

KARUK TRIBE
HEALTH BOARD MEETING AGENDA
Thursday, October 9, 2014 3 PM, Yreka, CA

A) CALL MEETING TO ORDER – PRAYER - ROLL CALL

AA) HEALTH MISSION STATEMENT

The mission of the Karuk Tribal Health Program is to provide quality healthcare for Native Americans, and other people living in the communities we serve as resources allow. Our purpose is to appropriately assess or reassess conditions of illness, disease, or pain, provide culturally appropriate educational, preventative, and therapeutic services in an environment of continuous quality improvement.

CH) APPROVAL OF THE AGENDA

EE) APPROVAL OF THE MINUTES (*September 11, 2014*)

F) GUESTS (*Ten Minutes Each*)

- 1.

H) OLD BUSINESS (*Five Minutes Each*)

- 1.

I) DIRECTOR REPORTS (*Ten Minutes Each*)

1. Rondi Johnson, Deputy Director (written report)
2. Patricia White, RPMS Site Manager (written report)
3. April Attebury, Interim Child & Family Services Director (written report)
4. Lessie Aubrey, Executive Director of Health & Human Services (written report)
5. Annie Smith, Director of Community Outreach
6. Eric Cutright, IT Director

II) REQUESTS (*Five Minutes Each*)

- 1.

K) INFORMATIONAL (*Five Minutes Each*)

- 1.

M) CLOSED SESSION (*Five Minutes Each*)

1. CHS (dinner break)
2. Laura Olivas
3. Suzanna Hardenburger
4. Barbara Snider

5. Tribal Council Members

N) SET DATE FOR NEXT MEETING *(Thursday, November 6, 2014 at 3 PM in Happy Camp*

OO) ADJOURN

**Karuk Tribe – Health Board Meeting
September 11, 2014 – Meeting Minutes
Orleans, CA.**

Meeting called to order at 3pm by Russell “Buster” Attebery, Chairman

Present:

Russell “Buster” Attebery, Chairman
Michael Thom, Vice-Chairman
Joseph “Jody” Waddell, Secretary / Treasurer
Alvis “Bud” Johnson, Member at Large
Charron “Sonny” Davis, Member at Large
Elsa Goodwin, Member at Large (late)
Arch Super, Member at Large (Arch arrived at 3:01PM)

Absent:

Josh Saxon, Member at Large (excused).

Sonny Davis completed a prayer and Buster read the Health Program Mission Statement. Also, a moment of silence was observed for the remembrance of 9/11.

Agenda:

Bud Johnson moved and Jody Waddell seconded to approve the agenda with changes, 5 haa, 0 puuhara, 0 pupitihara.

Minutes for August 14, 2014:

Arch Super moved and Jody Waddell seconded to approve the minutes of August 14, 2014, 3 haa, 0 puuhara, 2 pupitihara (Arch and Jody).

Guests:

1.) Vickie Walden, Dental Program:

Vickie is present to seek approval of dental equipment purchase and procurement of the large purchase. The budget is from Happy Camp remodel funding received from Indian Health Services in 2005. The equipment is for several items including chairs and etc. The total cost is \$45,781.

Michael Thom moved and Sonny Davis seconded to approve procurement and allow the purchase, 5 haa, 0 puuhara, 0 pupitihara.

2.) Mina Tennaca, Student Intern:

Buster had the Tribal Council introduce themselves to the guest.

Mina is present to introduce herself. She is a visiting medical student from the university of Chicago IL. The school is working with the Tribe on sending students to Chicago and then return back to be primary care physicians for the rural areas. During her four month visit, she is required to complete a community project; which she chose on complete an Elders survey. She has taken the Tribal Council’s first round of suggested changes regarding elder sensitivity. The IRB that is requiring the survey provides for information to be shared.

Elsa Goodwin arrived at 3:13pm

Buster noted that the Tribal Council needs to have the opportunity to review the questions and will seek formal approval later this evening in closed session. Buster commented that this would be beneficial to the elders and the youth to determine how there can be better interaction between the two groups.

Mina noted that this study has the potential to build on the first study and design a more in-depth project. She will also release the information to the Tribal Council prior to releasing publicly. Also, she inquired if the Tribe preferred the Tribe to be anonymous or listed on the study. Buster again commented that the Tribal Council will get back to her with their decision.

Old Business:

None at this time.

Director Reports:

1.) April Attebury, Children & Family Services:

April is not present but her report was provided.

Jody Waddell moved and Bud Johnson seconded to table April's report, 6 haa, 0 puuhara, 0 pupitihara.

2.) Rondi Johnson, Deputy Director:

Rondi is not present, out sick. Her report was provided.

Buster has a few questions on her report but she is not present. He noted that the minutes from the ACQI Meeting. Elsa asked if the items in the report are supposed to be reviewed and approved. Lessie commented that the minutes and the projects attached to her report for informational but the CQI Committee reviews them prior to the Health Board. Patti commented that the policies will come at a later time for formal approval.

Buster inquired about the provider reports. Lessie commented that they are medical chart reviews to ensure the providers are documenting appropriately and they are done every quarter. Buster reviewed the reports and questioned the immunization being entering into the system and other items. The N/A notation on the audit and that was confusing, because if it isn't applicable then charts should be pulled that are applicable. Lessie noted that if a chart review is taking place and the patient isn't required to have an immunization then you can't audit that, but random chart audits take place every quarter, regardless of the N/A, there are other items that can be audited. Lessie did note that every chart should have allergies documented. Elsa inquired if Babbie received assistance. Lessie commented that yes, that she received a template. Lessie further explained that the old chart reviews were done by hard copy and now the audits are being done in Electronic Health Record. Elsa asked about Mike Lynch's notation about AAAHC. Lessie noted that she is unfamiliar with his notation in the report. Annie explained that Mike's comment is that he would like to use AAAHC standards on auditing and not use IPC as their standards aren't the same or interact. Annie further explained that IPC will interject regarding patient care.

Buster then inquired about staff meetings being cancelled due to providers not being hired. He inquired how it was going finding providers. Sharon Denz noted that there are three full time providers in Yreka, so that is progressing. Buster asked if staff meetings were cancelled due to providing patient care. Sharon commented yes, and the meetings will begin again now that there is adequate staffing.

Arch Super moved and Jody Waddell seconded to approve Rondi's report, 6 haa, 0 puuhara, 0 pupitihara.

3.) Patti White, RPMS Site Manager:

Patti is present to review her report. She has no action items but provided her workload reports, active user requests for assistance which is only a snapshot of how many she truly receives. She continues to work on the BMI package. Image VISTA is being tracked and audited to ensure efficiently and once the staff are up to 90% she will not audit any further. She is working on an immunization package which will be uploaded soon. Risk Analysis is coming up again and will be done on an annual basis as usual.

Buster questioned technical assistance from Indian Health Services to provide a link to the Tribe. Patti noted that the web server is built with assistance from Dale however the system isn't working. She had discussed this with Indian Health Services last month but needs to get back to it. The RPMS system has two other systems for patient registration however this will be an upgrade and her time hasn't allowed her to get this done.

Elsa Goodwin moved and Jody Waddell seconded to approve Patti's report, 6 haa, 0 puuhara, 0 pupitihara.

4.) Eric Cutright, IT Director:

Eric is present to review his report. Eric noted that his last report included a challenge regarding the broadband project. Last week he received word that the Tribe can seek reimbursement and it has been applied for. The updated budget has been approved and until the funding is received then the project can't continue. Next month in October he will be presenting some construction projects based on that funding being reimbursed. He is hoping that sometime next spring the service will be up and running.

He noted that on the broadband project requires an extension to his grant, which doesn't require Council approval but he will provide a letter to Buster for signature after internal review.

Buster asked about the battery back-up systems being replaced. Buster commented that when he sees "not awarded" it concerns him. The battery backup systems were included in that grant application; however the grant was not awarded.

He is hoping to have more technical parts to allow for easier fixes, moving forward. The new systems are being reviewed as the old systems aren't working well.

Buster inquired about a budget change to the network. Eric confirmed that it was because when the grant was applied for three years ago, the engineering determined that the wireless signals weren't getting through. The tower had to be moved which required changes to the budget and work with KTHA, then also, the Siskiyou Telephone match wasn't allowed, which was another change. The two issues were a scope change and a budget change.

Arch Super moved and Jody Waddell seconded to approve Eric's report, 6 haa, 0 puuhara, 0 pupitihara.

5.) Annie Smith, Director of Community Outreach:

Annie is present to review her report. She has no action items. She thanked Tom Fielden for his expertise and his work during emergencies.

The clean air centers for the weekend have volunteers to keep them open. Staff may be paid or asked to work their time and then give them a day off later. There haven't been a lot of community members using the centers, maybe one or two. There have been a lot of placements of air purifiers in the community's so that may be adequate coverage. Buster noted that with plenty of resources there should be sufficient coverage. Annie noted that it has to be someone who has keys to the building.

Buster would recommend to access volunteers as available and then post a number to call if there are needs in the community. Jody agrees that on call is fine.

Consensus: on call for the air centers.

She then sought clarification on the transporting and services as in the report. She, Patti and Clarence are going to review Dolores and Carol Thom's data because the information isn't being captured correctly. Patti commented that Dolores noted that she was unaware that she could enter that data into the system. Annie did comment that Dolores is one of her best employees right now. The transporter in Yreka is working a very long hours and there are several transports that need to take place. The demand for transportation is extremely high. Annie noted that winter is coming and she would like to see that the Elders get out and that they continue to receive continued service. Annie noted that the CHR's are needed to complete home visits and she will eventually need to re-assign someone and she would like to know what the Council would like to do regarding complaints that may be coming. Jody asked about patients taking advantage of services rather than allowing equal use. Annie noted that there are some alternate resources available. Michael recommends that the patients be referred for services but if they cannot get services then they may call the Tribal Council, so they may evaluate the need.

Buster noted that the Council is thankful for Annie and her work during this busy time.

Jody Waddell moved and Bud Johnson seconded to approve Annie's report, 6 haa, 0 puuhara, 0 pupitihara.

6.) Lessie Aubrey, EDHHS:

Lessie has no report, but she is present because her medical leave was postponed. She does have one action item.

She provided a support letter for the Plumas County Public Health Agency for their HRSA grant.

Michael Thom moved and Arch Super seconded to approve the support letter, 6 haa, 0 puuhara, 0 pupitihara.

She then noted that it is time for the annual designee for the Medi-Cal matters affecting American Indians for 2014. Michael Thom previously held this position.

She then wanted to select the contractor's agreements for the patient satisfaction surveys. ITIN is a public agency that was hired by HRSA to complete the patient satisfaction survey and the Council will discuss this in closed session.

Arch Super moved and Bud Johnson seconded to approve Lessie's report, 6 haa, 0 puuhara, 0 pupitihara.

Closed Session:

Informational: Laura Olivas is present to provide Lessie Aubrey and the Health Board a Health Program financial report.

Arch Super moved and Jody Waddell seconded to approve the budget report, 6 haa, 0 puuhara, 0 pupitihara.

Laura Olivas provided a copy of the workers comp insurance and general liability insurance. That will be discussed next Thursday.

Arch Super moved and Bud Johnson seconded to approve credentialing and privileging for Jennifer Cronin, 6 haa, 0 puuhara, 0 pupitihara.

Consensus: move Council scheduling to 10/20 for the joint meeting.

Consensus: to seek an RFP for assistance with flag football rather than adding salaries to an already stressed budget.

Informational: ongoing issue with distribution of air purifiers in Yreka. Discussion will be to clarify what the issue is and to verify placement of equipment.

Informational: steps are being done to ensure Contract Health guidelines are being followed.

