clinic wants to protect their medical identity information.

3. Medical Record Security:
   a. All computers will be password protected and locked when the operator is away from the computer.

4. Portable Electronic and Data Devices that contain patient information:
   a. Employees and medical staff members are accountable for maintaining the security of patient information that may be contained on laptops, thumb drives, and other portable data devices.
   b. Any suspected or actual breaches or threats to the security of portable devices must be immediately reported to the Business Manager.

5. Patient Education:

   a. Patients will be educated on medical identity theft. New patients will receive information when registering for their appointment and have an opportunity at any time to ask questions. Patients receive notification to bring their photo identification on the monthly billing statement.

   b. Patient education includes, but is not limited to, review of:
      i. A definition of medical identity theft
      ii. How to identify medical identity theft
      iii. How to report actual and/or suspected medical identity theft
      iv. The patient's right to review and correct their medical record when discrepancies are identified and how to exercise this right.
      v. The patient's right to an accounting of medical record disclosures and how to exercise this right
      vi. The importance of guarding insurance card numbers and health insurance records.

6. Risk Management is responsible for developing and training all employee and medical staff upon hire, on an annual basis, and when significant changes have been made to the policy. Documentation will be kept by the trainee signing a training roster at the conclusion of a training session.

7. Any employee or medical staff member who obtains and/or uses patient financial or medical information fraudulently is subject to disciplinary action, including but not limited to, termination and/or revocation of privileges. Fraudulent activities will be reported to law enforcement and other agencies as necessary.

Home

D. Identification, Management, and Mitigation of Medical Identity Theft:

1. Reporting Suspected and Actual Identity Theft:

a. All employees and medical staff members are expected to immediately report verbal or written notice (e.g., patient-generated reports, receipt of a notice of address discrepancy) of suspected or actual identity theft to their immediate supervisor and to the Business Manager.

2. Patient Generated Reports of Actual or Suspected Medical Identity Theft:
   a. Patient-generated reports of actual or suspected medical identity theft (e.g., receipt of bills for services not rendered, knowledge of someone else using their information to obtain medical services) will be investigated under the direction of the Business Manager and University.
      i. A written response, including the results of the investigation and actions taken, will be provided to the patient/guardian/surrogate.

3. Investigation of Actual or Suspected Identity Theft:
   a. Investigations will be coordinated by the Business Manager.
   b. Upon completion of the investigation a written report will be completed. Included will be:
      i.Details outlining the investigation
      ii. Measures taken to prevent a re-occurrence of a similar event, if applicable.
      iii. Information regarding reports to law enforcement and/or outside agencies in response to confirmed identity theft.
      iv. Information regarding all communications made to the patient or guardian.
   c. Confirmed medical identity theft shall be reported to law enforcement and appropriate agencies, at the direction of the University.

4. Police and/or Agency Requests for Information of actual or suspected identity theft:
   a. Requests for medical record information and /or billing information shall be granted with the minimum necessary information given in the event of a suspected MIT.
   b. Any employee receiving a police or agency request for information shall immediately report it to their supervisor or the Business Manager.

5. Medical Record Corrections:
   a. Refer to the policy under HIPAA regarding patient rights, including the patient's right to request a correction/amendment to their medical records. All corrections to the medical record will be corrected according to HIPAA guidelines. The patient will be notified when corrections are made to their medical record.

Home

701 E Rosser Ave
Bismarck, ND 58501
701-751-9500
1-866-870-0464

Medical Identity Theft
Frequently Asked Questions

What is medical identity theft?

»It is when a person steals your name to get medical care.
»It is when a person steals your health insurance data to get medical care.

How do I know if I have been a victim of medical identity theft?

»You get a bill for care you did not have.
»You get a bill with the wrong name on it.
»You see wrong information in your medical record.
»Your health insurance company tells you that you have used all of your benefits and you have not received health care services related to those benefits.

What should I do if I think I have been a victim of medical identity theft?

»Please call *Center for Family Medicine-UND at 701-751-9500.*

What can I do to protect myself from medical identity theft?

»Keep your insurance card in a safe place.
»Look for wrong information in your medical record.
»Look for wrong information from your health insurance company.

Home

Infection Control of Reception/Waiting Room

As needed, the waiting room will be picked up, chairs and tables will be wiped down each month with appropriate wipes and cleaners by cleaning staff.

Waiting room toys and toy area will be cleaned daily if open, currently closed.

Home

Service Animals

Purpose:
To know the difference between service, emotional support, and therapy animals for our patients and to be able to identify the risks associated with presence of animals in the facility.

Policy:
Animals have become recognized for their ability to provide valuable support to people with physical and emotional disabilities.
Emotional Support animals: UND CFM providers will not approve applications for emotional care animals to reside with their owner in non-pet friendly housing. A patient can be referred to a counselor for further determination and evaluation.
Service animals: The ADA definition for a service animal is a dog or miniature horse that has been individually trained to do work or perform tasks for an individual with a disability. An emotional support animal describes animals that provide comfort just by being with a person. Because they are not trained to perform a specific job or task, they do not qualify as a service animal.
Rights of the patient:

1. ADA requires states to permit service dogs in all public places. Service miniature horses must also be allowed if they are housebroken.

Questioning the patient:

You may only ask the owner 2 questions to find out what task the service animal provides if it is not obvious.

1. Is the service animal required because of a disability?
2. What work or task has the service animal been trained to perform?

You cannot ask specifically about the person's disability, require medical documentation, request a special identification card or training documentation for the animal, or ask that the animal demonstrate its ability to perform the work or task.

Reduce the risk associated with animals present in the facility:

1. All animals should be vaccinated against rabies, and handlers should have all required immunizations.
2. Patients and handlers should wash their hands after touching and handling animals.
3. Service animals must be permitted in public areas, other types of animals will be restricted from the facility.
4. Staff members are not required to provide food or care to a service animal while in the facility.
5. Service animals must be controlled by their handler at all times by either leash or tether, or demonstrate control under the handler's commands.

Ask the owner to remove the service animal from the facility if:

1. The dog or horse is out of control and the handler does not take effective action to control it.
2. The dog or horse is not housebroken.
3. The dog's or horse's presence presents a risk of danger to the handler, staff or others in the facility.

If the animal is removed, we must offer the person with the disability the opportunity to obtain services without the animal's presence.

Home

NURSING/MEDICAL

Team Nursing

1. Provides communication between doctor, nurse and patient.

a. Duties of the team nurse:

1. Take phone calls from patients and relay the messages in Epic to the provider.
2. Make patient referral appointments as requested.
3. Call for reports.
4. Function as the contact person when the physician has special orders to be carried out.
(Always inform the team nurse or department head of any special procedures.)
b. Residents keep your nurse informed:

1. Regarding patients that may be calling in, i.e. patients you have talked to after hours or have seen in the ER.
2. Of care plans on your patients, i.e. when you are ordering lab work on a patient for a future date put in a Recall, or complete the order in the patient's EMR, changing the date to the anticipated future date.
3. When you are taking leave time and make sure to put the vacation tab in your folder.
4. Of your expectations.
5. If you change your schedule or if you will be late for clinic hours.
6. Leave orders with your nurse – **do not give them to the receptionist.**

NOTE: **First year residents are expected to discuss each case with the preceptor or faculty member prior to dismissing the patient.**

Standardization of Duties for Doctors and Nurses

Doctors will:

- Review Meds and Allergies, confirm changes made by nursing
- Review and Update History and other Pertinent Data, reconciled any outside records (orange band notifies of reconciliation needs)
- Enter Lab/X-ray Orders with appropriate Dx codes and link codes
- Enter Injection/IV Orders
- Review Care gaps and BPA and order any appropriate further actions
- Complete referral orders and if non-one chart notify nurse of orders to be faxed.
- Follow Clinic Flow Policies
- Complete AVS

**This policy does not apply to the Specialty Practices (Derm, OB/Gyn and Peds)

Nurses will:

- Open SOAP note
- Reconcile Medications and Allergies
- Enter VS
- Start/Update Preventive Wellness Form

- Initiate appropriate Care Templates
- Review standing orders, perform and/or order testing per screening and diagnosis of the patient.
- Prepare the Patient for any expected Exams/Procedures
- Complete any Treatment Orders
- Complete Referrals initiated by Provider
- Carry out any Preventive Wellness Orders by the Provider
- Complete Post-Procedure Phone Calls as Appropriate

Refill requests in Rcopia

1) All refill requests will be addressed within 24 hours or 1 business day from the time the electronic refill/fax was received.
2) Open In basket tab and check under Patient Rx Request
3) Nursing will review list of requests and initiate refills that are appropriate after reviewing provider notes.
4) If unable to initiate request or have questions and orders are unclear, message provider through Epic Chat.
5) If provider is not responding to messages appropriately or is unavailable, discuss refill with Chief resident.
6) If Chief Resident is not responding to messages appropriately or is unavailable, discuss with Attending.
7) If unable to finish request within 24 hours/1 business day, call the patient to notify them that the request was received.
8) Document actions in notes and route to appropriate person for further actions as needed to track unfinished renewals.
9) Add comments as necessary to renewal requests to notify actions taken to finish request appropriately.
10) Delete/Deny renewal request appropriately.

Emergency Call System

Each exam and procedure room is equipped with an emergency call button or cord which, when activated, will sound an alarm and light up outside the exam/procedure room door and on a panel in the nurse's hallways. These are to be used primarily for emergency situations. Please push the button for a nurse in an emergency or if assistance is needed while doing a procedure.

Pagers

Each physician is assigned a pager which is also capable of receiving text messages. The clinic staff will send text messages via this pager rather than via personal phones.

Home

Patient Flow

1. Appointments are reviewed the previous day by the nursing staff. Lab orders are entered into Epic and post-hospital records are requested if unable to locate in Epic or Care Everywhere.

2. When a patient arrives at the front desk the receptionist checks the patient in on Epic to inform the nurse. If lab work is requested the patient is sent directly to lab after the front desk checks them in.

3. The nurse will prepare for any necessary exam and will get the patient from the waiting room and admit them to an exam room.

a. **Pap smear** – supplies will be set out when there is a Pap scheduled. Thin Prep Pap test containers must be identified with a label on the vial. The pathology department at Sanford examines the Pap smear. Cervi-scrapers and cytobrushes or brooms are used to obtain specimens: cytobrushes must not be used on pregnant patients, use cotton tipped applicator in place of cytobrush.

b. **Combined Chlamydia/GC Cultures –** transport media stocked in the rooms or may be ordered from urine specimen.

c. **Wet Mounts –** each room is stocked with test tubes. Collect vaginal secretions with cotton –tipped applicator, put applicator in the tube and take to the lab.

d. **Cultures –** All cultures are done by physicians – culturette tubes are in every room.

e. **KOH –** Skin scrapings are done by physicians – scalpels, slides and cover slips are stocked in lab. Transfer dishes are also provided.

f. **Herpes,** ureaplasma media available upon request from our lab.

g. Arterial blood gases are not done or drawn in our clinic.

h. When using any sharps, please dispose of them in the sharps container after use.

4. The patient's vitals are taken and recorded in Epic before the patient is seen by the physician. The nurse will write a brief statement of reason for office visit, the patient's current medication list and known allergies are reviewed/updated, and "Marked as reviewed" in Epic by the nurse at each visit. The nurse will initiate any templates appropriate for the visit, which can be found under "Rooming" in the EMR. Once the patient is admitted and ready for the doctor, the nurse will badge out and the screen changes to waiting to indicate that the patient has been admitted and is now ready to see the doctor.

5. When the doctor has concluded the patient visit, he/she will discharge the patient.

Orders

1.Current – When requesting an injection, write an injection order in the EMR. Tell the patient to wait in the room. The nurse will direct the process from that point. If you wish to send the patient to the lab or x-ray, enter the lab/x-ray order into Epic with the diagnosis code, send the patient to the waiting room and have them check-in a the front desk for lab/x-ray

2.Referrals for diagnostic tests done outside the clinic and referrals to specialty physicians, many tests require special preparation or diet beforehand. Be sure to clear these things with your nurse.

*All patients on Medicaid must have a referral form faxed/sent in Epic when referred out of the clinic. Your nurse will take care of this.

Charges

1. Billing codes are entered into Epic.
2. All diagnoses/codes pertaining to the appointment are to be entered into Epic.
3. Surgical procedures – The nurse will assist with charges and CPT codes. Procedure codes are filed in a book at the nurse's station.

Home

Chaperones

Purpose: to provide guidance when it is appropriate for the presence of a chaperone in an exam room and to assure a patient of a professional exam that provides a witness to the physician's actions.

Policy:

A. The presence of a chaperone should be considered in an examining room when any of the following procedures take place:
   a. Breast exams
   b. Pelvic/genitalia; rectal exams
   c. Pelvic/genitalia procedures
   d. Sedation is used
   e. Disrobing for the exam
   f. Others: any procedure and/or exam that the physician feels having a chaperone present, is necessary

B. Physical examination of an infant, toddler, or child should always be performed in the presence of a parent or guardian.

C. This pertains to female and male physicians as well as midlevel providers, with no exceptions.

D. Patients are informed of the clinic's chaperone policy prior to the exam.

E. Patient refusal may result in a need to cancel the examination or to reschedule with a different provider. The refusal should be documented in the medical record.

F. The presence and name of the chaperone must be documented in the medical record.

A separate opportunity for a private conversation between the patient and the provider should be provided to the patient

Home

Diagnostic Reports

1. Physicians will review diagnostic reports in the patient's EMR.
2. The nurse will watch the "Tasks" for any of her doctors that are gone and diagnostic test results will be discussed with the chief resident.
3. If the situation requires a detailed explanation, the patient is called and an appointment with the physician is made.
4. If an appointment is not necessary a letter explaining the patient's diagnostic results may be sent to the patient by the physician.
5. If a voicemail needs to be left for the patient, state your name and UND Center for Family Medicine and ask the patient to call the clinic at their earliest convenience. Do not leave diagnostic results on the patient's voicemail.
4. If the patient has asked for the results to be left on a voicemail, consent will need to be obtained and this will be noted on the Incoming Phone Call template, to include the patients preferred phone number.

Consent to leave diagnostic results on the patient's voicemail will need to be specifically requested to the nurse or physician by the patient and documented in the EMR. Documentation shall include phone number that the patient has consented to for the voicemail message. (i.e. cell and/or home) and the information left on the voicemail.

Home

SAMPLE MEDICATIONS

Purpose:
Guidelines for sample medications pertaining to management, storage and distribution.

Policy:

1. Pharmaceutical Representatives:
   A. Representatives must schedule an appointment using the schedule binder located in the pharmacy. Appointments can be made Monday thru Friday from 1:30 pm to 3:30 pm. The clinic policies will be posted in the "Pharmaceutical Rep" binder on the Administration side. The policy will also be sent to the Pharmaceutical Rep Secretary.
   B. Upon arrival the representatives will check in at the pharmacy and the pharmacy staff will notify to medical staff. The doctors will visit with them in the back of the pharmacy. Sample medications can be left at the pharmacy where the staff will log in all samples using lot number, expiration date and strength. A drug sample report will be printed daily to the north and south nursing pods.
   C. Education of the new policies will come in the form of a letter from administration to the individual Representatives if policy is not adhered to.

2. Sample Medication:
   A. All sample medications with the exception of dermatology will be stored, logged, and dispensed in the pharmacy. Medications stored in the pharmacy will be located on the back shelf apart from pharmacy stock for retail.
   B. The medications will be checked for expiration dates when given to patients and on a monthly basis.
   C. Pharmacy will document all recalls according to FDA regulations and removed from stock immediately if necessary. Patients that have been given the recalled medication will be notified by pharmacy immediately if appropriate.
   D. All sample medications, with the exception dermatology will be dispensed from the pharmacist. The pharmacist will dispense the sample medication with either a verbal or written order from the physician. All 'SAMPLE' orders dispensed from the pharmacy will be entered into the pharmacy system.
   F. The Medication Room will be unlocked every morning by nursing personnel and locked every evening at the end of the clinic day.

3. Samples of Insulin, Nuva Ring and Dermatology Products:

   A. Samples of Insulins, as well as the Nuva Ring contraceptive, must be refrigerated and are kept in the pharmacy refrigerator.
   B. Samples of dermatology products will be stored in a locked cupboard in the dermatology procedure room.
   C. Medication samples will be logged into the pharmacy software with the following information: Name, lot number, expiration date and quantity received.
   D. Medications will be dispensed by the pharmacist ONLY with a SAMPLE prescription to the patient. The Pharmacist will process the sample prescription under the patients name so that there is record of the lot and expiration number given to the patient.
   E. Outdates will be done monthly or when necessary.
   F. When recalls are received the appropriate lot number of the medication will be disposed of immediately. Patients that have been given the recalled medication will be notified immediately if appropriate.

Home

ADULT DIABETES CARE

Purpose:
To provide the standard of care to all adult diabetic patients using the clinical guidelines from the American Diabetes Association (ADA) Standards of Medical Care in Diabetes – 2006.

Policy: It shall be the policy of the UND Center for Family Medicine to use the ADA Guidelines for Adult Diabetes Care to assist the physicians in managing adult patients with diabetes. The Diabetes Care Template will be initiated by the nurse for all diabetic patient's visit for physician documentation of lab, exams, etc.

Adult Diabetes Visit Procedure:

1. Patient height and weight measurements every visit. Record on the Diabetes Flow Sheet.
2. Calculate BMI each visit.
3. Have patient remove shoes and socks to allow for a foot exam every visit.
4. Ensure that the Diabetes Care Flowsheet is opened in the chart for the physician to complete.
5. If the patient is due for diabetes labs, then only a two-week refill or samples of meds may be given.
6. Lab standing orders:
   A. Lipid panel – yearly
   B. Chem 14 – yearly
   C. CBC – yearly
   D. Urine A/C ratio – yearly
   E. If A1C < 7%, then repeat every 6 months
   F. If A1C > 7%, then repeat every 3 months
   G. EKG – yearly

Home

Medication Safety Plan

Purpose:
UND Center for Family Medicine will promote safe practices in all phases of medication administration thereby reducing the possibility of medication errors.

The medication safety plan includes the following guidelines, as well as guidelines included in the Infection Control Plan.

Procedures:

A. Medication Equipment and Supply Safety:

1. Safety needles, syringes and IV catheters will be stocked and used by all clinic staff. Pre-filled syringes require the use of safety needles.

2. IV drip infusions of medications, as well as IV fluids, shall be done with the use of an IV pump, to control the flow and infusion time.

3. Medications are stored in the Nurses' Medication Room. The Medication Room is locked when clinic is closed.

4. Controlled substance medications ordered for administration on a patient in the clinic will be written on a prescription blank by the doctor and faxed to the CFM Pharmacy. Pharmacy staff will take the medication ordered to the appropriate nurse or the nurse can go to the Pharmacy to obtain the medication.

5. External-use medications will be separated from internal-use medications in the storage area and external-use medications will be labeled "For External Use Only."

6. All medications, reagents, and other products that carry an expiration date are checked on a monthly basis by the Nursing Supervisor, or designee, and discarded once they have expired.

7. Single-dose vials will be stocked and used as much as possible. **Single dose vials are used for one patient only and discarded**.

8. Multiple-dose vials of injectable medications must be labeled with the date opened and are to be discarded 30 days after the date opened. Multiple dose vials are stored in the Medication room and Procedure Rooms.

9. All medications (including samples) dispensed to patients will be properly labeled and documented in the medical record.

10. Hazardous chemicals are not accessible in drug preparation areas. Cytolite and Formalin will be stored in the Procedure Room(s).

B. Safe Injection Practices:

1. Use aseptic technique when preparing and administering medications.

2. Cleanse the access diaphragms ("rubber" stoppers) of medication vials with 70% alcohol before inserting a needle into the vial.

3. Never administer medications from the same syringe to multiple patients, even if the needle is changed or the injection is administered through an intervening length of IV tubing.

4. Do not reuse a syringe to enter a medication vial or solution.

5. Do not administer medications from single-dose or single-use vials, ampoules, or bags of IV solution to more than one patient.

6. Do not use fluid infusion or IV tubing for more than one patient.

7. Dedicate multidose vials to a single patient whenever possible.

8. Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture-resistant, and leak-proof.

C. Medication Procedures and Protocols:

1. A complete medication history, including over-the-counter medications, vitamins, and herbal products shall be obtained and documented for every patient and will be reviewed and updated at each office visit.

2. A list of allergies and allergic responses shall be obtained and reviewed/updated for every patient during each office visit.

3. A physician's written order is required for all medications to be administered (with the exception of immunizations) to include the name of the medication, dose and preferred route, indicating if consecutive doses are to be administered, e.g. Rocephin 1 Gm. IM x 3 days. All injectable medications that are to be repeated on an ongoing scheduled basis are to be ordered in the medical record using the Injection order template and entered into Epic.

4. **Verbal orders are to be avoided**; however, any verbal orders given to nursing are to be documented on a Progress Note in the EMR by the nurse and signed by the ordering doctor in a timely manner.

5. Medications will be set up/drawn up in the nurses' workroom to allow for fewer distractions and decreased risk of error.

6. The five rights of medication administration will be checked in all medication administration situations: Right patient (cross referenced by name and DOB), right medication, right dose, right route and right site.

7. Documentation of medication administration in the medical record will include the medication name, dose administered, route, site, patient response and the nurse's electronic signature.

8. A patient who has received a medication via injection for the first time (including vaccinations) must be observed for 20 minutes following the injection for possible symptoms of anaphylactic reaction. If symptoms of anaphylactic reaction occur follow the **Standing Order for Anaphylactic Reaction**. The Anaphylaxis treatment box (with standing order) is located in each Nursing Pod/Hallway.

9. Vaccines administered are documented in the patient's Epic chart and are automatically transferred into the NDIIS (Thor) system.

10. The clinic will follow the Vaccine Management Plan policies and procedures as a Preventive Partnership Provider with the ND Department of Health Division of Disease Control Immunization Program.

11. Vaccine Information Statements (VIS) for foreign-speaking clients are available on the Immunization Action Coalition website at www.immunize.org/vis/.

12. Medication errors will be reported to the patient's provider and to the Nursing Supervisor immediately.

13. Medication refills for patients are to be completed through the e-prescribe system, including Controlled/scheduled medications

D. High Risk Medications:

The following medications have been identified as "high risk" and additional safeguards are to be followed, as indicated, when administering these medications:

Insulin – The administering nurse should have a second staff nurse check the order and the dose once the insulin is drawn up and prior to administration.

Anti-coagulant medications (Coumadin, Warfarin, Jantoven):

1. Patients on anti-coagulation therapy are to have lab work (Protime/INR) done once a month when their lab values are within the therapeutic range; and more frequently, as determined by their doctor, when they have not achieved a therapeutic range or are in the process of adjusting their medication.

2. PT/INR lab values are reviewed by the doctor the same day as completed if the patient is above or below the therapeutic level, or within 24 hours if the patient is within their therapeutic range. Nurses also shall monitor PT/INR results on a daily basis.

3. All patients on anti-coagulants will have an "Anticoagulation Therapy" template in their medical record. This template is completed with every lab appointment.

Solu-Medrol IV:

1. Often ordered for Multiple Sclerosis patients in a dose of 500 – 1000 mg daily in a sequence of 3 days; however, follow the doctor's specific order.

2. Mix in 250 ml of 0.9% Normal Saline

3. Administer IV infusion over 4 hours, using an IV infusion pump.

4. Monitor the patients vital signs prior to starting the infusion, every 30 minutes

during the infusion, and at the end of infusion.

5. Check for patency of the IV catheter prior to infusion by flushing the IV lock with 1-2 ml of saline. Flush the IV lock again after the Solu-Medrol infusion is complete.

6. If patent, the IV lock may be kept in place for 72 hours. Wrap the site with kling dressing/tube gauze to protect the angiocath between infusions.

E. Storage Requirements:

1. Medications must be stored under the proper temperature requirements per the manufacturer and this information, if not known, can be found in the medication package insert.

2. Vaccines are to be kept refrigerated between 36F and 46F, with the exception of Varicella, Zostavax (Shingles) and Proquad (MMRV) vaccines which must be stored in the freezer at ≤5F (-1 C).

3. Other medications requiring refrigeration:

- Insulin
- Allergy solutions (labeled for specific patients)
- Ativan (Lorazepam) – injectable form
- Botox and Dysport
- Tuberculosis testing solution (PPD Mantoux)
- Proparacaine ophthalmic (analgesic) solution
- Rhogam
- Biologics (Stelera, Enbrel, Humira)
- Injectable Penicillins (BiCillin C-R, BiCillin L-A)
- Nuva Ring birth control
- T.R.U.E. Test allergen patch test

F. Education and Training:

1. The nursing staff resource for medications and administration information is the current edition of Mosby's Nursing Drug Reference, which is kept in the Nurses' Medication Room.

2. Vaccine Information Statements (VIS) for foreign-speaking clients are available on the Immunization Action Coalition website at http://www.immunize.org/vis/

3. Training and updating current practices for medication safety will be managed by the nurse supervisor. Training will be provided to all new employees and annually to clinic staff.

Home

Vaccine Management Plan

Purpose: To have standard guidelines for storage and handling of vaccines which correspond to the CDC and NDDoH protocols. It is the responsibility of all nursing staff members to be familiar with and to follow the Vaccine Management Plan.

Routine Vaccine Storage and Handling Plan:

1. Nursing personnel responsible for routine storage and security:
   - Donita Johnson, LPN 701-471-3216
   - Tara Specht, RN 612-618-2276
   - Lisa Davis, RN 701-471-4742

2. Vaccine ordering is done on the following basis:
   - Private vaccine is ordered as needed by Tara Specht, RN or designee.
   - VFC/State vaccine is ordered every other month by Donita Johnson,LPN or designee.

3. Proper temperature for storage of vaccine must be maintained:

Refrigerator	36^0 - 46^0 F	2^0 - 8^0 C
Freezer	$+5^0$ F to -58^0 F	-15^0 C to -50^0 C

4. Certified, calibrated thermometers are used to monitor and record temperatures twice a day (at the beginning and end of the clinic day) for each unit containing vaccine. Calibration of the thermometers is done bi-annually and the certificates of calibration will be made available to the NDDoH upon request. Thermometers used must be certified according to NIST or ASTM standards.
5. Immediate action must be taken if temperatures are out of range. This may include adjusting the temperature of the storage unit and rechecking the temperature in one hour or relocating the vaccine to another storage unit within the clinic, or in the event of a power failure relocating vaccine to the emergency storage site. These steps are outlined in the following section of this plan.
6. On the temperature log, document what was done to ensure vaccine viability as well as action taken to establish and maintain proper temperatures.
7. Temperature logs are to be kept on file for at least three years.
8. Vaccine shipments are received by the Lab or Pharmacy, who immediately notify the nursing staff of their arrival. Vaccine shipments are immediately unpacked by nursing personnel, enclosed temperature monitors are checked, and the enclosed invoice/shipping information is compared to the actual shipment to verify lot numbers and expiration dates. Vaccine is immediately placed into the proper storage unit.
9. Label VFC/State-supplied vaccines and store them separately from private stock.
10. Store and rotate vaccines according to expiration dates, and use vaccines with the shortest expiration dates first.
11. If vaccines are within 90 days of expiration and will not be used, arrange for provider-to-provider transfers according to NDDoH procedures.
12. If VFC vaccine is expired, wasted or spoiled complete the “Non-Viable Vaccine Return and Wastage” form. Procedures for wasting/returning state-supplied vaccine are detailed on the wastage form.
13. Nonviable opened or used vaccine supplies are to be disposed of in the black Hazardous Drug Disposal Container.

Emergency Vaccine Relocation Plan:

1. Personnel responsible for emergency vaccine storage and security:
   - Donita Roland, LPN 701-471-3216(C)
   - Tara Specht, RN 612-618-2276(C)
   - Lisa Davis, RN 701-471-4742(C)

2. Designated personnel will be notified via Sensiphone alarm in a vaccine storage emergency. Designated personnel have 24-hour access to the clinic and storage units.
3. The following steps are to be followed for proper storage and handling of vaccines to protect them from becoming spoiled:
    - Place in ice-pack-lined coolers and include the thermometer from the storage unit.
    - Transport vaccine-containing coolers immediately to the St. Alexius Inpatient Pharmacy.
    - Follow the same procedure to return vaccines to the clinic.
4. Designated alternate storage units or facilities are:
    - Private vaccine refrigerator in the Medication Room.
    - UND Pharmacy freezer. Contact Billie Krush, Pharmacist: 701-220-9168.
    - St. Alexius Inpatient Pharmacy, 900 E Broadway Ave. Bismarck, ND. Contact Kristy Vadnais, Asst. Director of Pharmacy: 701-530-6935 or 701-530-6900.
5. The designated refrigerator/freezer repair contact for equipment problems is: Josh at Appliance Solutions, 701-390-3732.

6. Vaccine refrigerator/freezer information for the vaccine storage units is:
    - Crosley Shevlvador (White Unit)
      Model #: CB19G6W
      Serial #: 11730542GP

    - Summit Commercial (Stainless Steel)
      Model #: SCRR230
      Serial #/UPC: 761101023290

7. Vaccine storage unit alarm company: Sensaphone Web 600. Contact Information: 610-558-0222 or www.sensaphone.com.
8. See the attached list of Vaccine Manufacturers and contact numbers for vaccine in the clinic inventory.

    Refer to https://www.ndhealth.gov/Immunize/Documents/Providers/Forms/VaccineManufacturersPhonelist2017.pdf for list of vaccine manufacturers' quality control phone numbers.

Home

Ordering and Administration of Injectable Medications

Purpose: To promote safe practices in the administration of injectable medications and reduce the possibility of medication errors.

Procedure:

1. Initiate an Injection Order form for the patient in the EMR.
2. The injection must be entered into Epic by the ordering doctor or their nurse indicating the frequency of administration, number of doses, and/or **expiration date**. **The prescription must be signed before the medication can be administered.**
3. The medication order must be renewed annually, with the exception of **Depo-Testosterone (Schedule III) which must be renewed every six months and all other Scheduled medications must be renewed every three months.**
4. Medication administration will be documented in patients chart under the "MAR" tab
5. The nurse giving the last dose before the renewal date is due should initiate the process of renewing the order.
6. The complete medication order (with dose and expiration date) can be found under patient's medication list.

Home

Storage and Warming of IV Fluids

PURPOSE:

To provide guidelines for the safe and appropriate warming and storage of IV fluids in the warming cabinet.

POLICY:

1. Whenever it is necessary to warm IV fluids, a medically designed warming cabinet with carefully controlled temperatures must be utilized. The use of a microwave oven and/or water bath must not be used for warming IV solutions.

2. Intravenous solutions placed in the warmer must have the plastic overwrap intact to ensure solution integrity. Write the date the fluid is placed into the warmer on the IV packaging.

3. Intravenous fluids may be stored/warmed in the warming cabinet up to 14 days provided the plastic overwrap is intact, and temperature does not exceed 104^0 F (40^0 C).

4. Once removed from the warming cabinet, solutions must be used within 24 hours and/or discarded, and not returned to stock supply or rewarmed.

5. It is acceptable to warm clean blankets in the same warming cabinet – place the blankets on the lower level and IV fluids on the top shelf.

The cabinet temperature will be monitored on a weekly basis and written on a temperature log.

Home

Perioperative beta-blocker

Purposes:
1) Apply evidence-based guidelines for the use of perioperative beta-blockers for patients undergoing non-vascular surgery.

2) Apply these guidelines consistently in all cases including clinic pre-operative recommendations and hospital preoperative consultations.

Policy:
1) The Revised Cardiac Risk Index (RCRI) will be calculated and documented for all patients.

RCRI
- 1 point for history of each of the following: CHF, Ischemic CAD, CRI, Stroke, DM
- 1 point given if high-risk procedure: AAA repair, Open thoracic operation, PVD grafts, Open cranial operation

2) Perioperative beta-blockers will be recommended for all patients whose RCRI is ≥ 2.

3) For all patients on chronic beta-blocker therapy, recommend continuing preoperatively.

4) All orders for beta-blockers will include "hold parameters" for bradycardia and hypotension.

5) Start beta-blocker therapy 1-4 weeks prior to surgery and titrate dose.
**Stop therapy and do not give preoperatively if bradycardia or other severe side effects.*

Cardiology Comments
- There is probably no benefit to starting BB a few days before surgery. True benefit occurs with >1 week of therapy according to current data.

- For surgical patients on B-Blockers prior to admission: if the B-Blocker is contraindicated preoperatively, the reason must be clearly documented in the H&P or progress notes. *This is in accordance with SCIP measure CARD-2 "Beta Blocker Therapy Pre-Op"*

Home

Acute Chest Pain Policy

Purpose: To provide a guideline for staff when dealing with patients on the phone or in the clinic with acute chest pain.

Rationale: Patients with acute chest pain should be triaged to the emergency room where they can receive rapid/optimal care to identify a cardiac episode.

Policy:

A. Patients Calling with Acute Chest Pain:

1. Any patient calling the clinic with complaints of acute chest pain (CP) should be instructed to go immediately to the Emergency Room (ER) of their choice.
2. The patient must have someone drive them, take a taxi or call an ambulance. An ambulance should be encouraged if the patient has additional symptoms with the chest pain, such as heartburn, nausea, sweating, shortness of breath (SOB), pain that radiates to the jaw or down left (L) arm.
3. Have the patient take all of their medications or a list of the medications with them to the ER.

B. Patients Presenting with Acute Chest Pain:

Anytime a nurse feels a patient may be presenting with a cardiac event the following protocol should be initiated:

1. Obtain a complete set of vital signs, history of present CP, and family history. Have the patient seen and assessed by a physician as soon as possible (ASAP).

2. Standing orders for acute chest pain:
   - Get an EKG
   - Administer Aspirin 325 mg (81 mg chewable x 4 tablets)
   - Administer Nitroglycerin (NTG) 0.4 mg sublingual every 5 minutes, until pain is gone, but do not exceed 3 doses. Continue to monitor VS, especially Blood Pressure (BP).
   - Administer oxygen (O2) via nasal cannula at 2-4 lpm, or by mask at 5-10 lpm
   - Cardiac monitor
   - Stat lab work to include: Cardiac enzymes and Chem 14

3. If the assigned physician is not available (not at the clinic yet or involved in a procedure), ask the Preceptor or another physician to see the patient initially.

Home

5/2005 C:\Documents and Settings\Nurses\Desktop\Nurse\How To\Acute Chest Pain Protocol.doc

Standing Order for Anaphylactic Reaction

Purpose: Patients who exhibit signs and symptoms of anaphylaxis should be treated immediately.

Supplies for Anaphylaxis Tray:

Epinephrine 1:1000 1ml vial (2) or EpiPen 0.3mg (2)
EpiPen, Jr. 0.15 mg (2)
Benadryl Oral Liquid
Benadryl Injectable Vial (2)
Syringes, 3 ml (6)
Safety Needles, 25g 5/8in,25g1in, 25g11/2 in (6 of each)
Alcohol Wipes
Gauze 2x2s
Band-Aids

Procedure:

A. Mild Reactions – itching, rash, subjective feeling of airway closer without facial swelling.
   1. Administer Benadryl 25 – 50 mg po stat.
   2. Patient to see physician as soon as possible.

B. Moderate to Severe Reaction – facial or neck swelling, hives, itching, respiratory distress.
   1. Administer epinephrine via syringe or EpiPen subcutaneously (SQ) stat:
      a. Child: One dose of epinephrine 0.01mg/kg **or** EpiPen, Jr. 0.15mg. May repeat in 15 minutes.
      b. Adult: – One dose of 0.3 mg of epinephrine **or** EpiPen (Adult) 0.3 mg. Additional doses of 0.15 – 0.3 mg can be administered every 10-15 minutes.
   2. Administer Benadryl 25 – 50 mg po.
   3. Patient to see physician as soon as possible or transfer to ER via ambulance or with a staff member (nurse or resident) with an EpiPen available.

Home

HIV Testing Policy

HIV Testing Policy

Purpose: To follow the CDC newly revised recommendations for HIV testing of adults, adolescents and pregnant women in health care settings. Routine HIV screening is recommended for patients aged 13-64 years of age in all health care settings after the patient is notified that testing will be performed, unless the patient declines (opt-out screening).

Procedure:

For patients in all health-care settings:

- Persons at high risk for HIV infection should be screened for HIV at least annually.
- North Dakota requires informed consent to be given to the patient before HIV testing by the physician.
- Separate written consent for HIV testing is required.
- Written consent is not needed for incarcerated patients.

For pregnant women:

- HIV screening will be included in the routine panel of prenatal screening tests for all pregnant women. HIV screening is recommended unless the patient declines (opt-out screening).
- North Dakota requires informed consent to be given to the patient before HIV testing by the physician.
- Separate written consent for HIV testing is required.
- Repeat screening in the third trimester will be performed if high risk of HIV infection is identified by staff or physician.

Home

TELEPHONE TECHNIQUES

I. Purpose:

A. To assure and adequate response to patient's needs and requests.
B. To instill good communication between physician and patient.
C. To maintain accessibility of physician to patient.
D. Guideline – Written protocols are defined for staff handling telephone calls, telephone triage and telephone advice including documentation requirements.

II. Procedure:

A. The clinic has a nurse phone line which is manned by a nursing staff member during clinic hours and can be accessed by prompts from the main clinic number (701-751-9500). When a telephone call comes into the nurses' phone line the answering nurse will:
   1. Answer the telephone promptly, stating her name and title and saying "May I help you?" speaking clearly and distinctly.
   2. Create a written message for the nurse or doctor who the call is for via "Incoming Phone Call" template in Epic and route it to the doctor's nurse.
   3. A few physicians prefer that their nurse handle all calls directly and those calls may be transferred to the individual nurse's phone line, unless they are out of the clinic. **Do not transfer any phone calls or messages to a doctor's direct phone line.**
   4. If it is a call regarding a child swallowing household cleanser, medication, etc. have caller call the Poison Control Center at 1-800-222-1222.
   5. If the patient wants to know if they need to make an appointment, tell the patient it is hard to assess a problem over the telephone. If they wish to come into the clinic would be happy to see them. If they do not wish to be seen, give common sense information, and if you have any questions, refer to the telephone triage books.
   6. Staff should understand that, if they have any doubts about proper instructions or advice, they must check with the physician first. The safest advice that a nurse or physician should provide by phone, when dealing with a medical problem, is to advise the individual to be seen in the office or go to the emergency room. Staff should be instructed never to practice medicine over the phone or give advice beyond their competence. Physicians should be receptive to questions by practice staff. Staff should obtain as much information about the patient's problem as possible to convey to the physician.

C. Calls for laboratory results: Create an "Incoming Phone Call" message in Epic and route it to the nurse, who will handle the call or route it to the appropriate doctor.
   1. Phone calls related to symptoms or illness will be answered within 24 hours.
   2. Phone calls related to test results, medication refills or other non-urgent matters will be answered within 48 hours.

D. Put a patient on "hold" when a need exists to discuss care with another doctor/nurse or if the party
   1. wished to speak to someone that is not available immediately. Always tell the patient when they
   2. are being placed on "hold".

E. Document **all** telephone calls **in the medical record,** especially when significant medical symptoms are
   1. communicated, abnormal test results communicated, medical advice offered, includes telephone
   2. calls during office hours and after hour on-call telephone communication. The documentation
   3. is necessary to provide a complete picture of the medical care that is being provided to the patients.
   4. Refer to After Hours phone documentation.

F. The physician must review and sign all documentation.
G. Instructions or orders should be carefully and thoroughly documented.
H. Verbal orders given over the phone should be signed as soon as possible.
I. **Licensed nurses** are assigned the responsibility for telephone triage/telephone advice.
J. Documentation on the Incoming and Outgoing Phone Call templates should include:

1. Patient name (and the caller name, if other than the patient)
2. Purpose of the call (in the caller's words).
3. Advice/orders given (including prescription refills).
4. Follow-up instructions and comprehension of instructions.
5. The signature of the staff member responding to the message/call.
6. Date and time

J. Providers will document After Hours calls in EPIC providing updated medical advice given to the patient.
K. Annual training will be provided.

Telephone advice is provided following physician consultation/orders or following written protocols that have been approved by the medical staff.

Recommend that telephone advice documentation be reviewed through the quality improvement process.

The manual used as a guideline for the nursing staff in handling telephone triage is **Telephone Triage Protocols for Nurses, Fifth Edition,** by Julie K. Briggs and **Pediatric Telephone Protocols, Office Version, 15th Edition**, by Barton D. Schmitt, MD.

Voice mail script for CFM Nurses:

Hello. You have reached (name and title) with the Center for Family Medicine. If this is an emergency please hang up and dial 9-1-1. Please leave your name, date of birth, phone number, your doctor's name and a brief message. I check my phone messages frequently throughout the day and will return your call as soon as possible. If you need a medication refill, please call your pharmacy and have them send us a request. Friday afternoon refill requests may not be processed until Monday. If you are calling after 4:00 p.m., please understand that your call may not be answered until the following business day. Thank you.

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Procedures Requiring Follow-Up Phone Calls:

Purpose: To provide optimal care for patients who have had in-office procedures and to assess for possible complications.

Procedure: A follow-up phone call must be completed the next business day to patients who have had any of the in-office procedures listed below. Documentation of the call will be completed on the appropriate procedural template.

Procedures requiring follow-up:

- Endometrial ablation (NovaSure)
- Circumcision
- Colonoscopy
- Colposcopy
- IUD placement
- LEEP
- Contraceptive implantation (Nexplanon)
- Toenail Removal
- Vasectomy
- Hysteroscopy

Home

Infection Control

Purpose: To prevent the transmission of infectious diseases (viral and bacterial).

The Infection Control Plan includes the following guidelines and also includes guidelines listed in the Bloodborne Pathogens, Medical Equipment, Pandemic Flu and Medication Safety Policies.

Hand Hygiene:

1. Hand washing/sanitizing will be performed between each patient contact following the CDC guidelines for appropriate hand washing in a healthcare setting.
2. Hand soap is available in every exam room, procedure room, restroom and at every sink.
3. Hand sanitizers are located in each Pod hallway, as well as bottles of hand sanitizer in all waiting areas, nurses' station and throughout the clinic.
4. Training will be provided annually for all front-line healthcare staff.