Informational: based on reports from staff, use of a domestic violence shelter may have the indication for higher use with males than females.

Informational: outstanding discussions regarding the policy and adherence for use of tribal vehicles and insurance use by programs, and to ensure non-compliance is resolved.

Consensus: to table the patient survey to the Planning Meeting.

Consensus: set a meeting for staff regarding grant compliance and general operations.

Jody moved and Bud Johnson seconded to appoint Michael Thom to the Medi-Cal consultation, 6 haa, 0 puuhara, 0 pupitihara.

Next Meeting: October 9, 2014 at 3pm in Yreka.

Bud Johnson moved and Arch Super seconded to adjourn at 5:28pm, 6 haa, 0 puuhara, 0 pupitihara.

Respectfully Submitted,

Russell "Buster" Attebery, Chairman

Recording Secretary, Barbara Snider

DEPARTMENT OF QUALITY MANAGEMENT

Karuk Tribal Health Board Meeting

October 9, 2014

Rondi Johnson

September Report



ACTION ITEMS: None.

SEPTEMBER ACTIVITIES:

Command & General Staff Meeting Sep 2nd, AAAHC Workgroup Meeting Sep 3rd, HC Clinic Ofc Meeting Sep 4th, Command & General Staff Meeting Sep 16th, Front Office/Billing Committee Meeting Sep 17th, HC Clinic Ofc Meeting Sep 18th, HC Dental Staff Meeting Sep 19th, ED Meeting Sep 23rd, HC Clinic Ofc Meeting Sep 25th,

SEPTEMBER TRAININGS/CONFERENCES & WEBINARS:

California Tribal VA billing Orientation/Training Sep 4th, IHS Director Hosts all Tribes Call Sep 4th, HANC Conf call Sep 5th, FTCA Conf Sep 7th – 9th, Webinar Rural Oregon Provider Recruitment Strategy Sep 18th, CalPIM Network Webinar Sep 22nd, Rural Outreach & Enrollment Peer Network Sep 25th,

ACQI COMMITTEE MEETING:

The Sep 10th, ACQI meeting agenda, performance improvement projects, minutes and reports are attached.

BUDGETS:

See below. Budget through 9/30/14. At this time I'm under budget.

Program	CQI
Budget Code	300002
Program Year	2013-2014
Expenses to Date	\$175,725.40
Balance	\$17,733.21
Percent Used	90.84%
Period Usage	12 months

Respectfully Submitted,
Rondi Johnson
Deputy Director of Health & Human Services

**Karuk Tribal Health & Human Services
Program
ACQI Committee Meeting/Conference Call
KCHC Teleconference Room
September 10, 2014
9:00 am-10:00 am**



1. Call Meeting to Order – Rondi Johnson
2. Roll Call/Sign In – Debbie Bickford
3. Approve Agenda – Rondi Johnson
4. Approve Minutes of August 13, 2014 – Rondi Johnson
5. Performance Improvement Reports Due
 - 5.1 HC/OR Eligibility Report – Nadine McElyea
 - 5.2 Yreka Eligibility Report – Sharon Denz
 - 5.3 HC CHDP Callback – Tracy Burcell
 - 5.4 Diabetes – Annie Smith
6. GPRA Reports
 - 6.1 Improve Childhood Immunization Rates Project – Vickie Simmons
7. New Business
 - 7.1 Complaints/Incidents/Suggestions –Rondi Johnson
 - 7.2 Policy Review
8. Old Business
 - 8.1 VFC Management Policy – Susanna Greeno
9. Next Meeting October 8, 2014 at 9:00 am
10. Adjourn

Karuk Tribe



**Karuk Tribal Health & Human Services Program
ACQI Committee Meeting/Conference Call
KCHC Teleconference Room
September 10, 2014**

Minutes

1. The meeting was called to order by Lessie Aubrey at 9:05 am.

2. **Attendance:**

Happy Camp: Debbie Bickford, Dr. Vasquez, Lessie Aubrey, Vickie Walden, Patti White, Chelsea Chambers, Nadine McElyea, Dr. Colas, Suzanna Hardenburger, and Tracy Burcell.
Yreka: Mike Lynch, Annie Smith, Sharon Denz, Dr. Walters, and Dr. Milton.
Orleans: Mina Tanaka (new intern)

3. Motion was made by Chelsea seconded by Patti to approve the agenda. However, the policies will be reviewed first.

4. Motion made by Annie and seconded by Dr. Colas to approve the Minutes of August 13, 2014.

5. **New Business**

7.2 Policy Review – all policies listed below were discussed.

- Notify AAAH.
- Personnel Identification Badge – a note that the PHC inspector said that the names had to be at least 18 pt. However, enrollment is using the largest available font.
- Performance Evaluations – delete Manager after CQI/QM.
- Native American Eligibility for Direct Care Benefits.
- Right to Be Excused Policy Provider Recruitment and Retention Plan – page 3, section 3, last paragraph, second line should read “low cost” not “lost” cost.
- Policy on Panamnik Facility Usage
- Patient Records Policy
- Nursing Policies / Procedure Manual – located in Michael’s office. We need electronic and hard copy sent to each provider. Patti needs copy for Policy Manual.
- Safe Injections
- Legally Mandated Reporting
- Annual Employee Flu Immunization Policy – only need to add info for Health Professionals (others already in folder). Need to add “wear mask” if decline immunizations.
- Laboratory Services Policy – set aside, need to revisit this one.
- Medical Triage Policy
- Kernicterus Screening and Assessment Policy

All policies (except the Laboratory Services Policy) were accepted with the changes within the documents and as noted above. The motion was made by Patti to accept these policies. A second to the motion was made by Dr. Colas.

6. Performance Improvement Reports Due

- a. HC / OR Eligibility Report (Nadine McElyea) – works in HC with MediCal and alternate resources. See written report. All applications go through Covered California website now, except SS/Disability/SSI. Suggests we need Benefits Coordinator to support all the activities and resources we supply. No real policy, except we will help everyone apply, as needed.
- b. Sharon Denz – working all over the clinic. See written report.
- c. Tracy Burrell – Much improvement. See written report. 94% in compliance.
- d. Annie Smith – Eye exams difficult with all the extra activities going on right now. Half year audit shows we are at 37.1%, want to be at 58% by end of year. Corrective Action – calls and visits to every patient. Good rapport with all clerks in all three clinics. One out of three eye exams have not been told they returned because they are not being referred through proper channels, so have to make an extra call to find out.

7. GPRA (Vickie Simmons) There have been some major improvements. (See written report). Our immunization goal is 70%. We currently have 60+% at two of the clinics. This is affected by parents who will not allow their children to be immunized. HRSA will not allow us to remove those children from our records. Some families go to other clinics, which also affects our numbers. With more providers, our numbers should continue to go up. We have met our goal to improve by 1 %.

8. Complaints (Lessie) This is a performance improvement project. We need to continue to improve so we can provide quality care.

9. VFC Management Policy (Susanna Greeno) TABLED

The next ACQI meeting will be held on October 8, at 9:00 am.

Vickie W. moved to have the meeting adjourned at 9:58 am. The motion was seconded by Suzanna Hardenburger.

Karuk Tribe



**Karuk Tribal Health & Human Services Program
ACQI Committee Meeting/Conference Call
KCHC Teleconference Room
August 13, 2014**

Minutes

1. The meeting was called to order by Vickie Simmons at 9:00 am.
2. Attendance:

Happy Camp: Debbie Bickford, Dr. Vasquez, Lessie Aubrey, Vickie Walden, Vickie Simmons, Patti White, Chelsea Chambers, Veronica Brassea, and Carrie Davis

Yreka: Mike Lynch, Annie Smith, Char Deala, Dr. Walters, Dr. Milton, and Dr. Millington

Orleans: Dr. Colas, Babbie Peterson

- It was requested that Chris Rotin (new PA) be invited to these meetings whenever possible.
3. Motion was made by Patti White and seconded by Dr. Vasquez to approve the agenda.
 4. Motion made by Patti and seconded by Dr. Vasquez to approve the Minutes of July 9, with the following comments:
 - a. Item 5.1 BMI : Patti clarified the numbers not improving, perhaps due to the Locum Tenens not focused on goals/plans.
 - b. Item 5.1 Reward: clarification needed about Lessie suggesting that perhaps rewarding the clients would encourage them to come in. Debbie suggested that maybe the providers/MA's should be offered the reward in order to encourage more follow through.

5. Performance Improvement Reports

5.1 KCHC Medical Records Audit (Carrie Davis) – See written report. 30 charts were reviewed and there were no errors. She commented that it is imperative that everyone work together as a team. This can be achieved by properly educating the staff and entering data promptly. Follow through is important after the Provider / MA have signed off chart.

5.2 Orleans Medical Records Audit (Babbie Peterson) – Babbie discovered that they were not using templates for this audit, therefore, their reports have not been in the same format. The next audit should show improvement because the staff / team are being trained to do it the right way. They now have an Audit Checklist and Babbie makes sure they are all complete. They are continually working to improve.

5.3 Yreka Medical Records Audit (Char Deala) – MA’s are doing really well. There were a few allergy and medications that were not reviewed. Reports are not sent to providers, but Char will do so from now on so they will know when there has been an error or omission. Vickie W. thanked all Medical Clerks for standardizing their reports and using graphs. Mike pointed out that Dr. Milton had a perfect performance for this audit.

5.4 EHR Reminders (Mike Lynch) – Amy and Mike worked collaboratively on selecting the measures which were the greatest health risk of the clients. Note that there were only two full time providers for this quarter (April-June 2014). There was no improvement for Colon Screening, Diabetic Eye Care or Pap Smears. There seems to be no pattern in the lack of Performance Improvements. Six months ago, Mike requested weekly staff meetings but due to lack of providers, etc... there have only been 5 or 6. Hopefully, restart in September. Because of the difficulty to meet all of IPC5 and AAAHC requirements, Mike’s recommendation was to terminate this report and start with new goals. Lessie directed that we need to continue and that others should be assisting Mike, so he is not responsible for all of it. Perhaps we need a different format, but the surveyors look for their method. Lessie is to meet with Amy and Mike to see how things can be improved.

6. **GPRA Reports**

6.1 GPRA Report/Increase Pap Smears Project (Vickie Simmons) – There has not been much improvement. Note the red comments are changes in the report. There was a drop in pap smears from 41.8 (2013) to 40.9 (2014). Annie suggested that letters be send out as reminders for those due for screening. Vickie commented that the new scanning process may inform us of outside screenings, which will improve numbers.

7. **New Business**

7.1 *Complaints/Incidents/Suggestions (Rondi Johnson)* – Tabled.

7.2 *VFC Management Policy (Susanna Greeno)* – miscommunication, no report available. Will work with Annie to develop own policy and procedure.

7.3 *Panamnik Facility Usage 03-002-15 (Babbie)* - no changes.

- Motion to accept by Lessie and seconded by Vickie Walden.

7.4 *Informed Consent 01-001-005 (Lessie Aubrey)* – no changes

- Motion to accept by Patti and seconded by Chelsea.

7.5 *Vision, Mission, Goal, and Value statements (Vickie Simmons)* – no changes

- Motion to accept by Patti and seconded by Lessie.

7.6 *Impaired health care Provider 03-001-136 (Vickie Simmons)* – no changes

8. Motion to accept by Patti and seconded by Lessie.

- Motion to accept by Patti and seconded by Lessie

7.7 *Orientation Checklist 03-001-130 (Vickie Simmons)* – changes in red; also omit Patti’s name, change to reflect IT only

- Motion to accept by Patti and seconded by Vickie Walden.

All changes to above policies were approved by a unanimous vote. Patti will update and have them ready for Council approval.

8. **Old Business**

8.1 HIV/AIDS (Mike Lynch)

- The number of patients needs to be changed to 18 on attached report. Chris Rotin will be taking over this report. Next meeting is on the 19th. Lisa has declined to meet with Chris. Walk-ins are covered. Chris is doing a great job!

9. Next Meeting September 10, 2014 at 9:00 am

10. Meeting was adjourned at 10:06 am.

Eligibility Report ACQI Meeting

April – June 2014
September 10, 2014

Time spent helping people with MediCal has decreased due to those applications being completed by Debbie Bickford via the Covered California program. I've done a few for people who already know they will be MediCal eligible. I am also following up on some disability applications for people who need help applying or requesting reconsiderations.

As of October 1st I will no longer do eligibility activities as I am only going to be working 20 hours per week as the Administrative Assistant for the Happy Camp Child & Family Services Behavioral Health program.

Following is data from the last full quarter, April to June of 2014. The time involved for these services are just over 15 hours.

	April 2014	May 2014	June 2014	Quarter Totals
MediCal	1	1	3	5
Covered CA	0	0	0	0
SSD/SSI	0	0	1	1
Follow up	14	5	4	23
Clients	9	6	6	21
Services Provided	15	8	7	30

I need to repeat my concern about the lack of any policy or procedure to guide the disability application process. I would like to see those developed for the protection of both the staff member and the client. Prior to my employment in July of 2012, no one within the Tribe helped with disability applications. Because I had previously done them, I continued to do so and the Tribe supported a one-day training for me, which was very helpful

And, to again repeat, I see a need for the Tribe to eventually have a full-time Benefits Coordinator to pursue disability applications as well as helping people apply for MediCal and Covered California. There's also a huge need for someone to help people with their choices and options for Medicare. I would recommend that in the future someone attend the training, held in Redding each year, to become qualified to provide those services under the HICAP program.

Nadine McElyea, Administrative Assistant/Patient Eligibility Worker
Child and Family Services, Happy Camp

Activity
Progress Report 2nd Quarter
April, May, June 2014

Title Eligibility Report

Purpose: To provide service to all clients.

Problems: None for this quarter.

Data: Clients for 2nd quarter processed for Medi-Cal

Findings: total applicants for 2nd quarter are (5)

APRIL 2014 (2)

(1) Pending Medi-Cal

(1) Eligible for Medi-Cal

MAY 2014 (2)

(2) Eligible for Medi-Cal

JUNE 2014 (1)

(1) Eligible for Medi-Cal

Sharon Denz

Eligibility Worker for Yreka

09/03/2014

KARUK TRIBAL HEALTH PROGRAM
Performance Improvement Activity
Progress report
September 10th, 2014 Report

PURPOSE/Problem:

1. Identify areas for improving the follow-up on CHDP's for patient's ages 0-18 years:
2. Objective is to make sure children are receiving their immunizations and CHDP's on time.

Objective/GOALS:

1. To establish a follow-up system that will help track patients who need CHDP's.
2. Data will be collected by keeping copies of completed CHDP's and entering into a system that will show when patients are due for their next CHDP.
3. This data will be collected on a continuous basis.

DATA:

Our first quarter report made for this project showed that we had 89 patients with 14 delinquencies. Our second quarter report made for this project showed that we had 89 patients with 10 delinquencies. Our third quarter report made for this project showed that we had 89 patients with 9 delinquencies. Our fourth quarter report made for this project showed we had 99 patients with 8 delinquencies. Currently as of 9-1-14 we have 107 patients with 7 delinquencies.

All patients that are delinquent have been sent letters requesting paren'st to make appointments, most of our delinquencies are patients that are chronically delinquent with parents that are non-compliant.

I believe that our records will indicate that we are constantly tracking our CHDP's and that each month our delinquencies are going down, which indicates that this system is working.

Corrective Action:

A follow up folder has been created for completed CHDP's so we have a continuous tracking system Of pending patients due for their immunizations and CHDP's, and that appointments are being made in a timely manner.

RE-Measure:

The tickler file and Excel spreadsheet that has been created for follow up on CHDP's is helping to keep track of patients who have moved, who have registered as new patients and who are delinquent/no show patients. This system has the capability of allowing us to easily update data on a daily basis and stay on top of getting all CHDP patients scheduled with letters being sent to remind parents that their child is due for their CHDP.

Additional Corrective Action:

We have found that we have not had to correct our new implementation of the Tickler System/Data Entry sheets because they are allowing us to stay on top of knowing when patients are due for their next CHDP's, before this system was implemented we were falling behind in getting patients appointments made in a timely manner.

Tracy Burcell

Karuk Tribal Health and Human Services Program

Performance Improvement Activity

September 2014

Improve the Performance of Eye Exams for Karuk Diabetic Patients

Part Three

- I. **Purpose of this study:** The purpose of this study is to improve the Best Practice we have chosen for our Diabetes Program, Grant, and Eye Exams. The current eye exam rate for the last diabetes audit ended on 12/31/2013 and was 50%. Current to date the eye exam rate is 37.1%. We are half way through the audit year. It is important to improve these rates to screen for and to prevent Diabetic Retinopathy and to insure that all patients diagnosed with retinopathy are referred to a higher level of care for retinal treatment and for continuing care.
- II. Our Electronic Health Records (EHR) and RPMS programs provide a reliable way to document and follow the path of any of our Diabetic patients for retinopathy. The EHR also provides reminders if the patient has not been screened for retinopathy for the past year. The standard we follow is the Indian Health Service (IHS) Special Diabetes Program for Indians (SDPI) which list eye exam rates target for year 2014 at 58.6%. Our records show we currently have 140 patients in our diabetes register.
- III. The data for this report is received through the EHR/RPMS and we only track accurate and consistent recording through our records.
- IV. If any of our medical staff in our system that enter into EHR are not consistent in entering the current status of each patient, or if the direct care nursing staff do not follow through with both questioning the patient and entering the data, then our records are inaccurate. If the data was not entered it was not done. Additionally the Community Outreach staff continues to call, visit and track the patients through questions and screening to insure we have all patient information. The call list for current patient within the diabetes registry has been split up and assigned to each member of our team and they are continually making home calls. Additionally, We have had staff turnover within our system this past year. It appears that we now are fully staffed and have a new Medical Director that is working on developing strong teams within each clinic. I look forward to this support as a means to improve all of our diabetes program targets.
- V. **Corrective action:** The Community Health Outreach Team has been trained on what to ask during their quarterly calls to patients on their portion of the list. The direct care staff at each clinic is reminded regularly, at each meeting to question each patient at every visit if

and where they were screened for retinopathy and to refer those that have not had their screenings to the diabetes nurse or to a local optometrist. Annie was able to straighten out the software problem with UC Berkeley and the pictures now translate without incident.

- VI. This project will be re-measured in three months. Hopefully we will see an increase to 60% in our eye exams screenings for retinopathy by the end of the next audit year end December 31, 2014. We have improved by 3.1% since the last report.

KARUK TRIBAL HEALTH AND HUMAN SERVICES PROGRAM

2014

Create an Immunization Recall System

I. Purpose of the Study

The purpose of this study is to create an immunization recall system so that our childhood immunization rates for two year olds will increase by 1% over the baseline rate reported in 2014 on the 2013 UDS Report.

II. Identification of the Performance Goal

The baseline rate for immunizations is 51.4%. This low rate must be increased because it is important that children receive the appropriate vaccinations at an early age in order to prevent death and disability from transmissible and infectious childhood diseases. Low immunization rates can result in deadly epidemics that affect both the children who are patients of our clinics as well as children in the communities where our clinics are located.

In 2014 we considered an increase of 1% per year to be reasonable **and** achievable.

III. Description of the Data

The baseline data for this performance improvement project was taken from the 2013 UDS Report. This information came from results for both Native American and Non-Native American, two year old children. HRSA now requires the same immunizations as GPRA.

UDS: 4DTaP, 3IPV, 1MMR, 3Hib, 3HepB, 1VZV, 4PCV

DTaP – Protects against diphtheria, tetanus, and pertussis (whooping cough)

IPV – Protects against polio

MMR – Protects against measles, mumps and rubella

Hib – Protects against *Haemophilus influenzae* type b.

HepB – Protects against Hepatitis B

VZV – Protects against chickenpox

PCV – Protects against pneumococcal disease

HRSA and GPRA will require that children be properly immunized by their 3rd year.

IV. Evidence of Data Collection

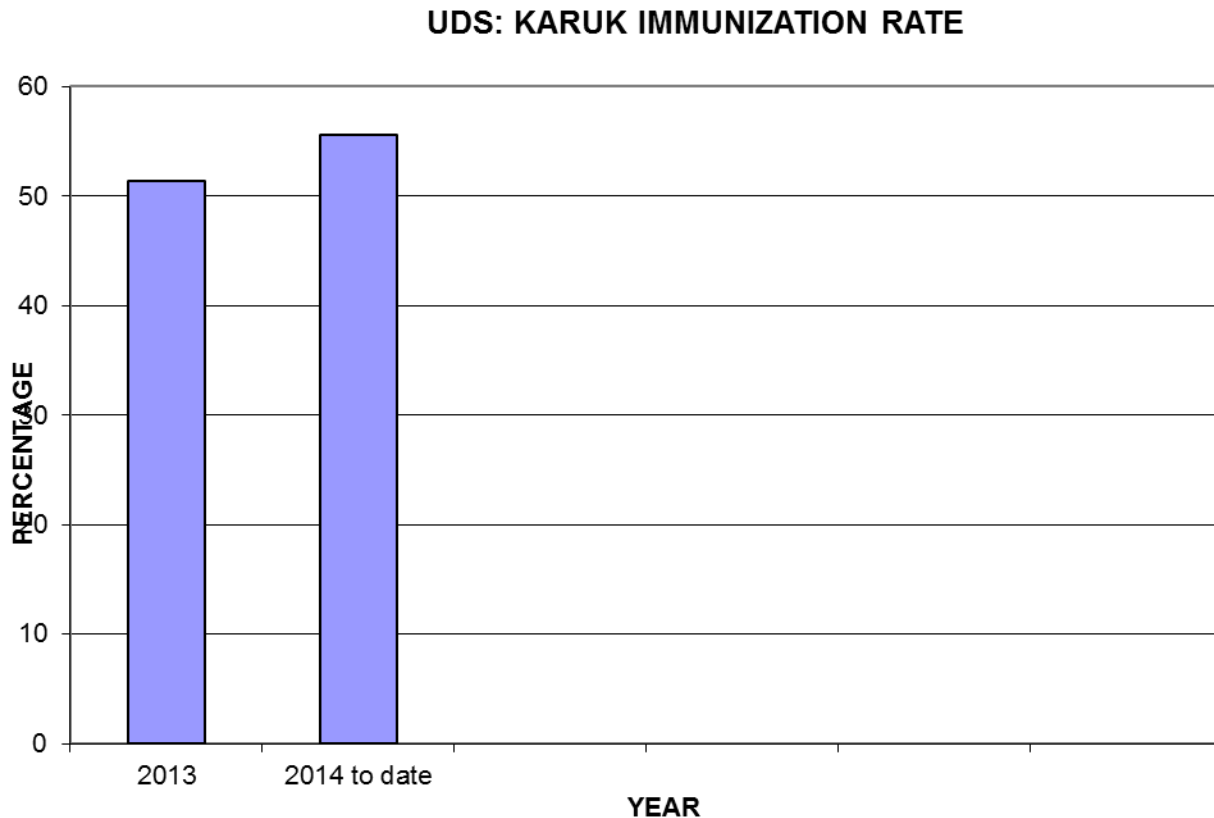
We are able to pull quarterly results from RPMS' UDS section so, in the future, we will be able to monitor improvement on a continuous basis.