Cleaning of Exam Rooms:

1. Exam table paper is changed after each patient.
2. Pillowcases are changed when soiled or if there has been direct patient contact, and at least weekly when the pillow has remained under the exam paper and there has been no direct patient contact.
3. Exam tables are wiped with approved disinfectant wipes after any wound care, invasive procedure or other situation where contamination with blood or body fluids has occurred.
4. Spills of blood or body fluid on the floor or carpeting will be cleaned up immediately with an approved spill kit.

Cleaning of Equipment:

1. Critical items – objects that enter sterile tissue or the vascular system (i.e. surgical instruments) must be cleaned in an approved disinfectant solution then packaged and sterilized following appropriate sterilization method.
2. Semi-critical – objects that contact mucous membranes or non-intact skin (endoscopes, laryngoscope blades, respiratory therapy equipment) require a high-level disinfection using FDA approved disinfectants and following manufacturer recommendations.
3. Non-critical items – items that contact intact skin (blood pressure cuffs, linens, crutches, bedpans) use an EPA-registered disinfectant following manufacturer's recommendations.

Environmental Cleaning:

1. Clean nonporous surfaces with a healthcare approved disinfectant (chairs, table surfaces, door knobs, handrails). Refer to contract with housekeeping provider.
2. Vacuum carpeted floors, dry mop exam room floors and wet mop as indicated. Wet mop procedure room floors. Refer to contract with housekeeping provider.
3. Clean toys in the children's area weekly with a nontoxic healthcare approved disinfectant.
4. **Pediculosis (lice) or scabies:** Clean the room as you would for any other patient and bag any linen. Upholstered furniture, carpets, rugs, pillows should be vacuumed. Contact precautions (gloves and/or gown, hand hygiene) should be followed for physical contact with the patient.
5. Biohazard garbage cans in the procedure rooms are emptied at least weekly (more often as needed). Refer to the Bloodborne Pathogens Control Plan.

Personal Protective Equipment:

1. Refer to the Bloodborne Pathogens Control Plan

Medication (Injection) Safety:

1. Single dose vials or prefilled syringes should be used as much as possible with safety needles.
2. Multi-dose vials should not enter the patient exam room – dose should be drawn out of the vial in the nurses' medication room or at the nurses' station and the individual syringe taken into the patient room (to prevent contamination of the vial). Multi-dose vials will be clearly labeled with the date that they were opened and will be disposed of 30 days after opening.
3. **A needle and syringe must be used only once.** If more of the medication is needed a new needle and syringe must be used to draw up the med.

Respiratory Hygiene:

1. Signs are posted at entrances and in patient care areas with instructions to patients with symptoms of respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissue, and to perform hand hygiene.
2. Tissues and no-touch receptacles for disposal of tissues are provided throughout the clinic.
3. Hand-sanitizers are provided in the waiting rooms and public areas of the clinic for patient use.
4. Masks are offered to coughing patients and other symptomatic persons upon entry to the facility. Symptomatic patients will be placed in an exam room as soon as possible.

Reporting of Infectious Disease:

1. The clinic will follow the ND Department of Health's Mandatory reportable conditions at http://www.ndhealth.gov/Disease/Disease%20Reporting/

2. Consults for Infectious Disease can be referred to Dr. Mateo at Sanford and Dr Supha Arthurs at St. Alexius.

Patient Education:

1. Education will be provided to all patients with infectious diseases to include, but not limited to the need for isolation, cough/sneeze etiquette, vaccinations and the need for protective barriers.

Training:

1. Training and updating current practices for infection control will be managed by the nurse supervisor and safety officer. Training will be provided to all new employees and annually to clinic staff.

Home

Procedural Sedation and Colonoscopy

Purpose: To provide guidelines for the safe and effective use of procedural sedation at the Center for Family Medicine. To ensure one standard of care for patient management and clinic process before, during and after procedural sedation. To view the colon for diagnostic and screening purposes.

Definitions: **Procedural Sedation** is the administration of sedative, amnestic and analgesic drugs – singly or in combination – with the goal of alleviating or reducing pain and anxiety associated with medical and surgical procedures.
Continuum of Sedation refers to the fact that patients can move from one level of sedation to another without warning. There is not perfect way to ensure an exact level of sedation. Sedation requires frequent assessment and adjustment of sedating medications.
Levels of Sedation are determined according to a pre-defined Sedation Score as shown.

Sedation Score	Level of Sedation	Level of Consciousness	Response-Verbal	Response-Tactile	Airway Patency	Ventilation Oxygenation
0	None	Fully aware of self & surroundings	P	P	P	P
1	"Light"	Mostly aware of self & surroundings, but sedate	P-L	P	P	P
2	"Moderate"	Slightly aware of self & surroundings, usually somnolent, arouses easily with stimuli	L-A	P-L	P-L**	P-L*
3	"Deep"	Not aware of self or surroundings, little arousal with stimuli	A	L (to pain)	L-A	L
4	General Anesthesia	Unconscious, no arousal with painful stimula	A	A (to pain)	L-A	A

P: Present, adequate, or normal
L: Limited, partial, mildly abnormal
A: Absent, inadequate
*: May need supplemental oxygen to keep SaO2≥ 90%
**: Airway may need limited support
Note: Deep sedation may be indistinguishable from general anesthesia and carries all the same risks

General Policies on Procedural Sedation

1. Procedural sedation may be utilized at the CFM Clinic for patients undergoing colonoscopy and other invasive procedures and/or diagnostic tests for the purpose of improving patient comfort and increasing the probability of a successful procedure/test.
2. Only a Certified Registered Nurse Anesthetist (CRNA) may provide procedural sedation.
3. In addition to the CRNA and the physician performing the procedure, an ACLS certified Registered Nurse or Licensed Practical Nurse must be present. The Nurses' responsibilities may include the continuous monitoring of the patient, assisting in supportive or resuscitative measures if necessary, and continuing to monitor the patient through recovery and discharge from the clinic.

Policy on Qualifications for Provision of Sedation

Because sedation is a continuum, it is not possible to predict how an individual receiving medication will respond. Administration of sedation medications could result in a risk of loss of protective reflexes. Therefore, persons responsible for provision of sedation must meet the following requirements:

1. Physicians must:
    a) Possess current certification in BLS and ACLS (PALS if performing pediatric sedation).
    b) Resident physicians must have a preceptor in the room.
2. Nurses must:

a) Recovery must be done by an RN.
b) Possess current certification in BLS and ACLS (PALS if performing pediatric sedation).
c) Be able to anticipate and recognize complications of sedation in relation to the type of medication being administered.
d) Review and follow all clinic policies and procedures relating to procedural sedation.

Policy on Pre-Procedural Patient Assessment by the Physician and Anesthesia Team Member

1. The anesthesia team member who is responsible for the overall conduct of the sedation/anesthesia, including the medication orders is required to: (1) assess the patient; (2) assign an ASA status (per table below); and (3) document the sedation plan prior to scheduling any procedure or test (and within 30 days of the procedure).

American Society of Anesthesiologists Patient Classification

ASA 1 - A normal healthy patient. The pathological process for which surgery is to be performed is localized and does not entail a systemic disease.
Example: An otherwise healthy patient scheduled for a cosmetic procedure.

ASA 2 - A patient with systemic disease, caused either by the condition to be treated or other pathophysiologic process, but which does not result in limitation of activity.
Example: A patient with asthma or diabetes that is well controlled with medical therapy, and has no systemic sequelae.

ASA 3 – A patient with moderate or severe systemic disease caused either by the condition to be treated surgically or other pathophysiological processes, which does limit activity.
Example: A patient with uncontrolled asthma that limits activity, or diabetes that has systemic sequelae such as retinopathy.

ASA 4 - A patient with severe systemic disease that is a constant potential threat to life.
Example: A patient with heart failure, or a patient with renal failure requiring dialysis.

ASA 5 – A patient who is at substantial risk of death within 24 hours, and is submitted to the procedure in desperation.
Example: A patient with fixed and dilated pupils status post a head injury.

E Emergency status. This is added to the ASA designation only if the patient is undergoing an emergency procedure.
Example: A healthy patient undergoing sedation for reduction of a displaced fracture would be an ASA 1E.

2. If the pre-procedure assessment is not completed immediately prior to the procedure, any interval changes as well as NPO status must be noted when a patient presents for the procedure. This interval assessment must include:
    a. Any significant changes in health status since the initial evaluation
    b. Examination of the heart and lungs
3. Pre-procedure history should focus on:
    a. The **indication** for the procedure/test
    b. **Cardiopulmonary Disease** may accentuate the cardiovascular and respiratory depression that can be caused by sedatives and analgesics. May require reduction in drug doses. Additional monitoring with an EKG is warranted.
    c. **Hepatic or Renal Abnormalities** may impair drug metabolism and excretion resulting in increased drug sensitivity and longer duration of drug action.
    d. **Medications** that the patient is currently taking may interact with the sedatives and analgesics.
    e. **Allergies**
    f. **Alcohol or Illicit Substance Abuse** may increase a patient's tolerance to sedatives and analgesics. On the other hand, acute use prior to sedation will be addictive or synergistic to the medication effects.
    g. **Tobacco Use** increases the risk of bronchospasm, and coughing during sedation.
    h. **Previous Adverse Reaction** to anesthesia or sedation may increase current risk.
    i. **Informed Consent** given by physician.

4. Physical exam should focus on:
    a. The **area/system involved** in the procedure/test.
    b. **Cardiac**
    c. **Respiratory/Airway** – including documenting the **Mallampati airway class.**
5. Pre-procedure diagnostic test should include:
    a. Chem 8
    b. EKG for individuals ≥ 50 years of age, if not done within the past year.
6. Individuals age 70 and older will be scheduled for an evaluation appointment with Dr. Hostetter prior to scheduling the procedure.
7. Only patients given an ASA Classification of 1 or 2 **AND** having a Mallampati class I – III airway will be qualified to receive clinic-based procedural sedation in the CFM.

Policy on Pre-Procedure Nursing Duties

Patient Instruction and Scheduling:

1. Identify the patient using two patient identifiers (full name and date of birth).
2. Give the Colonoscopy Instruction Packet to the patient, review the Colonoscopy Prep Instructions and schedule the procedure date.
3. Review with the patient the need for a responsible adult to drive the patient home and to be available to the patient for the remainder of the day. Explain to the patient that if a responsible adult is not available the procedure will be cancelled, or if the responsible adult does not return to pick up the patient after the procedure, the patient will be admitted to the hospital for observation, via ambulance from the Center for Family Medicine. The cost for the ambulance transfer and hospitalization may be the patient's responsibility.
4. Send the prescription for the colonoscopy prep to the Pharmacy of the patient's choice via eprescribe or fax.
5. A reminder call will be made to the patient the day before the exam to inform the patient of arrival time and to review prep instructions, NPO after midnight and that a responsible adult is to accompany the patient.
6. General discharge instructions will be reviewed with the patient pre-procedure, before the patient receives sedation. More detailed discharge instructions will be reviewed with the patient and responsible adult driver at the time of discharge and copies will be given to the patient. Educate the patient that these instructions will include what was done during the procedure, follow-up appointments and how to obtain biopsy results, if applicable.

On the day of the procedure, the nurse has the following responsibilities:

1. Verify the appropriate equipment is available including, but not limited to:
    a. Crash cart
    b. Monitoring equipment
    c. Functioning suction
    d. Positive pressure breathing device (bag-valve-mask and oxygen tubing)
    e. Battery backup power source
2. Set up procedure room and check equipment
3. Check to ensure the patient's medical record includes both a pre-procedure physician assessment and a signed informed consent. Verify the patient's NPO status has been a minimum of six hours.
4. Identify the patient using full name and DOB, obtain admission vital signs and Aldrete score (refer to the Aldrete Score Card), and complete pre-procedure paperwork and consents. Place an ID bracelet on the patient's wrist.
5. Have patient change into gown
6. Obtain a blood-glucose on all diabetic patients.
7. Urine pregnancy tests are to be performed on all women of childbearing age (<52), unless they have undergone a sterilization procedure.

8. Ensure the patient has dependable IV access.
9. Connect patient to monitors
10. Position patient on left side
11. CRNA will give IV sedation
12. Circulating nurse will assist physician as needed

Policy on Intra-Procedure Responsibilities

During the procedure, each member of the health care team must carry out the duties assigned to them to ensure maximal efficiency and patient safety. Patient identification, using full name and date of birth, shall be done just prior to the administration of the sedation.

1. The physician performing or precepting the procedure has the final authority and responsibility for all patient care decisions and shall be immediately available from the beginning of sedation until the patient has adequately recovered from their effects.

2. The CRNA should:
   a. Select medication based on procedure and patient specific indications, and titrate doses to patient response.
   b. Monitor and document the following vital signs during the procedure:
      i. Blood pressure
      ii. Heart rate
      iii. Oxygen saturation
      iv. Heart rhythm
      v. Sedation score
   c. Provide supplemental oxygen, when appropriate, to maintain pre-procedure saturation.
   d. Monitor the patient continually for adverse reactions to the medications or procedure.
   e. Document the procedure on the Procedural Sedation Progress Note.
   f. CRNA will monitor vital signs and assess patient's comfort level every 5-15 minutes, or more often if required during the procedure.
   g. Report the status of the patient, including VS, medications used and reversal agents) to the Recovery Nurse.

3. Equipment/Supplies:
   a. Cart with monitor, processor, light and water source
   b. Colonscopy
   c. Suction machine with tubing
   d. Water bottle with distilled water
   e. Mayo stand
   f. Exam gloves
   g. 4x4's
   h. Lubricating jelly
   i. Basin with distilled water
   j. Small towel
   k. Chux
   l. Gowns
   m. Drape sheet and blanket
   n. Biopsy forceps and snare
   o. Specimen trap
   p. Specimen container and pathology request forms
   q. 60cc catheter tip syringe

r. IV stand
s. Venipuncture supplies
t. IV fluid, usually Lactated Ringers or sodium chloride if indicated
u. EKG/BP/Pulse Oximeter
v. Sedation medication cart
w. Syringes/needles
x. Crash cart
y. Oxygen tank with nasal cannula or mask

3. The Procedure Nurse should:
   a. Assist the physician during the procedure, which may include assisting with equipment such as biopsy forceps, snare, and cautery, and to assist in obtaining biopsies.
   b. Assist the CRNA should the patient become unstable.
   c. If biopsies are taken, place specimen(s) in labeled pathology container (label with patient's name, DOB, and type of specimen). Complete the pathology form, and take specimen to lab.
   d. At completion of procedure, assist in positioning patient for comfort.
   e. Clean and reprocess colonoscope following proper procedure. Refer to the Pentax Video Lower GI Scopes Manual: Instructions for Use.

Policy on Post-Procedure Phase II Responsibilities

1. Identify the patient received from Post-Anesthesia Recovery using full name and DOB.
2. A RN will monitor the patient's Phase II recovery status until discharge criteria are fulfilled.
3. Blood pressure, heart rate and oxygen saturation will continue to be documented every 15 minutes x 4, every 30 minutes x 2 until the patient returns to their baseline.
4. Post-procedure monitoring will continue until the patient returns to their baseline neuro/cardio/respiratory status. The duration of monitoring must be individualized depending on:
   a. The level of sedation achieved
   b. The overall condition of the patient
   c. Any unplanned events occurring during sedation
5. Significant variations in physiologic parameters must be reported to the CRNA or physician immediately including:
   a. Significant cardiac arrhythmias
   b. Systolic blood pressure <100 or > 160, or pulse rate <60 or > 100.
   c. Oxygen saturation <90% and not improving
   d. Dyspnea, apnea
   e. Decreasing level of consciousness or need to assist patient to maintain their airway
   f. Any unexpected patient responses
6. Give patient something to drink (water, juice, coffee, tea).
7. Discontinue IV when patient is alert/oriented, vital signs are stable, and patient is tolerating fluids.
8. Review discharge instructions with patient and responsible adult.
9. Discharge patient with responsible adult, escorted to vehicle with nursing staff.
10. Documentation of patient's meeting all discharge criteria including:
    a. Returning to pre-procedure neuro/cardiac/respiratory status
    b. Tolerating oral liquids/food (water, juice, tea, crackers).
    c. Return to pre-procedure ambulatory status
    d. Aldrete score of 8 to 10, or at the pre-procedure baseline
    e. Written discharge instruction sheet discussed with the patient and responsible adult and given to patient
    f. Patient discharged to the care of another responsible adult
    g. Staff member shall escort patient to vehicle

11. Document the recovery on the Outpatient Phase II Recovery Form
12. Physician will dictate a procedure note
13. The nurse will make a follow-up phone call to the patient on the day following the procedure, or the next business day if the procedure was done on a Friday or the day preceding a holiday.

Welch Allyn Stress EKG

Purpose: A screening test for the presence of underlying ischemia or coronary artery disease.

Procedure:

1. Patients are reviewed and selected for Stress EKG testing according to the recommended guidelines published by the AAFP in the article "Ordering and Understanding the Exercise Stress Test" January 1 , 1999, American Family Physician.
2. Stress tests are scheduled by the Receptionist/Scheduler when a preceptor is available to assist the resident with the procedure. Allow 60 minutes for the test.
3. Upon scheduling the test, the patient will be given (or mailed) a copy of the Stress EKG Pre-Test Instructions.
4. A recent EKG must be available prior to the stress test; therefore, if an EKG has not been done within one month a resting EKG can be done at the time the patient is hooked up before initiating the stress test
5. An ACLS certified staff nurse will get the patient ready for the test and remain in attendance throughout the procedure to monitor and record vital signs and to run the computer-guided program.
6. The patient will be hooked up to the stress EKG machine by the nurse but the test itself must not be started until the resident and the preceptor are in the room.
7. Documentation will be completed by the physician who administers the stress EKG according to the attached guidelines.

Instruct the Patient (may be done in the stress test procedure room):

1. To get onto the treadmill by stepping on the outside edges of the machine.
2. Look forward while walking. People tend to get dizzy if they look down or watch their feet. Stand straight and tall towards the front of the treadmill.
3. Every 3 minutes the treadmill will incline and speed up for the next exercise level. Blood pressure will be checked at least every 3 minutes during the test and recovery period.
4. Tell patient that "AT ANY TIME, if you have CHEST PAIN, SHORTNESS OF BREATH, or are TOO TIRED TO CONTINUE, let the nurse/doctors know and we will STOP the test."
5. Tell patient: "When the test is completed, there will be a cool down period and you should continue to walk with it until the doctor tells you that you may step off the treadmill. You will remain connected to the monitor and blood pressure will be checked every 3 minutes until it returns to your pre-test baseline."

Administering the Test:

1. Move the computer cart to the head of the treadmill.
2. Connect the black cable from the treadmill into the black port on the back of the computer PC. **Tighten the screws** to hold the connector in place so as not to damage the connector. Turn on the treadmill (switch is located at front base of the treadmill just above where the cable attaches to the treadmill).

Note: Check the red Emergency Stop button on the treadmill and pull it out.

3. Plug in the grey power strip cord and **turn the power strip on**.
4. Turn on the computer and the monitor. The printer should already be turned on. Check to make sure there is paper in the printer.
5. Click the Windows icon – colored circle at the bottom left of the screen.
6. Choose "Computer" should be shown there with a blue line below

   Note: If there is a red X (not a blue line under) then right click on it and choose "Open" followed by "Use Another Account" and enter: ad\first.name.last name then enter your computer sign-on password and close the screen."Input" should also show up with a blue line below.

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7. Click on the WA CardioPerfect icon upper left of the screen. Make sure that the circle next to "Use database authentication "is checked, then enter your username and password. Click "log-in".
8. Search patient by name or account number, select patient in drop down and click "edit" (upper left of screen), then "Patient Card" and patient's race, height and weight will auto-fill.
9. If the patient's name doesn't show up on the WA Stress EKG screen, enter patient's full last name and choose "Go" or click enter
10. If the patient does not have an EKG on the chart that was done less than 30 days ago, he/she will need an EKG first. This can be done before the stress test.
11. Connect the EKG leads as indicated on the laminated guide (same as the previous stress EKG machine). The lower limb leads can be placed on the back, just above the waist or on the lower abdomen. The sticky lead patches are located in the plastic container with the pink lid (in the upper cupboard). If we are getting low on packages of sticky patches, let Nicole or Terri know so that more can be ordered. The EKG connecting cords are kept in the wire basket on the cart just below the monitor. Make sure the USB end is securely plugged in.**Note: Women should keep their bra on (unless it is an underwire bra) and give them a gown top or have them put their shirt back on after the leads are connected.** Men may walk without their shirt, if comfortable, or may wear a shirt or gown top.
12. Once the patient is hooked up, click **ECG** (if needed) or proceed to Exercise ECG.
13. To record an EKG wait until you see a good rhythm strip on the bottom of the monitor EKG screen then click record. The EKG will automatically print. Take this to the doctor to review before proceeding any further, but leave the patient hooked up.
14. **Do not start the stress EKG procedure until the Resident and Preceptor are in the room.**
15. To begin the stress EKG have the patient step on the stationary outside edge of the treadmill. Place the QRS box and belt around the handle of the treadmill and fasten the belt. Click on **"Go to Exercise"** at the top of the screen. The program will automatically run.
16. Take the patient's blood pressure manually when prompted by the BP popup on the computer screen (every 3 minutes). The machine will automatically increase in speed and elevation every three minutes and this occurs soon after the blood pressure is taken. Give the patient forewarning that this will occur.
17. Note: The red button on the front of the treadmill is the emergency stop button; you can also click on a red emergency stop icon at the top of the computer screen.
18. The program will automatically calculate 85% of the patient's target heart rate and will keep track of this (as well as how close you are to the test goal) at the top of the screen.
19. When the patient has reached the goal and the doctor says the test can be stopped, click **"Go to Recovery"** at the top left of the screen to begin the "cool down" and recovery phase. The treadmill will slow down to a slow walking rate and decrease the incline to level. After a 1-3 minute recovery, click **"Stop the Treadmill."** Once the machine stops, have the patient stand very still and take the patient's blood pressure.
20. The patient can then move to the exam table to rest. You will be prompted to take the patient's blood pressure every 2 minutes. Continue to take blood pressures until the patient returns to their pre-test blood pressure and pulse readings. At this point click **Stop** and confirm that you want to stop the test by clicking "**yes**". At this time the patient may be unhooked.
21. Print the report and have signed off by the preceptor and resident. It will then be scanned in and sent upstairs to HIM to be scanned into the patient's chart.
22. Offer the patient a towel to dry off with, if necessary and have the patient get dressed.
23. Close the program and turn off the computer and monitor.

Wipe the lead wires with a disinfectant, coil them loosely and put them, along with the QRS box, back into the wire basket on the cart.

Home

EKG Stress Tests – Notes to Residents

FIRST AND FOREMOST, the patient MUST meet criteria for test INCLUDING
Normal (i.e. flat) baseline ST segments on EKG

II. Criteria for a positive test
- A. Chest pain or other angina equivalents
- B. ST-segment changes:
  1. At least 1 mm of depression with flat or down-sloping ST segment 80 milliseconds after the J-point.
  2. At least 1.5 -2 mm of depression with up-sloping ST segment 80 milliseconds after the J-point.
- C. Loss of normal SBP increase with exercise.

III. Template for dictating an EKG Stress Test report:

Patient Name
Date
Referring/Performing Physician
Preceptor
Indication
Protocol
Test details:
1) Protocol
2) Heart rate: Resting, Max exercise, % of max predicted
3) BP: Resting, Max exercise
4) Time of termination
5) Reason for termination
6) ECG changes: Resting, Max exercise*
7) Clinical symptoms: Resting, Max exercise

Impression:*
Recommendations including follow-up:
Signature

* Comments/stock phrases to include in dictation (see attached example):

*6) Resting ECG: "normal sinus rhythm with normal interpretable baselines"

*Impression:
1. Adequacy of stress test; i.e. did they walk at least 6 minutes
2. BP response; i.e. "normal changes with exercise including an increase in SBP with widening of pulse pressure"
3. "(Any or No) clinical criteria for ischemia observed"
4. "(Any or No) ECG criteria for ischemia observed"

Home

REFUSAL OF TREATMENT BY A PROVIDER

Purpose:
The clinic strives to provide quality care to its patients, but occasionally has a situation where we wish to refuse to continue furnishing health care services to a patient. Instances for refusal of care may include:

- Patient or parental behavior is inappropriate and/or abusive and prevents the clinic from providing quality care to the patients;
- Patient falsifies information;
- Patient refuses to accept services and/or wishes to transfer to another clinic;
- Patient is unwilling to comply with plan of care;
- Outstanding/unpaid bills
- Evidence of Medical Identity Theft

Circumstances beyond the clinic's control may at times preclude the clinic from providing quality care to a patient. When these circumstances arise and are not able to be resolved, termination of the patient's care with the clinic may be necessary. The clinic will cooperate in transferring care and medical records to another provider at the patient's request.

Policy:
When a physician or the clinic, either individually or collectively, decides that it is in the best interest of the clinic to refuse/withdraw services:

1. Resolve any acute medical conditions prior to terminating the relationship.
2. The Health Plan must be notified in writing (or by the Health Plan's termination of care form) if the member is a managed care member.
3. The patient is notified in writing via a termination letter (see template), sent by certified mail, which must contain the following information:
   A. An offer to copy and send medical records to another provider of the patient's choice along with a release of information form included with the letter;
   B. A statement that care will be provided for a maximum of 30 days to allow transfer to occur. Clearly state date that termination will become effective;
   C. Provide emergency care until termination date.
   D. The phone number for member services at the Health Plan;
   E. Resources and /or recommendations provided to help a patient locate another physician by listing local medical groups and resources, not physicians by name.
4. A copy of the letter and receipts postcard from the certified letter is placed in the medical record. The managed care plan may also require a copy of the letter. All copies of the letter are marked CONFIDENTIAL
5. The medical records are transferred upon receipt of the signed release of information form.
6. Incident report needs to be filed with risk management.

Home

Letter Templates for Termination of Provider/Patient Relationship:

Certified Mail – Return receipt

Date
Patient's Name
Address
City, State XXXXX

Dear [patient name]:

With this letter, I must let you know that I need to now withdraw as your primary medical provider. Your health plan has been notified in writing of my current decision (if applicable).

Given these circumstances, I suggest that you place yourself under the care of another medical provider/physician without delay.

To assist you, I have provided the phone number for the local medical society [insert phone number]. I have also included the address and phone number of a facility where emergency care can be obtained if needed [insert local hospital names and numbers].

In order to give you reasonable advance notice, our office will be available for your immediate medical needs over the next 30 days, until [date: day, month, year], if you wish. After that date, our office will no longer be available to provide for your medical care.

Our office will be glad to send your medical records to your new physician. For that purpose, I am enclosing a consent form authorizing me to release your medical records to your new physician. Upon receipt of this form, signed by you and designating where to send a copy of the records, I will forward the records promptly.

If you have any questions regarding the content of this letter, you may reach me at my office during normal office hours.

Sincerely,

[Physician name typed]

Home

Scheduled II Medications

Policy:

The purpose of this policy is to ensure the patient receives their prescription for Scheduled II Medications.

Procedure:

1. Nurse/Provider will review PDMP and fill out scheduled medication template in Epic.
2. Nurse/Provide will inform patient that script has been electronically sent to pharmacy. If pharmacy does not accept electronic scripts, then hand written one will be mailed.
3. Nursing can hand carry scripts to UND CFM Pharmacy if necessary.
4. Patient will not be allowed to pick up narcotic prescriptions at front desk.

Home

CHRONIC PAIN MANAGEMENT

Purpose: To assure effective, efficient, consistent care and self-management of the chronic pain patient using the chronic care model.

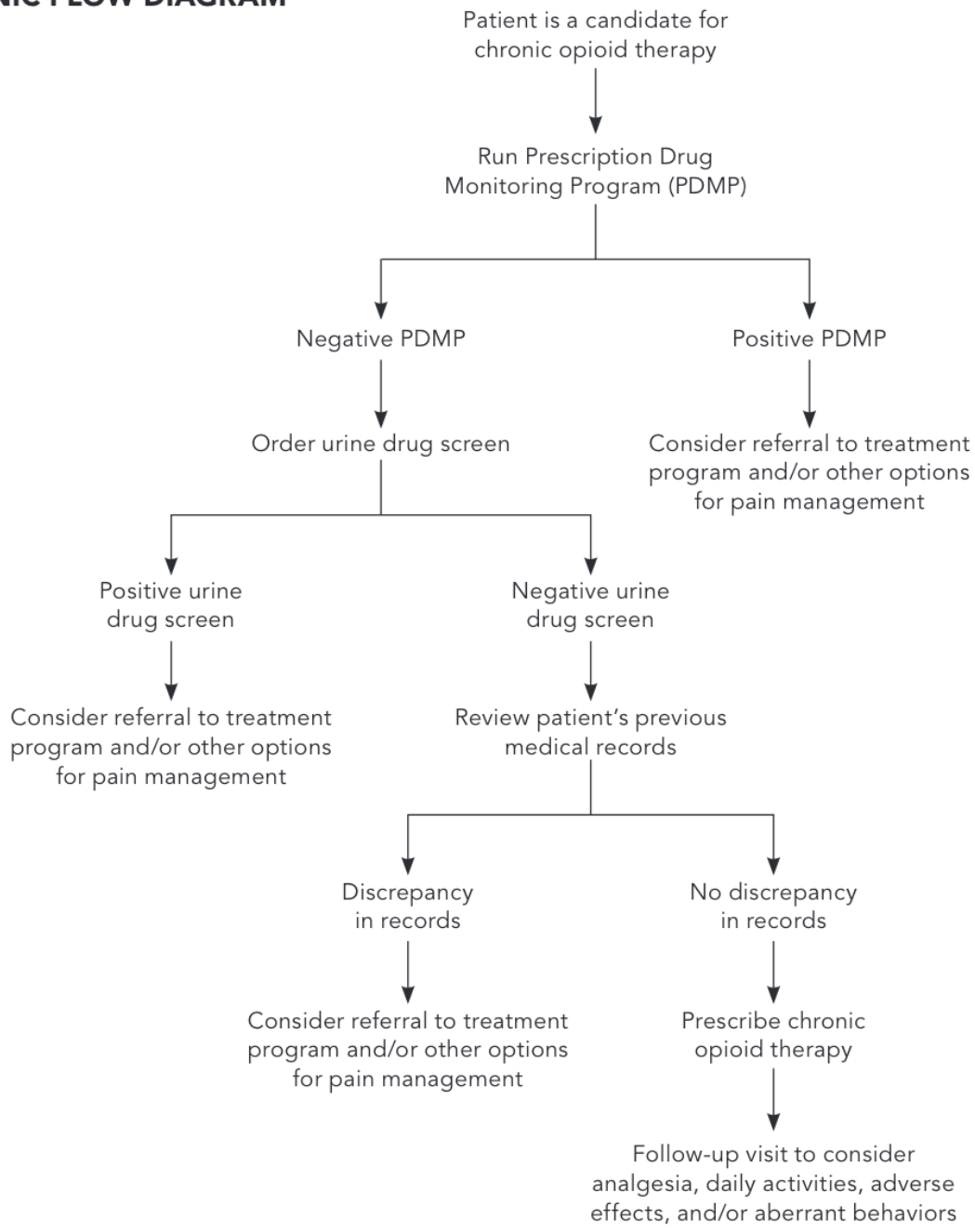
Procedure:

1. A Pain Management Committee consists of CFM Residency Program Director, the CFM Medical Director, a Chronic Care Coordinator, and other resident and faculty physicians.
2. Criteria for referral to the Pain Management Committee are
    1. Any patient whose provider feels they would benefit from the committee's recommendations
    2. Any patient on more than 3 medications indicated for pain. This includes non-opiates.
    3. Any patient needing more than 30 days of opiate therapy
3. An executive subcommittee will be formed. They will meet weekly as needed to review any patients with pain contracts issues or new contract requests. The whole committee will meet quarterly. Patients will be reviewed by the whole committee quarterly. The committee may decide to extend or minimize the quarterly review as they see fit.
4. If the Pain Management Committee feels as though the patient is too high risk for opiate therapy, they will be referred to an outside pain management provider if they desire opiate therapy. The UND provider should offer non-opiate therapy.
    1. High risk will be defined by the committee following the Opiate Risk Tool from Webster "Structuring Opioid Therapy," *Practical Pain Management*, Vol. 7, Issue 7 (9/07) pp. 12-16 which is attached
5. All chronic pain patients will be instructed about the Center for Family Medicine's Chronic Pain Management policy and team approach by their primary care physician (PCP) and will sign an informed consent for treatment of pain with opiates, if necessary. The consent will be entered into the EMR.
6. The chronic pain patient will be required to sign a medication contract and the guidelines for continuing pain treatment with their CFM provider. The original contract will be kept in the patient medical record and a copy will be placed in the nurse coordinator's file and will be entered into the EMR.
7. Each patient will have an individual treatment plan developed jointly with their provider and the chronic pain management committee setting realistic therapeutic goals in four main areas: physical abilities, social and vocational functioning, medication dosages and amounts, and duration of treatment. The treatment plan will also specify patient visit intervals. The treatment plan will be reviewed at each patient visit and updated or revised as needed then entered into the EMR.
8. Each patient will receive copies of the informed consent, their medication contract and their treatment goals.
9. All patients with a chronic pain contract will be seen every 3 months. If controlled substances such as opiates or benzodiazepines are part of the treatment plan, prescriptions will be provided for 28 day intervals.
10. The PDMP report will be checked at every refill request BEFORE the request is approved.
11. Random drug screens will be completed every three months to 1 year at the discretion of the primary prescriber. The RN and/or provider have the option to screen more frequently as they feel necessary.
12. The standardized UND Pain Assessment Form will be completed prior to being seen by the provider.
13. All patient requests for opiate meds will come from a pharmacy unless the pharmacy does not have the capability to do so.
14. Patients with a pain contract will ideally follow with their primary provider during the duration of their time at the residency. However, the contract is to be considered with the UND CFM as a whole and the patient can be seen by other providers if needed due to scheduling restraints or any other issues.

    Attachments: Risk Assessment Tool, Pain Management Agreement, Pain Assessment Tool, Pain Treatment Plan, Informed Consent for Opiate Therapy

Home

CLINIC FLOW DIAGRAM



Opioid Risk Tool

	Female	Male
Family History of Substance Abuse		
Alcohol	[ ] 1	[ ] 3
Illegal Drugs	[ ] 2	[ ] 3
Prescription Drugs	[ ] 4	[ ] 4
Personal History of Substance Abuse		
Alcohol	[ ] 3	[ ] 3
Illegal Drugs	[ ] 4	[ ] 4
Prescription Drugs	[ ] 5	[ ] 5
Age between 16 and 45	[ ] 1	[ ] 1
History of Preadolescent Sexual Abuse	[ ] 3	[ ] 0
Psychological Disease		
ADD, OCD, Bipolar, Schizophrenia	[ ] 2	[ ] 2
Depression	[ ] 1	[ ] 1

Risk Category Determination:

- Low – Score 0-3, 6% chance of aberrant behavior
- Moderate – Score 4-7, 28% chance of aberrant behavior
- High – Score >8, 90% chance of aberrant behavior

Adapted from Webster "Structuring Opioid Therapy," *Practical Pain Management,* Vol. 7, Issue 7 (9/07) pp. 12-16

Pain Assessment

Name: _____ Date:_____

Which side effects do you have?

Upset Stomach	Not at all	Mild	Moderate	Severe
Vomiting	Not at all	Mild	Moderate	Severe
Constipation	Not at all	Mild	Moderate	Severe
Itching	Not at all	Mild	Moderate	Severe
Brain Fog	Not at all	Mild	Moderate	Severe
Sweating	Not at all	Mild	Moderate	Severe
Fatigue	Not at all	Mild	Moderate	Severe
Overly Tired	Not at all	Mild	Moderate	Severe
Other:_____	Not at all	Mild	Moderate	Severe

How often does pain affect the following?

Your ability to do things around the house
Never Sometimes Often Always

Your job
Never Sometimes Often Always

Your time with family
Never Sometimes Often Always

Your time with friends
Never Sometimes Often Always

Your mood
Never Sometimes Often Always

Your sleeping pattern
Never Sometimes Often Always

Your overall functioning
Never Sometimes Often Always

What is your overall pain level over the past week if 0 is no pain, 10 is most severe pain?

0 1 2 3 4 5 6 7 8 9 10

Are you happy with your overall pain control? Yes No

Pain Management Agreement

I, _____, agree to the following rules and conditions regarding pain management, and—if prescribed--refills of opiate pain medications.

The greatest success in chronic pain management comes when there is a partnership based on mutual respect between patient and doctor.

The doctor understands that it is important for patients with pain to know that the doctor will:

- Listen and try to understand the patient's experience living with pain.
- Accept the patient's reports of pain and response to treatment.
- Thoroughly assess the patient's pain and explore all appropriate treatment options, including those suggested by the patient.
- Explain what is known and unknown about the causes of the patient's pain.
- Explain the meaning of test results or specialty visits/consultations, and what can be expected in the future.
- Explain the risks, benefits, side effects and limits to any treatment.
- Respect the patient's right to participate in making pain management decisions, including the right to refuse some types of treatment.
- Make sure that the patient has access to acute care, even when the provider is not personally available.

The patient understands that it is important for doctors that their patients with pain will:

- Understand that opiate therapy is only a small part of treating chronic pain and is often not indicated.
- Attend recommended therapy sessions and do their best to make recommended lifestyle changes.
- Be willing to be involved in programs that can help improve social, physical, or psychological functioning.
- Be willing to learn new ways to manage their pain.
- Take medication only at the dose and times prescribed.
- Make no changes to the dose or how the medication is taken without first talking to the doctor.
- Not ask for pain medications from other providers.
- Tell any provider they see all medications they are taking.
- Arrange for refills only through one doctor's clinic during regular office hours.
- Not ask for early refills.
- Protect their prescriptions and medications.
- **This means keep all medicines away from children AND from people (even family members) who might steal them.**
- **Take medications only for their own use and NOT share them with others.**

We both agree that the doctor may stop prescribing medication or the patient may decide to stop taking the medication if there is no improvement in pain or activity, or there are significant side effects from the medication.

We both realize and have discussed that there can be limitations to pain medication therapy. It may not be helpful or only partially helpful and that it is only one part of the treatment of chronic pain.

We both agree to work together to find the most effective ways to control pain and improve functioning.

Patient Name (printed):_____

Patient: _____ Date: _____

Doctor: _____ Date: _____

Patient Informed Consent and Notice of Risks For Treatment of Pain With Opiate Medications

We have discussed potential side effects and risks of opiate substances, including:

• sleepiness, confusion, difficulty thinking
• nausea, vomiting, constipation
• difficulty breathing, shortness of breath, wheezing
• rash, itching
• potential for allergic reaction
• potential for interaction with other medications (increasing effects or side effects of drugs taken together)
• potential for dose escalation/tolerance (need for higher doses for the same effect may occur with long term use)
• potential for dependence (after the body adjusts to these medications, they cannot be stopped abruptly without physical symptoms)
• potential for withdrawal (stopping medications abruptly may cause nausea, vomiting, abdominal pain, sweating, aching, abnormal heartbeat or other symptoms that can be life threatening; medication changes should be under provider supervision)
• potential for addiction (compulsive drug use not related to pain relief)
• potential for impaired judgment and/or motor skills (driving or operating machinery may be hazardous due to effects on the brain and nerves)
• potential for testicular atrophy and impotence in men

You signature below confirms that I have explained treatment alternatives and the risks of opiate medications to you. You are satisfied with that explanation and desire no further information.

You must sign this document indicating your consent to the use of opiate medications in treating your pain prior to starting treatment.

Patient Name (printed):_____

Patient: _____ Date: _____

Explained by me and signed in my presence:

Doctor: _____ Date: _____

Home

Circumcision Following Home Birth

1. Circumcision must be done within seven days of birth, unless infant is born premature, then within 10 days.
2. Vitamin K must be administered 24 hours prior to the circumcision.
3. The Vitamin K must be prescription-strength injectable ordered through a pharmacy. CFM Pharmacy does not carry Vitamin K. It may be ordered through the Sanford Outpatient Pharmacy for the patient. The parents can pickup the medication, bring to the clinic (with the infant) and a nurse will administer the Vitamin K 24 hours prior to the circumcision.

Home

Patient Transportation

Purpose: To provide transportation for clinic patients being admitted to the hospital.

Physicians will use their clinical assessment and judgment to decide on the transportation option for their patient that will include proper medical care and safety for the patient. Transportation options can be discussed with the clinic counselor or preceptor.
Documentation of the transport will be provided in dictation following an informed consent process.

Transportation Options:

1. Releasing the patient to a trusted family member
2. Medical Personnel (Nurse or Physician) walking the patient to the hospital
3. Ambulance
4. Mental Illness and Addiction

    Patients who present with mental illness will be transported by dispatch. Call dispatch and let them know we have a Request for Transportation for Emergency Detention.

    Proper forms need to be filled out for mental illness transportation:

    a. Request for Transportation for Emergency Detention (SFN 17265 GN-6) for transportation of patient that is willing to be transported to the hospital.
        Must be signed by the Physician (preceptor?) or Clinic Counselor.

    b. Request for Transportation for Emergency Detention (SFN 17265 GN-6); Application for Emergency admission (SN 17264 GN-5); Notice of Purpose and Effects of Custody (SFN 17267 GN-8) for transportation of patient that is not willing to be transported to the hospital.

Home

NST Protocol

Non-Stress Test (NST)

Purpose: Evaluation of fetal well-being represented with accelerations with fetal movements.

RN/LPN may perform a NST upon order of a physician.

1. **Definition**: The Non-Stress Test involves observation of the fetal heart by the electronic fetal monitor including rate, accelerations and decelerations (spontaneous or associated with fetal movement).