V. Data Analysis

The 2013 UDS result for immunizations was 51.4%. The UDS result for the period of January 1, 2014 thru August 25, 2014 is at 55.6%.

VI. Comparison of Current Performance Against Performance Goal

The rate has increased by 4.2%. This meets our goal of at least a 1% increase. Let's hope that it won't dip between now and the end of the year.



VII. Implementation of Corrective Action to Resolve Identified Problem

The following key steps will be initiated with the intended result that immunizations for **all** children who frequent our Karuk Clinics will be up to date by their 3rd birthday.

- Clinic receptionists will make recall appointments.
- Ensure that patients do not leave clinic without a follow-up appointment being made.
- Receptionists will make reminder calls the day before the appointment and also instruct the parent/guardian to bring current immunization card/record to appointment.
- A dynamic spreadsheet will be kept to track children's immunization needs using information gathered from RPMS.
- Reminder letters will be sent out to parents/guardians notifying them of the needed immunizations.
- Outreach workers will be sent out when parent/guardians do not respond.

VIII. Re-Measurement

Every three months (quarter) a UDS Table 6A Report or equivalent will be run for comparison with the last report. This is to determine whether the corrective actions have achieved the desired performance goal.

IX. Implementation of Additional Corrective Actions if Performance Goals Are Not Met

If the initial corrective actions did not achieve and/or sustain the desired improved performance, implement additional corrective actions and continue re-measurement until the problem is resolved.

X. Communication to Governing Bodies

Communicate findings of this quality improvement activity on a quarterly basis to the ACQI committee which in turn will report to the Tribal Health Board in the form of meeting minutes and report copies. In addition, these results will be posted on the ACQI bulletin board at each facility for review by clinic staff.

Respectfully Submitted by Vickie Simmons

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 (X) 03 () 04 () 13 () 14 () 15 () 16 ()			05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()			09 () 10 () 11 () 12 ()		
Function: Governance			Policy #: 02-001-060			Policy Title: Notifying AAAHC		
Tribal Chairman: Date: October 13, 2011 Signature:			Medical Director: Date: September 14, 2011 Signature:			Cross References:		
Supersedes Policy 02-001-060 dated 01-08-2009								

Purpose: To establish guidelines and the obligation for mandatory reporting to AAAHC

Policy: The Karuk Tribe shall require the EDHHS to notify AAAHC or in her absence, the Director of Quality Management, during an accreditation term, whenever significant organizational, operational, or financial changes occur.

Procedures: The Karuk Tribe shall notify AAAHC whenever any of the following occur:

- A. If the Karuk Tribal Health Program merges with another healthcare entity. In the event a change in the majority interest from Tribal members to community members, etc.
- B. If Karuk Tribal Health and Human Services receives a name change
- C. When additional services are added after accreditation has been achieved.
- D. When additional locations have been added.
- E. Whenever there are major renovations, or any interruption in service that exceeds 30 calendar days.
- F. Any change in state or federal status.
- G. If bankruptcy or a major change in financial viability occurs.
- H. When any government investigation, criminal indictment, guilty plea or verdict in a criminal proceeding occurs involving the Tribal Council, or staff, or directly or indirectly involving the Tribe or the Karuk Tribal Health Program.
- I. Adverse publicity or adverse media coverage related to the organization or its providers.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 (X) 04 () 13 () 14 () 15 () 16 ()			05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()				09 () 10 () 11 () 12 () 21 () 22 ()			
Function: Administration			Policy #: 03-000-110				Policy Title: Personnel Identification Badge			
Tribal Chairman: Date: October 13, 2011 Signature:			Medical Director: Date: September 14, 2011 Signature:				Cross References: Karuk Tribe's Personnel Policy - Attachment E: Employee Identification Policy			
Supersedes Policy 03-000-110 dated 5/14/2009										

PURPOSE. The wearing of the name badge ensures a patient's right to know who is providing their care or service. In addition, it ensures confidentiality, privacy, and promotes security of the clinic facilities.

POLICY. All personnel of the Karuk Tribal Health & Human Services Program (KTHHSP) shall wear a name badge during the performance of their duties and upon entering any Karuk Tribal facility during working hours. KTHHSP employees shall adhere to the procedures set forth in the Karuk Tribe's **Employee Identification Policy.**

No update required.
However, at the PHC clinic inspection, the inspector said that
Names on ID badges had to be in at least 18 pt. print.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 (X) 04 () 13 () 14 () 15 () 16 ()				05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()				09 () 10 () 11 () 12 () 21 () 22 ()			
Function: Human Resources				Policy #: 03-000-115				Policy Title: Performance Evaluations			
Tribal Chairman: Date: October 13, 2011 Signature:				Medical Director: Date: September 14, 2011 Signature:				Cross References: Employee Orientation Policy 03-001-130			
Supersedes Policy 03-000-115 dated 5/14/2009											

Purpose: To designate a time frame for the assessment of employee performance.

Policy: Performance evaluations shall be conducted initially (within 30 days of the 180 day initiation period) and annually thereafter. Annual evaluations will occur at the end of each calendar year, and will be completed by December 31st. The supervisor is responsible for assuring that all scheduled evaluations are completed in a timely manner. Performance evaluations shall be are conducted to determine *employee competence*.

Procedures:

1. Within 30 days of completion of the initiation period and annually thereafter, the supervisor, or his/her designee, will complete assure the completion of an ~~Employee Evaluation Form~~ **Employee Performance Evaluation form**, using the position description, which defines competencies to be assessed, as the basis for evaluation.
2. The supervisor/designee will complete the supervisor's portion of the report. The employee will complete the self-evaluation portion of this form. The need for further training or improvement must be noted.
3. The supervisor/designee will discuss both portions of the report with the employee, at which time any final adjustments to the supervisor's/designee's final evaluation will be made.
4. The supervisor/designee and employee must each sign and date the final evaluation.

5. The completed form is ~~then~~ **will then be** sent to the ~~CQI/Quality Management Department~~ **CQI/QM manager**, who will track training needs, in addition to confirming that the competency assessment was completed.
6. **After processing, the CQI/QM manager will send the final evaluation** ~~routes competency assessments to the KTOC~~ **personnel office** for filing **in each employee's permanent record.**

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 (X) 04 () 13 () 14 () 15 () 16 ()			05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()				09 () 10 () 11 () 12 () 21 () 22 ()			
Function: Administration			Policy #: 03-001-120				Policy Title: Native American Eligibility for Direct Care Benefits			
Tribal Chairman:			Medical Director:				Cross References:			
Date: October 13, 2011			Date: September 14, 2011							
Signature:			Signature:							
Supersedes Policy dated 5/14/2009										

PURPOSE. To establish Native American eligibility for direct care benefits (free services) at the Karuk Tribal Health & Human Services Program (KTHHSP) clinics.

POLICY. All patients presenting themselves for services at KTHHSP clinics shall provide Indian verification to be eligible for direct care benefits.

The following eligibility requirements are mandatory:

1. Any member of a federally recognized Indian Tribe or descendant with verification.
2. Any descendant of an Indian who was residing in California on June 1, 1852, but only if such descendant:
 - a. is living in California
 - b. is a member of the Indian community served by local program of the service, and
 - c. is regarded as Indian by the community in which such descendant lives.
3. Any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California.
4. Any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations under the Act of August 18, 1958 (72 Stat. 619) [unclassified], and any descendant of such an Indian.

NOTE: Nothing in this section may be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

BURDEN OF PROOF. It shall be the responsibility (burden of proof) of the patient to provide verification of eligibility. If verification is not provided by the second visit, the patient will be listed as **non-Indian** and will be billed for services.

PATIENT REGISTRATION DOCUMENTATION. It shall be the policy of KTHHSP to document patients without Indian verification as “pending” on page one. At the next visit, the patient will be listed as “non-Indian” unless verification is presented.

NON-INDIAN PREGNANT SPOUSE. She shall be eligible through her pregnancy and six weeks post partum for services related to her pregnancy. Non-married pregnant women carrying an Indian child shall obtain a letter from the father stating that he is the father of the unborn child or a court ordered paternity judgment.

ACUTE INFECTIOUS DISEASE DEEMED A PUBLIC HEALTH HAZARD. Non-Indians of an eligible Indian household shall be treated for infectious disease thought to be a public health hazard. To obtain services these patients must be referred from a KTHHSP medical provider or KTHHSP Public Health Nurse.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()				05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()				09 () 10 () 11 () 12 () 21 () 22 ()			
Function: Administration				Policy #: 03-001-125				Policy Title: Right to be Excused Policy			
Tribal Chairman:				Medical Director:				Cross References:			
Date: October 13, 2011				Date: September 14, 2011							
Signature:				Signature:							
Supersedes Policy 03-001-125 dated 07/30/2009											

PURPOSE. When patient care/treatment conflicts with a personal cultural value, ethic, and/or the religious belief of ~~the caregiver~~ a **staff member**, he/she may request to be excused from delivery of such treatment. This policy provides a process on how **staff members** may make their request, and how the organization will ensure that patient care is not compromised when such requests are granted.

POLICY. When a conflict in care arises due to a personal cultural, ethical, and/or religious belief of ~~the caregiver~~ a **staff member**, he/she may request to be excused from delivery of such care.

PROCEDURES.

A. **Orientation:**

- 1) A new employee should declare that a personal cultural value, ethic and/or religious belief, exists at the time of initial employee orientation.
- 2) The individual providing orientation must then note any conflicts in care on the orientation checklist.
- 3) The supervisor is then informed that a conflict in care exists.
- 4) If a conflict in care has not been declared at time of orientation, then the employee must submit a written request to be excused.

B. **Submission of Request:**

- 1) As the employee identifies care that conflicts with personal values, ethics and/or religious beliefs, he/she must submit a written request to be excused from such care.
- 2) The request must be signed and dated by both the employee and supervisor.

- 3) The employee must explain how and why his/her duties in providing care conflicts with personal values, ethics, or beliefs.
- 4) The request must be made in advance so that patient care is not jeopardized or compromised.
- 5) A copy of the request is then placed submitted for placement in the employee's personnel record.

C. **Request to be Excused Without Advanced Notice:**

- 1) In the event that the caregiver staff member realizes that the care he/she is responsible to deliver conflicts with personal value, ethics, and/or religious beliefs, he/she must immediately report to his/her supervisor, who will make a judgment call determine the merits of the request and determine whether to approve or to deny the request. The supervisor must ensure care will be provided before granting the request.
- 2) The employee's supervisor shall then write up document the incident and shall send submit a copy to for filing in the employee's personnel record. Multiple requests may identify a trend or pattern in the employee's performance.

D. **Administrative Review of the Request**

- 1) An initial review shall be done completed by the employee's supervisor.
- 2) If not reviewed by the immediate supervisor, approval must be granted from either the Medical/Dental Director of the relevant program.
- 3) Both the employee's supervisor and the Medical/Dental Director must approve the request to be excused from the specific job duty in order for the request to be considered officially approved.
- 4) If the written review denies the request to be excused, the reasoning rationale shall be provided.
- 5) If the written review approves the request to be excused, the specific job duties shall be listed.
- 6) Alternate methods to provide for the patient's care must be clearly defined in the approval.
- 7) No approval shall place undue hardship on other staff members or the organization as a whole.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 (X) 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Administration	Policy #: 03-001-135	Policy Title: Provider Recruitment and Retention Plan
Tribal Chairman:	Medical Director:	Cross References:
Date: 11/03/2011	Date: 10/12/2011	
Signature:	Signature:	
Supersedes Policy 03-001-135 dated 2009		

PHILOSOPHY: The Karuk Tribal Health and Human Services Program (KTHHSP) will recruit primary care providers dedicated to the provision of high-quality, comprehensive, cost-effective medical care. KTHHSP will maintain and support an on-going Provider Recruitment and Retention Plan that provides:

- A comprehensive recruitment package designed to employ primary care medical providers committed to the mission of community-based Tribal health centers, and dedicated to meeting the health care needs of the KTHHSP patients.
- A work environment that supports the personal and professional needs of primary care medical providers and their families, thus encouraging long-term employment commitments to the KTHHSP.

CENTER REQUIREMENTS: The success of the KTHHSP Provider Recruitment and Retention requires the KTHHSP to provide:

- A clear and definitive role of primary care providers as team leaders among the medical support staff in the provision of health services.
- An effective and efficient medical support team that works with primary care providers in meeting the overall health needs of clinic patients and special needs populations.
- A work environment that encourages the successful completion of established clinical goals.
- A work environment where administrative/management teams and primary care providers understand the unique organizational and financial structure of the Tribal health program, and work cooperatively in the planning, management, and evaluation of the health center.
- An opportunity for primary care providers to participate in community-based Tribal health care initiatives, networks, and cooperative agreements, and/or develop affiliations with other health care entities for the purpose of continued personal, professional, and/or academic growth and development.

RECRUITMENT OF PROVIDER STAFF:

1. Determine Need and Recruitment Strategy

The entire staff of the clinic will be involved in the process at varying stages. The following steps will be taken to ensure the most desirable outcome:

- a. Determine the need for recruitment, **involving**. ~~Involve~~ the provider staff in the process.
- b. Determine desirable provider attributes and position qualifications.
- c. Determine the feasibility of desirable recruitment methods.
- d. Select the method(s) that best suit KTHHSP's needs.
- e. Include mailings of the position profile containing a concise description of the practice opportunity:
 1. Specialty needed
 2. Practice opportunity location
 3. Description of the medical opportunity
 4. Brief summary of the compensation package
- f. Target graduating residents from Family Practice Resident Programs.
- g. Target the search area to the six or seven closest states; **and to** expand the area as necessary.
- h. Develop a "sourcing action plan" considering all likely resources:
 1. Residency programs
 2. Medical school alumni lists/publications
 3. Publication, **e.g.**, newspapers, journals
 4. Internet **searches**
 5. State medical scholarship programs
 6. Directories of **state licensure boards**
 7. JAMA's **annual education issue**
 8. National Health Service Corps
 9. Professional recruitment services
 10. **Recommendations from current KTHHSP providers**

2. Development of Candidates

Do not assume that all inquiries about the position are serious. Initial screening activities should include:

- a. Review **the** candidate's resume/~~CV~~-(curriculum vitae) for qualifications
- b. Conduct a phone interview to ascertain the level of interest, **to** answer questions about the practice opportunity, **and to** explain the recruitment process.
- c. If the candidate is viable, send a recruitment package with a sample contract, **and** schedule an in-depth phone interview.

- d. If five or more viable candidates complete this phase, select the top three for further consideration, based upon all available data.

3. Candidate(s) Site Visit

Before the candidate visits the site, certain preparations need to be completed, including the following:

- a. A pre-visit planning call to determine the objectives of the candidate.
- b. Arrangement of travel, lodging, and written itinerary for the visit two weeks prior to the visit, including recommendations for proper clothing for weather and events.
- c. A meeting of the recruitment/reception committee to review the site visit plans, their roles and preparation for the interview and responses to the candidate's questions regarding the community.

Explain the benefits of working for the Karuk Tribe; such as, assistance with student loan payments, relocation assistance, and the lost cost of living in the area. Allow time to discuss the contract thoroughly before the visit ends. Encourage the candidate to ask questions regarding the practice or the community. Offer each candidate interviewed a tour of the facility at which she/he will be working. Make every effort to ensure that the visit is pleasant and ends on a positive note.

4. Selecting the Candidate

Selecting the final candidate will include input from the provider staff, Health Board representatives, EDHHS, and other members as appropriate. Consideration will be based on:

- a. Candidate who best fits the qualifications and other desired attributes and requirements for the position.
- b. Candidate who best fits the health clinic practice site and community.
- c. The most mutually financially beneficial relationship for the health center and the provider.
- d. Overall fit and satisfaction of the candidate with the community.

5. Follow-up/Making the Offer

Immediately following the site visit and selection process by the recruitment committee, the following steps will be taken:

- a. Send a letter to the selected candidate which includes:
 1. An expression of thanks for visiting the program.
 2. An offer to accept the position with a designated time frame for reply.
- b. Encourage the recruitment committee members to also write letters.
- c. Send thank you letters to other candidates invited to visit the center.

6. Follow-up Acceptance Letter

The following steps will be taken to bring closure to the recruitment process:

- a. Immediately confirm the following in writing:
 1. The candidate's acceptance has been received.
 2. The acceptance is based upon the agreed contract.
 3. The expected start date.
- b. Finalize plans to relocate with candidate.
- c. Keep lines of communication open.

7. Retention

- a. **Health Center Orientation:** A provider will be assigned to each new recruit to:
 1. Introduce the new provider to the clinic.
 2. Provide orientation to the health center.
 3. Provide information about responsibilities of the medical staff, such as attendance at meetings, chart completion expectations, and protocols for scheduling patients.
 4. Assist with establishing the provider in becoming acquainted with the community.
- b. **Community Orientation:** The KTHHSP will work to assist the new provider in becoming acquainted with the community.
- c. **Open Communication:** Do not assume that the new provider will be integrated into the practice situation after the initial few days or weeks. The normal orientation phase takes about six months. During this initial period, it is important that the Medical Director communicate regularly with the new provider regarding the adjustment to the practice and community. Maintaining an open line of communication may prevent misunderstandings and conflicts from arising later.
- d. **Team Building:** Retention depends a great deal on instilling a "team" atmosphere for the new provider. It is important that the new provider become a part of the organization as quickly as possible. This process can be facilitated by a planned approach to involving the new provider in health center functions. The retention strategy will also incorporate teaching the history, traditions, and customs of the clinic and community.
- e. **Salary and Benefits:** These policies and procedures are particularly important for the retention of existing providers, as well as recruitment of new providers.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 (X) 04 05 () 06 () 07 () 08 () 09 () 10 () 11 () 12 () 13 () 14 () 15 () 16 () 17 () 18 () 19 () 20 () 21 () 22 ()	Policy #: 03-002-150	Policy Title: Policy on Panamnik Facility Usage
Function: Administration	Medical Director: Date: 10/12/2011 Signature:	Cross References:
Tribal Chairman: Date: 11/03/2011 Signature:	Supersedes Policy 03-002-150 dated 8/14/2008	

Purpose: To provide a system for fair and uniform scheduling and usage of the Karuk Tribal Panamnik Center facility.

Policy: All usage by programs requiring keyed entry to the Panamnik Center must be approved by Tribal Council and key issued by the Personnel Office at the administration office in Happy Camp. Usage of the facility during work hours are scheduled by the Panamnik Center Tribal staff. The building usage is reserved for Tribal and community program events that have been pre-scheduled.

Procedure:

1. Panamnik Center is open from 8:30am – 5:00pm Monday through Friday; building usage for these times can be scheduled with Center Staff, Senior Center Supervisor, Senior Center Cook, or Computer Center Director.
2. Tribal and community programs that require keyed entry must check with center staff to set up proposed schedule of usage to assure there are no usage conflicts and then schedule to be on the Tribal Council agenda to request approval for program usage of the facility with approval for a key.
3. Upon Tribal Council approved usage, program representative will meet with a center staff member to go over building orientation and security for building's nightly closure.
4. Programs will leave the building clean and not remove furniture or other items from the building.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 (X) 05 () 06 () 07 () 08 () 09 () 10 () 11 () 12 () 13 () 14 () 15 () 16 () 17 () 18 () 19 () 20 () 21 () 22 ()		
Function: Quality of Care Provided	Policy #: 04-002-175	Policy Title: Patient Records Policy
Tribal Chairman: Date: October 13, 2011 Signature:	Medical Director: Date: September 14, 2011 Signature:	Cross References:
Supersedes Policy 04-002-175 dated 04/09/2009		

POLICY: The Karuk Tribal Health & Human Services Program (KTHHSP) shall ensure that its medical records are complete and kept up-to-date, in order that patients receive the best quality care available to them through efficient information management.

PROCEDURES:

1. Each patient shall have a medical record assigned with a distinctive number.
2. The medical records personnel will review records of scheduled patients to ensure accuracy and completeness. Outside reports shall be scanned into the record for review by the provider.
3. Providers will be notified if their documentation is incomplete, and they will be instructed to complete it within 7 days.
4. The medical record will contain:
 - a. A complete history, physical, psychosocial, and functional assessment by the patient's third visit or documentation of refusal.
 - b. A complete and accurate problem list denoting significant active and inactive problems.
 - c. Significant past medical, surgical, and obstetrical history.
 - d. Drug and other allergies.
 - e. A current medication list.
 - f. Reports from outside sources, i.e. lab, x-ray, specialty consultation.
5. All entries will be signed and dated by relevant providers.
6. All hard-copy records will be kept in a designated locked area.
7. Copies of medical records will be released according to the policy on Release of Medical Records.
8. Medical records will be inactivated according to the policy for Inactivation of Medical Records.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 (X) 13 () 14 () 15 () 16 ()				05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()				09 () 10 () 11 () 12 () 21 () 22 ()			
Function: Quality of Care Provided				Policy #: 04-004-190, 04-004-191, 04-004-192, 04-004-193, 04-004-194, 04-005-195, 04-005-196				Policy Title: Nursing Policies			
Tribal Chairman: Date: 05/10/2012 Signature:				Medical Director: Date: 04/18/2012 Signature:				Cross References: Nursing Procedure Manual Lab Procedure Manual			
Supersedes policies 01-004-190/196 dated 11/03/2011 & 04/09/2009											

04-004-190 Administration of Medication

Registered Nurses, Licensed Vocational Nurses, and Medical Assistants shall administer medication per order or protocol of the attending physician or mid-level under his/her supervision.

04-004-191 Screening Procedures

Registered Nurses, Licensed Vocational Nurses, and Medical Assistants shall administer screening procedures per scope of training or supervision. ~~such as, but not limited to the following:~~

- ~~Hearing and Audiometric~~
- Hematoerit
- Vision
- Blood Glucose
- Blood Pressure
- INH
- PT
- HIV screen
- UA
- H Pylori
- Fecal Oecult blood
- Wet Mount
- Venipuncture

04-004-192 First Aid and Emergencies

Registered Nurses, Licensed Vocational Nurses, and Medical Assistants shall administer first aid or emergency procedures per scope of training or supervision in accordance with established procedures.

04-004-193 **Other Medical Procedures**

Registered Nurses, Licensed Vocational Nurses, and Medical Assistants shall work within their scope of practice or under direct supervision and shall follow established procedures where available.

04-004-194 **Laboratory Testing**

Registered Nurses, Licensed Vocational Nurses, and Medical Assistants shall perform “CLIA Waived” testing at Karuk Tribal Health Clinics in accordance to competence, and shall comply by Karuk Tribal Health Laboratory policies.

04-005-195 **Committees.**

Registered Nurses, Licensed Vocational Nurses, or Medical Assistants shall serve on the Karuk Tribal Health Program committees; e.g., Contract Health Services Managed Care, Performance Improvement, or the Medical Records Committee.