2. **Indications for NST**:

   a. Postdates
   b. Hypertensive disorders
   c. IUGR
   d. Sickle Cell Disease
   e. Maternal cyanotic heart disease
   f. History of stillbirth
   g. Discordant twins
   h. Hyperthyroidism
   i. Renal disease
   j. Maternal anemia
   k. Maternal Diabetes Mellitus
   l. Blood group immunization
   m. Hyperthyroidism
   n. Advanced maternal age
   o. Renal disease
   p. Oligohydramnios/Polyhydramnios
   q. Blood group immunization
   r. Advanced maternal age
   s. Verbalization of decreased fetal movement
   t. Other

3. **Contraindications:**

   a. Gestational age < 24 weeks (relative)

4. **Procedure**:

   a. Place patient in a supine position tilted on left side or a semi-fowler's position.
   b. Obtain routine vitals and explain procedure to patient.
   c. Place external fetal monitors capable of FHT's and uterine activity measurement on abdomen.
   d. Obtain baseline FHR while assessing uterine activity.
   e. If no accelerations of FHR noted within 20 minutes, the testing is continued for an additional 20 minutes.
   f. Residents will perform and interpret NST's with Dr. Schafer-McLean, Dr. Quisno, or Dr. Sauter.

5. **Key Points**:

   a. Non-Stress Tests are quick and non-invasive.

   b. NST's are easy to perform and can be done in an outpatient setting.

   c. In the non-stress test, the heart rate of the fetus that is not acidotic or neurologically depressed is expected to temporarily accelerate with fetal movement. Heart rate reactivity is believed to be a

good indicator of normal fetal autonomic function. Loss of reactivity is commonly associated with a fetal sleep cycle but may result from any cause of central nervous system depression, including fetal acidosis.

d. Results of non-stress tests are classified as reactive or nonreactive. Various definitions of reactivity have been used. Most commonly, the non-stress test is considered reactive, or normal, if there are two or more fetal heart rate accelerations within a 20-40 minute period, with or without fetal movement discernible by the woman, according to ACOG. The nonreactive stress test lacks sufficient fetal heart rate accelerations over a 40-minute period.

6. **Interpretation:**

a. Reactive test: In fetuses >32 weeks, 2 or more fetal heart rate accelerations of at least 15 bpm lasting at least 15 seconds from baseline to baseline in a 20-40 min period; baseline rates is within normal range (110-160), and variability is normal (5-15 bpm). In fetuses <32 weeks gestation, 2 accelerations of 10 bpm above the baseline for at least 10 seconds in a 20-40 min period are considered to be a reactive NST.

b. Non-Reactive test: Absence of accelerations of fetal heart rate during the testing period which should last no longer than 40 minutes.

c. Inconclusive test: Less than 2 acceleration less than 15 bpm and lasting less than 15 seconds, variability less than 6 bpm

*If the NST is not reassuring for gestational age, a Biophysical Profile is recommended.

Home

LEEP Protocol

Loop Electrosurgical Excision Procedure (LEEP)

Purpose: To remove cervical dysplasia from the cervix.

1. **Overview**: The LEEP is a safe and effective outpatient procedure. The LEEP is utilized as a diagnostic and treatment approach for abnormal cell growth found on tissues of the cervix, typically found after a pap, colposcopy and/or biopsy.

2. **Eligibility Criteria for LEEP**:

    a. Abnormal pap or colposcopy, especially if lesion is high grade or persistent.
    b. Visible concerning lesion.

3. **Relative Contraindications/Considerations for Additional Treatment versus Rescheduling:**
    a. Pelvic infection
    b. Severe cervicitis
    c. Severe vaginal infection
    d. Anogenital ulcer
    e. Bleeding disorder
    f. Patient pregnancy, unless there are concerns for invasive cancer.
    g. The patient is less than 12 weeks postpartum.
    h. Uncontrolled hypertension and cardiovascular disease.

4. **Procedure**:

    a. Obtain procedure consent
    b. Routine vital signs
    c. Verify negative pregnancy test
    d. Arrange for transportation post-procedure
    e. RN will inform patient of expectations, including description of set up, sounds in the room and description of discomfort they may experience.
    f. Pre-medicate patient according to physician's orders.
    g. Place patient in supine position with feet in stirrups and apply grounding pad to outer thigh.
    h. Physician will insert speculum into vagina to visualize the cervix. Physician to apply local anesthesia per preference.
    i. Physician to apply Lugol's iodine to facilitate visualization of the lesion, if preferred.
    j. The loop is inserted into the vaginal canal, activated and passed across the surface of the cervix to excise the abnormal tissue. Tissue sample is sent to pathology for assessment.
    k. The physician will assess cervix for bleeding and may use the cautery, apply topical silver nitrate or Monsel's solution to control bleeding.

5. **Key Points**:

    a. Generally done in an outpatient setting, the patient is able to remain awake during procedure.

b. The procedure generally takes 10-30 minutes and patient is able to go home following the procedure.

c. Patient should be instructed of post-procedure care and expectations such as:

   i. Mild cramping for a few hours after procedure

   ii. Vaginal bleeding/spotting for about 2-4 weeks.

   iii. Vaginal discharge for about 2-4 weeks. Discharge may be dark in color if Monsel's is used for hemostasis.

   iv. Avoid sexual intercourse, tampons, and douching for about 2-4 weeks.

   v. Warning signs of infection or complications.

   vi. Follow up to assess healing and further plan of care.

6. **Risks:**

   a. Excessive bleeding

   b. Pelvic infection

   c. Tissue damage to vaginal walls

   d. Scarring of the cervix

   e. Shortening of cervix

   f. Incompetence of the cervix

Home

Endometrial Ablation Protocol (NovaSure)

Overview: The endometrial ablation is used to attempt to destroy the lining tissues of the uterus so it cannot regrow. The procedure involves dilatation of the cervix into the uterus to visualize the inside of the uterine cavity. The physician will use electric energy to burn away the uterine lining.

1. **Indications**: The NovaSure system is intended to ablate the endometrial lining of the uterus in pre-menopausal women with menorrhagia (excessive bleeding) due to benign causes for whom childbearing is complete.

2. **Contraindications:**

    a. A patient who is pregnant or who wants to become pregnant in the future.

    b. A patient with known or suspected endometrial carcinoma or pre-malignant conditions of the endometrium.

    c. A patient with any anatomic condition (e.g., history of previous classical cesarean section or transmural myomectomy) or pathologic condition (e.g., long-term medical therapy) that could lead to weakening of them myometrium.

    d. A patient with active genital or urinary tract infection at the time of the procedure.

    e. A patient with an IUD currently in place.

    f. A patient with a uterine cavity length less than 4cm.

    g. A patient with a uterine cavity width less than 2.5cm.

    h. A patient with active pelvic inflammatory disease.

3. **Pre-Procedure**:

    a. Obtain procedure consent

    b. Obtain routine vital signs

    c. Verify negative pregnancy test

    d. Arrange for transportation post-procedure

    e. RN will inform patient of expectations, including description of set up, sounds in the room and description of discomfort they may experience.

    f. Pre-medicate patient according to physician's orders.

    g. Place patient in supine position with feet in stirrups.

4. **Procedure:**

    a. Physician will perform bimanual examination evaluating for severe anteversion or retroversion.

    b. Physician will insert speculum into the vagina and grasp cervix with tenaculum.

    c. Physician will take a sound measurement of the uterus to measure the length from fundus to external cervical os.

    d. Determine the length of the cervical canal and dilate the canal for device insertion.

e. Obtain appropriate cavity length settings.

f. Open NovaSure package. Place device with the connecting cord onto sterile field.

g. Open the non-sterile suction line desiccant box and pouch. Remove the red caps.

h. Connect appropriate tubing and ports.

i. Deploy the disposable device outside of the patient and ensure the screen message does not display when the array is opened. If the screen message is still displayed, close and open the disposable device again. If this does not resolved the problem, replace the disposable device.

j. Be certain WIDTH dial reads greater than or equal to 4.0 cm.

k. Unlock the disposable device by pressing the lock release button. Make sure the array is completely enclosed by the external sheath.

l. Check WIDTH dial reads approximately 0.5 cm.

m. Obtain appropriate cavity length settings and select length using up/down arrows.

n. Confirm cervix is dilated to a minimum of 6mm.

o. Maintain a slight traction on the tenaculum to minimize the angle of the uterus.

p. Angle the disposable device in-line with the axis of the uterus as the disposable device is inserted transcervically into the uterine cavity. By holding the front handle, advance the disposable device until the distal end of the sheath touches the fundus.

q. Withdraw the disposable device approximately 0.5 cm from the fundus. Slowly squeeze the handles (DO NOT LOCK) up to the point of increased resistance. The WIDTH dial should read approximately 0.5 cm. At this point, the external sheath has been retracted.

r. Continue to slowly squeeze the disposable device handles together while gently moving the disposable device, approx. 0.5 cm to and from the fundus and rotating the handle of the disposable device 45 degrees clockwise from the vertical plane until the handles lock. The WIDTH dial should read greater than 2.5 cm.

s. Gently move the disposable device using anterior, posterior and lateral movements. To complete placement, slightly pull back the disposable device until the WIDTH dial reading reduces by approximately 0.2-0.5 cm.

t. Hold the tenaculum, advance the disposable device slowly and gently to the fundus. The WIDTH dial should read greater than or equal to the previous measurement.

u. Slide the cervical collar forward using gentle pressure on the tab on the cervical collar, until the cervical collar forms a seal against the external cervical os.

v. Read the cornu-to-cornu measurement on the WIDTH dial indicator.

w. Begin the cavity integrity assessment

x. Once a successful cavity integrity assessment has been completed, press the ENABLE button and depress the foot switch a second time to initiate the ablation cycle.

y. After automatic termination of the ablation cycle (approximately 90 seconds), fully retract the cervical collar to its proximal position by using the tab on the cervical collar.

z. At the completion of the ablation cycle, a "Procedure Complete" screen will appear with a summary of the procedure. The "Procedure Complete" screen will capture the following info for each procedure.

i. Cavity length

ii. Cavity width

iii. Power level

iv. RF Ablation time

aa. Press the lock release button to unlock the disposable device. Gently pull the rear handle backwards until the closed array indicator reads "ARRAY CLOSED".

bb. Withdraw the disposable device from the patient and discharge as indicated by physician after post-operative care has been completed.

5. Commonly Reported Post-Procedure Events:

a. Cramping/pelvic pain

b. Nausea/vomiting

c. Vaginal discharge

d. Vaginal bleeding/spotting

6. **Risks:**

a. Failure of the procedure

b. Complications from anesthesia

c. Infection

d. Damage to or perforation of internal organs such as the uterus, bowel, bladder and vagina

e. Bleeding or hemorrhage possibly requiring transfusion and/or hysterectomy

f. Deep venous thrombosis or pulmonary embolus

g. Postoperative complications and/or death

Please refer to instruction manual for additional troubleshooting tips and detailed list of operating instructions.

7. Discharge Instructions:

a. The patient can experience menstrual-type cramping after the procedure.

b. The patient will have vaginal discharge, starting pink or bloody and may become watery, yellow or brown for approximately 2 weeks.

c. The patient is to refrain from any douching, tampons or intercourse for 2 weeks afterwards.

d. Physical activities are permitted as long as it does not increase in pain or vaginal bleeding.

e. Medications

Home

Transitional Care Management Guidelines:

TCM Requirements:

1. Discharge summary review: SOC (CHI St. Alexius) and COC (Sanford)
    a. Nursing Coordinator Reviews
    b. Document on TCM template in EMR.

2. ER visits from each hospital: Review monthly reports of ER visits to follow-up and medication review. Review monthly reports from hospital to look for 2 or more visits and possibly implement CCM for those patients with frequent visits to the emergency room.

3. Interactive communication with patient, caregiver (or two separate, unsuccessful attempts at communication during same time period) completed by Nursing Coordinator.
    a. Caregiver may include: family or responsible person
    b. Discuss follow up appointment at UND CFM.

4. Required face to face visit must occur no later than 14 days of discharge
    a. Moderate complexity – 99495 within 14 days
    b. High complexity – 99496 within 7 days
    c. Unless determined not medically needed.

5. Access community resources: Community Nursing Home, Hospice, etc.

6. Medication reconciliation performed at face-to-face visit by the nurse at follow-up visit.

7. Non-face-to-face care management services
    a. Performed by Chronic Care Coordinators
    b. Phone calls or home visits made to patient for remainder of 30-day cycle by Chronic Care Coordinators

8. TCM and CCM care cannot overlap for charged services.

9. Documentation by provider at visit.
    a. Date of Discharge
    b. Date you contacted within 48 hours
    c. Date of face to face
    d. Complexity of the medical decision making

Home

Annual Wellness Visit

The Annual Wellness Visit is a preventive screening, covered by Medicare part B, designed to develop, or update a personalized plan to prevent disease and/or disability based on the patient's current health or risk factors.

Included is a complete health history review, medication reconciliation, vital signs, screenings for depression, risk of falling, cognition, or other potential problems. What matters most to the patient is also discussed. Recommendations for additional wellness services and healthy lifestyle changes are discussed. Along with Advanced care planning and advanced directives.

Medicare will pay for a one time "Welcome to Medicare" Wellness Visit anytime during the first 12 months a patient is enrolled in Medicare Part B. Medicare will pay for an Annual Wellness Visit once every 12 months after the patient has been enrolled in Medicare Part B from more than 12 months, AND it has been more than 12 months since the initial "Welcome to Medicare" or prior to Annual Wellness Visit.

Chronic Care Management (CCM) Guidelines:

CCM Requirements:

1. Patients with 2+ chronic conditions expecting to last for the next 12 months or until death of the patient
2. Patient consent of CCM services with written or verbal consent obtained
3. 20 minutes of documented non-face-to-face encounter(s)/month (any certified healthcare professional under general supervision of the provider)
4. Access to 24/7 care management services
5. Timely contact with a healthcare provider for urgent chronic care needs
6. Access to a primary care provider team for successive appointments
7. Comprehensive plan of care (physical, mental, cognitive, psychosocial, functional, environmental) to include problem list; expected outcomes and prognosis; measurable treatment goal; symptom management; planned interventions; medication management; coordination of specialists; and community/social services ordered
8. Provide patient with a written or electronic copy of the plan of care
9. Management of care transitions (ER, post-hospitalization stays)
10. Coordination of home and community based services to support psychosocial and functional deficits
11. Opportunity for patient/family to communicate with provider

Chronic Care Protocol
Provider to refer patient to Chronic Care for Chronic Care Management (CCM) services.

i. Provider must inform patient of the availability of and obtain written or verbal consent for the CCM services before furnishing or billing the service. For new patients or patients that have not been seen within one year the provider must initiate this process during an Annual Wellness Visit (AWV), Initial Preventative Physical Exam (IPPE), or comprehensive E/M visit.

ii. The provider is to develop a comprehensive plan of care (physical, mental, cognitive, psychosocial, functional, and environmental) to include problem list; expected outcomes and prognosis; measurable treatment goal; symptom management; planned interventions; medication management; coordination of specialists; and community/social services ordered.

The final signed care plan is reviewed by the appropriate provider and signed off in the Electronic Medical Record (EMR) with follow-up as appropriately identified. A copy will be given to the patient. The care plan must be updated as least yearly.

Prior to the Visit – pre-visit planning - identify any barriers that can be addressed, such as transportation, medication adherence, etc.

- Review discharge summary
- Clarify outstanding questions, standing orders, etc.

- Reminder call, if needed, to patient or family caregiver to stress the importance of the visit and address any barriers; bring medications, medication list and all prescribed OTC preparations
- Provide instructions for seeking emergency and non-emergency after-hours care (SMC Hospital Care Coordinator)

During the Visit – Use "teach-back" method asking the patients to explain in their own words what they have been told to ensure patients understand instructions for taking their medications, managing their medical condition, and watching for "red flags" or warning signs that could signal a worsening of their medical condition.

- Ask the patient to explain his/her goals for the visit
- What medications he/she is taking and on what schedule
- Perform medication reconciliation
- Determine the need for medication adjustments
- Follow-up on test results
- Discuss and document advanced directives
- Discuss future plans (Community Care Coordination, CCM with written consent)
- Instruct patient on self-management tools to assist patient/family with knowing when to call as health status changes and promotion of self-management tools for chronic disease
- Provide instructions for seeking emergency and non-emergency after-hours care

Provider obtains consent for Chronic Care Management services and documents consent. *Team preceptor signs the consent*.

a. Invite patients to participate using an invitation brochure or letter
b. Explain how it works and that they can decline, transfer, or terminate at any time
c. Provide information on how to terminate or transfer
d. Documentation of patient/family acceptance or declination of CCM services including process for revoking services and patient/family received copy of consent and written plan of care
e. Authorization of electronic communication of medical information with other clinicians (as allowed by state and local rules and regulations)
f. Provides designated physician's name as well as the CCM nurse
g. Explains the scheduled nurse assessment visit, which should be treated like a regular visit even though it will occur by phone
h. Utilize Preventative Wellness for documentation of quality measures and facilitate claims workflow processes that align with provider practices.
i. Consent obtained regarding copay/payment notification

At the Conclusion of the Visit

- Print reconciled, dated, medication list and provide a copy to the patient or caregiver
- Communicate plan to the patient or caregiver and provide patient care summary
- Ensure follow-up plan is documented

During monthly nursing communication

Document number of minutes. Assess and document the following recommended patient needs:

- Immediate needs
- Medication review
- Home environment needs
- Follow-up plan of care including therapy or referral appointments made/attended, etc.
- 30 day plan of care

Claims processing no earlier than the 30th calendar day of the cycle for each patient.

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Referral Tracking

Nursing will review the In-Basket Orders list daily to claim their provider's referrals. Both one-chart and non-one chart will be reviewed and appointments will be made as necessary for the patient. Non-One chart referrals will need to be faxed and One-chart referrals will send electronically.

Staff will review reports for non-one chart referrals to outside physicians/facilities and diagnostic testing ordered by UND CFM providers. Consult and result reports will be attached to referral in EPIC, provider will be notified by in basket message and they will follow-up with patient.

FYI Chart Alerts

Purpose: Alerts will be used on a limited basis within EPIC to provided needed information to provide care to the patient.
Policy: The following alerts can be added to a chart as an FYI by the nursing supervisor or a provider. These alerts will be seen throughout the EPIC chart for that patient and across all Sanford facilities.

General-add a description of the needed alert and be sure to include "at UND CFM"
Special Patient Care Info- add a description of the needed alert and be sure to include "at UND CFM"

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NURSE ONLY VISIT

Patients may schedule to see only a nurse for the following types of visits: blood pressure checks, immunizations, injections (per doctor order), dressing changes (per doctor order), weight checks, clipping toenails.

Nurses will follow the Nurse Only Visit Flow Chart for these visits and all visits must be documented in the EMR and routed to the provider.

See Flowsheet

XOLAIR INJECTION POLICY PROCEDURE

Purpose: Patient's receiving Xolair injections are at a high risk of having an anaphylactic reaction; therefore, must be closely monitored during and after the injections as outlined below.

Equipment needed:

1. Xolair injection – either patient brings it or it is shipped directly to the clinic for the patient.
2. Oxygen saturation monitor
3. Cardiac monitor
4. Blood pressure monitor - May use the monitor from Procedure Room 1 with O2 sat, heart and BP monitors all in one.
5. Anaphylaxis kit
6. Crash cart - near the patient exam room

Procedure:

Injections are administered every two to four weeks as ordered. May be monitored by and RN or LPN. An ACLS certified nurse or physician must be in the clinic during the observation period.
The patient is responsible to bring their own Epi-Pen, or equivalent, to the appointment (for availability after discharge) and must be instructed to carry it with them at all times.

1. Directly observe the patient for **two hours** with the initial and second injections, monitoring oxygen saturation, heart rhythm and vital signs every 15 minutes x 4, then every 30 minutes x 2. Patient may be discharged after the observation period if stable.
2. Direct observation of the patient for **one hour** with the third and fourth injections, monitoring oxygen saturation, heart rhythm and vital signs every 15 minutes x 4. Patient may be discharged after the observation period if stable.
3. Directly observe the patient for **one-half hour** with the fifth and subsequent injections, monitoring oxygen saturation, heart rhythm and vital signs every 15 minutes x 2. Patient may be discharged after the observation period if stable.

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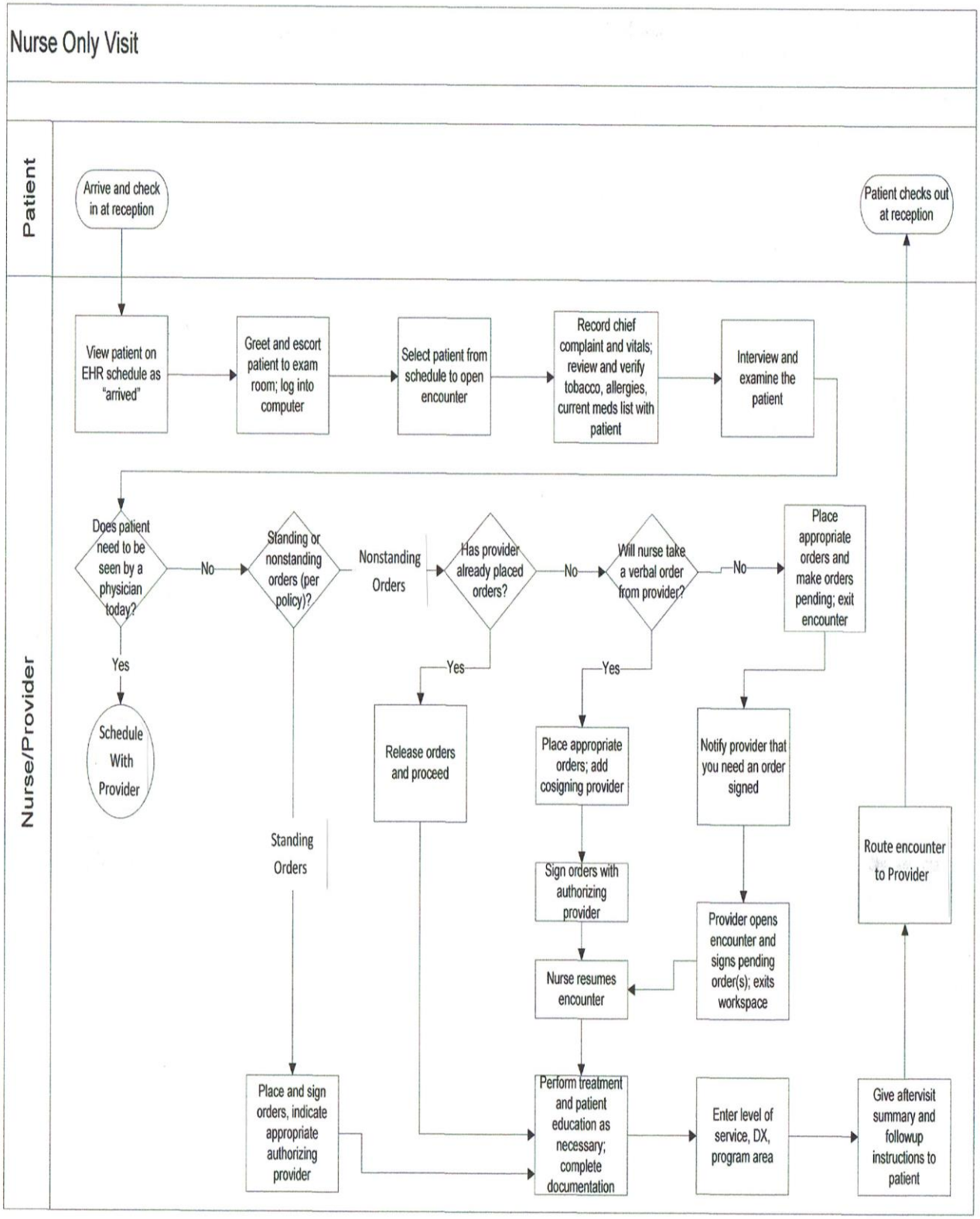


Adapted from "Nurse Only Visit" available at: http://www.hrsa.gov/publichealth/business/healthit/toolbox/HealthITAdoptiontoolbox/index.html

DEPRESSION SCREENING

Purpose
The recommendation is that providers routinely screen all individuals for depression.

Policy
PHQ-2 Depression screening will be provided to the following patients.

*annually for ages 12 years-adult;

Edinburg depression screening will be provided in lieu of PHQ-2 to the following patients.

*every OB visit;
*Post-Partum 6 weeks;
*Mother at each Well child visit for the first year

Nursing will provide screening during intake and document screen in VITALS template.

Patients that score >2 on the PHQ-2 will be evaluated using the PHQ-9 tool. The PHQ-9 score will be entered into the VITALS intake template.

Patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia (ICD-10 codes range F32-F34 will be rescreened within a year, + - 1 month from last screening.

PHQ-9 form will be scanned into the patient's chart.

ALCOHOL AND SUBSTANCE ABUSE SCREENING

Purpose:
An easy-to-use patient questionnaire to screen for problem drinking and/or substance abuse and potential alcohol and/or substance abuse problems.

Policy:

CAGE-AID
The CAGE screening tool will be provided to all initial family practice patient visits, ages 18 and older that present to the clinic for any visit reason.
Nursing will give screening to the patient and document completion in the PWV template.
This is best used in a clinical setting as part of a general clinical history taking and may be phrased informally.
The CAGE questions should **not** be preceded by any questions about alcohol intake - ie its sensitivity is dramatically enhanced by an open-ended introduction.
A total score of 2 or greater is considered clinically significant (sensitivity of 93% and a specificity of 76% for the identification of problem drinking).
Positive patient scores will be addressed by the provider by completing an SBIRT follow-up with the patient.

CRAFFT
The CRAFFT screening tool will be provided to all patient visits, ages 12 – 17 that present to the clinic for well child and sport physical exams.
Providers will give the screening to the patient and document completion in the appropriate exam template.
Two or more YES answers suggest a serious problem and need for further assessment.

Positive patient scores will be addressed by the provider by completing an SBIRT follow-up with the patient.

Colorectal Cancer Screening and Documentation

Introduction:
Colorectal cancer often begins as polyps, which are small growths inside the lining of the colon. While most polyps are harmless, some may turn into cancer. Colorectal cancer is the third most common cancer found in men and women in the United States. The lifetime risk for developing colorectal cancer is roughly 1 in 20.

CRC screening can detect evidence of colon polyps or blood which may be a sign of cancer. If a screening test is positive, a colonoscopy is needed to further investigate. In CRC, 9 out of 10 deaths can be prevented through regular screening.

Research shows that a recommendation from a health care provider is the most powerful single factor in a patient's decision about whether to obtain cancer screening, specifically colorectal cancer, breast cancer, and cervical cancer. In fact, lack of a doctor's recommendation is actually experienced as a barrier to screening. Therefore, this policy is being implemented to assure that every patient between the ages of 45 and 75 is offered CRC screening.

Purpose: To improve CRC screening and surveillance at the UND Center for Family Medicine Bismarck clinic.

Procedure:
1) UND Center for Family Medicine Bismarck will utilize the USPSTF Colorectal Cancer (CRC) Screening Guidelines to screen all eligible patients.

2) Nursing staff may use the criteria below for risk stratification of patients:
- A. Average risk patients – Patients aged 45-75 with:
  1. no symptoms. (No change in bowel habits, no visual blood in stool, no dark or tarry stool)
  2. No family history of colorectal cancer or adenomatous polyps
- B. High risk patients – Patients aged 45-75 with:
  1. family history of colorectal cancer or adenomatous polyps diagnosed at age Patients 55 or younger
  2. Personal history of colon polyp, CRC or Inflammatory Bowel Disease

3) Average risk patients – Nursing staff may use standing orders (see below) to order a fecal immunochemical test (FIT) annually or Cologuard every 3 years to screen for colorectal cancer

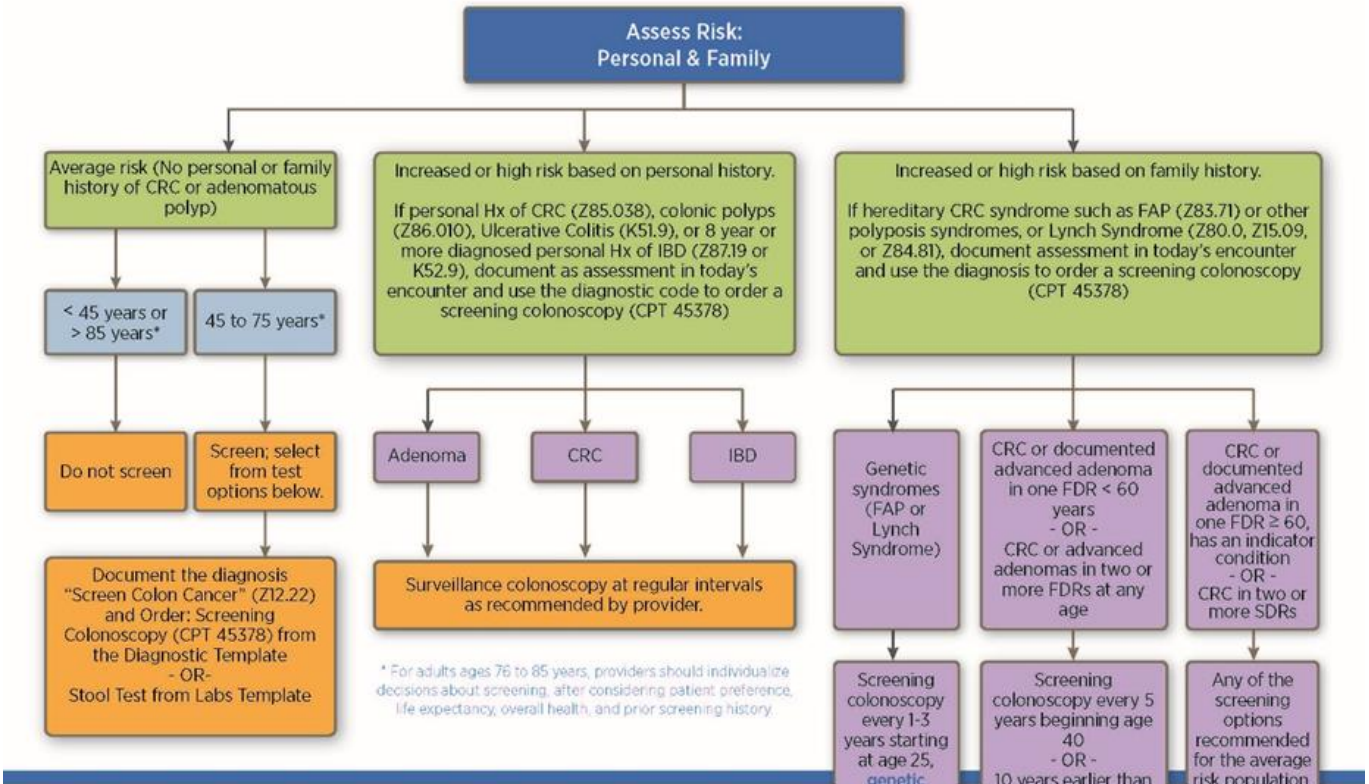
4) High risk patients – Nursing staff will refer to the provider to provide additional assessment and referral for colonoscopy.

5) If patients refuse testing, nursing staff will provide education, and will document refusal in the EMR

The figure below outlines this procedure in a flow sheet:

Sample Colorectal Cancer Screening Algorithm

Per the June 2021 USPSTF and May 2018 American Cancer Society Guidelines



SCREENING OPTIONS

Stool-Based Tests

- Yearly fecal immunochemical test (FIT)*, or
- Multi-target stool DNA (FIT-DNA) every three years, or
- Yearly high-sensitivity guaiac test (HS-gFOBT)*

Direct Visualization Tests

- Colonoscopy every 10 years, or
- CT colonography (virtual colonoscopy) every 5 years, or
- Flexible sigmoidoscopy every 5 years

* Stool samples obtained by digital rectal exam (DRE) have low sensitivity for cancer (missing 19 of 21 cancers in one study) and should *never be used for CRC screening*.

All patients who undergo a test other than colonoscopy as a first-line screening exam and receive a positive test result must follow up with a colonoscopy to complete the screening process.

For Medicare patients, use G codes:

G0105	Colonoscopy (high risk)
G0121	Colonoscopy (not high risk)
G0328	Fecal Occult Blood Test (FOBT), immunoassay, 1-3 simultaneous
G0464	Colorectal cancer screening: stool-based DNA and fecal occult hemoglobin (e.g., KRAS, NDRG4 and BMP3)

DEFINITIONS

- **IBD:** inflammatory bowel disease
- **CRC:** colorectal cancer
- **FDR:** first-degree relative
- **SDR:** second-degree relative
- **CTC:** computed tomographic colonography
- **FAP:** familial adenomatous polyposis
- **FIT:** fecal immunochemical test
- **Hx:** history

- **Screening colonoscopy** is performed on asymptomatic patients due for colorectal cancer screening because of age or familial risk indicators such as a family history of CRC or adenomatous polyps.
- **Surveillance colonoscopy** is performed when a patient has an indicator condition or has had a personal malignancy or premalignancy that needs follow up and requires colonoscopy at more frequent intervals. Examples are Personal history of CRC (Z85.038) or Personal History of Colonic Adenomatous Polyps (Z86.010).
- **Diagnostic colonoscopy** is performed when a patient has indicator condition requiring diagnostic workup that includes consideration of colon cancer as a potential diagnosis (i.e. persons with a history of rectal bleeding, anemia, or unexplained weight loss).
- An "**advanced adenoma**" is a lesion ≥1 cm in size or having high-grade dysplasia or villous elements.

Current as of July 2018

Standing Orders for Ordering FIT tests or Cologuard tests for CRC Screening

- For patients at average risk for CRC, nursing staff may:

1) Screen for contraindications to CRC stool-based screening tests
   A. Active hemorrhoid bleeding, wait until bleeding has stopped to perform test
   B. Menstrual bleeding, wait until bleeding has stopped to perform test
   C. Short life expectancy or too frail to do colonoscopy, check with provider before screening
   D. Symptoms suggesting colorectal cancer, refer to provider

2) If **FIT hemoccult test** is chosen method of CRC screening,
   A. Provide patient with test kit and written instructions in patient's preferred language
   B. Review instructions on how to complete test with patient
   C. Explain procedure to return completed test kit to clinic in postage stamped envelope provided for this purpose.
   D. Close the loop: have patient tell back the information, correct misinformation
   E. Document that kit was given to patient, and place order in the EMR.

3) If **Cologuard test** is chosen method of CRC screening,
   A. Document that Cologuard chosen for CRC screening, and place order in the EMR

- Result tracking and patient notification:

Once the test result is reported, the provider or nurse will do the following –

1) **Negative** – notify the patient stating the test was negative and recommend when to screen is to be repeated.
2) **Positive** – notify the patient with results and schedule follow-up appointment to discuss colonoscopy.
3) **Pending –** tracking for tests that are ordered and remain incomplete will be done monthly by staff. Patients will be reminded with a message or phone call.

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ANCILLARY

Laboratory Menu

Radiology Menu

Orders

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Referral Radiology Tests

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LAB MENU:

Hematology: CBC with or without, automated differential, Sed rate (ESR). Manual Differential, Hgb, Hct, Plt, WBC

Immunology: Monospot, RA

Urinalysis: Routine urinalysis, Urine pregnancy test.

Bacteriology: Rapid strep screen, Throat cultures For Group A Strep, Rapid Influenza

Coagulation: Protime and PTT.

Chemistry: Chem 14 profile, Basic Metabolic Panel, Liver profile, Lipid profile, Troponin, Glycosolated Hgb, Microalbumin, Uric Acid, Amylase, TSH, CRP

Miscellaneous: Wet mounts, KOH, Serum pregnancy test.

Reference Labs: Sanford Medical Center Lab & ND PHL

X-RAY MENU:
General Diagnostic X-rays
EKG's
Holter Monitors
Audiogram Screening
Spirometery

To **ORDER** lab and x-rays for your Patient:

Communicate all lab/X-ray orders with your nurse. Follow clinic flow for sending patients to lab and xray.

Lab: Electronic orders are generated from EHR. The Laboratory manages the orders from the lab schedule

X-ray: Electronic orders are generated from EHR. Radiology manages the orders.

Procedure:

1. Enter electronic orders in to the EMR.
2. Communicate with the patient to check in at the front desk for lab and/or xray. Lab/Xray will call the patient from the front waiting room.
3. After completion of the lab procedures the patient is instructed to wait in the waiting room for their radiology tests or for an available exam room.
4. If the patient is not waiting the lab/xray will discharge the patient.

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Results

Lab:

1. Completed labs will be interfaced to the EHR, changing the status to Results Received. The physician will receive a task to read the results for the patient.

2. Lab Personnel will not give out test results to patients unless instructed by the physician, or special circumstances.

3. Abnormal labs are reported to the nurse/Physician in the EHR denoted by the color red. Critical values are called to the nurse or physician ASAP. The nurse will notify the patient's physician.

4. Verbal results from reference labs will be given to the nurse or physician. These results are given verbally to the nurse. The technologist will verify the result with the written report when received.

Xray:

1. X-ray orders will be place via the EHR system by the physician, nurse, or technician. Patients currently seeing a physician, and needing x-ray now will be added to the x-ray schedule from the order, by **x-ray**. The front will change the status to "arrived", when the patient reports to the front. All other x-rays are scheduled by the front desk and put on the x-ray schedule, they are arrived upon check-in at the front.

2. The images can be viewed through the patients chart.

3. Images are officially read by a Sanford radiologist. Results are back within 24hrs. For verbal STAT reading a radiologist can be reached by calling 701-323-5210. e. **Results will be available in the patient's EHR, under the RAD tab once the radiologist has ended his reading. A task will be sent to the ordering provider to read the results.**

4. **Outside paper orders can be put in by the technician with the ORDER MODE of "per previous order, no cosgin required. The paper order will then go to HI for scanning into EHR. Results will need to be faxed to the ordering provider if there is no access to EHR.**

5. **PFTs and hearing screenings are to check in at the front desk. They will be added to the lab schedule and arrived. When completed the visit will be marked "visit complete". A hard copy is printed and must be ~~are~~ signed by the provider. HI will attach it to the electronic order.**

6. **EKG'S are performed by radiology and lab personnel. The patient will check in at the front and will be put on the lab schedule and arrived. The provider must indicate if the patient is to wait or not wait for results. When completed, a hard copy will be placed in the preceptor office. Use secure chat to notify the provider and preceptor that the EKG is done and ready to be reviewed. The ordering Resident must review this with the preceptor and have it signed. This signed hard copy is given to HI to attach to the EHR order.**

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MEDICAL RECORDS

Communication of Reports

Guidelines: Scanned Items

Release of Medical Information (form)

Release of Medical Information

Faxing

Dictation

Medical Charts-DO NOT REMOVE FROM CLINIC

Death Certificates

Duties of a Scribe

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Communication

Mail services to the hospitals

We pick up and drop off mail at St Alexius hospital. Sanford mail is picked up and dropped off daily at the Front Desk.

Interdepartmental mail to the clinics and hospitals
We have a wire basket, located on the counter in the mail center, to place mail which needs to go back to the hospitals and clinics. Place those items in that basket.

Mail which goes to the Post Office needs to be placed in the basket in the mail center. You do not need to worry about postage; we will take care of that for you, except if it is your personal mail. You will need to put postage on that.

Brown interdepartmental envelopes can be found in the drawer by the Interdepartmental Mail basket. Please check both sides of the envelope and cross off last place listed

Mailing envelopes are located in the supply cabinet in Medical Records.

If we have reports on a patient who does not have an established chart, those reports go to the CHIEF Resident and he/she is to present those reports at the weekly resident meeting.

Faxed Reports

All diagnostic reports will be scanned into the EMR and attached to the correlating order, which will send result to providers inbox. They need to be reviewed and mark as accepted. At that point you can dictate a letter to the patient or call the patient with results.

All faxes coming from Burleigh County Detention Center, will be given to the doctor who saw the patient and if they have never been here before, it goes to the Chief.

If we receive reports on a patient who does not have a chart at our clinic, we have a black file box in medical records, in which we file and hold all reports for 6 months. At the end of 6 months, we check to see if the patient has established a chart at our clinic and if they have we scan the report. If the patient has not been established, those papers are thrown into shredding to be destroyed.

Scanned Documents That Are Attached To The Office Visit Note

- Consents
- DOT Exam Forms
- Orders (if they are for that visit date)
- Title XIX/West Central Papers, authorizations, referrals
- Social Security Disability
- Paperwork
- Hit, Pride, Enable, Transitional Center, etc. referral forms, doctor's visit notes
- Workers Comp Forms (if they are for that visit date)

*All Scanned documents will populate to the media tab in the EMR if attached or not attached to an office visit note.

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MEDICAL RECORD AMENDMENT REQUEST FORM

Patient Name: _____ Date of Birth: _____
Patient Address:
_____
_____
Date(s) of Entry(ies) to be Amended: _____

Reason the information is incorrect or incomplete. What should the information say? A detailed explanation may be attached.
_____
_____
_____

Do you need this amendment sent to anyone to whom we may have disclosed information in the past? If so, please indicate the name(s) and address(es) of the individual(s) or organization(s)
_____
_____
_____

Signature of Patient or Legal Representative: _____
Relationship: _____ Date: _____

Privacy Officer Action/Comments:

Action must be taken within 60 days of the receipt of the request

____ Request approved

____ Request denied for the following reason:

____The information is accurate and complete

____ The information is not part of the patient's health record

____ The information is not available to the patient for inspection as required by law

____ The information was not created by UND Center for Family Medicine

____ Practice requests a 30-day extension to respond due to:_____

Signature of Privacy Officer _____ Date_____

Patient's Right to Amend a MEDICAL RECORD:

The HIPAA privacy rule is federal law and is outlined in the Code of Federal Regulations (CFR §164).

The HIPAA privacy rule, in general, provides the patient with the right to inspect, review and receive a copy of their medical and billing records. The patient must follow your office policy to obtain a copy of their medical records and may be charged a reasonable fee to obtain their medical records.

If the patient thinks the information contained in the medical record is incorrect, HIPAA states they may request that the health care provider amend the information in the medical record. The provider **must** respond to the patient's request and **must** amend the record **if it is incorrect**. If the provider does not agree with the patient's request to amend the record, the **patient** has a right to submit a statement of disagreement and the provider **must** add the disagreement to the medical record. (This means the written statement of disagreement must be filed in the medical record. It does not mean the provider has to agree with it).

Reviewing Patient Requests to Amend Records:

Individuals have the right to request amendment to PHI in the designated record set for as long as the records are maintained in the designated record set.

Writing Requirement: Requests for amendment must be in writing and the individual must provide a reason to support the requested amendment.

Time period for action: The UND Family Practice Centers must act on an individual's request to amend information within 60 days from receipt of the request. The time for action on a request may be extended for an additional 30 days if the UND Family Practice Centers is unable to take action within the original time period for action. To extend the time period for action, provide a written statement of the reasons for the delay to the individual within 60 days from receipt of request. One extension of the time period for action is allowed per request.

Accepting Amendments:

If the UND Family Practice Centers grants the request for amendment in whole or part:

1. Inform the individual in writing that the amendment is accepted.
2. Make the amendment to the Pl-ll or record by identifying the records in the designated record set that are affected and appending or otherwise providing a link to the location of the amendment.
3. Obtain the individual's identification of persons who have received PHI about the individual and needing the amendment.
4. Obtain the individual's agreement to have the UND Family Practice Center notify the persons they have identified for the purpose of informing the persons of the amendment.
5. Make reasonable efforts to inform and provide the amendment within a reasonable time to the following:

    i. persons identified by the individual;

    ii. persons, including business associates, that the health care component knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, upon the information to the detriment of the individual.

6. Follow the process for denying amendments as to any portion of the amendment that is not accepted.

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Denying Requests for Amendment:

Requests for amendment may be denied if:

- the information is accurate and complete;
- the PHI or record was not created by the Provider Component, unless the individual provides a reasonable basis to believe that the originator of PHI is no longer available to act on the request; or
- the PHI would not be available to the individual under the following unreviewable grounds for denial of access:

- the PHI is expressly excluded from the right to inspect and copy:
- the information is not maintained in the designated record set; §research that includes treatment and the research is still in progress, provided the individual agreed to the denial of access when consenting to participate in the research;

- it would be lawful to deny access to the records under the Federal Privacy Act, 5 U.S.C. § 552a; or
- the information was obtained from someone other than a health care provider under a promise of confidentiality, and allowing access is likely to reveal the source of the information.

- The PHI would not be available to the individual under the following reviewable grounds for denying access:

- the PHI refers to another person who is not a health care provider and access is reasonably likely to cause substantial harm to that person; or
- the access is reasonably likely to endanger the life or physical safety of the individual or another person; or
- the request for access is made by the individual's personal representative and giving access to the personal representative is reasonably likely to cause substantial harm to the individual or another person.

All denials must be in writing and must include:

1. the basis for denial;
2. statement of the individual's right to submit a written statement disagreeing with the denial and where to file the statement of disagreement;
3. statement that the individual may request that the Provider Component provide the request for amendment and denial with any future disclosures of the PHI that is the subject of the denied amendment; and
4. a description of how the individual may complain to the Provider Component, University or the Secretary, including the name/title, and telephone number of the Privacy Official.

Disputed Amendments: If the amendment is denied, permit the individual to submit a written statement of reasonable length disagreeing with the denial and the basis for disagreement. If the individual prepares a written statement of disagreement, the health care component may prepare a rebuttal statement in response. If a rebuttal statement is prepared, provide a copy to the individual who submitted the statement of disagreement.

Identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link the individual's request for amendment, the denial of the request, the individual's statement of disagreement and the rebuttal to the designated record set.

Future disclosures of PHI related to a request for amendment:

If the amendment is accepted, provide the amendment information with any subsequent disclosures. If the request is denied, and the individual does not submit a written statement of disagreement, provide the request for amendment and denial with future disclosures, if the individuals so requests.

Home

If the individual submits a written statement, provide the appended material related to the disputed amendment or an accurate summary of the appended information with any subsequent disclosure of the information to which the request for amendment relates.

When subsequent disclosures are part of a standard transaction that does not allow provision of the required information as part of the transaction, send the amendment information separately to the recipient of the standard transaction.

If the Provider Component is informed by another covered entity of an amendment to an individual's PHI agreed to by the other covered entity, amend the pm in the designated record set maintained by the University Provider Component.

What does this mean for you and what should you do?

- File the patient's request in the medical record
- Send a written response to the patient (*see below for sample language)
- Schedule an appointment for the physician to examine the patient and determine whether the patient has the particular medical conditions
    - The physician should document the purpose of the appointment (for example, *Patient is being evaluated today according to her request to amend her medical record to include the following conditions…* and list the conditions).
    - The physician should document his/her assessment as usual
    - The physician should document whether he/she agrees or disagrees with the patient's request to amend the medical record
        - If not, the physician's documentation of the assessment should clearly reflect why the physician disagrees
        - If so, the physician should ensure his/her documentation supports their conclusion

The patient may request a copy of the office visit. A copy of the office visit may be provided according to office policy (e.g., the patient signs the authorization for release of medical information).

The point of a medical examination is for the physician to decide whether the medical record should be amended to include this information. If the physician agrees the patient has the medical condition (that the patient requested to add to the medical record) without a medical examination then the record may be amended without a medical examination.

If the physician is unable to determine whether the patient has the medical condition without a medical examination then the patient must be evaluated by the physician. The physician may determine at that time whether the medical record should be amended. If the physician is unable to determine whether the patient has the medical condition without a medical examination and:

1) The patient lives out of state and cannot come in for an examination - send a written response to the patient acknowledging receipt of their request and state that the medical record cannot be amended without a medical examination. Invite the patient to contact the office to make an appointment. Inform the patient that their request to amend the record will be filed in their medical record. Provide the name and phone number of someone in the office to contact if they have questions. Keep a copy of any correspondence in the patient's medical record.
2) The patient refuses to make an appointment. send a letter to the patient with similar sample language as above (in the first bullet) .

Home

SANCTION POLICY

All employees must comply with all security and privacy policies and procedures or disciplinary action will be taken. It is every employee's responsibility to report a suspected breach.

Examples of some possible breaches are listed below; however, these are just some examples and not a complete list:

- Employee faxes the wrong PHI to another practice
- Employee emails PHI
- Employee views patient records out of curiosity, not necessity
- Employee shares PHI because the information is interesting or gossip-worthy, but not for treatment
- Employee shares computer passwords
- Employee discusses confidential patient information in an unsecure area
- Employee uses PHI for personal gain
- Employee uses PHI to cause harm, such as exposing information to unauthorized individuals out of spite or dislike of the owner of the PHI
- Employee gives access to PHI to an unauthorized individual

Failure to comply with all security and privacy policies and procedures could result in a verbal and/or written warning, re-education, suspension, or termination. Employees could also face civil or criminal penalties. Each breach will be handled on a case-by-case basis.

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HIPAA BREACH

Determine if there was a breach and/or if notification is necessary.

1. Is the data "PHI"?

   If the data is not PHI, stop here. No further action is needed.

2. Is the data "unsecured PHI"?

   If review determines PHI is secured, stop here. Document your review that came to this conclusion. Document any actions to reduce the likelihood of another breach from reoccurring.

   If not, proceed to next step.

3. Determine and document whether the incident falls under one of the exceptions of the breach definition:
   a. Unintentional access to PHI in good faith in the course of performing one's job and such access does not result in further impermissible use or disclosure. (EX: went into the wrong John Smith's account)
   b. Inadvertent disclosure of PHI by a person authorized to access PHI at a covered entity to another person authorized to access PHI at the same covered entity. (EX: PHI on employee's desk and another employee sees)
   c. When PHI is improperly disclosed but the covered entity believes in good faith that the recipient of the unauthorized information would not be able to retain the information.
   If the disclosure falls into one of these exceptions, notification is not necessary. You can stop at this point.

   If the disclosure does not fall into one of these exceptions, proceed to next step.

4. Complete a risk assessment to determine probability of a compromise to the PHI and whether breach notification is required, the HIPAA Breach Notification Rule requires consideration of **at least four factors**:
   a. Nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
      I. Identifying financial and demographic data: SS#, credit card info, financial data
      II. Clinical data: Diagnosis, treatment, medications
      III. Behavioral health, substance abuse, sexually transmitted diseases
   b. The unauthorized person who used the PHI or to whom the PHI was disclosed
      I. Does the person have obligations to protect privacy and security?
      II. Does the person have the ability to re-identify the PHI?
   c. Whether the PHI was actually viewed or accessed.
      I. Rarely an answer here. Hard to prove.
   d. The extent to which the risk to the PHI has been mitigated.
      I. Can the person who received the PHI provide satisfactory assurances that the PHI will not be further used or disclosed or that it will be destroyed?

i. PHI faxed to wrong doctor's office. They state they will destroy the PHI-no breach.
ii. Lost flash drive with PHI-would be a breach.

II. What level of effort has been expended to prevent future related issues and/or to lessen the harm of the actual breach?

5. Can it be concluded that there is a low probability that the information has been compromised?

If so, notification is not necessary. Complete documentation and retain for future reference or investigations (documentation must be saved for 6 years).
For a medium or high finding that data has been compromised, complete the appropriate notification steps for each individual affected.

Individuals must be notified within 60 days or without unreasonable delay. If patients are notified HHS must be notified. If over 500 individuals affected HHS notified immediately.

Breach Notification

Notify a patient of a breach:

1. Within a timely manner, which is outlined in HIPAA to be "within unreasonable delay and in no case later than within 60 calendar days of when you first discovered the breach."
2. A written notice of the breach by first class mail is required. The notification to the affected patients will include:
    a. A brief description of what happened
    b. The date of the breach and the date the breach was discovered
    c. A description of the type of PHI involved in the breach
    d. Steps the patient should take to protect themselves from potential harm as a result of the breach
    e. An apology from the practice
    f. A brief description of what the practice is doing to investigate, mitigate, and protect against further breaches
    g. Contact procedures for more information, which must include a toll-free number, email address, and website or postal address
3. If there is insufficient or out-of-date contact information, substitute notice may be provided (alternative form of written notice, telephone, or other methods of contact).
4. If there are 10 or more patients with insufficient contact information, a post, including a toll-free number, on clinic's website may be used and must be active for 90 days.

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Reporting the breach to the Government:

1. Contact UND School of Medicine's Associate Direct of Administration and Finance.
2. If the breach involves 500 or more patients, OCR must be notified immediately. Notification to the local media is also required.
3. If the breach involves 499 or less patients, OCR must still be notified but the report may be in log form on an annual basis (by February 28 of the next calendar year).
4. Breach notification forms are available at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule

Employee Access to Their Own, Family, Friends, Co-Workers PHI Policy

Employees may not access, through EHR or paper medical charts, information for themselves, family members, friends, co-workers or other individuals for personal or other non-work related purposes, even if written or oral authorization has been given.

In the rare circumstance when employee's job requires him/her to access and/or copy the medical information of a family member or friend, then he/she should report the situation to his/her supervisor who will assign a different employee to complete the task.

If an employee wishes to access his/her own PHI, he/she must follow the same process for accessing PHI as other patients (a release must be completed).

If an employee wishes to access a family members PHI and a release has been completed, they must follow the same process as other patient's family members.

Routine HIPAA audits, as required by HIPAA law, will be performed. If an employee violates these guidelines he/she will be subject to disciplinary action in accordance to UND Center for Family Medicine's Sanction Policy.

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RELEASE OF PATIENT MEDICAL INFORMATION

_____ _____ _____
Patient Name **Patient's Date of Birth** **Phone Number**

REQUESTED FROM: **TO BE RELEASED TO:**

_____ _____
Name of Clinic or Physician **Name of Clinic or Physician**

_____ _____
Address **Address**

_____ _____
City, State Zip Code **City, State Zip Code**

_____ _____
Phone Fax **Phone Fax**

PURPOSE OF THIS REQUEST: **DATE NEEDED BY: _____**

__ Personal use **___Legal**
___Insurance **___Military** **____Other (Please specify) _____**
___Continued Medical Care **___School**

Information to be released:

_____Last 2 years medical history ____Other (Please be specific)_____

Records of a sensitive nature will not be released unless specifically authorized below.
Any patients 14 years or older must authorize the release of their own sensitive information.

Psychiatric/Mental/Chemical Dependency _____Initial _____Date
HIV _____Initial _____Date
Contraception/STD _____Initial _____Date
Pain Management File _____Initial _____Date

I understand that if records are released to someone who is not a healthcare provider, health plan, or health care clearinghouse, the health information released as a result of this authorization may no longer be protected by the federal privacy standards and the information may a be further disclosed without obtaining my authorization.
I understated that I have a right to inspect or receive a copy of the health information I have authorized to be used or disclosed by this authorization form by contacting Medical Records Department.
I understand that if I sign this authorization, I have a right to receive a copy of this form if requested.
I understand that I am under no obligation to sign this form and the action requested in this release will not be executed without a signature. However, our medical treatment of the patient is not condition on the signing or failure to sign this form. This authorization is effective for one year unless otherwise specified as follows: _____.
I understand I may cancel this authorization at any time by written notification. For information regarding how to withdraw my authorization or to receive a copy of it, I may contact the Medical Records Department.
I have had an opportunity to review and understand the contents of this authorization. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the staff of Center for Family Medicine from all liability pertaining to disclosure of any information in association with this release. A photocopy of this release is as valid as the original.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
If not present, state relationship-proof may be required **Witness**

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Release of Medical Records

WHO NEEDS TO SIGN A RELEASE OF MEDICAL RECORDS?

1. Every patient who is transferring records
2. If we are requesting records from another physician, hospital, or clinic
3. If a patient is requesting their records to be sent to another physician, health care, or any other entity

WHEN DO WE NOT NEED A RECORD RELEASE?

1. If we are referring a patient for further treatment
2. If a patient brings a request for lab work by another physician and it is done at our clinic the reports can be sent without a signed consent
3. If an insurance company is requesting records only for the date of service. (If they are requesting more records a signed release is needed)

WHAT NEEDS TO BE FILLED OUT ON THE RELEASE OF RECORDS?

There are a few things which we need to watch for when filling out a release:

1. If the patient has a guardian, we need to have guardianship papers on file.
2. If another member of the family has Power of Attorney, we need to have a copy.
3. In the event of a death, a combination of the patient's death certificate and a court document establishing estate executorship is needed.

   The Privacy Rule permits a covered entity to disclose protected health information about a decedent to a family member, or other person who was involved in the individual's health care or payment for care prior to the individual's death, unless doing so is inconsistent with any prior expressed preference of the deceased individual that is known to the covered entity. This may include disclosures to spouses, parents, children, domestic partners, other relatives, or friends of the decedent, provided the information disclosed is limited to that which is relevant to the person's involvement in the decedent's care or payment for care. For uses or disclosures of a decedent's health information not otherwise permitted by the Privacy Rule, a covered entity must obtain a written HIPAA authorization from a personal representative of the decedent who can authorize the disclosure. A decedent's personal representative is an executor, administrator, or other person who has authority under applicable State or other law to act on behalf of the decedent or the decedent's estate.

The following information needs to be filled in:

1. Patient name
2. Date of birth
3. Requested information from
4. Reports to be released to
5. Purpose of request
6. Information to be released

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PLEASE NOTE THE FOLLOWING:

I. If the records contain anything that is related to Psychiatric/Mental Health the patient needs to initial and date. This includes a history of depression, ADHD, etc. Chemical dependency also includes alcohol abuse.
II. HIV/AIDS related material also needs to be initialed and dated.
III. If the patient is 14 years old and older and comes to the clinic for Contraception/STD, the minor needs to initial and date the request before it can be released to the parent. This is protected information.
IV. Pain management needs to be initialed and dated.
V. They need to sign and date the request.

RECEIVING RELEASE OF MEDICAL RECORDS

When receiving a release of records:

1. Pull the chart and access the patient's account in EHR.
2. Copy/Print (things to watch for)
   a. HIV reports.
   b. Mental health records including depression and anxiety.
   c. Read what the release is asking for and only send what is requested.
   d. Watch the ACOG (prenatal form) for HIV reports.
   e. No blue nurse's sheets (from paper charts) are copied unless they are going to a law office.
   f. Copy HIV and mental health reports ONLY if they have signed the form for this information to be released.
      i. If information in a note is not authorized to be released and needs to be blacked out be sure to stamp the record and complete a Records Request Letter.
      ii. Third party records may be released if requested by the patient.

Social Security Disability Determination Services exam notes cannot be released. If you receive a request for information regarding these notes, contact the patient and explain to them they need to contact Social Security Disability Determination Services to gain access to a copy of these notes.

Requested copies are usually mailed out within two weeks; however, legally we have 30 days to comply with the request.
Requests that will not be process are records that contain information that may be harmful to the patient or another person.

INCOMING MEDICAL RECORDS

1. Scan the incoming records into Document Manager under "Outside Medical Records" on the Patient Summary Screen.
2. Providers will then review the records.

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SENDING OUT MEDICAL RECORDS

1. If records are going to another physician for treatment and care, for information on a current medical charge, or directly to the patient you **do not** need to fill out a HIPAA "Accounting of Disclosures of Protected Health Information" form. All other locations receiving records need a form completed.
2. Mark the original request as sent or stamp it faxed, date it, and initial it.
3. Sending out, you can either fax, send out by mail, or send in interdepartmental mail to the local hospitals or local clinics.
4. Request is scanned into EHR on the Patient Summary Screen under "Medical Releases".

RELEASING INFORMATION TO FAMILY AND/OR FRIENDS

1. Patient must sign an Authorization for Release of Information stating who may receive the information and what information they are allowed to receive.
2. Release is scanned into EHR under "Medical Releases" with the title Ongoing Release.

FAXING PHI (Protected Health Information)

When faxing PHI, a coversheet **MUST** be used.

PATIENT ACCESS

A patient has a right to see or copy his/her electronic and/or paper medical record.

1. Check the patient's ID before allowing access to the medical record.
2. Pull the paper chart if appropriate.
3. Take the patient into a private room.
    a. Patient can page through their paper chart
    b. Patient can view their electronic medical record, with some help navigating the computer system.

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Faxing

Purpose

UND Center for Family Medicine has adopted this Fax Policy to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as modified by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") (hereinafter HIPAA); the Department of Health and Human Services ("DHHS") security and privacy regulations; and the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") accreditation standards, as well as our duty to protect the confidentiality and integrity of confidential medical information as required by law, professional ethics, and accreditation requirements. All personnel of UND Center for Family Medicine must comply with this policy. Familiarity with the policy and demonstrated competence in the requirements of the policy are an important part of every UND Center for Family Medicine employee's responsibilities.

This Fax Policy is based on the following assumptions:

- Often, UND Center for Family Medicine personnel will have a real or a perceived need to transmit or receive confidential medical information by fax rather than by a slower method, such as mail.
- Personnel may misdirect faxes to unauthorized recipients, faxes may be intercepted or lost in transmission, or UND Center for Family Medicine may not receive a fax intended for it because of one of these or other reasons.
- Thus, the potential for breach of patient confidentiality exists every time that such information is sent or received by fax.

Policy

All personnel must strictly observe the following standards relating to fax communications of patient medical records:

- UND Center for Family Medicine employees will send health information by fax only when the original record or mail-delivered copies will not meet the needs of immediate patient care.
- Health records or documents containing individually identifiable health information may be transmitted by fax only when urgently needed for patient care or required by a third-party payer for ongoing certification of payment for a hospitalized patient.
- Information transmitted must be limited to that necessary to meet the requester's needs.
- Except as authorized by law, a properly completed and signed authorization must be obtained before releasing patient information (see UND Center for Family Medicine's release of information policy).
- Especially sensitive medical information, including, but not limited to, AIDS/HIV information, other sexually transmissible disease information, mental health and developmental disability information, and alcohol and drug abuse information, may not be sent by fax without the express authorization of the Security Officer.
- The cover page accompanying the fax transmission must include the confidentiality notice.
- Reasonable efforts must be made to assure that the fax transmission is sent to the correct destination. Frequently used numbers will have pre-made cover sheets.
- Fax machines must be located in secure areas, and the department director is responsible for limiting access to them.
- Each supervisor is responsible for ensuring that incoming faxes are properly handled—not left sitting on or near the machine, but rather are distributed to the proper recipient expeditiously while protecting confidentiality during distribution, such as by sealing the fax in an envelope.
- Any misdirected faxes must be reported to the Security Officer immediately.
- The Security Officer will periodically and/or randomly check all pre-made cover sheets to ensure their currency, validity, accuracy, and authorization to receive confidential information.
- Users must immediately report violations of this policy to their immediate supervisor and to the Security Officer.

Dictation

Document all significant observations as soon as possible after each patient contact. When documentation is complete, sign your note and route to the preceptor if necessary. The preceptor will then review and lock the note, which will prevent future editing. If a note needs to be unlocked, the Medical Records Supervisor, Business Manager, and/or Medical Director can unlock the note.

Chart Corrections/Appending a Note

A correction is a change in the information meant to clarify inaccuracies after the original electronic document was signed or rendered complete.

If a correction is needed or if information is missing, the note will need to be appended.

******DO NOT append a note to include actions that took place after the clinic visit, in this case you would open a new progress note to document what took place.**

Deleting a Chart Note

A chart note can be deleted, however, it is strongly advised to review your note and make an attempt to clean up the note and delete only as a last resort.

Letter to patient-DO NOT INCLUDE THE FOLLOWING

HIV results may not be dictated in a letter to the patient. You may dictate a letter stating "the test which was done at the clinic is negative/positive without saying what the name of the test is. Please come to the clinic to get results." It is encouraged to have the patient come to the clinic for results. Please do not give results over the phone as the identity of the patient cannot be verified.

At no point is a chart ever to leave the UND Center for Family Medicine. If you need information at the hospital, please call and we will fax that for you. Please see MEMO:

Medical Charts-DO NOT REMOVE FROM CLINIC

Due to patient confidentiality, you are NOT allowed to take charts out of the Family Practice Center. This includes taking charts to the hospitals for admissions or taking them off the premises to catch up on dictations.

Death Certificates

Can be done on line by registering with Division of Vital Records:
Contact person is: Carmell Barth at 701-328-2303. She will set you up with a user number/password and you can sign them electronically.
cbarth@nd.gov

The website is: https://secure.apps.state.nd.us/doh/evers/login.htm **Home**

Duties of a Scribe

Intent –
Use of a scribe can reduce the provider's documentation time during a visit and thereby free the provider to spend more time with the patient, improve the overall quality of documentation, and increase charge capture. A scribe must have good computer skills, knowledge of medical terminology, and an understanding of health information privacy and security practices.

The scribe's primary role is to accurately document the patient encounter in real time as the care is being provided. The scribe's role should be limited to documenting care. Scribes are not permitted to enter provider orders. Order entry is outside the scribe's role, and poses the risk of transcription errors that may result in avoidable patient harm.

Note Documentation in EMR appropriately per EPIC work flow.

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HIPAA

Definition

Release Policy

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What is HIPAA?

A Federal law, known as "HIPAA" (the Health Insurance Portability and Accountability Act of 1996) requires health care providers to implement a comprehensive approach to protect the privacy of personal health information (PHI).

HIPAA requires all PHI be kept private and secure by all persons that handle, or have access to, that information. Since many health care program students, faculty, instructors, and staff use PHI as part of the educational process (i.e. students in the clinical setting, use of case studies, etc...), these individuals must be trained on the specifics of HIPAA compliance.

University of North Dakota training available at:

http://www.med.und.edu/administration/education-faculty-affairs/hippa2.cfm

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Medical Records Release Policy

No. 1
Effective Date 7/1/15

1.0 Purpose

This policy establishes guidelines by which medical records will be released.

2.0 Persons Affected

All employees of UND Center for Family Medicine

3.0 Policy

When using or disclosing PHI, all appropriate HIPAA guidelines will be followed. A patient's written authorization, or release, is required for any use or disclosure of PHI that is not for treatment, payment or health care operations or otherwise permitted or required by HIPAA's Privacy Rule.

4.0 Definitions

4.1 PHI-Protected Health Information

4.2 CE-Covered Entity

5.0 Responsibility

5.1 All employees are responsible for ensuring compliance of this policy

5.2 The Medical Records department is responsible for ensuring all HIPAA guidelines are met when disclosing PHI

6.0 Procedure

6.1 Examples of when a Release of Patient Medical Information form must be completed include if

- **6.1.1** A patient is transferring their records
- **6.1.2** We are requesting records from another physician, hospital, or clinic
- **6.1.3** A patient is requesting their records be sent to another physician, health care, or any other entity

6.2 Examples of when a release does not need to be completed include if

- **6.2.1** We are referring a patient for further treatment
- **6.2.2** A patient brings a request for lab work by another physician and it is done at our clinic
- **6.2.3** An insurance company is requesting records only for the date of service (if they are requesting more records a release must be signed)

6.3 The following information must be completed on the release form

- **6.3.1** Patient name
- **6.3.2** Date of birth
- **6.3.3** Where the information is being requested from
- **6.3.4** Where the requested information is to be released to
- **6.3.5** Purpose of this request
- **6.3.6** Information to be released

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6.3.7 If applicable, sensitive information acknowledgment (initial and date)
6.3.8 Sign and date request
6.3.8.1 If signed by patient's guardian or Power of Attorney, a copy of guardianship or Power of
Attorney papers must be on file
6.3.8.2 If patient is deceased, a combination of the patient's death certificate and a court
document establishing estate executorship is needed
(for specific policy regarding deceased persons see Privacy of Deceased Person Policy)

6.4 After receiving a completed request
6.4.1 Pull the paper chart if necessary and/or access the patient's account in EHR
6.4.2 Review the release to verify that only the requested information is released
6.4.3 Copy/Print
6.4.3.1 Watch for sensitive information-only copy if release is initialed and dated
6.4.4 If information in a note is not authorized to be released black out information and stamp the copy
"Redacted" and complete a Records Request Letter
6.4.5 Third party records may be released if requested by the patient
6.4.6 SOCIAL SECURITY DISABILITY DETERMINATION SERVICES EXAM NOTES CANNOT BE RELEASED.
If a patient requests these notes, contact the patient and explain to them they need to contact Social Security Disability Determination Services to gain access to a copy of these notes.
6.4.7 Requested copies must be mailed out within 30 days.

6.5 If records are going to another physician for treatment and care, for information on a current medical charge, or directly to the patient you do not need to fill out an Accounting of Disclosures of Protected Health Information form. All other locations receiving records need a form completed.

6.6 After records are sent, mark the original request as sent or faxed, date, and initial

6.7 Scan request into EHR on the Patient Summary Screen under "Outside Medical Records"

6.8 If a patient's family and/or friends are requesting PHI, a signed Authorization for Release of Information must be signed by the patient stating who may receive the information and what information they are allowed to receive.

6.9 HIPAA rules permit a CE to disclose PHI to law enforcement officials without the individual's written authorization, under specific circumstances (see Releasing Information to Law Enforcement Officials Policy)

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MINIMUM NECESSARY POLICY

When using or disclosing PHI, or when requesting PHI, reasonable efforts will be made to limit the PHI used, disclosed, or requested to the minimum necessary for the purpose of the applicable activity.

Minimum Necessary standard does not apply in the following circumstances:

1. Disclosures to or requests by a health care provider for treatment purposes
2. Uses or disclosures made to the patient or the patient's authorized representative
3. Uses or disclosures made pursuant to a valid authorization (in which case the disclosure will be limited to the PHI specified on the authorization)
4. Disclosures required for compliance with HIPAA and enforcement purposes (for example, the Secretary of Health and Human Services)
5. Uses and disclosures required by law

Accessibility by Workforce Members:

Employees may use, access, or disclose a patient's PHI only when necessary to carry out their normal job duties.

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Designated Record Set Policy No. 1
Effective Date: 7/1/15

1.0 Purpose

The purpose of this policy is to identify those records that comprise the designated record set.

2.0 Persons Affected

All employees of UND Center for Family Medicine.

3.0 Policy

The HIPAA Privacy Rule Requires that patients be permitted to request access and amendment to their Protected Health Information (PHI) that is maintained in a Designated Record Set. This policy documents the contents of the Designated Record Set.

4.0 Responsibilities

4.1 All UND Center for Family Medicine employees are responsible for following policies and procedures regarding designated record sets.

5.0 Procedure

5.1 Designated Record Set is a group of records maintained by or for UND Center for Family Medicine that consists of the medical records and billing record about a patient and is used, in whole or in part, by or for the facility to make decisions about the patient. The term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for the facility.

5.2 UND Center for Family Medicine maintains the following as the Designated Record Set:

- **5.2.1** Patient's clinical record, hard copy and electronic, including but not limited to:
  - **5.2.1.1** Notes or documentation by any health care provider or other individual authorized to make an entry in the patient's clinical record
  - **5.2.1.2** Consultant's reports
  - **5.2.1.3** Diagnostic reports of any type, from within or from outside the clinic
  - **5.2.1.4** Treatment records received from other health care providers and included with the individual's records
  - **5.2.1.5** Health information
- **5.2.2** Billing records, including, but not limited to
  - **5.2.2.1** Bills, invoices, and statements generated or processed relating to the individual
  - **5.2.2.2** Insurance information regarding the individual
  - **5.2.2.3** Payment records
  - **5.2.2.4** Collection records
  - **5.2.2.5** All other billing, claim, payment, and collection records

5.2.3 Any other record sets used in whole or part to make decisions about the individual.

5.3 Designated Record Set DOES NOT include:

5.3.1 Psychotherapy notes about the patient

5.3.2 Information that is compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding

5.3.3 Risk management records, quality assessment and improvement records, and peer review records that are used for operational analyses and not for making medical decisions about the individual.

5.3.4 Oral communications

5.3.5 Health information generated, collected, or maintained for purposes that do not include decision making about the individual.

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Disclosing Proof of Immunization Policy	No.	1
	Effective Date	7/1/15

1.0 Purpose

This policy/procedure establishes guidelines regarding the disclosure of immunizations

2.0 Persons Affected

All UND Center for Family Medicine employees

3.0 Policy

It is UND Center for Family Medicine's policy to follow the HIPAA guidelines when disclosing proof of immunizations to a school.

4.0 Responsibilities

4.1 The Medical Records department is responsible for obtaining an authorization, either written or verbal, for the disclosure of immunizations.

4.2 Nursing is responsible for obtaining an authorization or verifying there is an authorization on file to disclose immunizations.

5.0 Procedure

5.1 The Privacy Rule permits disclosure of proof of immunizations to a school that is required by state or other law to have such proof prior to admitting the student, provided the health care provider obtains and documents the authorization to the disclosure from either

5.1.1 A parent, guardian, or other person acting in loco parentis of the student, if the student is an unemancipated minor; or

5.1.2 The student himself/herself, if the student is an adult or emancipated minor

5.2 The authorization may be obtained verbally or in writing.

5.2.1 If the agreement is in writing, the release will be scanned into the patient's account on the Patient Summary screen under the Outside Medical Records heading

5.2.2 If the agreement is verbal, a note documenting the verbal authorization will be documented in the patient's account.

5.3 If applicable, the authorization may be revoked by the parent, guardian, or student.

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RELEASING INFORMATION TO FAMILY AND/OR FRIENDS

1. Patient must sign an Authorization for Release of Information stating who may receive the information and what information they are allowed to receive.
2. Release is scanned into EHR under "Outside Medical Records" with the title Ongoing Release.

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RELEASING INFORMATION TO LAW ENFORCEMENT OFFICIALS

HIPAA Privacy Rule permits covered entities to disclose PHI to law enforcement officials, without the individual's written authorization, under specific circumstances (see below):

A law enforcement official is an officer or employee of any agency or authority of the United States, or a State territory, political subdivision, or Indian tribe who is empowered to (1) investigate or conduct an official inquiry into a potential violation of law; or (2) prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

1. To comply with a court order or court-ordered warrant, subpoena, or summons issued by a judicial officer, or a grand jury subpoena. Only that information specifically described in the legal document may be disclosed.
2. To respond to an administrative request, such as an administrative subpoena or investigative demand or other written request from a law enforcement official. This legal document will be issued not by a court of law, but a federal or state agency, or law enforcement official, such as an attorney general. The request for PHI must be specific and limited in scope to the extent possible in light of the law enforcement purpose for which the information is requested; the PHI requested must be relevant and material to a legitimate law enforcement inquire; and de-identified information could not be used.
3. To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person; but the covered entity must limit disclosures of PHI to name and address, date and place of birth, social security number, ABO blood type and rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics. Other information related to the individual's DNA, dental records, body fluid or tissue typing, samples, or analysis cannot be disclosed under this provision, but may be disclosed in response to a court order, warrant, or written administrative request.

   This same limited information may be reported to law enforcement:

   a. About a suspected perpetrator of a crime when the report is made by the victim who is a member of the covered entity's workforce
   b. To identify or apprehend an individual who has admitted participation in a violent crime that the covered entity reasonably believes may have caused serious physical harm to a victim, provided that the admission was not made in the course of or based on the individual's request for therapy, counseling, or treatment related to the propensity to commit this type of violent act.
4. To respond to a request for PHI about a victim of a crime and the victim agree.

5. To report PHI to law enforcement when required by law to do so (for example, under state law that requires reporting of gunshot wounds).
6. To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct.
7. To report PHI that the covered entity in good faith believe is evidence of a crime that occurred on the covered entity's premises.
8. When consistent with applicable law and ethical standards:
    a. To a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public
    b. To identify or apprehend an individual who appears to have escaped from lawful custody
9. For certain other specialized governmental law enforcement purposes
    a. To respond to a request for PHI by a correctional institution or a law enforcement officials having lawful custody of an inmate if they represent such PHI is needed to provide health care to the individual or for the health and safety of the individual, other inmates, officers, or employees.
    b. To federal officials authorized to conduct intelligence, counter-intelligence, and other national security activities under the National Security Act.

When releasing PHI requested by a law enforcement official:

1. Ask for ID (law enforcement badge, for example) and make a copy of the ID for records
    a. Ask for necessary official paperwork and make copies for records

For accounting of disclosures purposes, record disclosures made under this policy, except 9.b., in the chart of the patient who was the subject of the PHI disclosed.

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Releasing Information For Judicial and Administrative Proceedings

HIPAA's Privacy Rule permits covered entities to disclose PHI in connection with a judicial or administrative proceeding under the following circumstances:

1. In response to a court order or the order of an administrative tribunal, provided that only the PHI requested by the order is disclosed.

2. In response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal if:

    a. The covered entity (UND Center for Family Medicine) receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by that party to ensure the individual who is the subject of the PHI has been given notice of the request; or

    b. UND Center for Family Medicine receives satisfactory assurance from the party seeking the information that reasonable efforts have been made by that party to secure a qualified protective order that meets the following requirements:

        i. The protective order is an order of a court or administrative tribunal, or a stipulation by the parties to the proceeding that:

            1. Prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which the PHI was requested;

            2. Requires that the PHI (and all copies) be returned to UND Center for Family Medicine or destroyed at the end of the litigation or proceeding.

<u>Satisfactory assurance</u>

The party requesting the information must provide a written statement and accompanying documentation showing:

For a subpoena, discovery request, or other lawful process

1. The party requesting the information has made a good faith attempt to provide written notice to the individual, or the individual's last known address; and

2. The notice included sufficient information about the litigation to permit the individual to raise an objection with the court or tribunal; the time for objections to be filed has passed; and either no objections were filed or, if an objection was filed, the court or tribunal has ruled on it and the ruling permits the disclosure that is being requested; or

3. UND Center for Family Medicine made reasonable efforts to provide notice to the individual that meets the above criteria.

For a qualified protective order

1. The parties to the proceeding have agreed to a qualified protective order and have presented it to the court or administrative tribunal; or

2. The party requesting the PHI has requested a qualified protective order from the court or tribunal.

For accounting of disclosures purposes, record disclosures made under this policy in the chart of the patient who was the subject of the PHI disclosed.

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DECEASED PATIENT RECORDS

Patients retain their right to keep their protected health information private even after death, for a period of 50 years following the death of the patient.
Who is authorized to exercise a deceased patient's rights, including access to a deceased patient's medical records?

- The personal representative of the deceased patient. This will be an executor, administrator or other person authorized under applicable law to act on behalf of the decedent or the decedent's estate. Documents evidence this authority will usually consist of a combination of the patient's death certificate and a court or other legal document showing the representative's authority.
- Protected health information may be disclosed to family members, relatives, and others who were involved in the care or payment for care prior to the patient's death, unless doing so would be inconsistent with any prior expressed preferences by the patient.

For uses or disclosures not permitted, a written authorization must be obtained from the personal representative of the decedent who can authorize the use or disclosure.

Special disclosure provisions:

1. To alert law enforcement of a patient's death, if there is a suspicion that the death resulted from criminal conduct
2. To coroners or medical examiners to identify a deceased patient, determine a cause of death, and perform other functions authorized by law; and to funeral directors as needed
3. For research when the researcher represents that the use or disclosure sought is solely for research on the protected health information of a decedent that the protected health information is necessary for the research, and, if requested, will provide documentation of the death of the individual about whom information is sought.
4. To organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donations and transplantation

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Employee Access to Their Own, Family, Friends, Co-Workers PHI Policy

Employees may not access, through EHR or paper medical charts, information for themselves, family members, friends, co-workers or other individuals for personal or other non-work related purposes, even if written or oral authorization has been given.
In the rare circumstance when an employee's job requires him/her to access and/or copy the medical information of a family member or friend, then he/she should report the situation to his/her supervisor who will assign a different employee to complete the task.
If an employee wishes to access his/her own PHI, he/she must follow the same process for accessing PHI as other patients (a release must be completed).
If an employee wishes to access a family members PHI and a release has been completed, they must follow the same process as other patient's family members.
If an employee violates these guidelines, he/she will be subject to disciplinary action in accordance with UND Center for Family Medicine's Sanction Policy. Routine HIPAA audits, as required by HIPAA law, will be performed.

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Patient Access

Patients, or their personal representatives, have a right to ask to see and get a copy of their protected health information (paper and electronic) that is contained in the designated record set.
The designated record set is the group of records consisting of: the medical and billing records of the patient; and those used to make decisions about the patient.

Procedure

A request for access must be made in writing and must be responded to in a timely manner, but no later than 30 days of receipt of the request. If the request cannot be processed within 30 days, the patient must be provided a written statement containing the reason for the delay and the date on which the information will be provided to the patient (which may be no more than 60 days from the date of the patient's initial request).

Processing Request

Request to inspect in-person

1. Verify the identity of the patient, or if a patient's personal representative, the legal authority of the representative.
2. Document the verification and request to inspect in the patient's chart.
3. Offer the patient or representative a convenient place and time, and private area, if possible, to view the record.

Request for a copy

1. Provide requested copy of the information (paper or electronic) in the form requested if the information is readily producible in such form, or, if not, in a readable hard copy or other form agreed to with the patient.
2. North Dakota state law limits the amount that can be charged for a paper copy of a patient's medical records and medical bills to $25.00 for the first 25 pages and $0.75 per page after 25 pages. For an electronic, digital, or other computerized format, the charge is limited to $30.00 for the first 25 pages and $0.25 per page after 25 pages. These changes include any administrative fee, retrieval fee, and postage expense.
3. If a copy of the records is requested for purposes of transferring a patient's health care to another health care provider for continuation of treatment, the copy must be provided free of charge.
4. Maintain the written authorization requesting the records in the patient's chart.

Denial of access

The Center for Family Medicine may deny access in the following circumstances.

A. Unreviewable denials:
    1. Psychotherapy notes;
    2. Information compiled for use in legal proceedings;
    3. Certain information held by clinical laboratories;
    4. Information requested by an inmate of a correctional institution if granting an inmate copy would jeopardize the health, safety, security, custody, or

rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institutional or responsible for the transporting of the inmate;

5. Information created or obtained during research that includes treatment, and the patient has previously agreed to the denial of access during the course of the research;
6. Information contained in records subject to the Privacy Act; and
7. Information obtained from someone other than a health care provider under a promise of confidentiality, and the copy requested would likely reveal the source.

B. Reviewable denials, provide the patient is given the right to request a review of the denial, when a licensed health care professional has determined, in the exercise of professional judgment, that:

1. The access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
2. The information makes reference to another person (other than a health care provider) and the access requested is reasonably likely to cause substantial harm to such other person; or
3. The request for access is made by the patient's personal representative and the access requested is reasonably likely to cause substantial harm to the individual or another person.

If a patient requests review as allowed under paragraph B above, it must be reviewed by a licensed health care professional designated by the Center for Family Medicine as the reviewer and who did not participate in the original decision to deny. The patient must be informed promptly of the decision.

A patient who has been denied access must be provided a timely written denial, which states in plain language the basis for the denial; and, if applicable, a statement of the patient's review right and how to exercise that right; and a statement of the patient's right to file a complaint with the Center for Family Medicine or the Secretary of HHS and a description of the complaint procedures, along with the name, title and telephone number of the contact person.

A written denial must be maintained in the patient's chart.

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ACCOUNTING OF DISCLOSURES POLICY

Individuals have a right to request an accounting of certain disclosures of their protected health information made by a covered entity in the six years prior to the date of the request.