04-005-196 **Patient Education**

Patient education is one of the most important aspects ~~nursing care and the role of the nurse as a health educator offers a constant challenge. In an effort to help each individual patient achieve maximum health, the nurse shall assists the patient in learning to practice health promotion activities and adjust to conditions or diseases that effect health and lifestyles.~~ **roles of medical professionals. KTHHSP is committed to helping patients achieve their maximum health potential. Professional staff, licensed to provide formal education, will attempt to help patients reach their potential. This policy acknowledges the patients’ role in their self-care. However, the medical team’s approach to helping patients maximize their self-care is essential. An approach, starting with where the patient ought to be and what the patient ought to do, is generally successful only with the most motivated of patients. The greatest success can be achieved by starting with the patient’s baseline perception of what she/he can and wants to achieve. If the baseline does not match the estimated potential, the medical team will coach their patients, patiently and in a stepwise manner, to reach their potential. This policy does not exclude the value of medical staff members, who are not licensed to provide formal patient education. All staff members can encourage our patients in their journey to optimal health, and are encouraged to do so.**

List of Nursing Policies

- 04-004-190 Administration of Medication
- 04-004-191 Screening Procedures
- 04-004-192 First Aid and Emergencies
- 04-004-193 Other Medical Procedures
- 04-004-194 Laboratory Testing
- 04-005-195 Committees
- 04-005-196 Patient Education

~~Blood Pressure Screening~~

~~Preparation for complete PE~~

~~Preparation for Breast Exam~~

~~Pap smear~~

~~WIC Examination~~

~~Vision Screening~~

~~Hearing Screening~~

~~Mantoux Test Administration for TB Screening~~

~~Hepatitis Vaccination Administration~~

~~Burn Care~~

~~Eye Burns-~~

- ~~Corneal Burns,~~
- ~~Caustic Burns to the eye, and~~
- ~~Acid Burns to the eye.~~

~~Suture Removal~~

~~Irrigation of the Ear~~

~~Cast Care~~

~~Blood Glucose Monitoring~~

~~Chest Pain~~

~~Obtaining EKG~~

**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**

This entire section should be replaced by the new Nursing Procedure Manual.

BLOOD PRESSURE SCREENING:

Who may perform:

~~—RNs, CHW's, LVNs and Medical Assistants may perform blood pressure screening.~~

EQUIPMENT:

~~—Sphygmomanometer~~

~~—Stethoscope~~

~~—Blood pressure screening card (if applicable)~~

~~—Adult Cuff—recommended size of the inflatable bag.~~

~~— a. Width—40% of arm circumference~~

~~— b. Length—80% of arm circumference~~

~~—Child Cuff—recommended size of the inflatable bag.~~

~~— a. Width—75% of the upper arm or upper leg length~~

~~— b. Length—100% or more of the upper arm or upper leg circumference~~

PROCEDURE:

~~—Explain the procedure to the patient~~

~~—Wash your hands~~

~~—Apply the correct size blood pressure cuff~~

~~—Ask the patient to relax and breathe quietly~~

~~—Palpate the brachial artery and place stethoscope diaphragm over it~~

~~—Inflate the cuff to 180-200 mm~~

~~—Slowly and smoothly, release the air from the cuff~~

~~—Note the onset of the first Korotkoff sound while continuing to release air~~

~~—Note the point at which the sounds muffle or disappear; this is the diastolic reading~~

~~—Completely deflate the cuff and remove~~

~~—Record the result~~

FOLLOW-UP:

~~Anyone with blood pressure readings of 140/90mmHg and above will be referred to the provider.~~

~~Anyone with a diastolic reading of 100 or above will be referred to a provider immediately.~~

~~Anyone on medication for high blood pressure with a reading of 100/60mmHG or lower will be referred to a provider.~~

~~Anyone with a pulse of 50 or lower will be referred to a provider.~~

TEACHING:

Person with a diagnosis of hypertension:

- Reinforce that hypertension is a life long disease.
- Explain that office visits should NOT be missed.
- Ask if patient is on any other medication other than that for hypertension.
- If a CHW visit, record B/P reading and give to patient and report to the RN prior to the clinic visit.
- Give pertinent handouts and informational material.

PERSONS WITHOUT HISTORY OF DIAGNOSED HYPERTENSION:

- Maintain good health for a normal blood pressure.
- Advise persons with borderline high blood pressure to see their physician.
- Schedule repeat blood pressures weekly for three weeks.
- If CHW visits, record B/P readings and give to RN prior to patient's appointment with physician.

DOCUMENTATION:

Record in the PCC/EHR:

- Blood Pressure and Pulse reading.
- Instructions given to patient regarding F/U care.

AGE	CRITERIA FOR COUNSELING AND SURVEILLANCE	CRITERIA FOR DIAGNOSIS AND TREATMENT
Under 8 years	115/75 to 120/80	over 120/80
8 through 12 years	125/80 to 130/85	over 130/85
Over 12 years	135/85 to 140/90	over 140/90

**~~KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES~~**

PREPARATION OF PATIENT FOR COMPLETE PHYSICAL EXAMINATION:

Supplies:

- ~~———— Otoscope and Ophthalmoscope~~
- ~~———— Ear Speculum~~
- ~~———— Sphygmomanometer and Stethoscope~~
- ~~———— Tongue Depressors~~
- ~~———— Percussion Hammer~~
- ~~———— Pap Supplies if needed~~
- ~~———— Gloves and Lubricant~~
- ~~———— Gown and Drape~~
- ~~———— Vaginal Speculum~~

Preparation of Patient:

- ~~———— Check chart to see if form for H & P is completed~~
- ~~———— Ask patient to obtain UA (see procedure)~~
- ~~———— Have patient undress and put on gown~~
- ~~———— Do vital signs, weight/height and record~~
- ~~———— Ask female patients when last pap was done~~
- ~~———— Set up for pap if necessary~~
- ~~———— Notify clinician when patient is ready~~
- ~~———— Do EKG if requested~~
- ~~———— Draw blood if requested by clinician~~
- ~~———— Clean room and instruments~~

~~**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**~~

~~**PREPARATION OF PATIENT FOR BREAST EXAMINATION:**~~

~~— **Note:**~~

~~— Breast examinations are usually done in conjunction with Physical or Pelvic Examination. However, if the patient's chief complaint is of a breast problem, proceed with the following:~~

~~—— Record patient's chief complaint.~~

~~—— Take and record vital signs and weight.~~

~~—— Prepare patient (have patient disrobe from waist up and put on a gown).~~

~~KARUK TRIBAL HEALTH AND HUMAN SERVICES NURSING PROCEDURES~~

~~PAP SMEAR:~~

~~Who May Perform:~~

- ~~Physicians, PAs and Nurse Practitioners obtain pap smears.~~
- ~~An RN, LVN or Medical Assistant may assist.~~

~~Equipment:~~

- ~~Gloves and water-based lubricant~~
- ~~External light source~~
- ~~Vaginal speculum~~
- ~~Surepath specimen container labeled with patient's name~~
- ~~Surepath cytobrush~~
- ~~VCE glass slide and holder (labeled with patient's name) only if Surepath not indicated~~
- ~~Spatula or wooden cytology scraper~~
- ~~Cytobrush~~
- ~~Fixative~~
- ~~Culture tubes as indicated~~
- ~~Cytology requisition for Pap smear~~

~~Procedure:~~

- ~~Obtain brief history, specifically last menstrual period, gravida and parity, any abnormal bleeding or history of abnormal pap smears, and medication, especially hormones.~~
- ~~Explain procedure to patient.~~
- ~~Obtain and record information required on cytology form.~~
- ~~Assemble equipment.~~
- ~~Have patient empty her bladder and undress from waist down.~~
- ~~Place patient in dorsal lithotomy position on table and drape with sheet.~~
- ~~Assist clinician as needed.~~
- ~~Surepath cytobrush is inserted into collection vial, cap lid securely.~~
- ~~Smear standard specimens on proper section of VCE slide.~~
- ~~V-Vagina, C-Cervix and E-Endocervical.~~
- ~~Fix slide immediately with appropriate fixative. Spray fixative 6-8 inches from slide for 2-3 seconds. Do not over spray because specimen will wash off slide.~~
- ~~Ensure that frosted end of slide is labeled with patient's name.~~
- ~~Arrange for transport of specimens to appropriate laboratory.~~

~~— **Follow-Up Procedure:**~~

~~—— Inform patient how to obtain pap smear results.~~

~~— **Documentation:**~~

~~—— Procedure done and type of specimen obtained~~

~~—— Teaching information provided (if applicable).~~

~~—— Patient history.~~

~~—— Instructions for follow-up provided.~~

~~**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**~~

~~**WIC EXAMINATION:**~~

~~**Note:** WIC examinations are conducted according to the forms brought in by the parent
from the WIC Department.~~

~~**Procedure:**~~

~~Check to see if the patient has the proper form.~~

~~Obtain child's height and weight (no shoes or outer clothing when possible).~~

~~Obtain HCT and other information as needed.~~

~~Plot height, weight and/or HGB on the growth grid.~~

~~**Note:** Refer patient for follow-up examination if HCT and/or HGB is low and/or note in
chart if
parent is taking child to another clinic or physician.~~

**~~KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES~~**

VISION SCREENING:

Who May Perform:

~~— RNs, LPNs, Medical Assistants may perform vision screening.~~

Equipment:

- ~~— Effective occluder/spoon-shaped wand, index card or an opaque paper cup.~~
- ~~— Eye Chart or Flash Cards.~~
- ~~— Illustrated or Snellen E Chart.~~
- ~~— Distance is marked off on floor with tape or foot print at twenty feet from chart.~~
- ~~— Client's heel should be at the line.~~

Procedure:

- ~~— Explain to client what you will be doing and what is expected from him/her.~~
- ~~— Do brief eye positions. Note obviously crossed eye/fluttering of eye, ptosis or any evidence of eye injury. Also note any inflammation, redness, crusting, swelling, discharge, straining to see or sensitivity to light.~~
- ~~— Choose appropriate chart (dependent on age or preference).~~
- ~~— Have client stand at required distance.~~
- ~~— Review chart you are going to use with client to make sure she/he can identify objects on chart.~~
- ~~— Test client with both eyes first then proceed to test right and left eyes separately.~~
- ~~— Give client the occluder. Assist the client as necessary.~~

~~— The National Society For The Prevention Of Blindness recommends you refer for complete examination any child with the following:~~

- ~~— Any sign of possible visual disturbance regardless of acuity.~~
- ~~— One line or more difference between the two eyes, even with passing standards.~~

According to Age as Follows:

- ~~— 3 years old — 20/50 or less~~
- ~~— 4 years old thru grade 3 — 20/40 or less~~
- ~~— Grade 4 and up — 20/30 or less~~

Follow-Up Procedure:

~~———— Notify provider verbally if visual acuity is abnormal or if child or parent complains of
———— any signs or symptoms indicative of possible visual disturbance.~~

~~———— Refer any child you are unable to test.~~

~~———— **Documentation:**~~

~~———— Record on the progress notes.~~

~~———— Vision results from right eye, left eye and both eyes as determined by individual chart.~~

~~———— Observation made with eye inspection.~~

~~**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**~~

SCREENING FOR HEARING:

~~**Purpose:** The aim of auditory screening is to identify persons who have reduced hearing sufficient to interfere with their social and educational contacts and responses. More specifically, the aim is to detect central auditory problems, sensorineural hearing loss and conductive hearing impairment at the earliest possible age.~~

~~**Procedure:** Six months through 24 months: Evaluation of this age group will be done by parent answered questions and physical examination. The medical history will be reviewed if the child has not been previously seen by a physician.~~

~~**Findings:**~~

~~———— Turns head toward a sound
———— Sometimes at 4 months
———— Yes at 7 months
———— Will seek at 9 to 12 months~~

~~———— When sleeping will startle or jump at a very loud sound
———— Sometimes at 4-9 months
———— Occasionally at 12 months~~

~~———— 12 months — begins to repeat some of the sounds you make.
———— 24 months — points to at least one part of his/her body when you tell child without seeing your lips. Points to the right object, when asked, without seeing your lips. Follows a simple command without seeing your lips.~~

~~**Three to 20 Years of Age:**~~

~~———— Evaluate using pure tone audiometry testing of each ear at 1000-2000-3000-4000Hz at 25dB.
———— At age 11 and over include 6000 and 8000Hz.~~

~~———— A positive response will be the failure to respond to any two frequencies for either or both ears. If a positive response is found an examination of the ear and external auditory canal will be done to check for build up of wax or ear infection. If either of these things are present; the parent will be informed of the reason that the test may not be completed
———— and the test will be rescheduled for a maximum of one month later. If the results are still~~

—positive, then the individual will be referred to an ENT specialist.