Procedure:

1. Maintain an accounting of disclosures of protected health information on each patient for at least six years. A disclosure, as defined under 42 C.F.R. § 160.103, is "the release, transferm, provision of access to, or divulging in any other manner of information outside the entity holding the information."
2. Information that must be tracked and included in an accounting:
    a. Date of each disclosure
    b. Brief description of the protected health information disclosed
    c. Name and, if know, address of the individual/entity who received the information
    d. Brief statement of the purpose of the disclosure (or a copy of the written request for a disclosure)
    e. Multiple Disclosures to the same person for the same purpose may have a summary entry. A summary entry includes all information (2 a-de) for the first disclosure, the frequency or number of disclosures made, and the date of the last disclosure.
3. An accounting must include all disclosures except:
    - To carry out treatment, payment, or healthcare operations
    - To the individual of protected health information about that individual
    - Pursuant to a patient's written authorization
    - Incident to a permissible or required use or disclosure
    - To people involved in the individual's care
    - For National security or intelligence purpose
    - To correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody
    - Prior to compliance date of April 14. 2003
4. All other disclosures of protected health information must be tracked.
5. Disclosures may be tracked by :
    a. Manual logs with one log per patient maintained in the patient's health record
    b. Authorization forms maintained in the patient's health record
6. A patient may make a request for an accounting using the Request for Accounting of Disclosures of Protected Health Information form. A copy of both the request and the written accounting that was provided to the patient must be retained, along with documenting the name of individual who received and processed the accounting request.
7. The individual will be provided with an accounting of disclosures within 60 days after receipt of the request.
    a. If the accounting cannot be provided within 60 days after receipt of the request, the individual will be given a written statement of the reason for the delay and the expected

   b. completion date, which must be no more than 30 days after the initial 60-day processing period.
   c. Requests can cover a period of up to six years prior to the date of the request.
8. The accounting will be provided to the individual at no charge for a request made during any 12-month period. For any subsequent request within the 12-month period by the same individual, a reasonable fee may be charged provided the individual is informed of the fee in advance and given an opportunity to withdraw or modify the request.

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Patient's Right to Amend a Medical Record

Individuals have the right to request amendment to their PHI in the designated record set for as long as the records are maintained in the designated record set.

Writing Requirement: Requests for amendment must be in writing and the individual must provide a reason to support the requested amendment.

Time period for action: The UND Family Practice Centers must act on an individual's request to amend information within 60 days from receipt of the request. The time may be extended an additional 30 days if the UND Family Practice Centers is unable to act within the original time period for action. To extend the time, provide a written statement of the reasons for the delay to the individual within 60 days from receipt of request. One extension of the time period for action is allowed per request.

Accepting Amendments:

If the UND Family Practice Centers grants the request for amendment in whole or part:

6. Inform the individual in writing that the amendment is accepted.
7. Make the amendment to the PHI or record by identifying the records in the designated record set that are affected and appending or otherwise providing a link to the location of the amendment.
8. Obtain the individual's identification of persons who have received PHI about the individual and need the amendment.
9. Obtain the individual's agreement to have the UND Family Practice Center notify the persons identified in step3.
10. Make reasonable efforts to inform and provide the amendment within a reasonable time to:

    i. persons identified by the individual in step 3;

    ii. persons, including business associates, that UND Center for Family Medicine knows have the PHI that is the subject of the amendment and that may have relied, or could foreseeably rely, upon the information to the detriment of the individual.

11. Follow the process for denying amendments as to any portion of the amendment that is not accepted.

Denying Requests for Amendment:

Requests for amendment may be denied if:

- the information is accurate and complete;
- the PHI or record was not created by UND Center for Family Medicine, unless the individual making the request provides a reasonable basis to believe that the originator of PHI is no longer available to act on the request;
- the PHI is not part of the designated record set; or

- the PHI would not be available to the individual under the following unreviewable grounds for denial of access:
    1. Psychotherapy notes;
    2. Information compiled for use in legal proceedings;
    3. Certain information held by clinical laboratories;
    4. Information requested by an inmate of a correctional institution if granting an inmate copy would jeopardize the health, safety, security, custody, or rehabilitation of the individual or other inmates, or the safety of any officer, employee, or other person at the correctional institutional or responsible for the transporting of the inmate;
    5. Information created or obtained during research that includes treatment, and the patient has previously agreed to the denial of access during the course of the research;
    6. Information contained in records subject to the Privacy Act; and
    7. Information obtained from someone other than a health care provider under a promise of confidentiality, and the copy requested would likely reveal the source.

- The PHI would not be available to the individual under the following reviewable grounds for denying access that must include a determination by a licensed health care professional in the exercise of professional judgement that:
    1. The access requested is reasonably likely to endanger the life or physical safety of the individual or another person;
    2. The information makes reference to another person (other than a health care provider) and the access requested is reasonably likely to cause substantial harm to such other person; or
    3. The request for access is made by the patient's personal representative and the access requested is reasonably likely to cause substantial harm to the individual or another person

All denials must be in writing and must include:

1. the basis for denial;
2. statement of the individual's right to submit a written statement disagreeing with the denial and where to file the statement of disagreement;
3. statement that the individual may request that UND Center for Family Medicine provide the request for amendment and denial with any future disclosures of the PHI that is the subject of the denied amendment; and
4. a description of how the individual may complain to UND Center for Family Medicine or the Secretary of HHS, including the name/title, and telephone number of the Privacy Official.

Disputed Amendments: If the amendment is denied, permit the individual to submit a written statement of reasonable length disagreeing with the denial and the basis for disagreement. If the individual prepares a written statement of disagreement, UND Center for Family Medicine may prepare a rebuttal statement in response. If a rebuttal statement is prepared, provide a copy to the individual who submitted the statement of disagreement.

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Identify the record or PHI in the designated record set that is the subject of the disputed amendment and append or otherwise link the individual's request for amendment, the denial of the request, the individual's statement of disagreement and the rebuttal to the designated record set.

Future disclosures of PHI related to a request for amendment:

If the amendment is accepted, provide the amendment information with any subsequent disclosures. If the request is denied, and the individual does not submit a written statement of disagreement, provide the request for amendment and denial with future disclosures, if the individuals so requests.

If the individual submits a written statement, provide the appended material related to the disputed amendment or an accurate summary of the appended information with any subsequent disclosure of the information to which the request for amendment relates.

When subsequent disclosures are part of a standard transaction that does not allow provision of the required information as part of the transaction, send the amendment information separately to the recipient of the standard transaction.

If UND Center for Family Medicine is informed by another covered entity of an amendment to an individual's PHI agreed to by the other covered entity, amend the PHI in the designated record set maintained by UND Center for Family Medicine.

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Requests for Restriction Policy

No.	1
Effective Date	4/1/15
Revised	5/13/15

1.0 Purpose

Patient's right to request restriction on use and/or disclosure of PHI.

2.0 Persons Affected

All employees of UND Center for Family Medicine

3.0 Policy

According to the HIPAA Privacy Rule, patients/personal representatives have the right to request restrictions on the use or disclosure of the individual's PHI to carry out treatment, payment, or health care operations; or the disclosure of PHI to a family member or friend who is involved with the patient's care or payment of the patient's care, but UND Center for Family Medicine is not required to agree to the restriction.

A patient/personal representative also has a right to restrict the disclosure of PHI to a health plan if the PHI pertains to health care services for which the individual or other person has paid for the service in full. UND Center for Family Medicine must agree to the restriction.

4.0 Definitions

4.1 PHI (Protected Health Information)-Individually identifiable health information

4.2 Personal Representative-A person legally authorized to make health care decisions on an individual's behalf. Documents evidencing this authority includes, a court order appointing them as guardian or durable Power Of Attorney.

5.0 Responsibilities

5.1 All employees shall ensure compliance of this policy.

5.2 The Front Desk staff is responsible for making a copy of the Notice of Privacy Practices available at the time of the individual's registration and alerting all departments involved in the request for the restriction.

5.3 HIPAA Privacy Officer's responsibility to approve/deny all requests for restriction and notify the individual of the decision.

5.4 The Billing Department is responsible for excluding the charge from insurance if the patient chooses to restrict visit from their insurance.

5.5 The Medical Records Department is responsible for ensuring restricted notes are not released to restricted individuals/organizations.

6.0 Procedure

6.1 Individuals will be informed of their rights to request restrictions on how their PHI is used and/or disclosed for treatment, payment, and healthcare operations in the Notice of Privacy Practices, which is offered and available at the front desk upon registration.

6.2 Except a restriction on disclosure to a health plan for services paid in full by the patient, UND Center for Family Medicine is not required to approve restrictions but will accommodate reasonable restriction requests when possible.

6.3 If an individual requests a restriction, a "Request for Restrictions" form must be completed by the patient/personal representative.

6.3.1 The patient will pay in full on the same day of service if he/she wishes to restrict their insurance company from receiving a claim for services. The front desk will inform the billing department and the nurse.

6.3.2 The front desk will generate an alert stating there is a restriction in the patient's account.

6.3.2.1 Under the Ticket heading, select Transaction Code Restricted and Post the item (Post the item to the correct date of service).

6.3.2.2 Enter what is being restricted i.e. date of service, address/phone, etc. (Make entry very descriptive).

6.3.3 The address, phone number, etc. that the patient does not want to be used will be deleted out of the account.

6.3.3.1 The front desk will explain to the patient when/if they want the old address, phone number, etc. reactivated they will need to let the Front Desk know since our system is unable to have more than one address in the account.

6.3.4 The EMR note will be restricted by the physician/nurse by selecting the Restricted icon in the SOAP note. This will also alert the medical records department that the note is restricted and cannot be sent to the specified organization.

6.3.5 All "Request for Restriction" Forms will be given to the HIPAA Privacy and Security Office who will scan the form into the patient's account and alert all supervisors of the restriction.

6.4 If a restriction is accepted, no use or disclosure of the patient's health information will be made in violation of the specified restriction unless:

6.4.1 Emergency treatment is needed and the restricted information is needed to provide care to the patient. If the information is disclosed to another health care provider for the emergency care, request that the provider not further use or disclose the information.

6.4.2 The Secretary of the U. S. Department of Health and Human Services request the information for compliance and/or investigation purposes

6.4.3 The restricted information is required by the law to be disclosed

6.5 An agreed-to restriction may be terminated by the patient or, except a restriction on disclosure to a health plan for services paid in full by the patient, by UND Center for Family Medicine.

6.5.1 The patient may terminate the restriction by one of three ways, which the HIPAA Privacy and Security Officer will be made aware

6.5.1.1 The patient may sign the "Request for Restriction" form on the Request Revoked line

6.5.1.2 The patient may verbally inform the staff of UND Center for Family Medicine that he/she wishes to terminate the restriction

6.5.1.3 The patient may provide a written request to terminate the restriction

6.6 If a restriction is terminated the following steps must be completed:

6.6.1 Under the Ticket heading, select Transaction Code Termination and Post the item

6.6.2 Enter what restriction is being terminated (Date of services, Address, Phone, etc.)

6.6.3 Remove the checkmark from the alert in the Alert box.

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Patient Privacy-Related Complaints Policy No. 1
Effective Date: 7/1/15

1.0 Purpose

Provide a process for patients to file a complaint if the patient feels his or her privacy rights have been violated.

2.0 Persons Affected

All employees of UND Center for Family Medicine

3.0 Policy

UND Center for Family Medicine will follow a process for the patient to file a complaint if he or she feels their privacy has been violated.

3.1 The HIPAA Privacy Officer will receive and investigate the complaints.

3.2 Any intimidation of or retaliation against patients, families, friends, or other participants in the complaint process is prohibited.

3.3 If the patient's rights have been violated, employees who violates those rights are subject to disciplinary action (see sanction policy).

4.0 Responsibilities

4.1 All employees of UND Center for Family Medicine are responsible for following all HIPAA policies and procedures.

4.2 The HIPAA Privacy Officer is responsible for investigating and responding to the complaint.

5.0 Procedure

5.1 Patients may make a complaint by calling, writing, or presenting in person to the HIPAA Privacy Officer.

5.2 The HIPAA Privacy Officer will summarize the complaint on the Patient Complaint Report Form.

5.3 The complaint will then be investigated by the Privacy Officer

5.4 A written response will be provided to the patient within 30 days from the date the complaint was filed.

A written summary of the complaint and actions taken will be filed with the Privacy Officer.

5.5 Patients or others can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

5.6 All documentation will be retained for six years. **Home**

HIPAA BREACH NOTIFICATION POLICY

HIPAA requires a covered entity notify individuals whose unsecured protected health information (PHI) has been impermissibly acquired, accessed, used, or disclosed, compromising the security or privacy of the PHI. Notification only applies to a breach of unsecured PHI.

A. Definitions

1. **Breach** means the acquisition, access, use, or disclosure of PHI in a manner not permitted under HIPAA, which compromises the security or privacy of the PHI.

Breach excludes:

I. Any unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or a business associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under HIPAA.

II. Any inadvertent disclosure by a person who is authorized to access PHI at a covered entity or business associate to another person authorized to access PHI at the same covered entity or business associate, or organized health care arrangement in which the covered entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.

III. A disclosure of PHI where a covered entity or business associate has a good faith belief that an authorized person to whom the disclosure was made would not reasonably have been able to retain such information.

2. **PHI** means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.
3. **Unsecured PHI** means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology, such as encryption or destruction, as specified by the Secretary of Health and Human Services.
4. **Workforce** means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity or business, is under the direct control of such covered entity or business associate, whether or not they are paid by the covered entity or business associate.

B. Discovery of Breach

A breach shall be treated as discovered by a covered entity as of the first day on which such breach is known to the covered entity, or, by exercising reasonable diligence, would have been known to the covered entity to the covered entity or any person, other than the person committing the breach, who is a workforce
member, or agent of the covered entity.
Upon discovery of a potential breach, it shall be reported to the HIPAA Privacy & Security Officer, who shall initiate and document an investigation, including a risk assessment, and, based on the results of the investigation, determine whether notification is required.

A breach is presumed to have occurred unless the covered entity can demonstrate there is a low probability that the PHI has been compromised based on the investigation and risk assessment.

C. Determine if there was a breach

6. Is the data "PHI"?
   If the data is not PHI, stop here. No further action is needed.

7. Is the data "unsecured PHI"?

   If review determines PHI is secured, stop here. Document your review that came to this conclusion. Document any actions to reduce the likelihood of another breach from reoccurring. If not, proceed to next step.
8. Determine and document whether the incident falls under one of the exceptions of the breach definition:
   a. Good faith, unintentional acquisition, access, or use of PHI in the course of performing one's job and such access does not result in further impermissible use or disclosure. (EX: went into the wrong John Smith's account)
   b. Inadvertent disclosure of PHI by one workforce member to another and no further impermissible use or disclosure of PHI (EX: PHI on employee's desk and another employee sees)
   c. When PHI is improperly disclosed but the covered entity believes in good faith that the recipient of the unauthorized information would not be able to retain the information.

   If the disclosure falls into one of these exceptions, notification is not necessary. You can stop at this point.
   If the disclosure does not fall into one of these exceptions, proceed to next step.
9. Complete a **risk assessment** to determine probability of a compromise to the PHI and whether breach notification is required, the HIPAA Breach Notification Rule requires consideration of **at least the following four factors**:

e. Nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
   I. Identifying financial and demographic data: SS#, credit card info, financial data
   II. Clinical data: Diagnosis, treatment, medications
   III. Behavioral health, substance abuse, sexually transmitted diseases

f. The unauthorized person who used the PHI or to whom the PHI was disclosed
   I. Does the person have obligations to protect privacy and security?
   II. Does the person have the ability to re-identify the PHI?

g. Whether the PHI was actually viewed or accessed.
   I. Rarely an answer here. Hard to prove.

h. The extent to which the risk to the PHI has been mitigated.
   I. Can the person who received the PHI provide satisfactory assurances that the PHI will not be further used or disclosed or that it will be destroyed?
      i. PHI faxed to wrong doctor's office. They state they will destroy the PHI.
      ii. Lost flash drive with PHI
   II. What level of effort has been expended to prevent future related issues and/or to lessen the harm of the actual breach?

10. Can it be concluded that there is a low probability that the PHI has been compromised?

If so, notification is not necessary. Complete documentation and retain for future reference or investigations (documentation must be saved for 6 years).
For a medium or high finding that data has been compromised, complete the appropriate notification steps for each individual affected.
Individuals must be notified within 60 days or without unreasonable delay. If patients are notified HHS must be notified. If over 500 individuals affected HHS notified immediately.

11. A breach assessment must also be conducted under North Dakota State breach notification law (N.D. Cent. Code Ch. 51-30). (NOTE: **North Dakota breach notification law only applies to computerized data.**)
    a. Was the electronic information "personal information?"

    Personal information means an individual's first name or first initial and last name in combination with any of the following data elements: 1) the individual's social security number; 2) the operator's license number; 3) a non-driver color photo identification card number; 4) the individual's financial institution account number, credit cred number, or debit card number in combination with any required security code, access code, or password that would permit access to the individual's financial accounts; 5) the individual's date of birth; 6) the maiden name of the individual's mother; 7) medical information; 8) health insurance information; 9) an identification number assigned to the individual by the individual's employer; or 10) the individual's digitized or other electronic signature. Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

    If yes, proceed to next question. If no, stop here.

    b. Was the electronic personal information encrypted or otherwise rendered unreadable or unusable?

    If yes, stop here. If no, proceed to next question.

    c. Was electronic personal information impermissibly acquired?

    Factors to consider in determining whether information has been acquired, or is reasonably believed to have been acquired: 1) Indications that the information is in the physical possession and control of an unauthorized person, such as a lost or stolen computer or other device containing information; 2) Indications that the information has been downloaded or copied; or 3) Indications that the information was used by an unauthorized person, such as fraudulent accounts opened or instances of identity theft reports.

    If yes, proceed to next question. If no, stop here.

    d. Does the exception apply:

    A good faith acquisition of person information by an employee or agent of the covered entity is not a breach, if the personal information is not used or subject to further unauthorized disclosure.

If yes, stop here. Breach notification is not required. If no, breach notification is required. Complete the steps for notifying affected patients. Unlike HIPAA, North Dakota law does not require notification to the media or the government.

Notification Steps

Notify a patient of a breach:

5. Notification to affected patients must be provided without unreasonable delay and in no case later than within 60 calendar days of when you first discovered the breach.
6. A written notice of the breach by first class mail is required. The notification to the affected patients will include:
    a. A brief description of what happened
    b. The date of the breach and the date the breach was discovered
    c. A description of the type of unsecured PHI involved in the breach
    d. Steps the patient should take to protect themselves from potential harm as a result of the breach
    e. A brief description of what the practice is doing to investigate, mitigate, and protect against further breaches
    f. Contact procedures for patients to ask questions or learn more information, which must include a toll-free number, email address, and website or postal address
7. If there is insufficient or out-of-date contact information for 10 or fewer patients, substitute notice may be provided by an alternative form of written notice, telephone, or other methods of contact.
8. If there are 10 or more patients with insufficient contact information, substitute notice may be provided by either a conspicuous posting on the home page of the clinic's website for 90 days or conspicuous notice in major print or broadcast media in geographic areas where the affected patients by the breach likely reside. Both methods must include a toll-free phone number that remains active for 90 days where a patient can learn whether the patient's unsecured PHI may be included in the breach.

Reporting the breach to the Government and the media:

5. Contact UND School of Medicine's Associate Direct of Administration and Finance.
6. If the breach involves 500 or more patients, OCR must be notified without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Notification to the OCR should be made at the same time notification is made to the affected patients. Notification to the local prominent media is also required without unreasonable delay and in no case later than 60 calendar days after discovery of a breach. The same information must be included for notification to the media as is required for individual notice described above.

7. If the breach involves 499 or less patients, a breach log must be maintained and provided to the OCR on an annual basis (by February 28 of the next calendar year).
8. Breach notification instructions and forms are available at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule

Delay of notification for law enforcement purposes

A. If a law enforcement official states to the practice that a breach notification, notice, or posting required under HIPAA would impeded a criminal investigation or cause damages to national security the practice shall:
   a. If the statement is in writing and specifies the time for which a delay is required, delay such notification, notice, or posting for the time period specified by the official; or
   b. If the statement is made orally, document the statement, including the identity of the official making the statement, and delay the notification, notice, or posting temporarily and no longer than 30 days from the date of the oral statement, unless a written statement as described above is submitted during that time.

Business associate responsibilities

As required under the practice's business associate agreements, a business associate shall, without unreasonable delay and in no case later than 60 calendar days after discovery of a breach of unsecured PHI, notify the practice of a breach. Such notice shall include identification of each individual whose unsecured PHI has been, or is reasonably believed by the business associate to have been, access, acquire3d, used, or disclosed during the breach. The business associate shall provide the practice with any other available information that the practice is required to include in notification to the patient at the time of the notification or promptly thereafter as information becomes available. Upon notification by the business associate of discovery of breach, the practice will be responsible for notifying affected patients, unless otherwise agreed upon by the business associate agreement.

Home

User Auditing Policy No. 1
Effective Date: 7/1/15

1.0 Purpose

To ensure that appropriate safeguards are in place to protect the confidentiality, integrity, and availability of patient ePHI. To ensure these safeguards are in place and effective, user access and activity will be audited.

2.0 Persons Affected

All UND Center for Family Medicine employees.

3.0 Policy

All EMR users' access and activity of ePHI will be audited biannually, unless suspicious activity or a patient complaint warrants an investigation.

4.0 Definitions

4.1 Audit-Internal process of reviewing system access and activity.

4.2 ePHI-Electrionic protected health information

4.3 Audit Log-Record of activity maintained by the system

4.4 Audit Trail-Means to monitor system operations by providing a chronological series of events. An audit trail identifies who (login) did what (create, read, modify, delete, add, etc.) to what (data) and when (date, time)

5.0 Responsibilities

5.1 HIPAA Privacy and Security Officer and Risk Management Director to audit all users.

6.0 Procedure

6.1 The HIPAA Officer and Risk Management Director will audit all users by running security audit log reports

- **6.1.1** Select Administration
- **6.1.2** Select Security Audit Logs
- **6.1.3** Select the user and date range. Refresh to populate the audit log, which will show the audit trail of the user.

6.2 The auditing process will address

- **6.2.1** Login/logoff attempts-appropriate times/dates, denials, "timeout sessions"
- **6.2.2** User activity-accounts accessed, activity performed

6.3 An Audit Form will be completed for each user, indicating the user, who reviewed the audit, the date range the audit was completed for and what activity was found.

6.4 If unauthorized activity is found

- **6.4.1** Further investigation will be completed
- **6.4.2** The supervisor will be notified
- **6.4.3** If unauthorized activity is performed by a supervisor, the HIPAA Officer will address the activity
- **6.4.4** Appropriate corrective action will be taken and documented on the Audit Form

6.5 Audit summaries will be retained for six years.

Home

SANCTION POLICY

All employees must comply with all security and privacy policies and procedures or disciplinary action will be taken. It is every employee's responsibility to report a suspected breach.
Examples of some possible breaches are listed below; however, these are just some examples and not a complete list:

- Employee faxes the wrong PHI to another practice
- Employee emails PHI
- Employee views patient records out of curiosity, not necessity
- Employee shares PHI because the information is interesting or gossip-worthy, but not for treatment
- Employee shares computer passwords
- Employee discusses confidential patient information in an unsecure area
- Employee uses PHI for personal gain
- Employee uses PHI to cause harm, such as exposing information to unauthorized individuals out of spite or dislike of the owner of the PHI
- Employee gives access to PHI to an unauthorized individual

Failure to comply with all security and privacy policies and procedures could result in a verbal and/or written warning, re-education, suspension, or termination. The appropriate sanction for a violation will depend on the severity of the violation; for example, whether it was intentional or unintentional and whether it was part of or indicates a pattern or practice of improper use and disclosure of PHI. Employees could also face civil or criminal penalties. Each breach will be handled on a case-by-case basis.

Home

Electronic Communications

Purpose

To assure the appropriate use of electronic communication within the UND Center for Family Medicine in addition to the general UND Computing and Network Usage Policy.

Procedure

Password Protection:

All assigned to or created passwords by an employee are private and should not be shared with others. All electronic devices and applications shall be password protected. Passwords need to be changed frequently using a unique password.

Workstation screensavers shall be password protected to prevent a possible breach of PHI.

Only use a program under your personal login information. Do not use a program accessed by another employee. Log employee out and then log in with your information.

E-mail:

When using the University of North Dakota's e-mail system, the individual user must understand that it is an unsecure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect against a HIPAA breach.

E-mail is used within the clinic appropriately by staff using the University assigned email address for an employee. By State of North Dakota law, university email content is considered public record, and thus may be open and accessible for inspection.

E-mail communication with patients shall be done with a secure system. Encryption is the only approved mechanism to electronically transmit PHI. The use of the EMR patient portal will provide a secure means to communicate with patients.

Mobile Applications:

Google Drive is accessed on mobile devices to be used by Providers for patient care. It is administered by a designated UND Center for Family Medicine Faculty member. Each member (Provider's Only) is added by the Administrator to the application. A password is needed to access the application. Information on is updated by Providers and provides a means of communication for each patient.

Personal Device:

All personal devices are not required by staff to fulfill an employee's job requirements. By State of North Dakota law, all electronic communication records are public records, and thus may be open and accessible for inspection. The use of personal devices opens the employee to personal liability for discoverable electronic communication.

Texting:

When using texting the individual user must understand that it is an secure form of communication. NO patient protected health information (PHI) may be included in the message. Care must be taken at all times to protect confidential information.
Texting should not replace a phone conversation in order to avoid miscommunication between you and the patient or employee. Texting should be avoided during patient care to prevent errors.
Texting is not to be used for communication with patients.

Social Media:

Social media is a means of communication using web-based and mobile technologies for the exchange of information. Social Media is not to be used for communication with patients about patients and/or their PHI. No health or medical related information that relates to official activities may be posted on social media.

Lost or Stolen Device:

All lost or stolen devices need to be reported to the department supervisor as soon as possible. The mobile provider will need to be called to deactivate the phone. If a PHI breach is a concern the HIPAA officer will need to notified of the breach.

Applications are available for devices that can locate the lost device and the phone can be remotely locked or the information can be deleted from the phone. i.e. Find My iPhone. It is recommended that electronic mobile devices have this or a similar application.

Termination or Resignation of Employment:

All employee access to current software applications and devices will be deactivated.

For complete UND policy see the office of Human resources and Payroll Services Annual Notification of Policies.

Home

Media Reuse/Disposal Policy

No. 1
Effective Date: 4/1/15

1.0 Purpose

This policy/procedure establishes guidelines by which media containing PHI will be reused and/or disposed of.

2.0 Persons Affected

All employees in the Medical Records, Laboratory, and Radiology Departments at UND Center for Family Medicine that process ePHI requests.

3.0 Policy

It is UND Center for Family Medicine's policy to ensure the privacy and security of PHI in the maintenance, retention, and eventual destruction of media. Media containing PHI may be reused when appropriate steps are taken to ensure that all stored PHI has been effectively rendered inaccessible.

3.1 If a request that PHI be received in electronic form, however the media is not picked up by the patient after 30 days, the media will be wiped and reused.

4.0 Definitions

4.1 ePHI (Electronic Protected Health Information)-Any individually identifiable health information protected by HIPAA that is transmitted by or stored in electronic media.

4.2 Media- Any device which will be used to store ePHI. (CD, USB drives, etc.)

5.0 Responsibilities

Anyone who processes a request for ePHI will ensure media is wiped before using.

6.0 Procedure

6.1 Any media device not picked up by the patient after 30 days will be wiped clean by deleting all records.

6.1.1 Insert CD

6.1.2 Select Computer on your menu

6.1.3 Select the CD you are working with

6.1.4 Right click and select Format. Remove the "label" and start the format, which will erase everything on the CD

6.2 If a media device must be destroyed, the media will be placed in the locked shred bin where it will be disposed of properly.

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INSTRUCTIONS FOR DESTRUCTION OF CHARTS

Retention schedule is:

1. Decreased for more than 10 years
2. Date of last visit plus 10 years or until age 19, whichever is longer

Example:

1. Patient was 2 years old on last visit date-can be destroyed
2. Patient was 17 years old on last visit date-must add another 10 years before being destroyed.

ALL CHARTS FOR DESTRUCTION MUST BE RECORDED
IF USING THE LAPTOP COMPUTER, INSERT THE USB FLASH DRIVE

Record in Microsoft Office Excel

Go to Microsoft office Excel
Open folder
Select patient chart for destruction
Click on open

Home

University of North Dakota

Bismarck Center for Family Medicine

701 E. Rosser Ave
Bismarck, North Dakota 58501
701.751.9500 Fax: 701.751.9508

NOTICE OF PATIENT PRIVACY PRACTICES

Effective Date May 31, 2021

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Ask us to correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we use or share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at our address or phone number listed at the beginning of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Records Retention

Your medical records will be maintained for as long as you are a patient at the UND Center for Family Medicine at Bismarck. Your medical records are kept for 10 years after the date of your last visit or until age 19, whichever is longer. When your medical records have met their retention time they will be destroyed following appropriate procedure.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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HIPAA Privacy Officer

The HIPAA Privacy Officer shall oversee all ongoing activities related to the development, implementation, and maintenance of UND Center for Family Medicine's privacy policies in accordance with the applicable federal and state laws.

Responsibilities:

A. Establish and maintain written policies and procedures that place appropriate administrative, technical, and physical safeguards to protect the privacy of protected health information from intentional or unintentional uses and disclosures that are in violation of the law.
   a. Update policies and procedures as necessary and appropriate, and in compliance with UND Center for Family Medicine's Notice of Privacy Practices, to comply with changes in the law.
   b. Make necessary changes to the Notice of Privacy Practices.
   c. Maintain policies and procedures (including any changes made) in written or electronic form for six years from the date of its creation or the date when it last was in effect, whichever is later.

B. Make all reasonable efforts to limit incidental uses and disclosures.

C. Provide training of the established policies and procedures as necessary and appropriate to carry out individual job functions and document training provided.
   a. To new workforce members
   b. To existing workforce members annually
   c. To existing workforce members when there are changes to job function of an individual or policy and procedures changes.

D. Act as the responsible contact person for workforce members and patients to report complaints concerning compliance of the law and UND Center for Family Medicine's HIPAA policies and procedures.
   a. Promptly and properly investigate and address reported violations, taking steps to prevent recurrence.
   b. Document all complaints and follow up documentation.

E. Ensure workforce members and patients who make reports or participate in an investigation of violations in good faith will not be subject to intimidation, threats, coercion, discrimination against, or any other retaliatory action as a consequence.

F. Mitigate any harmful effect that is known to UND Center for Family Medicine of a use or disclosure of PHI in violation of its policies and procedures or the requirements of the law.

G. Consistently enforce the law, policies, and procedures through appropriate disciplinary mechanisms.
   a. Actions taken against a workforce member who failed to comply with the policies and procedures are documented and filed in the Privacy Officer's files.

H. Monitor, audit, and reinforce compliance with the law and UND Center for Family Medicine's policies and procedures.

I. Provide assistance to patients and other workforce members about the law, policies, and procedures.

J. Not require individuals to waive their legal rights as a condition of the provision of treatment or payment.

K. Implement, distribute and maintain the Notice of Privacy Practices
   a. Maintain a copy of the Notice (including changes made) for six years from the date when it was last in effect
   b. Update the Notice to reflect changes in the law, polices, and/or procedures
   c. Distribute the Notice
   d. Answer questions regarding the Notice

Home

HIPAA Security Officer

The HIPAA Security Officer shall oversee all ongoing activities related to the development, implementation, and maintenance of UND Center for Family Medicine's security policies in accordance with the applicable federal and state laws.

Responsibilities:

A. Oversee and enforce all activities necessary to comply with the Security Rule.
B. Establish, update, and maintain written policies and procedures to comply with the Security Rule.
    a. Retain them for six years (including any changes made) from the date of creation or date it was last in effect, whichever is later.
C. Periodically and as necessary, review and update documentation to respond to environmental or operational changes affecting the security of ePHI.
D. Perform internal audit of data access and use to detect and deter breaches.
E. Ensure risk assessments are conducted, documented, and updated, as necessary, to comply with the Security Rule and maintain the documentation for six years from the date of creation.
F. Implement procedures for the authorization and/or supervision of workforce members who work with ePHI or in locations where it may be accessed.
G. Implement policies and procedures to address security incidents
H. Receive reports of security breaches.
    a. Promptly and properly investigate and address reported violations, taking steps to prevent recurrence.
    b. Work with the Business Manager to apply consistent and appropriate sanctions against workforce members who fail to comply with the security policies and procedures.
    c. Mitigate any harmful effect know of a use or disclosure of ePHI in violation of policies and procedures.
I. Provide training for its workforce members of the established policies and procedures as necessary to and appropriate to carry out their job functions and document training provided.
    a. To new workforce members
    b. To existing workforce members annually
    c. To existing workforce members when there are changes to job function of an individual or policy and procedures changes.

Home

EMR Contingency

Purpose:

To provide a plan for each clinic department to follow when the computers and/or software are not working properly.

ALL DEPARTMENTS:

Retain copies all forms listed in this policy for use. Update forms on a yearly basis if applicable.

Front Reception:

In the event of an unplanned downtime, first action is to call the Technology Support Center and contact local IT staff member. 1-877-949-4678.

Contingency computer is located on the west wall of the front reception area. This computer must be left on and restarted weekly to keep files up to date. Daily schedules can be found in the Sanford Applications; One Chart Downtime Read only. Access is your EMR login. **TEST THIS MONTHLY, including PRINTING. This computer will be audited monthly following the downtime PC audit EPIC workflow.

1. All patients will complete the Downtime packet.
2. Photocopy insurance cards as needed.
3. Copy demographics to travel with patient to the nurse/provider.
4. Notify nurse of patient admitted to be seen by phone.
5. Keep a log of patients calling into make an appointment; call patients when it is possible to schedule in EPIC. Record patient's name, DOB and phone number.
6. Copayments and payments will not be collected, patients will be called to make payments after the computers are available.

NEED: Patient Registration Forms in Downtime Packet
COVID-19 Downtime Screening
COVID-19 Vaccine Documentation
Patient Telephone Encounter

Nursing/Physicians:
Documentation of visit will be done on a Patient Office Visit Downtime Form for each visit to include the following information as needed: SOAP/progress notes, referrals, history, medications, immunizations, communication and nursing orders, patient education, lab/xray orders.
Prescriptions will be hand written on prescription pads and keep copy with the notes for the visit.
NEED: Patient Office Visit Downtime Form
Prescription Pads
ABN
MRI Screening Form
Patient Telephone Encounter

Lab/X-ray Orders
Fill out lab and x-ray requisitions completely as possible. Including name, DOB, chart #, ordering physician, dx codes. Notify lab/x-ray that the patient is ready. Remember to mark waiting or not-waiting. Any known insurance and demographic information should also be sent with lab/x-ray orders.
NEED: Lab/X-ray Requisition form

Health Information

Nursing/Provider chart needs, call Ext 26754. Ask for the possibility of EMR records and updated access to EMR.

Business Office Assist other departments as needed.

Residents/Faculty Scheduling can be found on MedHub and at the front reception desk.

Post Computer Downtime

Master list of patients will be sent to Appointment, Nursing and Business Office Supervisors. Return calls to patients that called wanting an appointment to schedule their appointment. Add appointments to the DOS on EMR schedule.

Providers and Nurses will document the visit in the appropriate encounter. Complete the documentation from the Patient Office Visit Downtime Form. Medications, Orders and Referrals will be added to the patient's records as necessary. Health Information and Business Office will audit chart for completion.

Home

BUSINESS OFFICE

Guidelines for Determining Fees

Documentation Guideline for Evaluation and Management Services

Charges

Hospital Charge Submission

Employee Discount

Financial Assistance

Financial Assistance Adjustments

Collections

Home

Guidelines for Determining Fees

1. The provider is responsible for checking the appropriate level of service.
2. Diagnosis coded to the highest specificity must be recorded in every EMR note. The provider is responsible for entering the diagnosis code into the EMR note.
3. Use E/M Office Visit Auditing Tool to decide your appropriate level of service (next page)

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Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

*TIME Method	Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
			Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
	99211	N/A	N/A	N/A	N/A
15-29 mins 10-19 mins	99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment

30-44 mins
20-29 mins
	99203
	99213
		Low	Low
			• 2 or more self-limited or minor problems;
			or
			• 1 stable chronic illness;
			or
			• 1 acute, uncomplicated illness or injury
				Limited
				(Must meet the requirements of at least 1 of the 2 categories)
				Category 1: Tests and documents
				• Any combination of 2 from the following:
				  • Review of prior external note(s) from each unique source*;
				  • review of the result(s) of each unique test*;
				  • ordering of each unique test*
				or
				Category 2: Assessment requiring an independent historian(s)
				(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
					Low risk of morbidity from additional diagnostic testing or treatment

45-59 mins
30-39 mins
	99204
	99214
		Moderate	Moderate
			• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
			or
			• 2 or more stable chronic illnesses;
			or
			• 1 undiagnosed new problem with uncertain prognosis;
			or
			• 1 acute illness with systemic symptoms;
			or
			• 1 acute complicated injury
				Moderate
				(Must meet the requirements of at least 1 out of 3 categories)
				Category 1: Tests, documents, or independent historian(s)
				• Any combination of 3 from the following:
				  • Review of prior external note(s) from each unique source*;
				  • Review of the result(s) of each unique test*;
				  • Ordering of each unique test*;
				  • Assessment requiring an independent historian(s)
				or
				Category 2: Independent interpretation of tests
				• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
				or
				Category 3: Discussion of management or test interpretation
				• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
					Moderate risk of morbidity from additional diagnostic testing or treatment
					
					Examples only:
					• Prescription drug management
					• Decision regarding minor surgery with identified patient or procedure risk factors
					• Decision regarding elective major surgery without identified patient or procedure risk factors
					• Diagnosis or treatment significantly limited by social determinants of health

60-74 mins
40-54 mins
	99205
	99215
		High	High
			• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
			or
			• 1 acute or chronic illness or injury that poses a threat to life or bodily function
				Extensive
				(Must meet the requirements of at least 2 out of 3 categories)
				
				Category 1: Tests, documents, or independent historian(s)
				• Any combination of 3 from the following:
				  • Review of prior external note(s) from each unique source*;
				  • Review of the result(s) of each unique test*;
				  • Ordering of each unique test*;
				  • Assessment requiring an independent historian(s)
				or
				Category 2: Independent interpretation of tests
				• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
				or
				Category 3: Discussion of management or test interpretation
				• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
					High risk of morbidity from additional diagnostic testing or treatment
					
					Examples only:
					• Drug therapy requiring intensive monitoring for toxicity
					• Decision regarding elective major surgery with identified patient or procedure risk factors
					• Decision regarding emergency major surgery
					• Decision regarding hospitalization
					• Decision not to resuscitate or to de-escalate care because of poor prognosis

*Time information added by AHCAE for education purposes.

Documentation Guideline for Evaluation and Management Services

Medical record documentation is required to record pertinent facts, findings, and observations about the individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is important element contributing to high quality care.

General Principles of Medical Record Documentation

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

4. The documentation of each patient should include:

    - Reason for the encounter and relevant history, physical examination findings and prior diagnostic results;
    - Assessment, clinical impression or diagnosis;
    - Plan for care;
    - Date and legible identity of the observer.

5. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

6. Past and present diagnoses should be accessible to the treating and/or consulting physician

7. Appropriate health risk factors should be identified.

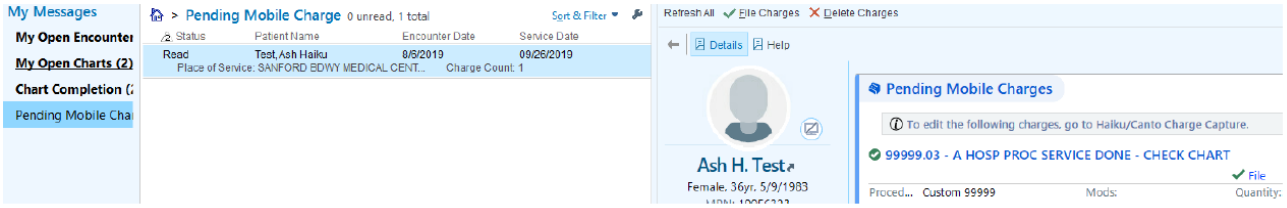
8. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

The CPT and ICD-10CM codes reported should be supported by the documentation in the medical record.

Home

Hospital Charge Submission

Hospital charges are completed, by the attending physician, on all Center for Family Medicine patients, for admissions, consultations, and ER services. Patients are billed directly from the charge capture. All information concerning the patient's care must be recorded daily.



Employee Discount

1. 100% Courtesy: (excluding any cosmetic services. i.e. hair removal, botox)

   a. Center for Family Medicine physicians, and their dependents.
   Please Note: Eligible dependents are defined as those that reside within the same household.

   b. Employees, their spouse and dependent children insured by policy holder.

2. Physician's Professional Fee (excluding lab tests, x-rays, shots, supplies, etc.)

   a. Medical students and their dependents

3. Miscellaneous

   a. Individual consideration for a discount for any patient may be available with approval of the Business Manager. A 10% discount may be available if requested by the patient. The discount will only be applied of the balance due is paid within 30 days of initial billing date.

   b. In all cases of employee discount, where health insurance benefits are payable, the Center for Family Medicine will file a claim for the full insurance benefit, and adjustments are made after receiving Insurance Explanation of Benefits.

Home

Financial Assistance

Purpose:

UND Center for Family Medicine – Bismarck (UND CFM) is committed to providing quality health care to individuals and families in the Bismarck –Mandan community regardless of their ability to pay. This charity care policy is in effect for uninsured patients seeking medical services. It is also in effect to serve as a consistent, objective process for determining eligibility.

Policy:

In recognizing its responsibility to provide healthcare to members of the community, the UND CFM offers reduced or free care to eligible patients. Eligibility for this program is based on verified annual household income and family size. Each applicant will be required to complete an application form and provide the requested supporting documentation for verification. The income standards used are in accordance with the Federal Poverty Guidelines established by the Health and Human Services Department.

Responsibilities of UNDCFM

- Will allow all patients the opportunity to apply for charity care.
- Will respond within 14 days of receipt of application with either a denial or approval letter.
- Will allow the applicant 14 days to appeal a denial or correct any errors in documentation
- Will work with any denied applicant in determining a payment plan
- Documentation of successful and unsuccessful requests for charity care will be kept on file.

Responsibility of Applicant:

- Will actively participate in the screening process
- Will complete the application, Financial Assistance Application, in full and return it to UND CFM within 14 days
- Will annually re-apply for charity care eligibility

If responsibilities are not followed, the application will denied and the applicant will be responsible for all outstanding balance.

Other Conditions:

- Only one denial request for review will be offered per year
- Conditions of the policy are subject to change
- Persons who are found eligible for charity care, that have not been extended 100% charity care, are still required to make monthly payments on their accounts. If the account becomes delinquent, the charity care will be reversed and the remaining outstanding amount will be sent to collections.

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UND Center for Family Medicine
Charity Care Adjustments
Based on 2022 Federal Poverty Guidelines

	100% Discount		80% Discount		60% Discount		40% Discount		20% Discount	
Family Size	Above	Below	Above	Below	Above	Below	Above	Below	Above	Below
1	$0	$ 13,590	$ 13,591	$ 16,987.50	$ 16,989	$ 20,385	$ 20,386	$ 23,783	$ 23,784	$ 27,180
2	$0	$ 18,310	$ 18,311	$ 22,888	$ 22,889	$ 27,465	$ 27,466	$ 32,043	$ 32,044	$ 36,620
3	$0	$ 23,030	$ 23,031	$ 28,788	$ 28,789	$ 34,545	$ 34,546	$ 40,303	$ 40,304	$ 46,060
4	$0	$ 27,750	$ 27,751	$ 34,688	$ 34,689	$ 41,625	$ 41,626	$ 48,563	$ 48,564	$ 55,500
5	$0	$ 32,470	$ 32,471	$ 40,588	$ 40,589	$ 48,705	$ 48,706	$ 56,823	$ 56,824	$ 64,940
6	$0	$ 37,190	$ 37,191	$ 46,488	$ 46,489	$ 55,785	$ 55,786	$ 65,083	$ 65,084	$ 74,380
7	$0	$ 41,910	$ 41,911	$ 52,388	$ 52,389	$ 62,865	$ 62,866	$ 73,343	$ 73,344	$ 83,820
8	$0	$ 46,630	$ 46,631	$ 58,288	$ 58,289	$ 69,945	$ 69,946	$ 81,603	$ 81,604	$ 93,260
% of Poverty	100%		125%		150%		175%		200%	

For families with more than 9 members, for each additional member add $4720

Home

COLLECTION POLICIES

1. Payment is expected at the time of service unless arrangements are made with the patient accounts representative, or insurance coverage is available.

2. The front desk will collect **co-pays** at the time of service. This is to be done in every case where we know the deductible and co-pay amounts. A routine collection of $25 should be collected when co-pay amounts cannot be determined.

3. The insurance office will bill all insurance carriers. The patient is responsible to provide proper insurance information to the front desk.

4. If no insurance, a minimum of $25 is requested up front. After visit, patient is to set up payment arrangements in the Business Office.

5. All collection activities are subject to some flexibility depending on known history of the patient and availability of staff.

6. All account balances older than 120 days are subject to collections. Collection letter #1 will be sent and if no response is generated within 30 days, letter #2 will be sent. If there is still no response from the account holder within 10 days of letter #2 then the account will be turned over to the collection agency and written off. All accounts ready to be sent to collections must be approved by the Business Manager, and Associate Dean of Administration and Finance.

Home

EMPLOYEE ONLINE TRAINING

Harassment

UND SafeColleges Training

HIPAA

Home

Harassment/Discrimination

The University of North Dakota does NOT TOLERATE harassment or discrimination OF ANY KIND!

Refer to all policies: http://und.edu/affirmative-action/harassment.cfm

Use this website page for the following links for training and information: http://und.edu/affirmative-action/harassmenttraining.cfm

Equal Employment Opportunity/Affirmative Action Office
Tel: 701.777.4171
Fax: 701.777.2077

Home

UND VectorSolutions SafeColleges Training

https://campus.und.edu/safety/resources/safe-colleges.html

Login Active Directory

As employees of a public institution of higher education, we are each responsible to complete various safety training programs, as well as designated federally-mandated training. The University of North Dakota is pleased to announce that the institution now offers convenient access for you to complete these training programs online.

Online Training -

The online training is available and offered to all University of North Dakota employees. This program offers several self-paced safety courses which can be accessed 24/7 and comes with a printable certificate of successful completion. The certificates do not need to be signed for completion.

Training will be assigned as needed to employees; notification of required training will be by email.

Home

SAFETY

General

Substance Abuse/Drug-Free Workplace

Safety Training

UND Emergency Codes

Emergency Evacuation (All Personnel Alert)

- Severe Weather /Community Action (Code Lockdown)
- Power Outage
- Fire Prevention

Emergency Eyewash Station/Shower

Preventative Maintenance

Medical Emergency

- Code Blue

Emergency Management-Respiratory

Emergency Management-Ebola

Emergency Management-COVID-19

- Moderate/High Risk
- Low Risk

Code Amber

Communicable Diseases

- Aerosol Transmissible Diseases
- Minimize Measles Transmission
- Bloodborne Pathogens
- Large-Scale Communicable Outbreak

Bloodborne Pathogens Exposure Control Plan

Sharps

Evaluation of Safety Devices

Respiratory Protection Program

Respirator PAPR

Regulated Medical Waste Management and Segregation

Hazard Communication Standard

Radiation

Workplace Violence (Security Alert)

Emergency Telephone Contacts

ASSURANCE Alert System

Emergency Management-Disaster

EPIC Contingency

Home

***Refer to UND Environmental and Safety information at** https://campus.und.edu/safety/public-safety/additional-resources/office.html

General Safety Policies

The Center for Family Medicine strives to provide a safe and healthy environment for its students, facility, staff and visitors. Teamwork is necessary for all involved to provide a safe environment and operations under their control.

Space Heaters

*University policy at http://und.edu/health-wellness/workwell/resources/ergonomic-assessments.cfm

Ergonomics and Work Station Arrangements

*University policy at http://und.edu/health-wellness/workwell/resources/ergonomic-assessments.cfm

Ergonomics involves adjusting work processes or stations to fit a particular employee. Improper ergonomic design can cause debilitating long-term musculoskeletal effects. Ergonomic assessments will be provided to staff upon request. Report any symptoms to your supervisor.

Ladders and Step stools

Always use an approved ladder or step stool to reach any item above your extended arm height. Never use a makeshift device, such as a desktop, file cabinet, bookshelf, chair or box, as a substitute for a ladder or step stool.

Home

Substance Abuse/Drug-Free Workplace

https://campus.und.edu/human-resources/careers/notices-reports.html

Employees are required to report to work in a condition to perform their jobs in a safe, efficient, and satisfactory manner. The presence of alcohol and other drugs on the job and the influences of those substances on employees during working hours are inconsistent with the objectives of a drug and alcohol free workplace and will not be tolerated.

The clinic prohibits the use, possession, and manufacturing, distribution, selling or being under the influence of alcohol or illegal drugs or use legal drugs illegally. In addition, the legal use of prescribed drugs is permitted on the job only if it does not impair an employee's ability to meet standards and perform the essential functions of the job in a safe manner that does not endanger other individuals, equipment, or property in the workplace.
Staff or employees who violate this policy shall be subject to disciplinary action such as reprimand, suspension, or dismissal.

Any employee who is convicted of unlawful manufacture, distribution, possession, or use of controlled substance or other criminal drug stature is required to notify his/her supervisor no later than five working days after such conviction shall be grounds for disciplinary action up to and including dismissal and/or participation in a substance abuse rehabilitation or treatment program. Violations may also have legal consequences.

A manager may require an employee to leave the workplace if the manager determines the employee has reported to work in an inappropriate condition and cannot perform the essential functions of the job effectively in a safe manner that does not endanger themselves or others. The employee should not operate a motor vehicle; the manager should arrange transportation for the employee. If the employee refuses to accept transportation and insists on operating a motor vehicle, they will be informed by the manager that law enforcement officials will be notified that the employee appears unfit to operate a motor vehicle. Law enforcement officials should be appropriately notified.
The use of alcohol and illegal use of drugs while operating a state vehicle is prohibited. Individuals operating a state vehicle under the influence of alcohol or illegal drugs will be subject to disciplinary action up to and including termination of employment.

Employees with questions and concerns about substance dependency or abuse are encouraged to use the resources of the Employee Assistance Program. Employees may also wish to discuss these matters of this policy with their supervisor to receive assistance or referrals to appropriate resources in the community.

Tobacco-free Building
The University of North Dakota tobacco-free campus policy provides a healthy working and learning environment**.**

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Safety Training

Employees of the clinic are provided with the training necessary to perform their duties in a safe, competent, and responsible manner. Training will be documented by employees signing in on a clinic employee roster. The roster will be filed with the business manager.

Reporting of Injuries, Accidents or Hazards

Emergency assistance should be requested by dialing 911 whenever a situation poses a threat to person or property.
A person receiving any injury must report this without delay to their supervisor. When notified of the injury/accident, the supervisor shall immediately set any accident preventive measures in motion and shall be responsible for seeing that a report is filled out by the injured and given to business manager to file.

If the injured person is a UND employee, medical treatment must be obtained from the University's Designated Medical Provider (DMP) or the employee's own physician of choice if the employee has designated one on their DMP form. Staff at Safety and Environmental Health will file the Workforce Safety and Insurance (formerly ND Workers Compensation) claim for injured employees. The Incident Report and Incident Investigation forms must be completed and sent to Safety and Environmental Health within 24 hours of the incident. Forms can be faxed to 777-4132.

Accident/Workers Compensation Claims Investigations - All accidents must be investigated to determine the cause so as to avoid any future accidents. Accidents involving minor damage or injuries requiring only first aid must be investigated by the person in charge. After the investigation, the ~~A~~Incident Investigation@ form must be completed and submitted to Safety and Environmental Health. In the case of more serious property damage or injury requiring medical attention, Safety and Environmental Health will conduct an investigation in addition to that done by the person in charge. Please notify Safety and Environmental Health immediately if there is a serious injury or incident at 777-3341.

Report ANY unanticipated event

- An Incident is an event that is inconsistent with the routine operation or care of a patient or a visitor including situation s considered to be "near misses" or that do not result in an injury.
    - Near Miss
    - Allergic Reactions
    - Falls (any incident of an employee injury)
    - Equipment failures or improper use of equipment resulting in injury
    - Workplace Violence
    - Improper Consent
    - Procedures performed without informed consent
    - Refusal of Treatment
    - Refusal to be informed
    - Lost or broken valuables
    - Patient leaving or signing out against medical advice-noncompliance
    - Unanticipated patient outcome
    - Misdiagnosis
    - Wrong patient treated or wrong procedure performed.
    - Medication-related occurrences (including near-misses)
    - Situations where litigation might occur
    - Data breaches and cyber issues
- CONTACT your Supervisor to file an incident report.
    - Incident reports are used to investigate a need for change and improve the way something is done. They are NO FAULT/NO BLAME reports-Non-punitive.
    - Documentation-Remember to document the facts of what happened in the chart if applicable as well as on the incident form. DO NOT mention incident form or investigation in the chart.
- For patient care incidents

https://www.nd.gov/eforms/Doc/sfn53601.pdf
For employee or patient injury incidents that do not involve patient care.
https://campus.und.edu/safety/_files/docs/incident-reporting-form-persons.pdf

GIVE COPY OF THE INCIDENT REPORTING PROCEDURES TO BOTH ENTITIES
ALL OTHER INCIDENTS WHETHER EMPLOYEES, STUDENTS OR VISITORS MUST BE **FILED ONLINE BY THE SAFETY OFFICE.**

Safety meetings, corrective actions, and training programs for employees will be documented. Safety policies and procedures will be re-evaluated annually.

THE INCIDENT REPORTS AND THE INCIDENT INVESTIGATION FORMS CAN BE FOUND ON THE FOLLOWING WEB SITE:

https://www.nd.gov/risk/riskvision/rmis/Incidents/default.asp?guest=true

Reporting and eliminating Unsafe Practices and Hazardous Conditions
Near accidents, hazardous conditions and practices must be promptly reported to the supervisor. The Safety and Environmental Health office at UND can be contacted for advice.

Safety evaluation
Safety meetings, corrective actions, and training programs for employees will be documented. Safety policies and procedures will be reevaluated annually.

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UND Emergency Codes

Security HOT KEYS F9/F11
Code Red Fire
Alarm…Fire/Visible Smoke
CODE BLUE
MEDICAL/Resp/Cardiac Arrest
Weather Alert
-Tornado Watch
-Tornado Warning
-Define other types
Security Alert
-Missing Person*-age/gender
-Manpower needed*
-Armed Intruder* (location)
-Lockdown*
*Notify Sanford Security @ 214-9269 or
Front desk dial Sanford phone 1111
Paging on ALL Phones
Dial 4646; WAIT for 1 sec delay
Announce CODE plus Location 3 times. Speak slow and clearly.

Home

EMERGENCY EVACUATION

Severe Weather (Weather Alert) /Community Action (Security Alert-Lockdown)

In the event of an emergency/severe weather the Business Manager/Director will determine if the clinic operations will be continued or discontinued. If the clinic will be closed the employees will follow an emergency evacuation plan. If the weather emergency happens before the start of the clinic day, the employees will be notified by Assurance Alert System of the emergency and directions. Patients will be directed to contact the local hospital if they need care.
The community of Bismarck has and Emergency Alert System that all persons need to understand in order to know what to do in the event of an emergency. There are many different reasons that this alert system may be activated. Some examples include Tornados, Floods, Wind Storms, Terrorist/War Threat, Violence or Chemical Spill. These emergencies often come with little or no warning.
Typically, notification of emergencies having an immediate potential for injury or death will be initiated by the sounding of the civil defense sirens. When you hear these sirens, immediately turn on either a radio or television. The designated Emergency Alert Stations are KFYR 550 AM, KFYR-TV and KXMB-TV. Do not contact 911 or your local emergency provider for information. Local television and radio stations will provide the appropriate instructions relative to the emergency. These instructions may be to evacuate the area/neighborhood or seek shelter indoors. For specific hazards, special instructions will also be provided (wet towels under doors, turn off furnace, etc.) Be familiar with the sirens, the system is tested monthly on the last Friday at 9 a.m.

Tornado (Weather Alert)
Emergency conditions such as tornados can develop very quickly and without warning. In the event of the weather conditions that set up the possibility of a tornado, the weather should be monitored using a weather radio.
Tornado Watch: Means weather conditions are right or favorable for a tornado to develop. In the event of a tornado watch the employees will be notified by the safety officer or the business manager to be on alert incase the weather worsens. Continue alert until an "all clear" is announced.
Tornado Warning: Is declared when a funnel cloud has been sighted or indicated by radar. If notice is received to seek shelter and move to safer locations. **Alert staff using paging system and/or UND mass communications.**

1. Evacuation of patients will be handled by the employees. Have everyone evacuate to the hallways. Person(s) should then proceed to the nearest protected inside area away from windows and cluttered areas. Assume a crouched position with arms over your head. Remain there until the "ALL CLEAR" is announced by the weather service.
2. Person(s) located on second floor need to evacuate to the lowest level using the stairs.

Evacuation:

1. Call 9-911 if necessary to alert them of the evacuation.

2. Provide notification to all staff by using Lynx Mass Notification and Assurance alert system by phone, email and text messages. These alert systems are used when there is a severe or imminent threat to public safety and health of our clinic community.

3. It is the responsibility of the staff to remove all patients to safety. Refer to the Emergency Evacuation route maps to be familiar with evacuation routes.

4. Daily patient schedules can be accessed by calling UND School of Medicine at 777-4168 to run daily reports that can be emailed to the Business Manager.

5. Key staff have access to laptops and mapping our shared drives to shared files.

6. Evacuation of People with Disabilities:

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*Refer to the clinic's Building Emergency Action Plan(BEAP)

The clinic staff and faculty will provide assistance to people with disabilities.
Areas of Rescue (Stairwells) are located on second floor at the East and West corridors. Disabled Persons will be rescued by rescue personnel from these areas. Person(s) can wait here if they are unable to use the stairwell. A rescue call button is located at each Area of Rescue. Push to alarm that someone is at the Area of Rescue and to speak to rescue personnel.

7. Staff will exit after all patients are removed from danger. All staff and patients should be instructed to meet in the south reception area if safe or in the southeast corner of the clinic parking lot. The Business Manager and Department Supervisors will account for all patients and staff. All staff and patients may return after rescue personnel have given the "All Clear".

8. Evacuation Responsibilities to clear patients and visitors from the clinic during an emergency evacuation

Receptionist-Clear Front waiting room Bathrooms, Waiting Rooms, Monitor Elevator to be sure no one uses the elevator and monitor stairs so no one goes to the second floor.
Business Manager or their Designee-Direct Traffic and assist emergency personnel. Inform the fire department that the building is all clear or the areas in which patients or staff may need additional assistance in evacuating.
Nursing-Clear all exam rooms and Procedure Rooms 2, 3, 4. Keep the nursing side hallway door open when the room is cleared after all rooms are cleared, staff members from each hallway quickly close all nursing hallway exam doors to stop the spread of fire. Clear employee bathrooms.
Lab/X-ray-Clear lab bathrooms, phlebotomy rooms, x-ray changing rooms. Assist to clear Procedure room 1. Clear Residency Offices.
Medical Records/Business Office-Clear employee bathrooms, employee exercise room, locker rooms.
Residency/Physician Offices-Clear conference room, kitchenette, conference room
Pharmacy-Clear pharmacy and assist with Procedure rooms 2, 3, 4
School of Medicine-Clear all classrooms, office space, conference room and student lounge.

9. Shelter-In-Place will be decided to fit the emergency. A Shelter-In-Place is where we will evacuate to if the emergency alert system is requesting us to stay inside to wait for further instructions. Possibilities are the Conference Room and Employee Health Center.

10. Training will be provided annually. Evacuation drill will be included with the fire drill annually.

Fire Prevention

Refer to full policy at https://campus.und.edu/safety/public-safety/fire-safety.html

The following rules are critical to the prevention of most fire emergencies:
*Never block or obstruct fire lanes, they must remain clear at all times to provide access for emergency vehicles.
*Do not obstruct any of the required exits or exit pathways from buildings.
*Never store flammable or combustible^ liquids in areas used for exits, stairways, or normally used for the safe passage of people.
*Store flammable or combustible liquids^ only in approved closed containers.
*Never tamper with or attempt to alter any fire protection equipment. **Home**

*Never overload existing power circuits.

*Carryout good housekeeping practices.

*Candles, incense, or similar devices with open flames are prohibited in the clinic.

* Holiday Decorations must not disguise, cover or interfere with any fire safety device.

The clinic complies with the fire codes and standards for the State of North Dakota. Combustibles are objects that are capable of catching fire and burning, including but not limited to: paper, cardboard, wood, and fabric.

FIRE PROCEDURE (Code RED FIRE)

1. The person who discovers the fire will notify the rest of the clinic by pulling the nearest fire pull located on the wall.
2. The staff member nearest the location of the fire will bring the nearest fire extinguisher to the fire and attempt to put out the flames if it can be done safely.
3. When a room or area of the clinic is cleared, close doors to stop the spread of fire.
4. Follow the Evacuation policy to remove everyone from the building.
5. Staff will exit after all patients are removed from danger. All staff and patients should be instructed to meet in the southeast corner of the clinic parking lot The Business Manager and Department Supervisors will account for all patients and staff. All staff and patients may return after the fire department has given the "All Clear".

Fire Extinguishers

Location of extinguishers can be found on all fire evacuation maps on each floor.
Fire Extinguishers will be maintained and inspected yearly. Monthly visual checks for proper location, accessibility and visibility, intact tamper seal, allowable pressure range, corrosion or damage to the tank, clogging of the discharge nozzle.

Only consider using a fire extinguisher if you are trained to do so, and if you can safely do so without risk to yourself or other persons. Consideration should be given to the type of extinguisher needed to combat a particular class of fire. The type of extinguishers available in the clinic is dry chemical.
Fire Classifications are as follows:

Class A: Fire in ordinary combustible materials such as wood, cloth and paper, where the quenching and cooling effect of large quantities of water or solutions containing a large percentage of water is of first importance. Use water or the dry chemical extinguishers for this type of fire.
Class B: Fires in flammable liquids such as gasoline, fuel oil, alcohol or grease, where a blanketing effect is essential. Use the dry chemical fire extinguisher for this type of fire. DO NOT USE WATER.
Class C: Fires in electrical equipment where the use of an electrically nonconductive extinguisher agent is of first importance. Use the dry chemical fire extinguisher only for this type of fire. DO NOT USE WATER.

The inspection of the Fire Extinguishers is done yearly by Dakota Fire Station Inc.

Sprinklers
Maintain 18 inches directly underneath sprinklers in all areas of the clinic.

Fire Exit Drill
Fire Drills are coordinately yearly with the Sanford Safety Department, Watchmen and Fire Station. **Home**

The purpose of a drill is to insure familiarity and safe use of all available exits and fire extinguishers. Proper drills insure orderly evacuation without undue panic. Speed in vacating the building, while desirable, is not in itself the objective and should be secondary to the maintenance of proper order and discipline. All fire drills must be coordinated with Sanford Safety, ElectroWatchman, Fire Dept, School of Medicine and CFM Administration. Record results on Fire Evacuation Drill Form, listing any changes or problem areas.

False Alarm
Report by calling 221-6801

Electrical Safety/Power Outage

Safe work practices must be used to prevent electric shock or other injuries that may result from contact with an energized circuit. Electrical equipment needs to be free from recognized hazards that are likely to cause death or serious physical harm. Employees should report any dangerous hazards.
Keep work areas clean and dry. Cluttered work areas invite accidents and injuries.
Preventive maintenance plays a key role in electrical safety and prevention of electrical accidents
Some common conditions to be aware of are:

- Flickering lights
- Warm switches or receptacles
- Burning Odors
- Loose connections
- Frayed, cracked or broken wires
- Tripped circuit breakers
- Wet or damp locations

Emergency Lights located throughout the clinic will be inspected monthly and maintenance performed as needed. These lights will automatically turn on during a power outage.
If you are involved in a procedure in the treatment room during the power outage, there is a backup battery located in the room to plug the instruments and lights into at all times. This backup battery will power the instruments for up to 1 hour. This battery is monitored by the nursing department and checked monthly.

Care of Refrigerated Medicine and Reagents during a Power Outage

Purpose: To outline the action to be taken to protect vaccine and other refrigerated or frozen medications in the nursing department, as well as the chemical reagents used in the laboratory from spoilage in the event of an extended power outage.
Procedure:

1. Refrigerator temperature min and max for the last 24-48 hours will be checked and documented each morning Monday through Friday on the temperature log sheet. This will alert the nursing staff if the temperature has been out of the acceptable range for viability of the medications. If the temperature has been out of range, a nursing staff member will contact the vaccine manufacturers to determine if the vaccine remains viable and can be used.
2. In the event of a power outage, Web 600 Sensaphone will monitor and alert appropriate staff to the change in temperature for laboratory and nursing refrigerators. The Web 600 will start notifying when the temperature is out of range set up in the Web 600 program.

Home

Procedure for Vaccines and Medications by Nursing Personnel:

In the event of a power outage and the Sensaphone on the refrigerator alarms, Nursing will go to the clinic and remove refrigerated vaccines and medications, placing them into ice-pack-lined coolers and transport to St. Alexius Medical Center Inpatient Pharmacy for temporary storage until the power is restored at the Center for Family Medicine.

1. Dennis Delabarre, Assistant Director of Inpatient Pharmacy at St. Alexius Medical Center has agreed that their pharmacy will be able to provide temporary storage of our refrigerated vaccines and medications.

2. Frozen vaccines are to be placed into an ice-packed-lined cooler and transported to St. Alexius Medical Center Inpatient Pharmacy for temporary storage.

Procedure for pharmaceuticals by Pharmacy personnel:

1. Pharmacy personnel will be notified and call Heritage Pharmacy to temporarily store pharmaceutical supplies at Heritage Pharmacy.

Procedure for Chemical Reagents by Laboratory Personnel:

1. All Laboratory staff will be notified and will call Sanford lab, to determine if the CFM chemical reagents can be temporarily stored at their facility until power is restored at the CFM.
2. Lab personnel will transport the chemical reagents to the Sanford Lab in coolers.
3. If Sanford Lab is unable to store the chemical reagents from CFM lab, another alternative is Northern Plains Lab.

Home

Emergency Eyewash Station/Shower

Emergency drenching/flushing equipment must be available when reasonable potential for exposure to injurious corrosive materials exists. The clinic's eyewash station is located in the laboratory, north hallway and soiled utility.
To activate North Hallway Eyewash:

1. Pull off the green caps.
2. Turn on the cold water.
3. Pull the silver knob on the front of the eyewash faucet.
4. Position eyes/skin continuously over the stream of water for at least 15 minutes. Hold eyelids open with fingers so flushing fluid can fully irrigate the eyes. Never use homemade neutralizing solutions.
5. People may not always be able to flush their eyes on their own because of intense pain. Persons nearby should be prepared to assist.
6. Turn water off and replace caps when finished.

To activate Eyewash in Laboratory

1. Pull down eyewash.
2. Position eyes/skin continuously over the stream of water for at least 15 minutes. Hold eyelids open with fingers so flushing fluid can fully irrigate the eyes. Never use homemade neutralizing solutions.
3. People may not always be able to flush their eyes on their own because of intense pain. Persons nearby should be prepared to assist.

To activate Shower/Eyewash in Soiled Utility Room

1. Shower-Pull handle straight down and stand under water for ≥15 minutes for corrosive materials.
2. Eyewash-Push handle located on the right side of eyewash. Position eyes/skin continuously over the stream of water for at least 15 minutes. Hold eyelids open with fingers so flushing fluid can fully irrigate the eyes. Never use homemade neutralizing solutions. People may not always be able to flush their eyes on their own because of intense pain. Persons nearby should be prepared to assist.

Notify supervisory personnel and seek medical attention after use of emergency shower/eyewash station.
Maintenance:
Eyewash/Shower stations will be tested weekly. Temperature of the Eyewash/Showers will be monitored periodically.

Home

Preventive Maintenance of Medical Equipment

Purpose:

To safely inspect, manage and maintain all equipment in use at the clinic routinely. Report all malfunctioning equipment to your supervisor. Do not use equipment that is malfunctioning or compromises the safety of the patient or staff.

Policy:

1. All equipment is regularly inspected on a PM schedule provided by each department supervisor. Supervisors will maintain all PM records. An equipment list will be kept for each department.

2. Business Manager/Department Supervisors will maintain and update equipment contracts.

3. Department Supervisors will supervise all equipment repairs and return equipment to use in the clinic.

4. Proper training of employees will be documented when new equipment is implemented. Supervisors will complete a yearly competency evaluation of existing equipment.

5. Defective Equipment Guidelines

   Steps to take if an Incident occurs:

   a. Do not use equipment that is malfunctioning or compromises the safety of the patient or staff. Remove equipment from use immediately.
   b. Staff will remove equipment from use and tag as "DO NOT USE-NEEDS REPAIR". Tag equipment visibly when equipment is cumbersome to move.
   c. Report all malfunctioning equipment to your supervisor.
   d. Supervisor will investigate equipment failure and decide when and if the piece of equipment can be used again for patient care.
   e. Repair equipment as soon as possible. Decontaminate item to be serviced by cleaning all visible residue whenever possible. Where infectious materials were used, disinfect all surfaces with an effective disinfectant. Place into a red biohazard bag before shipping equipment to be repaired. Label with a biohazard label if bagging is not possible.
   f. Document all equipment investigation and repair. Person(s) involved in incident will properly fill out incident report and forward it to their Supervisor.

6. Documentation of all medical device recalls will be kept by department.

Training: Training will be provided during orientation and annually.

Home

MEDICAL EMERGENCY

Code Blue

1. The first person to discover a medical emergency shall use the telephone intercom. Press "**Page**" and announce "**Code Blue**" and location three times.

2. If the medical emergency is a cardiopulmonary arrest, resuscitation (CPR) should be initiated as quickly as possible.

Clinic Personnel will respond to a CODE BLUE as Follows:

Code Leader: Physician in charge (first to arrive) or, in the absence of a physician, an ACLS certified nurse.

Nursing: Bring AED (automatic external defibrillator) and crash cart. Provide nursing services. Call the ambulance **(Dial 911).** Keep crash cart medications up-to-date and keep crash cart adequately stocked. Take Narcan from the crash cart if emergency is located on second floor.

Lab/X-ray: Bring the lab drawing tray and EKG machine. Assist as needed with crash cart, open IV bag and tubing/medication boxes and assist with CPR as needed.

Front Desk: Remain at the reception desk and direct the ambulance to the code site. Offer to record event and time as needed, hold elevator at first floor for crash cart if emergency is on second floor.

Recorder: Designated by the code leader. Keep records-time of day, condition of patient, medications administered, procedures administered, time of ambulance arrival and departure, condition of patient at the time of departure.

Med. Records: Do not need to respond to the code, unless more help is needed, you will be notified if help is needed. When emergency is on second floor, monitor elevator to help remove the crash cart from the elevator as needed.

Business Office: Do not need to respond to the code, unless more help is needed.

Bus. Manager: Goes to the waiting room to direct traffic.

CPR Certification

All clinic employees are required to maintain Basic Life Support (BSL) certification. This is accomplished by passing the required written test and practical test given by qualified instructors in Basic Life Support, in accordance with the standards of the American Heart Association.

New employees who are not BLS certified have the opportunity to take the initial basic learning session, which will qualify them for BSL certification.

BLS renewal certification is made available to all employees every two years. The nurse supervisor will set up recertification.

Home

Emergency Management

Respiratory (Pandemic Flu, SARS, SARS-CoV-2)

Response Team:

Business Manager Representative Response Coordinator

Nursing Supervisor Representative Infection Control

Risk Management/Lab Representative Education

Administration Representative Communication

Nursing Representatives Infection Control
Community Outreach

Radiology Representative Surveillance Coordinator

Reception Representative Surveillance

Surveillance/Communication:

1. Monitor State, County and City Public Health advisories. The clinic will monitor all facsimiles, emails and telephone calls. Updates will be made to the Response team and communicated to all clinic employees by posting updates on the Pandemic Bulletin Board and staff meetings. Refer to contact list (Appendix 1).
2. Inform members of the Response team when pandemic respiratory illness is in the U.S. and when it is nearing the geographic area.

    - ND Health Alert Network(HAN)
      Categories of Health Alert messages:
      • Health Alert conveys the highest level of importance; warrants immediate action or attention.
      • Health Advisory provides important information for a specific incident or situation; may not require immediate action.
      • Health Update provides updated information regarding an incident or situation; no immediate action necessary.
      • Health Information provides general information that is not necessarily considered to be of an emergent nature.

3. Monitor and review respiratory illness activity in patients cared for by clinical staff.

    - The clinic is a sentinel provider involved in the NDrespiratory illness Surveillance Network. respiratory illness data is reported to the state respiratory illness Coordinator on a weekly basis during the normal influenza season. The network will notify the clinic if there is a need to increase reporting requirements. We will monitor any changes and increase reporting requirements accordingly.

4. Report unusual cases of respiratory illness like illness to the local and state health department.

    - The health department will provide recommendations to health care providers using the HAN. We will be responsible for reporting potential cases. Clinicians should immediately contact the health department when they suspect a human case of infection with an avian or animal strain of influenza or any other novel human respiratory illness strain. Nursing will call public health for current information when a patient is suspected of having contact with a pandemic strain of respiratory illness.

- Clinical Criteria-Fever plus one of the following, sore throat, cough and dyspnea. Different flu strains may present differently. For more current information refer to www.cdc.gov/

5. Periodically, updates to the local regional pandemic plans will be monitored at the local county health department and NDDOH.

6. Communication with other community hospitals and clinic will be accomplished by attending the bimonthly SW Hospital Region Emergency Response and Preparedness Planning meetings.

Home

Phases of a Pandemic: (WHO)

In the 2009 revision of the phase descriptions, WHO has retained the use of a six-phased approach for easy incorporation of new recommendations and approaches into existing national preparedness and response plans. Phases 1–3 correlate with preparedness, including capacity development and response planning activities, while Phases 4–6 clearly signal the need for response and mitigation efforts. Furthermore, periods after the first pandemic wave are elaborated to facilitate post pandemic recovery activities.

Clinic Response:

PHASE 1-4

1. Prepare for Pandemic.
2. Stockpile PPE for clinic staff.
3. Continue Surveillance.

PHASE 5:

1. Post Signage: Cough Etiquette, Notice to Patients.
2. Stock isolation masks to be given to patients with flu like symptoms in proper areas. (receptionist desk, nursing halls)
3. Limit the patient's movement within the clinic.
4. Employees should stock N 95 masks for use with patient care.
5. Provide facial tissues and hand sanitizers for patient and employee use.
6. Provide Patient Education.
7. Continue Surveillance and employee updates.
8. Inform staff to use proper infection control measures and to follow HAN directives.

PHASE 6: PANDEMIC

1. Continue PHASE 5 response.
2. Response team will meet to discuss changes in patient care and clinic response. (Cancel/Rescheduling of Non-Essential Appointments, Designating separate times for non-pandemic and pandemic patients, Hospitalization)
3. Triage patients to determine who requires medical evaluation. Follow the TRIAGE PROTOCOL (Appendix 2)
4. Follow HAN directives.

POST-PANDEMIC

1. Response team will evaluate clinic's response to the pandemic and discuss changes that are needed.

Continue Surveillance and prepare for the second "wave" of the pandemic flu.

Infection Control

Infection Control

Summary of Infection Control Practices can be found in Appendix 4

1. **Personal protective equipment**
   a. **PPE for standard and droplet precautions**
   PPE is used to prevent direct contact with the pandemic virus. PPE that may be used to provide care includes surgical or procedure masks, as recommended for droplet precautions, and gloves and gowns, as recommended for standard precautions (Box 1). Additional precautions may be indicated during the performance of aerosol-generating procedures (see below). Information on the selection and use of PPE is provided at www.cdc.gov/ncidod/dhqp/gl_isolation.html.

- **Masks (surgical or procedure)**
  - Wear a mask when entering a patient's room. A mask should be worn once and then discarded. If pandemic patients are cohorted in a common area or in several rooms on a nursing unit, and multiple patients must be visited over a short time, it may be practical to wear one mask for the duration of the activity; however, other PPE (e.g., gloves, gown) must be removed between patients and hand hygiene performed.
  - Change masks when they become moist.
  - Do not leave masks dangling around the neck.
  - Upon touching or discarding a used mask, perform hand hygiene.
- **Gloves**
  - A single pair of patient care gloves should be worn for contact with blood and body fluids, including during hand contact with respiratory secretions (e.g., providing oral care, handling soiled tissues). Gloves made of latex, vinyl, nitrile, or other synthetic materials are appropriate for this purpose; if possible, latex-free gloves should be available for healthcare workers who have latex allergy.
  - Gloves should fit comfortably on the wearer's hands.
  - Remove and dispose of gloves after use on a patient; do not wash gloves for subsequent reuse.
  - Perform hand hygiene after glove removal.
  - If gloves are in short supply (i.e., the demand during a pandemic could exceed the supply), priorities for glove use might need to be established. In this circumstance, reserve gloves for situations where there is a likelihood of extensive patient or environmental contact with blood or body fluids, including during suctioning.
  - Use other barriers (e.g., disposable paper towels, paper napkins) when there is only limited contact with a patient's respiratory secretions (e.g., to handle used tissues). Hand hygiene should be strongly reinforced in this situation.
- **Gowns**
  - Wear an isolation gown, if soiling of personal clothes or uniform with a patient's blood or body fluids, including respiratory secretions, is anticipated. Most patient interactions do not necessitate the use of gowns. However, procedures such as intubation and activities that involve holding the patient close (e.g., in pediatric settings) are examples of when a gown may be needed when caring for pandemic patients.
  - A disposable gown made of synthetic fiber or a washable cloth gown may be used.
  - Ensure that gowns are of the appropriate size to fully cover the area to be protected.
  - Gowns should be worn only once and then placed in a waste or laundry receptacle, as appropriate, and hand hygiene performed.
  - If gowns are in short supply (i.e., the demand during a pandemic could exceed the supply) priorities for their use may need to be established. In this circumstance, reinforcing the situations in which they are needed can reduce the volume used. Alternatively, other coverings (e.g., patient gowns) could be used. It is doubtful that disposable aprons would provide the desired protection in the circumstances where gowns are needed to prevent contact with virus, and therefore should be avoided. There are no data upon which to base a recommendation for reusing an isolation gown on the same patient. To avoid possible contamination, it is prudent to limit this practice.

- **Goggles or face shield**

In general, wearing goggles or a face shield for routine contact with patients with

pandemic is not necessary. If sprays or splatter of infectious material is likely, goggles or a face shield should be worn.

b. **PPE for special circumstances**

- **PPE for aerosol-generating procedures**

During procedures that may generate increased small-particle aerosols of respiratory secretions (e.g., endotracheal intubation, nebulizer treatment, bronchoscopy, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a N95 respirator or other appropriate particulate respirator. Respirators should be used within the context of a respiratory protection program that includes fit-testing, medical clearance, and training. If possible, and when practical, use of an airborne isolation room may be considered when conducting aerosol-generating procedures.

- **PPE for managing pandemics with increased transmissibility**

The addition of airborne precautions, including respiratory protection (an N95 filtering face piece respirator or other appropriate particulate respirator), may be considered for strains of respiratory illness exhibiting increased transmissibility, during initial stages of an outbreak of an emerging or novel strain of respiratory illness , and as determined by other factors such as vaccination/immune status of personnel and availability of antivirals. As the epidemiologic characteristics of the pandemic virus are more clearly defined, CDC will provide updated infection control guidance, as needed.

- **Precautions for early stages of a pandemic**

Early in a pandemic, it may not be clear that a patient with severe respiratory illness has pandemic respiratory illness . Therefore, precautions consistent with all possible etiologies, including a newly emerging infectious agent, should be implemented. This may involve the combined use of airborne and contact precautions, in addition to standard precautions, until a diagnosis is established.

c. **Caring for patients with pandemic** respiratory illness

Healthcare personnel should be particularly vigilant to avoid:

- Touching their eyes, nose or mouth with contaminated hands (gloved or ungloved). Careful placement of PPE before patient contact will help avoid the need to make PPE adjustments and risk self-contamination during use. Careful removal of PPE is also important.
- Contaminating environmental surfaces that are not directly related to patient care (e.g., door knobs, light switches)

Essential Staff

The number of staff necessary for patient care during a severe pandemic on a given day will include physicians, nurses, x-ray, lab and receptionists. If necessary, nonessential staff will be moved to administration based on patient care needs and infection control for staff and patients.

Vaccine and Anti-viral

Vaccine and Anti-viral will follow CDC recommendations for use. Updated information can be found at https://www.cdc.gov

Seasonal Influenza Vaccine

a. All employees who are directly involved in patient care are required to receive the seasonal influenza vaccine.
b. Employees with egg allergies are to receive the recombinant seasonal influenza vaccine.
c. Exceptions for seasonal influenza vaccine:
   i. A history of severe medical complications from seasonal influenza vaccine. A note from a physician will be required.

ii. Religious conflicts; the exact nature of this must be reported. Reporting "It is against my religion" is not acceptable.

d. Staff who cannot receive the seasonal influenza vaccine will be
   i. Reassigned to non-patient care duties or
   ii. Required to wear a mask when seasonal influenza is present in the community at the discretion of the employee's direct supervisor.

The Response Team will monitor employees who are at increased risk of flu complications and symptomatic employees. Employees that are exposed can discuss the need for and use of antivirals with a physician. Antiviral medication will be given to employees by prescription to a pharmacy.

Home

Appendix 1

CONTACTS LIST FOR A PANDEMIC

LOCAL HEALTH CONTACTS: BURLEIGH COUNTY HEALTH
ALTERT NETWORK
ADDRESS: 500 E. FRONT AVE., BISMARCK, ND 58504
PHONE: 701-222-6525

CHERYL UNDERHILL: "Regional Emergency Response Coordinator"
Phone: 701-355-1546
Fax: 701-226-6524
E-MAIL: cunderhill@nd.gov

GLORIA DAVID: "Public Information Officer"
Phone: 701-355-1306
Fax: 701-222-6407
E-MAIL: gdavid@nd.gov

STATE HEALTH DEPT: "NORTH DAKOTA DEPARTMENT OF
HEALTH EMERGENCY
PREPAREDNESS & RESPONSE"
ADDRESS: 918 E. DIVIDE AVE.BISMARCK, ND 58505
PHONE: 701-328-2270
FAX: 701-328-0357

TIM WIEDRICH: "Director of Emergency Preparedness and
Response"
Phone: 701-328-2270
E-MAIL: twiedrich@nd.gov

IT/Health Alert Network(HAN) Coordinator"
Phone: 701-328-2297

SUPPLIES WEBSITE: http://hanassets.nd.gov/

Supplies are stockpiled and can be requested
from this site.

HEALTHCARE ENTITIES CONTACT:
ST. ALEXIUS MEDICAL CENTER PRIME CARE
EMERGENCY PREPAREDNESS & SAFETY OFFICER
PHONE: 701-530-8620 OR 530-7000

SANFORD
BRAD ERICKSON: SAFETY OFFICER
PHONE: 701-323-6319 OR 323-6000

LAB RESOURCES

ND PUBLIC HEALTH LABORATORY

PHONE: 701-328-6272
FAX: 701-328-6280

Home

Appendix 2

TRIAGE PROTOCOL FOR PATIENTS WITH SUSPECTED RESPIRATORY INFECTION (ANTIVIRAL MEDICATIONS)

Use for established CFM patients only – Non-established patients should be told to come into the clinic to see a doctor and medications will be prescribed if indicated.