~~KARUK TRIBAL HEALTH AND HUMAN SERVICES NURSING PROCEDURES~~

MANTOUX TEST ADMINISTRATION FOR TUBERCULOSIS SCREENING:

Who May Administer:

— RNs, LVNs and MAs administer the Mantoux test per clinician's order.

Equipment:

— One vial purified protein (PPD) 5 tuberculin units per 0.1cc.

— Tuberculin syringe, 26 gauge 3/8 inch needle

Procedure:

— Wash your hands.

— Explain procedure to patient

— Don gloves.

— With an alcohol swab, cleanse the skin on the volar surface of the forearm about 4 inches below the bend of the elbow and allow to dry.

— Draw up 0.1 cc PPD in tuberculin syringe.

— Remove needle cap and with bevel of needle upward, insert needle at an angle almost parallel to skin (10—15 degrees). Insert needle so that only the bevel penetrates the skin.

— Inject solution slowly. A small circular bump (wheal) will appear on the skin.

— Withdraw needle and discard in a needle-proof container.

Test Interpretation:

— Have the patient return in 48—72 hours for test reading.

— Palpation technique: Using the fingertips, palpate carefully and mark the borders of the indurated area in two axes at right angles. Record results in millimeters.

— A test is positive if there is >10mm of measurable induration. A reaction of >5mm is classified as positive in:

— Persons with HIV infection or persons with risk factors for HIV infection who have an unknown HIV status.

— Persons who have had close recent contact with infectious tuberculosis cases.

— Persons who have chest radiographs consistent with old healed tuberculosis.

Document:

- ~~Procedure done including site of administration.~~
- ~~Instructions to return for reading.~~
- ~~Positive reaction in millimeters; refer at once for chest X-ray and notify the primary provider.~~
- ~~Negative reaction: no palpable induration at test site.~~

~~**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**~~

~~**HEPATITIS VACCINATION ADMINISTRATION:**~~

~~**Who May Perform:**~~

~~————— LVN's, Medical Assistants (under supervision) or RN's may administer the hepatitis vaccination on the order of the Primary Provider.~~

~~**Purpose:**~~

~~————— To provide immunity against infection caused by Hepatitis B virus.~~

~~**Equipment:**~~

~~————— N/A~~

~~**Procedure:**~~

- ~~————— Inform patient of purpose of hepatitis vaccine administration.~~
- ~~————— Have patient read and sign Hepatitis B Immunization Consent Form and place in medical record.~~
- ~~————— Question patient regarding Hepatitis B antibody status. If patient is antibody positive, no vaccine is given. If patient is antibody negative or status unknown, draw HBsAb if requested.~~
- ~~————— If positive, no vaccine is given. If negative, continue with the procedure.~~
- ~~————— Take and document patient's temperature. If greater than 100°F, defer vaccine administration.~~
- ~~————— Ask the patient the following questions:~~
 - ~~————— a. Any regular medications?~~
 - ~~————— b. Any chronic illness?~~
 - ~~————— c. Pregnancy status?~~
 - ~~————— d. Breast feeding?~~
 - ~~————— e. Allergies, specifically to alum or mercury compounds.~~
- ~~————— If the answers to the above questions are all negative and the patient has no questions:~~
 - ~~————— a. Question patient regarding last PPD (If more than 1 year ago, recommend PPD).~~
 - ~~————— b. Question regarding rubella status (if unknown, offer titer or MMR).~~
 - ~~————— c. Administer Hepatitis B vaccine according to appropriate dosage schedule. If the answers to the above questions are positive or if the patient has questions, refer the patient to a provider.~~

~~**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**~~

~~**BURN CARE:**~~

~~**Who May Perform:**~~

~~— RNs, LVNs and Medical Assistants may provide initial treatment of first degree burns. Burns assessed to be second or third degree must be referred to the provider.~~

~~**Purpose:** To relieve pain, prevent blistering and promote uncomplicated recovery.~~

~~**Equipment:**~~

~~— Cool water and compresses as necessary~~

~~— Silver Sulfadiazine Cream~~

~~— Gauze, sterile~~

~~**Procedure:** Understand definition of and differential diagnosis of First, Second and Third degree burns as noted:~~

~~— First Degree Burn — superficial burn damage being limited to outer layer of epidermis (redness).~~

~~— Second Degree Burn — damage extends through epidermis and into dermis, but not to extent of interfering with regeneration of the epidermis (redness and blisters).~~

~~— Third Degree Burn — both the epidermis and the dermis are destroyed with damage extending into underlying tissue.~~

~~— Immerse immediately into cool water or apply cold compresses. Soak for 15—30 minutes allowing patient to remove involved area from water every 2 minutes to re-warm area. This will help to relieve pain and prevent blistering.~~

~~— Apply sterile dressing to the area. Dressing will be determined by burn location.~~

~~— Silver Sulfadiazine Cream (If patient is not allergic to sulfa) and dry sterile dressing is the preferred treatment.~~

~~— Administer tetanus prophylaxis if indicated.~~

~~**Follow-up:** Instruct patient to report the following:~~

~~— Drainage that is thick, discolored or foul smelling.~~

~~— Fever greater than 101F~~

~~— Return in 24 hours for dressing change and site inspection.~~

Documentation:

- ~~_____ Treatment provided.~~
- ~~_____ Dressing applied.~~
- ~~_____ Tetanus prophylaxis if given.~~
- ~~_____ Instruction provided regarding follow up care.~~

~~KARUK TRIBAL HEALTH AND HUMAN SERVICES NURSING PROCEDURES~~

~~EYE BURNS:~~

- ~~— Notify the provider at once of any burns to the eye.~~
- ~~— Mild conjunctival burns require irrigation with tap water as the only treatment in many cases.~~
- ~~— Conjunctival burns of a more severe degree require cold compresses and ice packs applied immediately.~~
- ~~— Eye patches should be applied and patient referred to an Ophthalmologist.~~
- ~~— Severe cases should be referred immediately to an Ophthalmologist, or the Emergency Department.~~

~~CORNEAL BURNS:~~

- ~~— If burns to the cornea are superficial, non-emergent treatment is the same as for conjunctival burns.~~
- ~~— If there is extensive injury to the eye, the patient should be referred to a specialist or Emergency Department.~~

~~CAUSTIC BURNS TO THE EYE:~~

- ~~— Irrigate the eye for at least 15 minutes with tap water or sterile saline. Never attempt to use a neutralizing agent in eye injuries.~~
- ~~— Instill ophthalmic anesthesia drops to control pain if directed to do so by a provider.~~
- ~~— Apply patch.~~
- ~~— Refer to a specialist for immediate care.~~

~~ACID BURNS:~~

- ~~— Wash thoroughly with running water for an extended period of time.~~
- ~~— Cleanse the area thoroughly with non-medicated white soap or surgical scrub and warm water.~~
- ~~— Apply petroleum gauze dressing and hold in place by loosely applied elastic bandage.~~
- ~~— Refer to a specialist for immediate care.~~

~~Administer tetanus prophylaxis if indicated.~~

~~Follow-up Care of Burns:~~

~~Objective:~~

~~————— To promote healing and prevent complications.~~

~~————— **Equipment:**~~

- ~~————— Sterile mesh gauze~~
- ~~————— Sterile basin~~
- ~~————— Sterile irrigating solutions~~
- ~~————— Sterile gloves~~
- ~~————— Sterile stretch gauze bandage (sterile Kerlix)~~
- ~~————— Silvadene Ointment (if patient not allergic to sulfa)~~
- ~~————— Sterile tongue blades or applicators~~

~~————— **Procedure:**~~

- ~~————— Administer analgesic as prescribed by clinician.~~
- ~~————— Cleanse burn area with non-medicated white soap or surgical scrub, then irrigate with sterile saline solution.~~
- ~~————— Place sterile towel under burn.~~
- ~~————— Remove loose or necrotic tissue from area using sterile forceps and scissors.~~
- ~~————— Apply Silvadene cream or other prescribed topical agent.~~
- ~~————— Cover the site with sterile mesh gauze and apply Kerlix bandage.~~
- ~~————— Dressings should be changed twice daily until healing is complete.~~
- ~~————— Instruct patient to take all medication and return to clinic as directed by clinician.~~

**~~KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES~~**

SUTURE REMOVAL:

Who May Perform:

~~— RNs and LVNs/MAs with special training may perform the procedure.~~

Equipment:

- ~~— Sterile suture removal set~~
- ~~— 4x4 sterile sponges~~
- ~~— Anti-infective swabs~~
- ~~— Steri strips (optional)~~
- ~~— Band Aide (optional)~~

Procedure:

- ~~— Explain procedure to the patient.~~
- ~~— Position patient on exam table with area to be treated exposed.~~
- ~~— Assess condition of the skin, including healing suture line, erythema around skin and any drainage from suture line.~~
- ~~— Cleanse affected area with anti-infective swabs per clinician preference.~~
- ~~— Pat dry with 4x4 sponge.~~
- ~~— Count the number of sutures intact in the wound.~~
- ~~— Using forceps to lift each suture, cut suture between knot and skin as close to skin as possible with surgical scissors one by one, and remove entire suture.~~
- ~~— Reassess skin condition and wound closure.~~
- ~~— Apply sterile dressings as needed.~~

Documentation:

Record in Progress Notes:

- ~~— Wound assessment.~~
- ~~— Number of sutures removed.~~
- ~~— Dressing applied or not applied and follow-up instructions.~~

**~~KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES~~**

IRRIGATION OF THE EAR:

Who May Perform:

~~Physicians, PAs, FNPs, RNs, LVNs and MAs may perform irrigations according to the clinician's orders and under appropriate supervision.~~

Equipment:

~~Otoscope
Ear Basin
Warm Water
Ear or 20cc syringe
Towels
Emesis basin or graduate~~

Procedure:

~~Explain procedure to the patient.
Position patient in a comfortable upright position.
Drape neck and shoulder on side or ear to be irrigated.
Fill emesis basin or/graduate with warm water.
Fill syringe with warm water.
Hold pinna up and back.
Inset tip of syringe in canal in a manner that does not occlude the opening.
Flush canal and Tympanic Membrane (TM) – note condition.
Periodically examine canal and TM.
Discontinue if patient complains of vertigo and/or discomfort.~~

Documentation:

~~Record in Progress Notes.
Brief note regarding patient tolerance of procedure.
Amount of cerumen obtained.
Procedure done.~~

**~~KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES~~**

CAST CARE:

Who May Perform:

~~— RNs and LVNs may provide instruction in general cast care to all patients and family.~~

Purpose:

- ~~— To maintain cast integrity~~
- ~~— To maintain proper circulation, sensation and motion of the affected body part.~~
- ~~— To maintain immobilization of the affected body part.~~

Equipment:

- ~~— Material to elevate affected extremity~~
- ~~— Moleskin Tape~~

Procedure:

- ~~— Reinforce physician's explanation of the reason for the cast.~~
- ~~— Instruct patient or family regarding the following:~~
 - ~~— a. Care of a wet cast~~
 - ~~— b. Care of soiled cast~~
 - ~~— c. Care of skin around cast~~
 - ~~— d. Sign and symptoms of circulatory sensory or motor impairment~~
 - ~~— e. Reportable symptoms.~~

Follow-up Procedures/Instructions:

- ~~— Do not get cast wet — even fiberglass casts have cotton lining, they do not dry.~~
- ~~— A plaster cast will feel warm; it dries from the inside out.~~
- ~~— Note any reddened or sore areas around cast.~~
- ~~— Check skin color and temperature. Your skin color should NOT change. Extremity should be warm.~~

**~~KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES~~**

BLOOD GLUCOSE MONITORING:

Who May Perform:

— RNs, LVNs and MAs may monitor patient's blood glucose.