1. Has Pandemic influenza been documented in the community?
If no, do not use this protocol.
2. Is there a documented fever of 100ºF (37.8ºC) or higher?
If no, go to item 12.
3. Does the patient have symptoms of runny nose/nasal congestion, cough, or a sore throat?
If no, go to item 12.
4. Did the illness start abruptly (e.g., going from feeling well to quite ill in a few hours)?
If no, go to item 12.
5. Is there any rash?
If yes, go to item 11.
***There is an 80 percent likelihood of influenza infection (when influenza is present in the community).**
6. Is the patient between the ages of 5 and 49 years?
If no, go to item 11.
7. Has the illness been present for less than 36 hours?
If no, go to item 11.
8. Does the patient or patient's parent or caregiver feel that the patient should be seen by a physician?
If yes, go to item 11.
9. Does the patient have an ongoing chronic illness, or is there any coexisting psychiatric illness or any indication of renal failure?
If yes, go to item 11.
10. This patient is a candidate for over-the-phone prescribing of antiviral therapy. Advise follow-up if condition worsens and routine follow-up two to three days after initiating therapy.
***A. Does the patient have any allergies?**
***B. What pharmacy does the patient use?**

11. This patient should be evaluated (interviewed and/or examined) by a physician.

12. The illness may be influenza or another respiratory virus. If significant concerns exist on the part of the patient, parent, or other person, consider scheduling a visit with a health care professional. Otherwise, advise hydration, rest, acetaminophen or ibuprofen for fever and aches, and follow-up as needed.

Home Care Guidance
Physician Directions to Patient/Parent

Provide the most update information to the patient by visiting the CDC website or the local and state website(s).

Home

Appendix 4

Summary of Infection Control Recommendations for Care of Patients with Pandemic Influenza

Component	Recommendations
Standard Precautions	
Hand hygiene	Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items; after removing gloves; and between patient contacts. Hand hygiene includes both handwashing with either plain or antimicrobial soap and water or use of alcohol-based products (gels, rinses, foams) that contain an emollient and do not require the use of water. If hands are visibly soiled or contaminated with respiratory secretions, they should be washed with soap (either non-antimicrobial or antimicrobial) and water. In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water because of their superior microbicidal activity, reduced drying of the skin, and convenience.
Personal protective equipment (PPE) • Gloves • Gown • Face/eye protection (e.g., surgical or procedure mask and goggles or a face shield)	• For touching blood, body fluids, secretions, excretions, and contaminated items; for touching mucous membranes and nonintact skin • During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated • During procedures and patient care activities likely to generate splash or spray of blood, body fluids, secretions, excretions
Safe work practices	Avoid touching eyes, nose, mouth, or exposed skin with contaminated hands (gloved or ungloved); avoid touching surfaces with contaminated gloves and other PPE that are not directly related to patient care (e.g., door knobs, keys, light switches).
Patient resuscitation	Avoid unnecessary mouth-to-mouth contact; use mouthpiece, resuscitation bag, or other ventilation devices to prevent contact with mouth and oral secretions.
Soiled patient care equipment	Handle in a manner that prevents transfer of microorganisms to oneself, others, and environmental surfaces; wear gloves if visibly contaminated; perform hand hygiene after handling equipment.
Soiled linen and laundry	Handle in a manner that prevents transfer of microorganisms to oneself, others, and to environmental surfaces; wear gloves (gown if necessary) when handling and transporting soiled linen and laundry; and perform hand hygiene.
Needles and other sharps	Use devices with safety features when available; do not recap, bend, break or hand-manipulate used needles; if recapping is necessary, use a one-handed scoop technique; place used sharps in a puncture-resistant container.
Environmental cleaning and disinfection	Follow standard facility procedures for cleaning and disinfection of environmental surfaces; emphasize cleaning/disinfection of frequently touched surfaces (e.g., bed rails, phones, lavatory surfaces).
Disposal of solid waste	Contain and dispose of solid waste; wear gloves when handling waste; wear gloves when handling waste containers; perform hand hygiene.

Respiratory hygiene/cough etiquette	Cover the mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacles; perform hand hygiene after contact with respiratory secretions; wear a mask (procedure or surgical) if tolerated; sit or stand as far away as possible (more than 3 feet) from persons who are not ill.
Droplet Precautions	
Patient placement	Place patients with symptoms in a private room or cohort with other patients with symptoms influenza.* Keep door closed or slightly ajar; maintain room assignments of patients in nursing homes and other residential settings; and apply droplet precautions to all persons in the room. *During the early stages of a pandemic, symptoms should be laboratory-confirmed, if possible. Personal protective equipment Wear a surgical or procedure mask for entry into patient room; wear other PPE as recommended for standard precautions.
Patient transport	Limit patient movement outside of room to medically necessary purposes; have patient wear a procedure or surgical mask when outside the room.
Aerosol-Generating Procedures	During procedures that may generate small particles of respiratory secretions (e.g., nebulizer treatment, suctioning), healthcare personnel should wear gloves, gown, face/eye protection, and a fit-tested N95 respirator.

Home

Emergency Management-Ebola

Clinic Protocol

- Daily review areas of interest for EBOLA.

  https://www.cdc.gov/vhf/ebola/index.html

- Front Desk-Triage Patients

  - Daily review areas of interest for EBOLA
    https://www.cdc.gov/vhf/ebola/index.html

  - Phone:

    - Do you have a fever? If yes,
    - Have you traveled from or been in contact with someone from an area of interest for Ebola?
    - Symptoms:
      - Headache
      - Weakness
      - Muscle pain
      - Vomiting
      - Diarrhea
      - Abdominal pain
      - Bruising or Bleeding
    - **Patient has a fever and travel history to an area of interest instruct patient to go to the emergency room.

  - Walk-In/Illness Visit

    - Fill out a Triage sheet for each patient that is here for an illness visit. DO NOT give the patient the form, staff will ask questions and fill out for them.
    - Patient presents with a fever and has a travel history: Immediately mask patient and send to Procedure Room 1. Notify nursing.
    - Give the form and travel ticket to the Nurse.

- Medical Staff

  - Post precautions signage-Isolation
  - DO NOT bring computers, paper or travel ticket into the room.
  - All staff entering the room must sign in using the room entry sign-in sheet.
  - Access EMR after entering the isolation room on the provided tablet located in Procedure Room 1. EMR messaging will be used for communication with clinic staff.
  - Use appropriate Blood and Body Fluid precautions and PPE.
  - Complete intake and evaluation of patient. Assess the patient's symptoms, temperature and pulse.
  - Discuss symptoms and vitals with the Physician. Physician will decide on plan and transportation of a possibly infected EVD patient to the emergency room. Keep patient in isolation until ambulance arrives.

- Disinfect room using 10 % Bleach solution.
- Remove PPE appropriately
- Exit Room.
- Document in EMR

Infection Control:

- **http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html**
  - The following procedures provide detailed guidance on the types of personal protective equipment (PPE) to be used and on the processes for donning and doffing (i.e., putting on and removing) PPE for all healthcare workers entering the room of a patient with Ebola virus disease. And emphasizing the importance of **training, practice, competence, and observation** of healthcare workers in correct donning and doffing of PPE selected by the facility.
- This guidance contains the following key principles:
- Prior to working with Ebola patients, all healthcare workers involved in the care of Ebola patients must have received repeated training and have demonstrated competency in performing all Ebola-related infection control practices and procedures, and specifically in donning/doffing proper PPE.
- While working in PPE, healthcare workers caring for Ebola patients should have no skin exposed.
- The overall safe care of Ebola patients in a facility must be overseen by an onsite manager at all times, and each step of every PPE donning/doffing procedure must be supervised by a trained observer to ensure proper completion of established PPE protocols.
- In healthcare settings, Ebola is spread through direct contact https://www.cdc.gov/vhf/ebola/transmission/index.html (e.g., through broken skin or through mucous membranes of the eyes, nose, or mouth) with blood or body fluids of a person who is sick with Ebola or with objects (e.g., needles, syringes) that have been contaminated with the virus. For all healthcare workers caring for Ebola patients, PPE with full body coverage is recommended to further reduce the risk of self-contamination.
- To protect healthcare workers during care of an Ebola patient, healthcare facilities must provide onsite management and oversight on the safe use of PPE and implement administrative and environmental controls with continuous safety checks through direct observation of healthcare workers during the PPE donning and doffing processes.

  PERSONAL PROTECTIVE EQUIPMENT – PPE:
  - Gown
  - Gloves – 2 pair
  - N95 Respirator mask
  - Safety Glasses (optional)
  - Hair Bonnet or Hood
  - Boot Covers

DONNING PPE:

PPE must be put on in the order listed below and <u>you will need a properly trained partner to observe and help</u> you make sure the PPE is properly worn. PERFORM HAND HYGIENE BEFORE BEGINNING.

1. **Engage Trained Observer**:
2. **Remove Personal Clothing, Jewelry and Items**:
3. **Inspect PPE Prior to Donning**
4. **Perform Hand Hygiene**.
5. **Put on Inner Gloves**: Put on first pair of gloves.
6. **Put on Boot *or* Shoe Covers.**
7. **Put on Gown *or* Coverall**: Put on gown *or* coverall. Ensure gown *or* coverall is large enough to allow unrestricted freedom of movement. Ensure cuffs of inner gloves are tucked under the sleeve of the gown *or* coverall.
8. **Put on N95 Respirator**: Put on N95 respirator. Complete a user seal check.
9. **Put on Surgical Hood**: Over the N95 respirator, place a surgical hood that covers all of the hair and the ears, and ensure that it extends past the neck to the shoulders. Be certain that hood completely covers the ears and neck.
10. **Put on Outer Gloves**: Put on second pair of gloves (with extended cuffs). Ensure the cuffs are pulled over the sleeves of the gown. Tape if necessary
11. **Put on Face Shield**: Put on full face shield over the N95 respirator and surgical hood to provide additional protection to the front and sides of the face, including skin and eyes.
12. **Observer Verify**: After completing the donning process, the integrity of the ensemble is verified by the trained observer. The healthcare worker should be comfortable and able to extend the arms, bend at the waist and go through a range of motions to ensure there is sufficient range of movement while all areas of the body remain covered.
13. **Disinfect Outer Gloves**: Disinfect outer-gloved hands with ABHR. Allow to dry prior to patient contact.
14. **SIGN THE EBOLA ISOLATION SIGN IN SHEET** before entering the room.

REMOVING PPE:

PPE must be removed in the order listed below and <u>assisted/observed by a trained partner (who is also attired in the PPE).</u>

1. **Inspect**: Inspect the PPE to assess for visible contamination, cuts, or tears before starting to remove. If any PPE is visibly contaminated, then disinfect using 10% Bleach or Sani-Cloth.
2. **Disinfect Outer Gloves (DO THIS BETWEEN ALL STEPS)**
3. **Remove Boot *or* Shoe Covers**: While sitting down, remove and discard boot *or* shoe covers.
4. **Disinfect and Remove Outer Gloves**: Remove and discard outer gloves taking care not to contaminate inner gloves during removal process.
5. **Inspect and Disinfect Inner Gloves**: Inspect the inner gloves' outer surfaces for visible contamination, cuts, or tears. If an inner glove is visibly soiled, cut, or torn, then disinfect the glove. Then remove the inner gloves, perform hand hygiene and don a clean pair of gloves. If no visible contamination, cuts, or tears are identified on the inner gloves, then disinfect the inner-gloved hands.
6. **Remove Face Shield**: Remove the full face shield by tilting the head slightly forward, grabbing the rear strap and pulling it over the head, gently allowing the face shield to fall forward and discard. Avoid touching the front surface of the face shield.
7. **Disinfect Inner Gloves**
8. **Remove Surgical Hood**: Unfasten (if applicable) surgical hood, gently remove, and discard. The trained observer may assist with unfastening hood.
9. **Disinfect Inner Gloves**
10. **Remove Gown *or* Coverall**: Remove and discard. Depending on gown design and location of fasteners, the healthcare worker can either untie fasteners, receive assistance by the trained observer to unfasten to gown, or gently break fasteners. Avoid contact of scrubs or disposable garments with outer surface of gown during removal. Pull gown away from body, rolling inside out and touching only the inside of the gown.
11. **Disinfect and Change Inner Gloves**: Don a new pair of inner gloves.
12. **Remove N95 Respirator**: Remove the N95 respirator by tilting the head slightly forward, grasping first the bottom tie or elastic strap, then the top tie or elastic strap, and remove without touching the front of the N95 respirator. Discard N95 respirator.
13. **Disinfect Inner Gloves**
14. **Disinfect Washable Shoes**: Sitting on a new clean surface (e.g., second clean chair, clean side of a bench) wipe down every external surface of the washable shoes.
15. **Disinfect and Remove Inner Gloves**: Remove and discard gloves taking care not to contaminate bare hands during removal process.
16. **Perform Hand Hygiene**
17. **Inspect**: Perform a final inspection of healthcare worker for any indication of contamination of the surgical scrubs or disposable garments. If contamination is identified, immediately inform supervisor before exiting the room.

Hand Hygiene

Perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.

Response Team:

Medical Director	Response Coordinator
Nursing Supervisor	Infection Control
Risk Management/Lab	Education
Administration Representative	Communication
Nursing Representatives	Infection Control
	Community Outreach
Radiology Representative	Surveillance Coordinator
Reception Representative	Triage/Surveillance

Surveillance/Communication:

- Monitor State, County and City Public Health advisories for changes in information. The clinic will monitor all facsimiles, emails and telephone calls. Updates will be made to the Response team and communicated to all clinic employees by posting updates and staff meetings.
- Inform members of the Response team when U.S. and when it is nearing the geographic area.
    - ND Health Alert Network(HAN) https://www.health.nd.gov/epr/han/health-alerts/
        - Categories of Health Alert messages:
            - Health Alert conveys the highest level of importance; warrants immediate action or attention.
            - Health Advisory provides important information for a specific incident or situation; may not require immediate action.
            - Health Update provides updated information regarding an incident or situation; no immediate action necessary.
            - Health Information provides general information that is not necessarily considered to be of an emergent nature.
- Monitor and review Ebola in patients cared for by clinic staff.
- Report any cases of Ebola to the local and state health department.
    - The health department will provide recommendations to health care providers using the HAN. We will be responsible for reporting potential cases. Clinicians should immediately contact the health department when they suspect a human case of infection with ebola.
    - Nursing will call public health for current information when a patient is suspected to have contact with Ebola
    - Clinical Criteria-Fever plus travel to area of interest.
      For more current information refer to www.cdc.gov/
- Periodically, updates to the local regional pandemic plans will be monitored at
    - CDC: http://www.cdc.gov/vhf/ebola/hcp/index.html

- OSHA: https://www.osha.gov/SLTC/ebola/
- NDDOH: http://www.ndhealth.gov/disease/ebola/Training/Default.aspx

- CDC and NDDOH website includes a Checklist **for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States checklist.**

Essential Staff

The number of staff necessary for patient care during a severe pandemic on a given day will include physicians, nurses, x-ray, lab and receptionists. If necessary, nonessential staff will be moved to administration based on patient care needs and infection control for staff and patients.

Employee Exposures

An exposure is defined as persons with percutaneous or mucous membrane exposures to blood, body fluids, secretions or excretions from a patient with suspected Ebola VD or breach of the PPE.

When exposure to a patient with known or suspected EVD occurs, employees should:

- Stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (eyes) should be irrigated with copious amounts of water or eyewash solution.
- Immediately contact your supervisor and NDDOH.
- Staff who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an exposure through direct contact to blood or body fluids of a patient with Ebola VD should:
    - Not report to work or should immediately stop working and notify their supervisor and NDDOH. Seek medical evaluation and testing.
    - Comply with work exclusion until they are deemed no longer infectious to others by primary care provider and NDDOH.

      **Staffing concerns and exposure will be assessed on a case by case basis by the NDDOH, Kirby Krueger.

For asymptomatic staff who had an unprotected exposure (not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with Ebola VD:

- Should receive medical evaluation. Follow-up care will include fever monitoring twice daily for 21 days after the last known exposure
- Maintain temperature log.
- May continue to work if asymptomatic while receiving twice daily fever checks.
- IF employee develops symptoms, employee must stop work immediately and contact supervisor and NDDOH.

Contact List for Ebola

- Sanford Health – Jodi Barnum, Infection Control 323-6168
  One Call 323-1225
- St. Alexius – Sue Zieman, Infection Control 530-7648
- Metro Ambulance – Dan Schafer 255-0812
- NDDoH:
  - Tim Wiedrich, Emergency Preparedness & Response 328-2270 (monitored 24/7)
  - Kirby Kruger, Medical Services Director (staff concerns) 328-2378
  - Tracy Miller, State Epidemiologist 328-2378
  - Michelle Feist, Epidemiology & Surveillance 328-2378
- NDPHL:
  - Tim Brosz, ND Specimen Collection and Testing 328-6272
  - State Radio, AHC NDPHL 1-800-472-2121
- CDC Laboratory Testing:
  - Consult all testing with CDC 1-770-488-7100

Transportation

- Sanford Health: One Call 323-1225
  - **Before transferring the patient** call the One Call to give them the patient information re: temp, travel hx to area of interest for Ebola, and other symptoms and that it is a suspected Ebola case
  - Call Metro Ambulance service and give them patient information and that it is a possible Ebola case.

- Metro Area Ambulance: Dan Schafer, Admin. 255-0812
  - Transporting patients to emergency rooms

Disinfection

https://www.osha.gov/Publications/OSHA_FS-3756.pdf
10 % Bleach solution (9 C. Water and 1C.Bleach).
PDI Sani-Cloth Bleach Wipes

- **To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows or mattresses, and textile privacy curtains into the waste stream and disposed of appropriately.**
- Cleaning and disinfection of hard, non-porous surfaces (e.g., high-touch surfaces such as bed rails and over bed tables, housekeeping surfaces such as floors and counters) should be done.[4] Before disinfecting a surface, cleaning should be performed. Use cleaning and disinfecting products according to label instructions. Check the disinfectant's label for specific instructions for inactivation of any of the non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) follow label instructions for use of the product that are specific for inactivation of that virus. Use disposable cleaning cloths, mop cloths, and wipes and dispose of these in leak-proof bags. Use a rigid waste receptacle designed to support the bag to help minimize contamination of the bag's exterior.

Waste Management

ALL BIOHAZARD TRASH RECEPTICLES WILL BE TRIPLE LINED WITH RED BIOHAZARD BAGS

- **The Ebola virus is a classified as a Category A infectious substance by and regulated by the U.S. Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported offsite for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, and used health care products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used Personal Protection Equipment (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.) or byproducts of cleaning) contaminated or suspected of being contaminated with a Category A infectious substance.**

- **Stericycle** works closely with the U.S. Department of Transportation (DOT) and Centers for Disease Control (CDC), Stericycle has been advised to address each situation on a case-by-case basis until such time that they have an all-encompassing protocol.

    - A Special Permit will be obtained by Stericycle for Category A Waste removal. Once granted, Stericycle will provide a current copy of the special permit to be maintained at the Generator's site as per DOT regulations.
    - All waste generated from a suspected/confirmed patient should be treated as special Category A waste and packaged and handled according to the attached guidance.
    - Additional guidance for contingency planning will be provided as more information becomes available.

Category A Waste Handling & Packaging Procedures

Guidelines for a Suspected or Confirmed Case of Ebola

• With a suspected or confirmed Ebola case immediately contact the local/state health department and CDC.

• All waste generated from a suspected/confirmed patient should be treated as special Category A DOT waste as follows:

1. Make sure you are utilizing all PPE and following all applicable guidelines as directed by the following link from the CDC:

http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html?mobile=nocontent

2. Place soft waste or sealed sharps containers into a primary medical waste bag (min 1.25 or1.5ml – ASTM tested; can be provided by Stericycle).
3. Apply bleach or other virocidal disinfectant into the primary bag to sufficiently cover the surface of materials contained within the bag; securely tie the bag.

4. Treat the exterior surface of the primary container with bleach or other virocidal disinfectant.
5. Place the primary bag into a secondary bag and securely tie the outer bag.
6. Treat the exterior surface of the secondary bag with bleach or other virocidal disinfectant.

If you HAVE Stericycle 55 gallon special Category A DOT Waste "GREEN DRUMS" on site go to Step 10 below

If you do NOT have special Stericycle 55 gallon special Category A DOT Waste "GREEN DRUMS" on site continue to Step 7 below

7. The double bagged waste should then be placed on a hard non-porous surface in a secure room close to the point of use. Make sure the collection area is clearly labeled special Category A DOT Waste.
8. Contact your Stericycle representative who will arrange delivery of the special Category A DOT Waste containers (containers can be shipped for overnight delivery).
9. As soon as your special Category A DOT Waste Containers arrive follow step 10 below.
10. The double bagged waste should then be place into special Category A DOT Waste packaging/drums provided by Stericycle with the liner tied securely and container closed per the packaging instructions provided. Label the special Category A DOT Waste with provided labels.
11. Store the special Category A DOT Waste containers separate from other regulated medical waste in a secure area preferably isolated and with limited access.

• Stericycle recommends using disposable sharps containers for suspected/confirmed Ebola cases. The disposable container should be sealed and disposed of as special Category A waste following the instructions above. If a reusable sharps container is inadvertently used that container should also be sealed and disposed of inside the bags with the Category A waste.
• Contact your Stericycle representative who will begin the process with the DOT to acquire a "Special Permit" as required.

• Stericycle has been advised by the DOT and CDC that we must address each situation on a case by case basis until such time that they have an all-encompassing protocol.
• Once the Special Permit has been granted, Stericycle will provide a current copy of the special permit to be maintained at the Generator's site as per DOT regulations.
• Contact your Stericycle representative should you need additional supplies to properly package Category A waste.

TRIAGE PROTOCOL FOR PATIENTS WITH SUSPECTED EBOLA

UND CFM
701 E. Rosser Ave
Bismarck, ND 58503

Fever Questionnaire
Patient Name: _____
Date of Birth: _____
Do you have a fever? Yes /No
Have you traveled from or been in contact with someone from an area of interest for Ebola?
_____
Do you have any of these symptoms?

a. Headache
b. Weakness
c. Muscle pain
d. Vomiting
e. Diarrhea
f. Abdominal pain
g. Bruising or Bleeding

Home

Emergency Management-COVID-19

High/Moderate Risk
If you are experiencing the onset of symptoms and/or have a fever, contact your supervisor right away.

UND employees must follow these procedures at https://und.edu/covid-19/employee-reporting-procedures.html in accordance with the guidance from the ND Department of Health (NDDoH) and Centers for Disease Control and Prevention (CDC). Refer to the link for complete information.

Purpose: To maintain the safety of staff and patients by triaging every patient before they enter the clinic when possible and to limit the amount of time the patient(s) are at the clinic.

Patient asked to wear cloth mask from home or the clinic will provide them with a surgical mask if they do not come with their own mask.

1. Patient asked to sanitize their hands upon arrival into the clinic.
2. No visitors to the appointment, only if necessary for proper care during the appointment.
3. Have the patient call when they arrive to assigned phone # 751-9502 to check-in if possible. Triage immediately if patient registers in person.
4. Walk-ins for any type of appointment will be given a mask ASAP and asked to use sanitizer. Triage patient immediately. Ask them to wait in their cars or in an assigned area of the waiting room. Call nursing if possible COVID patient to room immediately.

*Ensure supplies are available for the patients; masks, tissues, soap, sanitizer etc.

Receptionist

1. **Every** patient is triaged for COVID exposure/symptoms.
2. Schedule and reschedule appointments with demographics, insurance to be updated at time of the call.
3. Cards and signatures will be gathered.
4. Block of 6 foot areas, patients
5. Phone calls to those patients already scheduled for Thursday and beyond in EMR to explain new process and update demographics.
6. Disinfecting high touch surfaces often in patient areas and department.
7. Wearing proper PPE in department and common areas.

Nursing

1. Assign checked-in appointments to a room. Call patient and triage patient for COVID symptoms and exposure BEFORE entering the clinic. **Every** patient is triaged.
2. Phone Nurse Only-assigned daily; provide timely answers to patients.
3. Shot Nurse- setting times for shots; 9-10 am daily, 3:30-4:30 pm and as needed with a set time.
4. Disinfecting high touch surfaces often in patient areas and department.
5. Wearing proper PPE in department and common areas.

Provider

1. COVID-19 appointment process, follow previous guidelines in the clinic.
2. Telemedicine appointment, schedule follow-up in house exam(s) as needed.
3. Well Child appointment-Call patient to answer bright future questions (Resident on pediatric rotation.) as a telemedicine and then set up follow-up immunization and exam in house.
4. Lab/Xray will come and get the patient from the room when orders are ready. Patient will be returned to the room or discharged as needed.
5. Wearing proper PPE in department and common areas.
6. For questions related to COVID-19, health care providers can call the NDDoH Division of Disease Control at COVID-19 hotline at 888-391-3430 Sunday through Saturday, 24/7.

Lab Only/Xray Only/Nurse Only

1. Patients scheduled for a specific time.

2. Patient check-in with front desk when they arrive in the parking lot.
3. Lab and Xray will triage their patient and ask them to come in to the clinic when orders are ready.
4. Nursing Only appointments will be triaged by nurse when patient checks-in.
5. Disinfecting high touch surfaces often in patient areas and department.
6. Wearing proper PPE in department and common areas.

Pharmacy

1. Closed, continue to offer deliveries and mailed prescriptions as needed.
2. Proper PPE and blocking off areas for patients to physical distance.
3. Disinfecting high touch surfaces often in patient areas and department.
4. Wearing proper PPE in department and common areas.

Triage questions:

Has a household or close contact tested positive of COVID-19?

Has a household or close contact have symptoms of COVID-19?

In the past 14 days have you experienced any of the following symptoms?

• Fever or chills
• Cough
• Shortness of breath or difficulty breathing
• Fatigue
• Muscle or body aches
• Headache
• New loss of taste or smell
• Sore throat
• Congestion or runny nose
• Nausea or vomiting
• Diarrhea

Suspected COVID-19 exam and testing

1. Schedule appointment and let patient know to call (751-9502) when they are outside and nursing will escort them in the building
2. Nursing will put on a surgical mask and gloves to meet patient outside and will bring a mask along with to give to the patient and instruct them to place surgical mask on before entering clinic and to leave it in place for the duration of their visit unless instructed otherwise. Patient will be asked to sanitize their hands.
3. Nursing will escort the patient from the south doors into COVID room, avoiding going through procedure rooms.
4. Nursing will put patient in room and leave immediately.
5. Resident will don proper PPE to see patient and get supplies needed to test the patient. Be sure to have everything you need before entering the room.
6. Label N95 respirator mask with WW9 and your first name.
7. Resident/Provider will see patient, take vitals and collect sample for testing. Make sure to put the testing swab into the red capped vial provided. Once you are donned and entered the room you stay in the room until finished, communicate your needs from inside the room. If you must leave the room you will need to doff all PPE before doing leaving the room.
8. When done seeing the patient knock on the door to let nursing know that you are done with the patient

9. Nursing will meet patient at the outside door and escort patient outside.
10. Provider will disinfect all surfaces in the room, including the lab sample bag with the Caviwipes1 (black lid)
11. Use proper doffing protocol to remove your PPE and bring out specimen and take to lab. Dispose of N95 mask in the designated container.

PPE requirements

Possible COVID patient care: gown, face shield, N95 respirator, gloves

Contact <6 feet from patient or co-worker: surgical mask and eye protection

Hand Hygiene

Perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.

Waste Management

Possibly contaminated waste can be disposed of in the regular black bags. Follow all standard precautions to use blood borne pathogen protocols for biohazardous waste.

Dispose of N-95 masks in the designated container for cleaning by Battelle.

Disinfection

Use of approved cleaners from the following list https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

- Cleaning and disinfection of hard, non-porous surfaces (e.g., high-touch surfaces such as bed rails and over bed tables, housekeeping surfaces such as floors and counters) should be done. Check the disinfectant's label for specific instructions for inactivation of any of the non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) follow label instructions for use of the product that are specific for inactivation of that virus. Use disposable cleaning cloths, mop cloths, and wipes and dispose of these in leak-proof bags.

Cleaning and disinfecting if an employee is sick

North Dakota Department of Health (NDDoH) will lead the contact investigation.

Employee's workspace will be closed off for 24 hours, or as long as feasible, prior to cleaning and disinfecting.

Employee's workplace common areas (bathrooms, breakroom, etc.) will be cleaned and disinfected.

Home

Emergency Management-COVID-19: Low Risk

If you are experiencing the onset of symptoms and/or have a fever, contact your supervisor right away.

UND employees must follow these procedures at https://und.edu/covid-19/ in accordance with the guidance from the ND Department of Health (NDDoH) and Centers for Disease Control and Prevention (CDC). Refer to the link for complete information.

Purpose: To maintain the safety of staff and patients by adhering to recommended protocols according to local risk.

Patient asked to wear cloth mask from home or the clinic will provide them with a surgical mask if they do not come with their own mask.

5. Patients asked to sanitize their hands upon arrival into the clinic.
6. Patients for any type of appointment will be given a mask ASAP and asked to use sanitizer. Triage patient immediately.

*Ensure supplies are available for the patients; masks, tissues, soap, sanitizer etc.

Reception

8. **Every** patient is triaged for COVID exposure/symptoms.
9. Schedule and reschedule appointments with demographics, insurance to be updated at time of the call.
10. Reception area to use shields at counter.
11. Cards and signatures will be gathered.
12. Disinfecting high touch surfaces often in patient areas and department.
13. Encourage wearing proper mask in department and common areas. Masks required in patient contact areas, optional in non-patient contact areas.

Nursing

6. Assign checked-in appointments to a room.
7. Disinfecting high touch surfaces often in patient areas and department.
8. Encourage wearing proper mask in department and common areas. Masks required in patient contact areas, optional in non-patient contact areas.

Provider

7. COVID-19 appointment process, follow previous guidelines in the clinic.
8. Offer telemedicine appointments, schedule follow-up in house exam(s) as needed.
9. Encourage wearing proper mask in department and common areas. Masks required in patient contact areas, optional in non-patient contact areas.
10. For questions related to COVID-19, health care providers can call the NDDoH Division of Disease Control at COVID-19 hotline at 888-391-3430 Sunday through Saturday, 24/7.

Lab Only/Xray Only/Nurse Only

7. Patients scheduled for a specific time.
8. Patient check-in with front desk.
9. Lab and Xray appointments to check in at front desk
10. Nursing Only appointments will be triaged by nurse when patient checks-in.
11. Disinfecting high touch surfaces often in patient areas and department.
12. Encourage wearing proper mask in department and common areas. Masks required in patient contact areas, optional in non-patient contact areas.

Pharmacy

5. Open, offer mail and drop off as appropriate and able.
6. Proper PPE using shields at counter and blocking off areas for patients to physical distance.
7. Disinfecting high touch surfaces often in patient areas and department.

8. Encourage wearing proper mask in department and common areas. Masks required in patient contact areas, optional in non-patient contact areas.

Triage questions:

Has a household or close contact tested positive of COVID-19?

Has a household or close contact have symptoms of COVID-19?

In the past 14 days have you experienced any of the following symptoms?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Suspected COVID-19 exam and testing

12. Schedule appointment and let patient know to call (701-751-9502) when they are outside of the clinic. Nursing will meet them and escort them in the building.
13. Nursing will put on an N-95 respirator mask, eye protection, and gloves to meet patient outside and will bring a surgical mask along with to give to the patient and instruct them to place mask on before entering clinic and to leave it in place for the duration of their visit unless instructed otherwise. Patient will be asked to sanitize their hands.
14. Nursing will escort the patient into COVID room.
15. Nursing will put patient in room and leave immediately doffing their PPE using proper doffing protocol.
16. Resident will don proper PPE, to include N-95 respirator, gown, gloves, and eye protection, to see patient and get supplies needed to test the patient. Be sure to have everything you need before entering the room.
17. Resident/Provider will see patient, take vitals and collect sample for testing. Make sure to put the testing swab into the red capped vial provided. Once they are donned and have entered the room, they must stay in the room until finished, and communicate your needs from inside the room. If the provider must leave the room, they will need to doff all PPE before doing leaving the room.
18. When done seeing the patient, the provider will knock on the door to let nursing know that you are done with the patient.
19. Nursing will meet patient at the outside door and escort patient outside. If the patient has tested positive for COVID, the nurse will wear an N-95 respirator mask and eye protection. If the patient has tested negative for COVID, the nurse will wear at least a surgical mask.
20. Provider will disinfect all surfaces in the room, including the lab sample bag with Caviwipes (black lid).
21. Provider will use proper doffing protocol to remove your PPE and bring out specimen and take to lab. Dispose of N95 mask in the designated container.

PPE requirements

Possible COVID patient care: gown, face shield, N95 respirator, gloves

For all other patient care: surgical mask when contact <6 feet from patient

Masks required in patient contact areas, optional in non-patient contact areas.

Hand Hygiene

Perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.

Waste Management

Possibly contaminated waste can be disposed of in the regular black bags. Follow all standard precautions to use blood borne pathogen protocols for biohazardous waste.

Dispose of N-95 masks in the designated container.

Disinfection

Use of approved cleaners from the following list https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19

- Cleaning and disinfection of hard, non-porous surfaces (e.g., high-touch surfaces such as bed rails and over bed tables, housekeeping surfaces such as floors and counters) should be done. Check the disinfectant's label for specific instructions for inactivation of any of the non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) follow label instructions for use of the product that are specific for inactivation of that virus. Use disposable cleaning cloths, mop cloths, and wipes and dispose of these in leak-proof bags.

Cleaning and disinfecting of work space if an employee is sick

North Dakota Department of Health (NDDoH) will lead the contact investigation.

Employee may be eligible for Emergency Sick Leave under the FFCRA or traditional Family Medical Leave (FMLA). Further information is on the UND HR website or they may call or email their divisional HR manager.

Employee's workspace will be closed off for 24 hours, or as long as feasible, prior to cleaning and disinfecting.

Employee's workplace common areas (bathrooms, breakroom, etc.) will be cleaned and disinfected.

Health Care Workers will follow the NDDoH Guidance for Health Care Workers Return to work procedure.

Home

Code Amber

If a Parent/Guardian approaches a staff member and reports a child missing, Follow these steps:

1. Notify the Business Manager (Code Leader) to a possible missing child. The Business Manager will interview the parent promptly. If the Business Manager is unavailable lab or x-ray personnel will be available.
2. Ask the following:
    a. What is the child's name? _____
    b. How long ago did you see the child? _____
    c. Where was the last place you saw the child? _____
    d. Did you check the area where the child was last seen?
    e. Get a detailed description of the child.
        i. Name_____ Age_____
        ii. Hair Color_____ Eye Color_____
        iii. Approximate Weight_____ and Height_____
        iv. What is child wearing (remember to ask shoe color and style)
        _____
        _____
3. Announce CODE AMBER ALERT over the PA system ASAP. Repeat CODE AMBER X3. Give complete description of child. *Script below**
4. Notify Sanford Security ASAP using Sanford house phone or dialing 214-9269.
5. Explain to the parent what is happening and ask them to remain calm. Keep the parent with you in an open exam room.
6. Designated staff move to designated exit door and other staff begin sweep of all clinic areas.**Report to the Code Leader when you are finished with your area.
7. Place a call to local police by calling 911 following the initial sweep of all clinic areas if child is still reported missing.
8. When child is found notify Code Leader and 911 ASAP.
9. If the child is found and appears to have been just lost and unharmed, the child is reunited with parent/guardian.
10. If the child is found accompanied by someone other than the parent/guardian, use reasonable efforts to delay their departure without putting the child, staff, or visitors at risk. Notify police and give details about the person, vehicle, direction of travel etc…
11. The Code Amber is canceled after child is found. Over PA system repeat CODE AMBER CANCELED X3.
12. Complete incident report and file with risk management.

*Script: Attention, Code Amber, Code Amber, Code Amber; we have a lost child named _____, age ___, with_____ hair and _____eyes, weighs approximately _____ pounds and _____ feet tall, last seen wearing _____.

**Exit Doors: (Fire Evacuation Route Map) Listed is the entrance or exit that needs to be monitored followed by the assigned department.

1. Front Doors and Elevator First Floor-*Reception*
2. Elevator/East Stairwell Second Floor-*Business Office*
3. South Stairwell First Floor-*Pharmacy*
4. West Stairwell First Floor-*Nursing/Residents*
5. South and West Stairwells Second Floor-*Medical Records/Administrative Asst.*

**Clinic Areas: Listed is the clinic area that needs to be checked for the missing child followed by the assigned department.

1. Toy Room/Bathrooms/coat closet/Elevator: *Front Desk*

2. South Stairwell/Equipment Rooms/Clean and Soiled Utility: *Pharmacy*
3. Second Floor Bathrooms/Elevator/ East Stairwell: *Business Office*
4. Second Floor Offices/Conf. Room/Employee Health Ctr/Employee Lounge: *Medical Record/Administration/Admin Asst.*
5. Procedure Rooms 2-4/exam rooms/nursing hallways/offices/resident offices: *Nurse/Resident*
6. Lab Bathrooms/Proc Rm 1/Xray rooms: *Lab/X-ray*
7. Administration Entrance: *Administrative Asst*
8. Administration Exit: *Administrative Asst*

Home

COMMUNICABLE DISEASES

University of North Dakota Safety policy: **http://und.edu/finance-operations/_files/docs/lc-communicable-diseases.pdf**

AEROSOL TRANSMISSIBLE DISEASES EXPOSURE

Purpose:

All health-care settings need an infection-control program designed to ensure prompt detection, airborne precautions, and treatment of persons who have suspected or confirmed disease.

Procedure:

1. Patients who have suspected or confirmed aerosol transmissible disease should be considered infectious. Several infectious diseases to consider are Sars, Sars-Co V-2, influenza, measles, tuberculosis, mumps, rubella, CMV, MERS, Diphtheria.

Tuberculosis infection is possible if the patient is coughing, undergoing cough-inducing procedures, or have positive sputum smear results for acid-fast bacilli (AFB); and they are not receiving adequate therapy or have just started therapy.

2. Particulate filter respirators certified by the CDC and NIOSH such as PAPR masks are to be worn by staff in direct contact with a suspected or confirmed aerosol transmissible disease patient.

3. The patient is to wear a surgical mask to stop the spread of the disease as well. Stock masks appropriately in patient areas. Limit the movement of the patient within the clinic and in the waiting room. All rooms with patient contact should be disinfected with appropriate cleaning agents.

4. If an employee is exposed to someone with a known active TB disease:

The employee will be seen by a physician and a baseline test should be done and if negative followed up with another test 8-weeks after their last exposure. If the initial test is positive, a chest x-ray should be performed to rule out any disease process going on with the contact.

The employee should watch for the following symptoms; unexplained weight loss, loss of appetite, night sweats, fever, fatigue, chills, coughing for > 3 weeks, and chest pain. The employee will report any of these symptoms to their supervisor.

PAPR/N95 3M mask:

University of North Dakota Safety Policy: https://campus.und.edu/safety/public-safety/additional-resources/ppe.html

Respiratory PAPR/N95 mask training will be completed annually and at hire. All employees will complete a health assessment each year.

Respirator training is done for essential staff. PAPR disposable hoods and all PAPR equipment will be stored with each PAPR in its storage bag. Replacement filters and battery chargers will be managed by the safety officer.

Minimize Measles Transmission

1. **Ask patients with a febrile rash illness** about a history of international travel, contact with foreign visitors, or possible exposure to a measles patient in the 3 weeks prior to symptom onset. Suspect measles in patients with such a history. During measles outbreaks, also suspect measles in anyone with either a febrile rash illness or fever in combination with a least one of the following: cough, runny nose, conjunctivitis, or otitis media.
2. **Mask and move suspect measles patients to an exam room immediately.** Surgical masks are appropriate. Do not allow suspect measles patients to remain in the waiting area or other common areas.
3. **Allow only employees with documentation of 2 doses of MMR vaccine or laboratory evidence of immunity.** (IgG positive) to enter the room with the patient. Most persons born before 1957 are likely to have been infected naturally and presumed to be immune. For HCWs born before 1957 who *lack evidence* of measles immunity have concerns of immune status, should consider vaccinating with 2 doses of MMR vaccine separated by at least 28 days. Avoid exposure during pregnancy even if likely immune, this is the recommendation from ACOG as infection can lead to miscarriage, preterm delivery, and still birth.
4. **All employees entering the room need to use a PAPR respirator**
5. **Do not allow susceptible visitors in the patient room if possible.**
6. **Close exam room for at least 2 hours after the possibly infectious patient leaves.**
7. **Immediately contact NDDOH for further recommendations and reporting of a possible measles patient** at 701-328-2378.
    a. Minimize movement of suspect patient within the clinic, for example have pharmacy, lab etc come to the patient. Minimize the number of employees and other patients exposed to the suspect patient.
8. **This flowchart walks you through when to test the patient for measles.** Immune status testing may be performed post exposure; however testing should be performed as soon after exposure as possible because IgG due to measles infection may rise prior to onset of symptoms.
9. **Instruct suspect measles patients and exposed persons** to inform all health care providers of the possibility of measles prior to visit.
10. **Make note of the employees and other patients who were in the area during the time the suspect measles patient was in the facility and for 2 hours after they left.** If measles is confirmed in the suspect case, exposed people will need to be assessed for measles immunity. Consult with NDDOH for recommendations on notification and follow-up with these employees and patients.
11. **Evaluate exposed employees immune status.** (shared airspace at the same time or, in a closed area, up to two hours after a person with measles has occupied the area) Contact NDDOH to discuss post-exposure prophylaxis. Measles vaccine is effective at preventing measles when administered to a susceptible person within 72 hours following exposure and should be offered unless medically contraindicated. IG may prevent or modify measles disease in susceptible persons when given within 6 days following exposure. IG is typically reserved for children <12 months, pregnant women and immunocompromised persons.
12. **Susceptible employees should be excluded work beginning 5 days through the 21st day following exposure.** It is recommended regardless of whether the employee receives post-exposure vaccine or IG. An employee who develops measles symptoms after exposure should be excluded from work until 4 days after rash onset, or until measles is ruled out.

BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN

University of North Dakota Safety policy: http://und.edu/finance-operations/_files/docs/6-27-bloodborne-pathogens-ecp.pdf

EMPLOYEES POTENTIAL FOR RISK

The following job classifications in this facility have occupational exposure to blood or other potentially infectious materials (category 1): PHYSICIANS, NURSES, LABORATORY TECHNICIANS, RADIOLOGY TECHNICIANS

The following job classifications in this facility may occasionally have contact with blood or other potentially infectious materials (category 2). Their exposure is limited to emergency situations, entering the laboratory to ask questions, and carrying specimens to the laboratory (this is to be limited by requesting the patient to deliver the sample): RECEPTIONIST, MEDICAL RECORDS, BILLING PERSONNEL

WORK PRACTICES and ENGINEERING CONTROLS

The nurses will disinfect and decontaminate surgical instruments and miscellaneous instruments and supplies with the appropriate method either cold disinfection or by autoclaving (See cleaning schedule).

Mechanical pipettes are required in this facility where appropriate. Mouth pipetting is not allowed for any reason. Blood and other potentially infectious materials are handled with care in this facility. Employees have been trained in these procedures.

Laundry service is supplied by Central Dakota Laundry and AmeriPride Linen and Apparel Services. Place soiled garments in the appropriate bins in the Utility Room. Laundry grossly contaminated with body fluids or blood, place it in a clear bag, label the bag with BODY FLUID OR BLOOD. Place clear bag in a red biohazard bag. Place it in the laundry so it is not thrown out as biohazard waste.

Bader Maids provides daily cleaning and waste disposal for the clinic.

Eyewash equipment is located in the laboratory, north nursing hallway and soiled utility room.

Engineering controls are inspected and maintained annually.

PPE by TASK

TASK ASSESSMENT

TASK	PROTECTIVE EQUIPMENT	ENGINEERING CONTROLS
Phlebotomy	Gloves, gown	Sharps container, safety sharps
Processing blood samples	Gloves, gown	
Plating cultures	Gloves, gown	
Aspirations	Gloves, gown	Sharps container
Inoculations	Gloves	Sharps container
Lesion excisions	Gloves, gown (as indicated)	Sharps container
Wound care	Gloves, gown (as indicated)	
Colonoscopy	Gloves, scrubs	Sharps Container
Colposcopies	Nurse-gloves, Doctor-glove, gown	
IUD insertion	Nurses-gloves, Doctor-gloves	
Vasectomies	Gloves	Sharps container
Vaginal Exam	Gloves	
OB care	Gloves	
Biopsies	Gloves, gown (as indicated)	

Lacerations	Gloves, gown (as indicated)	Sharps container
I&D	Gloves, gown, face shield	
Sigmoidoscopy	Gloves, gown	
Circumcision	Gloves	Sharps container
Catheterization	Gloves	
Nasal Laryngoscopy	Gloves	
Cryotherapy	Gloves	
Eye and ear irrigation	Gloves	
Spinal tap	Gloves, gown	Sharps container
Toenail Removal	Gloves	

As indicated in such cases that clothing contamination is possible. For example: Any large or bloody wound, any wound irrigation, or any wound irrigation or any situations where possible aerosols may be generated. These situations would require a gown to be worn. There are face shields available if desired for protection.

Contaminated Laundry:

- Laundry contaminated with body fluids or blood, bag it in a clear bag and label the bag with BODY FLUID OR BLOOD.
- Laundry grossly contaminated with body fluids or blood, place it in a clear bag, label the bag with BODY FLUID OR BLOOD. Place clear bag in a red biohazard bag. Place it in the laundry so it is not thrown out as biohazard waste.

Schedule for Decontamination of Work Areas

WORK PRACTICE	PERSON RESPONSIBLE	DUTY
Sharp Containers	Nurse/Lab	Replace as needed when 75-80% full
Exam Tables	Nurse	Wipe down at the end of the day and as needed with Cavi-wipes
Laundry	Nurse/Lab	Place in Utility Room as needed
Analyzers	Lab	Clean appropriately as needed
Protective Coverings	Nurse/Lab	Replace if visibly contaminated
Surgical/Misc Instruments	Nurse	Autoclave M 11 Ultraclave daily/as needed
Drawing station chairs	Lab	Wipe down after each patient with Cavi-wipes

Evaluation of Safety Devices

The Needlestick Safety and Prevention Act requires that healthcare employers evaluate safety-engineered sharp devices on a n annual basis.

The evaluation team includes a few members that represent lab and nursing. The team should be properly trained and allowed sufficient time to familiarize themselves with use of the device before performing the procedure with a new safety device. An evaluation form will be used to evaluate each new and current safety device. Completed forms should be assessed and a decision made to implement or not implement the device.

1. Select device for evaluation.
2. Devine criteria for evaluation.
3. Select evaluation team.
4. Define evaluation period.

5. Train team members on use of device.
6. Use of the device during procedures.
7. Team members complete an evaluation form.
8. Review evaluations.
9. Make final decision on implementation of the device.

Home

PROCEDURES WITH RISK FOR EXPOSURE

Patient examinations
Aspirations
Inoculations
Lesion excisions
Wound care
Colposcopies
IUD insertions
Colonoscopy
Vasectomies
Vaginal examinations/OB Care
Biopsies
Venipuncture
Capillary blood draw
Lacerations
I&D
Sigmoidoscopy
Catheterization
Circumcisions
Processing of blood samples
Ear and eye irrigation
Spinal taps
Cryotherapy
Collection for Cultures
Nasal Laryngoscopy

CONTACTS for Exposure

Exposure Control Officer (ECO): Nursing Supervisor and Laboratory Supervisor

Rapid HIV testing available for source patient.

Home

Sharps

University of North Dakota Safety policy: https://campus.und.edu/safety/public-safety/

Stericycle will pick up the sharps container for disposal on a weekly basis from the laboratory and nursing designated storage areas.

Home

Regulated Medical Waste Management and Segregation

All waste must be in the proper containers. Maintain the integrity of the original packaging. Access to storage areas must be limited to authorized personnel only. Areas used for storage should be labeled with the universal biohazard symbol and the word BIOHAZARD. Storage area must be operated so there are no spills or releases to environment.

1. Identify the waste and determine how it is regulated.
2. Ensure the waste is properly segregated and disposed of in the correct container.
3. Secure properly labeled containers.
4. Dispose of the waste per regulations and maintain manifest records.

Infectious Waste (Red Bag & Sharps containers)
Cultures and stocks of infectious agents and associated biologicals.
Pathological waste
Sharps that have been used for patient care. *(DO NOT DISPOSE OF USED SHARPS IN TO A Rx BLACK CONTAINER)*
Broken or unbroken glassware that was in contact with infectious agents.
Isolation waste
Unused sharps

Non RCRA hazardous Waste

All expired medications will be returned to EXP Pharmaceuticals Services Corporation by the pharmacy staff.

RCRA Hazardous Waste (Black containers)

Hazardous pharmaceutical waste to include any syringes and ampoules with hazardous pharmaceuticals that have not come into contact with patients.

Any product that is considered by the EPA as being ignitable, corrosive, reactive, or toxic.

**If questioning appropriate waste disposable, contact DrugDisposalQuestion@stericycle.com with the product name and NDC number.

Pharmaceutical waste should not be disposed of with medical waste, down the drain or in the trash. UND CFM is considered a Small Quantity Generator (SQG) as we have less than 2.2 lbs of pharmaceutical waste.

All containers are noted with a start date and proper RCRA classification.

Clinic waste containers are kept near the point of waste generation. All black Rx containers must be kept closed unless actively placing Rx waste in the container.

Compatible waste-approximately 99% of all Rx waste are compatible and can be disposed of in the same 8 gal black waste container located in the Med room.
Incompatible waste-Rx waste that must be placed in its own container due to the potential for a chemical reaction if combined with other Rx wastes. These items need to be placed in their OWN appropriate 2 gal container.

Inhalers/Aerosols (special label) in X-ray
Corrosives (special label) in Med Room
Oxidizers (special label) in Med Room
Collodion/Nitrocellulose (generic label) in Med Room
Botox/Myobloc (generic label) **in Proc. Rm 4**
Ignitable (generic label) in Med Room

Controlled Substances (testosterone & morphine)

Products listed on Schedule I-V of Title 21 United States Code Controlled Substances Act will be disposed by the Pharmacy if partially filled. Empty vials will be placed in the red biohazardous waste.

All expired medications will be returned to EXP Pharmaceuticals Services Corporation by the pharmacy staff.

Stericycle Pick-up schedule

All Stericycle manifests will be kept for a period of 3 years and filed in the laboratory.

All biohazardous waste is picked up weekly by Stericycle.

Pharmaceutical waste pick will need to be scheduled by calling Stericycle at 866-783-7422.

Label all containers for pick up with end dates that are 2/3 full.

Inform Stericycle of the container you are requesting to be picked up and have a replacement container sent to the clinic. Stericycle will bring all shipping paperwork at the time of pickup. Appropriately trained employees from your facility will sign the manifest for the transportation and destruction of waste. Only individuals who completed DOT training within the last 3 years can sign the manifest.

Pick-up and delivery can take up to two weeks from the time you call. Pick-ups are scheduled on an "on call basis". Stericycle is contracted to pick up 2 containers for the clinic twice a year.

Training

All medical staff will be initially trained to handle medical, infectious and pharmaceutical waste. Pharmaceutical training must be completed within 90 days of employment or assignment. Appropriate training will be given annually or biannually to all x-ray, lab and nursing staff. Retraining is required every 3 years for Rx DOT and every year for Medical waste.

Home

Hazard Communication Standard

In 1983 OSHA created the original Hazard Communication Standard and based it upon a simple concept: employees have both the need and the right to know the hazards of chemicals to which they are exposed at work. They also need to know what protective measures they can use to safeguard themselves from exposure to those hazardous chemicals.
In March of 2012, Federal OSHA adopted elements of the United Nations' Globally Harmonized System of Classification and Labeling of Chemicals and is now in force on a national basis.
Globally Harmonized System's requirements now adds the "right to understand" by requiring pictograms and other simplified communication elements that will make hazard communication easier.
Manufacturers, importers, and their distributors are required to transmit the required information to downstream employers who purchase and use the products.
OSHA defines a hazardous chemical as one that is a physical hazard or a health hazard, a simple asphyxiant, combustible dust, pyrophoric gas, or a hazard not otherwise classified. A simple asphyxiant is a substance or mixture that displaces oxygen in the ambient atmosphere, and can thus cause oxygen deprivation in those who are exposed, leading to unconsciousness and death. Combustible dust refers to fine particles that present an explosion hazard when suspended in air in certain conditions. A pyrophoric gas means a chemical in a gaseous state that will ignite spontaneously in air at a temperature of 130 degrees Fahrenheit or below.

Health Hazards

"Health hazards" refer to any of the following hazardous effects that a chemical might exhibit:

- Acute toxicity, through any route of exposure
- Skin corrosion or irritation
- Serious eye damage or irritation
- Respiratory or skin sensitization
- Germ cell mutagenicity
- Carcinogenicity
- Reproductive toxicity
- Specific target organ toxicity through either single or repeated exposure
- Aspiration

Physical Hazards

"Physical hazards" refer to any of the following:

- Explosives
- Flammables (gases, aerosols, liquids, or solids)
- Oxidizers (liquid, solid, or gas)
- Gases under pressure Compressed, liquefied, refrigerated liquefied, dissolved
- Self-reactives
- Pyrophorics (liquid, solid, or gas)
- Self-heating chemicals
- Organic peroxides
- Corrosive to metal
- Chemicals which, when in contact with water, emit a flammable gas.

Physical hazard criteria are presented in detail in Appendix B of the Standard.

Labeling

Manufacturer Product Labels
Chemical manufacturers and importers are required to provide labels on the chemicals they sell that include the following elements:

A product identifier or name;

A signal word such as “danger” or “warning” used to emphasize hazards;

A hazard statement using standard phrases for particular hazard classes and categories;

Pictograms, or symbols, that convey health and physical information assigned to a Globally Harmonized System hazard class and category;

Precautionary statements that provide measures to minimize or prevent adverse effects; and

Supplier information including the name, address, and telephone number of the manufacturer or supplier.

Pictograms
In addition to the other label requirements, OSHA has adopted 8 of the 9 Globally Harmonized System pictograms shown below. Pictograms are simple graphics used on labels and Safety Data Sheets to communicate specific hazards.

Health Hazard  • Carcinogen • Mutagenicity • Reproductive Toxicity • Respiratory Sensitizer • Target Organ Toxicity • Aspiration Toxicity	**Flame**  • Flammables • Pyrophorics • Self-Heating • Emits Flammable Gas • Self-Reactives • Organic Peroxides	**Exclamation Mark**  • Irritant (skin and eye) • Skin Sensitizer • Acute Toxicity (harmful) • Narcotic Effects • Respiratory Tract Irritant • Hazardous to Ozone Layer (Non-Mandatory)
Gas Cylinder  • Gases Under Pressure	**Corrosion**  • Skin Corrosion/ Burns • Eye Damage • Corrosive to Metals	**Exploding Bomb**  • Explosives • Self-Reactives • Organic Peroxides
Flame Over Circle  • Oxidizers	**Environment** (Non-Mandatory)  • Aquatic Toxicity	**Skull and Crossbones**  • Acute Toxicity (fatal or toxic)

Each of the pictograms is discussed individually below.

Health Hazard Pictogram

The health hazard pictogram shows a black silhouette of a human form with a white area in the chest region. This pictogram is used to indicate hazardous chemicals that are:

Carcinogens;

Respiratory sensitizers;

Toxic to the reproductive system;

Toxic to a target organ;

Cause mutations in sperm or egg cells, or that;

Present a hazard of being aspirated through the oral or nasal cavities.

Chemicals that are toxic to specific organ systems might be toxic as the result of a single exposure or through repeated or prolonged exposure.

Flame Pictogram

The flame pictogram might be used with flammable gases or aerosols, flammable liquids, and/or flammable solids. Flammable, of course, refers to things that can burn, but OSHA has very technical definitions for such terms. Appendix B2 of the Standard provides the following precise definitions.

A flammable gas is one having a flammable range in air at 68°F and a standard pressure of 14.7 psi;

An aerosol is a gas that is compressed, liquefied, or dissolved under pressure in a container with a release valve that ejects it in the form of gas, foam, paste, powder, or liquid particles;

Aerosols are considered flammable if they have any component that is a flammable gas, a flammable liquid, or a flammable solid.

We've already seen OSHA's definition for what a flammable gas is, but what about a flammable liquid or a flammable solid?

A flammable liquid is basically one that has a flash point under 200°F;

There are 4 categories of flammable liquids Liquids with a flash point below 73.4°F and an initial boiling point equal to or less than 95°F are Category 1, or most flammable and, therefore, most hazardous;

Liquids with a flash point below 73.4°F and an initial boiling point above 95°F are Category 2;

Liquids with a flash point equal to or greater than 73.4°F and equal to or less than 140°F are Category 3;

Liquids with a flash point greater than 140°F and less than or equal to 199.4°F are Category 4.

A flammable solid means a solid that is a readily combustible solid, or a solid that can cause or contribute to fire through friction; Readily combustible solids are powdered, granular, or pasty chemicals that are dangerous if they can be easily ignited by brief contact with an ignition source such as a burning match and if the flame spreads rapidly.

In addition to flammables, the Flame pictogram can be used with:

Pyrophoric;

Self-heating substances;

Substances that emit flammable gas;

Self-reactive; and

Organic peroxides.

Exclamation Mark or Sensitizer Pictogram

The exclamation mark pictogram covers a wide variety of health hazards as discussed in detail in an Appendix to the Hazard Communication Standard:

Corrosive reactions that might be ulcers, bleeding, running scabs, or discoloration due to blanching of the skin, and which include: Skin corrosion that is the product of irreversible damage to the skin for up to four hours following the application of a chemical

Skin irritation that is the production of reversible damage to the skin for up to four hours following the application of a chemical

Dermal chemicals that cause a substantial proportion of exposed people or animals to develop an allergic reaction in normal dermal tissue after contact;
Acute toxicity refers to those adverse effects that occur following oral administration of a single dose of a substance, or multiple doses given within 24 hours, or an inhalation exposure of four hours. Acute toxicity, depending on severity, can also be communicated by the skull and crossbones pictogram that will be discussed further below;
Narcotic effects have to do with chemicals that cause dulling of the senses, alteration of mood or behavior, or that cause drowsiness or sleep;
A respiratory tract sensitizer or irritant means a chemical that will lead to hypersensitivity of the airways following inhalation;
An exclamation mark pictogram can be used for any chemical that causes any of the above health hazards. It can also be used with chemicals that are hazardous to the ozone layer, although that particular hazard is actually regulated by the Environmental Protection Agency rather than OSHA.

Gas Cylinder or Gases Under Pressure Pictogram

The gas cylinder pictogram is used for gases under pressure. Gases under pressure refer to gases that are contained in a receptacle having pressure equal to or greater than 29 pounds per square inch, or gases that are liquefied, or liquefied and refrigerated. A gas under pressure can be a compressed gas, a liquefied gas, a refrigerated liquefied gas, or a dissolved gas. Gases under pressure can explode if heated, or if they are refrigerated gases, they can cause cryogenic burns or injuries.

Corrosion Pictogram

The corrosion pictogram is used for chemicals that can cause severe skin burns and eye damage or for chemicals that can be corrosive to metals.

Exploding Bomb Pictogram

The exploding bomb pictogram is used with chemicals that can cause an explosion or fire, with self-reactives, or with organic peroxides.

An explosive chemical refers to a solid or liquid chemical that is, in itself, capable, by chemical reaction, of producing gas at such a temperature and pressure and at such a speed as to cause damage to the surroundings;

A pyrotechnic chemical is a chemical designed to produce an effect by heat, light, sound, gas, or smoke, or by a combination of these, as a result of non-detonative, self-sustaining, exothermic, chemical reactions;

Pyrotechnic chemicals are included in this classification even when they do not evolve gases;

An unstable explosive is an explosive that is thermally unstable and/or too sensitive for normal handling, transport, or use;

An intentional explosive is a chemical or item that is manufactured with the intent to produce a practical explosive or pyrotechnic effect;

Organic peroxide means a liquid or solid organic chemical that is considered a derivative of hydrogen peroxide.

Organic peroxides are liable to: Explosive decomposition;

Burn rapidly;

Be sensitive to impact or friction;

React dangerously with other substances.

Flame over Circle or Oxidizer Pictogram

The flame over circle pictogram is used for oxidizers. Oxidizing liquids, solids, or gases can cause fire or explosion or can intensify fires caused by other means.

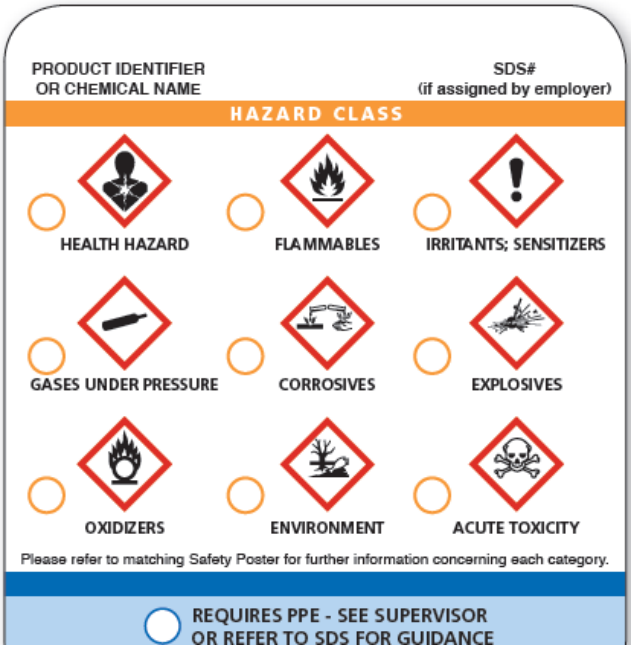
Environment Pictogram

In the United Nations Globally Harmonized System, the Environment pictogram is used to refer to chemicals that are hazardous to the aquatic environment. In the United States, however, it is the Environmental Protection Agency, rather than OSHA that regulates environmental concerns. For that reason, OSHA has not itself adopted the Environment pictogram. You might, however, still see it on labels.

Skull and Crossbones or Acute Toxicity Pictogram

The skull and crossbones pictogram refers to acute toxicity, meaning those adverse effects that might occur following oral or general administration of a single dose of a substance, or multiple doses given within 24 hours, or from an inhalation exposure of four hours. Acute toxicity might occur through swallowing, contact with the skin, or through inhalation of gases, vapors, dusts, or mists.

Workplace Labels



When a hazardous chemical is purchased, the manufacturer's information will, of course, be present on the original product label. If some of the chemical from the original container is transferred to a secondary container, however, then a workplace label must be attached to that secondary container. Secondary containers must be labeled with workplace labels in English. Workplace labels are required to contain either much of the same information that a manufacturer's original product label contains (product identifier, signal word, hazard statement, pictogram, and precautionary statement), or, alternatively, they are considered acceptable to OSHA if they contain at least the following 2 items of information:

Product identifier; and

Words, pictures, symbols, or combination thereof that provide at least general information about the hazards of the chemical.

Employers are also permitted to use workplace labels in languages other than English, as long as an English workplace label is also provided.

Workplace Labeling Poster

To go along with the new workplace labels discussed above, posters explains the meaning for the various pictograms used on those labels. These posters will be posted in Lab and the Medication Room.

Exceptions to Workplace Labeling

There are some exceptions to when workplace labeling is required, even upon a worker pouring a hazardous chemical from its original container into an unmarked workplace or secondary container. For example, an employee is not required to label secondary containers into which a hazardous chemical has been transferred (from its labeled container), if the chemical is intended only for the immediate use of the employee who performed the transfer.

Another exception permits drugs that are dispensed by a pharmacy to a healthcare provider, for direct administration to a patient, to be exempted from labeling required by the Hazard Communication Standard.

Safety Data Sheets

The clinic needs to obtain and maintain the classification information developed by the producers/importers and then to communicate that information to their workers via a comprehensive, written Hazard Communication Program. This includes proper container labeling, employee training, Safety Data Sheets, and other forms of warnings as discussed below.
Safety Data Sheets (abbreviated as SDS) are the documents that OSHA requires manufacturers, producers, or importers of hazardous chemicals to prepare for the purpose of transmitting information about hazardous chemicals downstream to employers and users. Safety Data Sheets are similar to what were formerly referred to as Material Safety Data Sheets, but there have been significant revisions to what they must now contain and how that information must now be presented.

Safety Data Sheets are required to be written in English. Additional languages are permitted, but they do not take the place of an English version. A completely different OSHA Standard, the Access to Medical Records Standard, 1910.1020, requires that "some record" of hazardous chemicals be maintained in the workplace for a period of 30 years, and keeping SDSs for that period of time, therefore, is one means of compliance with that requirement.

The Safety Data Sheet is the document that answers such questions as:

What is the material?

What do I need to know?

What do I need to do if a hazardous situation occurs?

How can I prevent hazardous situations?

Any other useful information.

Safety Data Sheets must now contain the 16 sections that are discussed below.

Format for Safety Data Sheets

As of June 1, 2015, the Hazard Communication Standard will require new Safety Data Sheets to follow a uniform format and to include the section numbers, the headings, and the associated information presented below:

Section 1, Identification includes product identifier, manufacturer or distributor name, address, phone number, emergency phone number, recommended use, restrictions on use.

Section 2, Hazard(s) identification includes all hazards regarding the chemical and required label elements.

Section 3, Composition/information on ingredients includes information on chemical ingredients and any trade secret claims.

Section 4, First-aid measures includes important symptoms/effects, whether acute or delayed, and any required treatment.

Section 5, Fire-fighting measures lists suitable extinguishing techniques, equipment, and any chemical hazards from fire.

Section 6, Accidental release measures lists emergency procedures, protective equipment, and proper methods of containment and cleanup.

Section 7, Handling and storage lists precautions for safe handling and storage, including any incompatibilities.

Section 8, Exposure controls/personal protection lists OSHA's Permissible Exposure Limits (PELs), Threshold Limit Values (TLVs), appropriate engineering controls, and Personal Protective Equipment (PPE).

Section 9, Physical and chemical properties lists, as the section name indicates, the chemical's physical and chemical characteristics.

Section 10, Stability and reactivity lists chemical stability and possibility of hazardous reactions.**OSHA's**

Section 11, Toxicological information includes routes of exposure, related symptoms, acute and chronic effects; and any numerical measures of toxicity.

Section 12, Ecological information*

Section 13, Disposal considerations*

Section 14, Transport information*

Section 15, Regulatory information*

Section 16, Other information, includes the date of preparation or last revision.

*** Special Note:**

Since other Agencies regulate the information for the sections above marked with asterisks, OSHA will not itself be enforcing the requirements of Sections 12 through 15 and will leave enforcement to the appropriate Agencies.

Consumer Products Exemption

There are some exemptions to the requirements of the Hazard Communication Standard for certain types of products. One such exemption is for "consumer products," provided such consumer products are used for the:

Same purpose;

Same duration of time; and

Same frequency of use as that of general consumers.

Consumer products are products that can be purchased in a retail store for general consumers.

Other Items Not Covered by the Hazard Communication Standard

In addition to consumer products, other types of products, which are exempt from the requirement to have Safety Data Sheets, include:

Pesticides regulated by FIFRA, the Federal Insecticide, Fungicide, and Rodenticide Act;

Toxic substances regulated by the Environmental Protection Agency through the Toxic Substances Control Act. Tobacco;

Natural wood products for retail sale;

Articles that do not result in employee exposure via inhalation, ingestion, or skin absorption;

Food or alcoholic beverages;

Ionizing and non-ionizing radiation;

Biological hazards; and

Food, drugs, * and cosmetics.

*See next section for discussion of the drugs.

Hazardous Drugs

An asterisk has been placed beside the word drugs in the last line above, because although most drugs are exempt from the Hazard Communication Standard, hazardous drugs are not exempted from the requirement to have Safety Data Sheets and other requirements of the Standard. OSHA treats hazardous drugs exactly like any other hazardous chemicals. While there is not a precise definition for drugs that OSHA considers hazardous, there are at least some helpful guidelines. OSHA uses the American Society of Hospital Pharmacists guidelines and considers any drug to be hazardous if the drug is in liquid or aerosol form at the time it is taken by the patient and if the drug can:

Affect a cell's genetic material;

Cause cancer;

Cause developmental malformations to an embryo or fetus; or

Target specific organ systems (such as kidneys, nervous system, blood forming system, etc.).

Training Requirements

OSHA requires Hazard Communication training whenever a worker is initially assigned to a position where there is a potential for exposure to hazardous chemicals. Retraining is required whenever a new chemical hazard, for which employees have not previously been trained, is introduced into the work area. Some states also have Workers Compensation or Right to Know regulations that require similar annual training on hazardous chemicals. It is, therefore, recommended that annual Hazard Communication training be provided in all states just to ensure that an employer has covered all the bases.

Hazard Communication training is required to cover the following areas of information:

Hazards of chemicals in the work area, including: Physical hazards

Health hazards

Simple asphyxiation

Combustible dust

Pyrophoric gas

Hazards not otherwise classified;

Methods and specific procedures workers can use to protect themselves, including: Work practices

Emergency procedures

PPE to be used;

Operations where hazardous chemicals
are present;

• Details, location, and availability of: The employer's written Hazard Communication Program

Master list of hazardous chemicals

Explanation of labels received on containers

Workplace labeling system used by the employer

Safety Data Sheets, including Order of information

How employees can obtain and use correct hazard information, and the

Methods used to detect the presence or release of hazardous chemicals.

Incorporation of the Globally Harmonized System has also created some specific training requirements about changes to the Standard. OSHA requires training to be completed by December 1, 2013 on the following elements of the Globally Harmonized System:

Revised label elements, including pictograms; and

Revised Safety Data Sheets.

Home

RADIATION SAFETY

EMPLOYEES-TECHNOLOGISTS
Our technologists are certified by the American Registry of Radiologic Technologists (ARRT) or are Limited Diagnostic X-Ray Operators. They must have completed the educational requirements of the ND Radiologic Health Rules 33-10-06-03 for limited x-ray operators.

All radiology technologists wear whole body dosimetry badges. These badges are monitored by "Landauer , Inc.". Badges are measured bi-monthly. Reports are sent to us with replacement badges and reviewed upon receipt. These reports are placed in the radiology department manual for future reference.

EQUIPMENT
Our equipment is registered with the ND Department of Health by their Air Quality/Radiation Control Program. A "Radiation Protection Survey Report" is provided to us. The registration/survey is done bi-annually or when implementing new equipment.

A quality control program is in place within our facility also.

PATIENT PROTECTION
A variety of lead shields are available for the patients (and staff) protection.
Female patients are screened for possible pregnancy before the exam by their ordering physician . Signs are posted in the dressing room and exam room alerting female patients to warn the technologist before having and x-ray if she may be pregnant. The physician will then order a pregnancy test and make the final decision whether or not to proceed with the exam.

ALARA (as low as reasonably achievable) is the radiation safety principal by which we provide quality exams along with radiation safety for the patient.

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Workplace Violence (Security Alert)

Workplace violence is any physical assault, threatening behavior or verbal abuse occurring in the work setting. It includes, but is not limited to, beatings, stabbings, suicides, attempted suicides, shootings, rapes, psychological traumas such as threats, obscene phone calls, and intimidating presence and harassment of any nature.

Purpose:
To provide guidelines for the prevention or intervention related to violent or threatening behavior involving employees, patients, visitors, volunteers, students, and temporary personnel. Violence can be expected but can be avoided or minimized through training and understanding of what you should do in a violent situation with a fellow employee or patient.

Definitions:

Threats and Acts of Violence: Behavior consisting of, but not limited to, any expressed intention, directly or indirectly to:

1. Harm another individual or oneself.
2. Endanger a group of employees or others in the clinic.
3. Destroy personal or clinic property.

Threats may be verbal, written, contained in a letter/package, electronic mail, telephone/voice, or overheard in conversations.

Non-Imminent Threat: Behavior consisting of, but not limited to, actions or statements that are not considered an immediate potential for violence against persons or property. This includes:

- threats
- harassment
- intimidation
- history of physical abuse
- verbal abuse, and /or
- Coercion from employees, patients, customers, visitors, or others.

Imminent or Direct Threat: Behavior consisting of, but not limited to: a potential physical assault or use of a weapon, actions or statements that have the immediate potential for violence against persons or property (e.g. breaking or throwing objects, gesturing with a fist, etc.)

Policy:

*Refer to the clinic's Building Emergency Action Plan (BEAP)

It is the policy of Center for Family Medicine to make every effort to maintain a safe work place environment and protect employees, patients, medical staff, visitors, volunteers, temporary personnel and students from harm caused by violent acts of others. Any act of verbal, physical, or emotional assault or threat, which may result in physical or psychological harm, is considered a serious offense and is not tolerated.

Employees are responsible for helping to maintain a safe work place. No employee may commit an act of violence or threat of violence while on clinic property, in state vehicles, or during working hours (including lunch and breaks) or during non-working hours when such acts may impact and employee's work performance and /or safety of others.

Employees who threaten or engage in harassment, intimidation, physical abuse, verbal abuse, stalking or coercion are subject to disciplinary action up to and including termination. This policy does not exempt and employee or non-employee from any legal or civil action. Appropriate legal action may also be taken against non-employees for violation of this policy.

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All employees are required to immediately report any threat or potential violence related to the work place, directed against himself/herself, to their supervisor or nearest coworker, unless disclosure could result in personal harm.

Procedure:

If the victim or witness to any of the above situations, or others not mentioned, you will do the following:

1. All UND CFM personnel must wear a valid clinic ID daily.
2. Notify your supervisor or the physician immediately if anyone has reason to believe that a patient, visitor, employee appears at risk for self-harm or potential harm to others.
3. Supervisor, employee and physician will work together to obtain and maintain a safe environment for the patients, and staff. It will be explained that any behavior, which is threatening or violent in nature, is not acceptable, and if the behavior continues, the involved person(s) will be asked to leave the clinic.
4. Call a SECURITY ALERT. Notify the Sanford Security via Lynx with hotkeys F9/F11 at the nearest computer.
5. Sanford Security will respond to the call.
6. Dial 9-911 when the danger of physical harm appears to be imminent. Give your name, location, name and description of suspects. Trust your instincts. If you feel uncomfortable in a place or situation, call 9-911.
7. If evacuation of clinic is warranted, follow the fire evacuation plan.
8. Try to remember details so you can describe the offender(s), including sex, age, race, hair, clothing and distinguishable features. Also attempt to obtain a description and license number of any vehicles involved. Note the direction taken by the offender(s) or vehicles and report these to police.
9. Where possible, preserve the crime scene. Do not touch any items involved in the incident. Close off the area of the incident and do not allow anyone in the crime area until police arrive.
10. Documentation: An employee will report a situation/incident within 24 hours. *Patient*-medical record and incident report. *Visitor*-Incident Report, *Employee*-Incident Report. When the danger of physical harm does not appear to be imminent, the endangered employee or observing employee must still provide an incident report.

    If an employee is harmed during the incident a Workman's Comp form, UND investigation report and UND incident report will be completed.

Dealing with Potentially Violent or Disruptive Persons

If you find yourself in a situation where a person is disruptive or potentially violent use the following suggestions to deal with the person. If you are able, try to notify your supervisor or a coworker for help. The police will be called if the situation escalates.

11. Assess the situation.
12. Project calmness.
13. Be patient and empathetic, and encourage the person to talk.
14. Ask questions. Find out specifically what the problem may be.
15. Focus your attention on the other person to show you are interested I what he/she has to say.
16. Maintain a relaxed, yet attentive, posture and position yourself at a right angel rather than directly in front of the other person.
17. Acknowledge the person's feelings.
18. Ask for small, specific favors such as asking them to move to a quieter area.
19. Establish ground rules if unreasonable behavior persists, but accept criticism positively.
20. Use delay tactics that will give the person time to calm down.
21. Be reassuring and point out choices.
22. Ask for recommendations and repeat what you feel is being requested.
23. Arrange yourself so that your exit is not blocked
24. Have a neutral manager or third party in the room with you.
25. Don't use styles of communication that generate hostility.

26. Don't reject all of their demands from the start.
27. Don't pose in challenging stances.
28. Avoid any physical contact, finger pointing or long periods of eye contact.
29. Don't make sudden moves that may seem threatening.
30. Don't challenge, threaten or dare the individual.
31. Never belittle or make the person feel foolish.
32. Don't criticize or act impatient, especially if the person is agitated.
33. Don't attempt to bargain with a threatening individual.
34. Don't make false statements or promises you cannot keep.
35. Don't explain technical or complicated information when emotions are high.
36. Don't take sides or disagree with fabrication.
37. Don't take remarks personally.
38. Don't show your anger.
39. Don't patronize, show respect.
40. Don't invade the individual's personal space.

Sexual Assault

If you have been sexually assaulted, you are encouraged to seek medical treatment immediately. It is recommended you do not bathe, douche, use the toilet or change clothing. Report the crime as soon as possible.

Telephone Harassment

Notify your supervisor immediately. Note the time, date and telephone number at which the treat was received. If the threat involves an imminent act of violence, such as a bomb threat, report it immediately to the staff by announcing a CODE YELLOW and calling 9-911. Other harassing phone calls should be reported if they persist. If you receive such a call, remain calm and hang up. Inform your supervisor. Complete an Incident Report within 24 hours of the incident.

Bomb Threat

***Refer to the clinic's Building Emergency Response Plan (BEAP)**

***Refer to UND policy for more information** https://campus.und.edu/safety/emergencies/

Written Threats

Notify your supervisor immediately. Handle the written material and any envelopes as little as possible, and then only by the corners. Place both the written material and any envelope in a large envelope. Note the names of any one who handled the material after its arrival. If the threat involves an imminent act of violence, such as a bomb threat, follow the bomb threat protocol.
If the treat is not imminent, report it to your supervisor. Complete an Incident Report within 24 hours of the incident.

Minimize employee risk

- State clearly to patients, clients and employees that violence is not permitted.
- Employees will report all assaults or threats to a supervisor.
- Respond promptly to all complaints.
- Prohibit employees from working alone in remote areas of the clinic. Another employee will be available for assistance if needed before 8:00 a.m. or after 5 p.m.
- Follow the fire evacuation policy if immediate evacuation is necessary.
- Treat and interview aggressive or agitated patients in relatively open areas that still maintain privacy and confidentiality. Nurses will assess patients before rooming them into the exam room.

- Survey the facility periodically to remove tools or possessions left by visitors or staff that could be used inappropriately by patients.
- Patients should not be allowed into the residence offices, locker rooms or workout room.
- Departments are to discuss how to alert a fellow coworker if a violent situation occurs and what they would do to escape a dangerous situation. Think of rooms that have doors that lock if you are unable to escape out of the building.

Response to Incidents of Violence/Counseling of Employee

Violence against employees, patients or visitors will be managed by staff and supervisor during the emergency and prompt response to complaints will be investigated by the supervisor and risk management and appropriate action will be taken to protect employees, patients, visitors, and property. Employees are expected to cooperate in any investigation in the clinic's efforts to maintain a safe work place.

Employees are encouraged to report incidents and will not be discriminated against for initiating a report. It is the responsibility of all clinic staff and faculty to reduce and eliminate risks of workplace violence. Report any unsafe or questionable situations to your supervisor. Employees making malicious or bad faith reports are subject to disciplinary action.

Employees will be given comprehensive treatment if victimized, prompt treatment of staff and psychological evaluation whenever an assault takes place, regardless of its severity. Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries including, short and long term psychological trauma, fear of returning to work, changes in relationships with coworkers and family, feelings of incompetence, guilt, and powerlessness, fear of criticism by supervisors, managers or coworkers. Counseling is available to employees through the Employee Assistance Program. 1-800-327-7195

Prohibition of Weapons

In accordance with NDCC Section 12.1-01-04(6)(10), and Chapter 62.1-01, the possession, storage, or use of weapons are prohibited on UND property. This applies to all faculty, staff, students, visitors, and residents on University property. The possession of weapons, or the unreported knowledge of such items, on the University's premises or during University programs, on or off campus, is considered a serious offense subject to disciplinary actions.

The prohibition of weapons does not apply to authorized law enforcement officials in the lawful discharge of their duties. Temporary exemption may be granted with advance written permission by the University's Chief of Police or authorized designee for job related, educational, or demonstration purposes. Concealed weapons permits are not valid on UND property or at sanctioned events where prohibited by venue.

Adult Protective Services

Intervention for clients/families: Adult Protective Services Carla Backman 328-8868

RESPONSIBILITY OF UNIVERSITY MANAGERS AND SUPERVISORS – University managers and supervisors are expected to learn to recognize the early signs of hostile and potentially threatening behavior that could jeopardize the safety of a member of the UND community while on campus. Ignoring the early signs can be mistaken as approval of the behavior and lead to further unsafe conduct.

LEGAL ORDERS OF PROTECTION – Members of the University community are expected to notify UPD whenever a legal order of protection is granted which identifies University property or involves a member of the University community. Victims of domestic violence who believe the violence may extend into the University community are also encouraged to notify UPD. Appropriate efforts will be made in all cases to protect the privacy and sensitivity of the information provided.

Students, Staff, Faculty and Family Assistance

UND's Employee Assistance Program (EAP) allows staff, faculty, and their families to obtain immediate, confidential, and professional help when personal difficulties begin to affect home life, health, or job performance. Managers, supervisors, or co-workers should refer colleagues who appear to be under personal stress to EAP. Stress may be brought on by: marital conflicts; family concerns; personal relationships; domestic violence; dating violence; lifestyle changes related to divorce, aging, retirement, illness, etc.; drug or alcohol abuse; legal or financial problems; or job pressures. For additional information about UND's EAP services, contact Human Resources.

Students may seek assistance at any time from the UND Counseling Center at no charge. Referrals may be made upon request for relatives, partners, and friends.

Training/Evaluation:

Training will be provided to employees upon hire and periodically. This policy will be evaluated and updated on an ongoing basis due to an incident occurring within the clinic and/or annually. Training updates will be provided to employees at staff/resident meetings. All employees will attend initial and recertification training at Sanford for Management of Aggressive Behavior (MOAB)

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Emergency Telephone Contacts

Call Telecom to notify them of the disaster/phone outage in the event that phones are not working or need to be forwarded outside the building, call Telecom @ 701 777-4111
Telecom will contact Midco and have phone lines 751-9500 and 751-6800 rerouted to the Minot CFM.
751-9500 to 858-6781
751-6800 to 858-6801

Once the clinic has dispersed and is able to handle calls, Telecom will again be called and all lines will be transferred using the EC500 option to send calls to staff cell phones. Once the clinic has dispersed the Bismarck CFM will let telecom know what cell phone numbers to send the 751-9500 line and 751-6800 line to. Once the phone lines are up, staff will use the EC500 option to direct desk phones as appropriate.

Fire/Ambulance/Police		911
Bismarck Police		1-701-223-1212
UND Safety Officer	Terry Wynne	1-701-777-3759
CDC National Aids Hotline		1-800-342-2437
National Clinicians'Postexposure Prophylaxis Hotline (PEP)		1-888-448-4911
ND Department of Health		1-701-328-2372

ASSURANCE

The North Dakota Assurance System is used to contact all clinic and SW campus employees during an emergency. The system is maintained by the safety officer and the ND OMB Risk Management Division.

Emergency Management-Disaster

The UND CFM clinic will respond to emergencies following the University's Emergency Management plan located at https://campus.und.edu/safety/emergencies/index.html. Follow the link to all campus emergencies.

The Office of Emergency Management is responsible for coordinating the University's preparation for (the before), response to (the during), and recovery from (the after) any major emergency, no matter the cause. This includes all off campus departments.

The Business Manager and Medical Director will work closely with the Office of Emergency Management, City, County and State entities to respond to all needs of the clinic.

The UND CFM clinic and the Office of Emergency will prepare a new location and equipment for patient care if the need arises. Hospitals in the city of Bismarck will be contacted for temporary supplies and physical location possibilities. The School of Medicine IT will be contacted to help implement VPN access and to assist with connection to new computers until IP addresses are open to the servers.

BUILDING EMERGENCY ACTION PLAN (BEAP)

The UND Center for Family Medicine and the UND Southwest Medical School have a joint plan filed with the UND Office of Emergency Management. A copy of the plan is filed with the UND CFM Business Manager and the Southwest Campus Administration. **Home**