Equipment:

- Blood glucose monitors
- Appropriate test strips
- Gloves
- Sterile lancets
- Alcohol wipes
- Dry cotton ball
- Band Aids

Procedure:

- Wash your hands.
- Check glucose monitor for proper function and calibration.
- Remove a test strip from its wrapper.
- Have the patient wash their hands.
- Don gloves.
- Cleanse the side of a finger pad with alcohol and let dry.
- Puncture the finger pad with a sterile lancet.
- Wipe away the first drop of blood, then apply the second drop to the test area on the strip.
- Activate the glucose meter timer per manufacturer's instructions. Insert the strip
- as directed and read the result.

Document:

- Document the reading in the appropriate spot on the PCC.
- Notify the primary care provider of abnormal results.

~~**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**~~

CHEST PAIN:

Procedure:

- ~~———— Obtain chief complaint and a brief history.~~
- ~~———— Take vital signs, including weight (if pulse is irregular or patient is in acute distress, notify clinician and obtain EKG if ordered).~~
- ~~———— Place on 3 lead EKG monitor as needed.~~
- ~~———— Ask patient to remove upper clothing, gown.~~
- ~~———— Leave patient in room, notify clinician that patient is ready.~~
- ~~———— Perform necessary tests as ordered (EKG, blood work, etc.).~~
- ~~———— Have oxygen available.~~
- ~~———— Be prepared for IV start per provider's order.~~
- ~~———— Arrange for emergency transportation as instructed by the clinician.~~

**KARUK TRIBAL HEALTH AND HUMAN SERVICES
NURSING PROCEDURES**

OBTAINING AN EKG:

Patient Preparation:

- Explain the procedure.
- The patient must undress sufficiently to expose the entire chest, forearms and lower legs; provide gowns and drapes as needed to protect privacy.
- Apply electrodes as shown below:

ELECTRODE LOCATION	ALPHABETICAL CODE	COLOR CODE
Right Arm	RA	White
Left Arm	LA	Black
Right Leg	RL	Green
Left Leg	LL	Red
Fourth intercostal space, — right sternal border	V1	
Fourth intercostal space, — left sternal border	V2	
Midway between V2 — and V4	V3	
Sixth intercostal space, — midclavicular line	V4	
Midway between V4 — and V6	V5	
Seventh intercostal space, — anterior auxiliary line	V6	

Record the EKG according to the directions on the machine, ensuring that patient data is entered correctly. Give to the provider.

— **Artifacts:** Minimize artifacts by ensuring that electrodes are securely applied, cleansing the skin with acetone if need be, and by keeping the patient warm during the EKG.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 (X) 13 () 14 () 15 () 16 ()				05 () 06 () 07 () 08 () 17 () 18 () 19 () 20()				09() 10 () 11 () 12 () 21() 22()			
Function: Quality of Care (Nursing)				Policy #: 04-004-497				Policy Title: Safe Injections			
Tribal Chairman: Date: 06/01/2012 Signature:				Medical Director: Date: 06/01/2012 Signature:				Cross References:			
New 2012											

PURPOSE: To establish guidelines in order to perform injections in an optimally safe manner for patients, health care personnel, and others.

POLICY: Only qualified staff of The Karuk Tribal Health and Human Services Medical and Dental Department shall give injections to patients.

BACKGROUND INFORMATION:

The administration of medicine by injection requires equipment (needles and syringes) that is sterile, accurate in measuring dosage, convenient to use, and that will produce as little discomfort and/or hazard for the patient as possible.

Patient safety is a critical factor for the basic medical personnel. Aseptic techniques must be strictly maintained during the preparation and administration of a medication.

Injection safety ~~or~~ **and** safe injection practices are ~~practices~~ intended to prevent transmission of infectious diseases. ~~Patients and healthcare providers must insist on nothing less than~~ One Needle, One Syringe, Only One Time for each and every injection. **A fresh needle and syringe must be used for each injection. Never reuse a needle or syringe. Immediately after each injection, engage the safety feature of the needle, and dispose of the needle/syringe unit in a sharps container. All sharps containers must be firmly affixed to a wall, and must be replaced when the contents of the container reaches the designated maximum fill point.**

PROCEDURE:

1. **Wash your hands** thoroughly using soap and hot water. Wipe your hands on a clean towel until they are completely dry. Put on rubber gloves if desired.
 - a. Injection Methods:

- Subcutaneous (Hypodermic) Injections- The medication is injected by syringe and needle into the tissues just beneath the skin. **The needle is inserted at a 45° angle to the skin surface.** A preparation for subcutaneous use must be a sterile liquid capable of complete absorption or it will irritate the tissues.
- Intramuscular- The medication is injected into a muscle, usually in the buttocks, sometimes in upper arm or the thigh. The needle is inserted at a 90° angle to the skin **surface**, through the skin and subcutaneous tissue into the underlying muscle.
- Intradermal- The medications is injected into the upper layers of skin, rather than under the skin as in a subcutaneous injection. **The needle is inserted at a 10° to 15° angle to the skin surface.** Minute amounts are given intradermally, usually to test for drug sensitivity before administering larger amounts by other methods.
- Intravenous- **The medication is injected hydermically** ~~hypodermic injection~~ into a vein for instilling a single dose of medication or beginning an IV infusion.

2. Gather Equipment and place on medication tray.

- a. Choice of needle. The length of the needle you choose will depend upon the type of injection. The gauge size you choose will depend upon the type of medication
- b. Choice of syringe-The choice of syringe depends on the amount of solution and the type of solution administered.
 - i. When selecting **the** syringe, check for the total capacity of the syringe. The syringe is usually calibrated in cubic centimeters (cc) **or milliliters (mL).** **One cubic centimeter (cc) is equivalent to one milliliter (mL).** Be sure the syringe is large enough to contain enough medication to give the shot and should only be large enough to accommodate the dosage being given.
 - ii. Check the calibration of the syringe so you can place the exact amount of medication the syringe
 - iii. Inspect packaging for defects. If the package has been opened or has any holes, discard the package and obtain sterile equipment.
 - iv. Unpack the syringe from its packaging without contaminating any sterile parts. The sterile parts are the needle adapter and the shaft of the plunger, which goes into the barrel.
 - Flexible wrapper
 - Peel the sides of the wrapper apart to expose the rear end of the syringe
 - Grasp the syringe by the barrel with the free hand.
 - Pull the syringe from **its** packaging
 - Dispose of empty packaging in **an** appropriate receptacle.
 - Syringe in hard plastic tube (cartridge package).
 - Press straight down on top of tube with your thumb or use **a** twisting motion

- Press until you hear a distinct click. The click indicates that seal has not previously been broken. If you do not hear a click, discard the syringe.
 - Remove the cap from the tub and put it down on **the** work surface.
- c. Vials
- d. Sterile saline or sterile water, if necessary
- e. Alcohol swabs

3. Injection Preparation

- a. Verify the medication. The medical personnel should check the doctor's orders for the type, route and dose of medication to administer.
- b. Assemble the needle and syringe-
 - i. Remove the protective cover from the needle adapter on the syringe. Insert the needle adapter into the needle hub.
 - ii. Tight the needle with one-fourth turn to ensure it is securely attached to the syringe.
 - iii. Do not touch the needle adapter or the syringe to avoid contamination of the sterile surface.
 - iv. Remove protective cover from the needle by pulling straight off. Do not twist as this may cause needle to come off the needle hub.
 - Inspect the needle for burrs, barbs or other damage.
 - Check for contamination. Rust or foreign particles on needles
 - If **the** needle has any defects, discard **it**; ~~and~~ obtain a new sterile needle; and repeat the process.
 - v. Replace **the** cover on needle until **the** medication is ready to draw.
- c. Check the medication container label.
 - i. Verification should be made at least three times to ensure accuracy. **Verify** at the following times
 - When the medical personnel obtains the container from the place of storage, usually a medicine cabinet
 - Before the medications is withdrawn from the container
 - When the container is returned to the place of storage
 - ii. Follow directions on **the** container regarding **the** expiration date and follow policy regarding use of multidose vials.
 - iii. Check to determine if **the** medication was stored properly (~~refrigerated~~).
- d. Dilute the medicine in a vial according to directions if necessary. If a powder, mix **the powder** in a vial with the amount of prescribed sterile saline **solution** or sterile water. Some medicines come in ready-to-use vials.
- e. Examine the rubber stopper on the vial.
 - i. If the vial is new, remove the metal protective ~~cap~~ **cap**.
 - ii. Examine the rubber stopper for defects.
 - iii. If a defective stopper is identified, hold the vial to the light to examine **the contents** for any foreign particles and **to** detect any changes in color and consistency of the medication. If there are foreign particles in the solution, or if there is any change in color of the solution, discard **it** and obtain another container. If the used container is dark colored glass,

(wipe **the** top of vial with alcohol swab first) insert **the** needle and draw some solution to examine its color. **If** defective, discard **the** vial, **the** syringe, and **the** needle, and obtain new solution. ~~You may want to~~ **If you have any questions or concerns, obtain request** guidance from your supervisor.

- iv. Check the date the multidose vial was opened and the expiration date on the medication. **If the solution is not a vaccine, and if the vial has been opened over 28 days or does not have a date of opening annotated on the vial, do not use this vial. Use another vial and inform your supervisor.**
- f. Wipe the top of the vial with an alcohol swab and leave the swab on the stopper for at least 30 seconds.
- g. Uncap the needle on the syringe, pull the plunger out, and fill the syringe with air equal to the amount of medication ordered.

- h. Place the vial on a flat surface and insert the needle into the rubber stopper. Make sure the needle tip passes ~~complete~~ **completely** through the cap. When inserting the needle, the bevel should face up with a slight pressure being exerted down and forward against the needle to prevent **the** rubber from contaminating **the** medication. (See figure 1.) The hub of the needle should not touch the rubber cap. (See figure 2.)

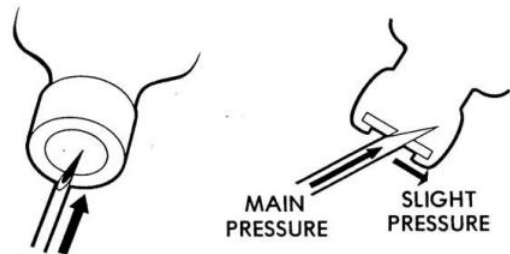


Figure 1

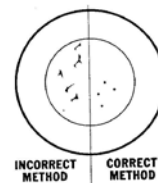


Figure 2

- i. Invert the vial and pull back the plunger until the syringe fills with the prescribed amount of medicine. Draw slightly more the amount of medication (about 0.2 cc more) prescribed. The extra medication will be expelled when the syringes is cleared of air bubbles. (See figure 3.)

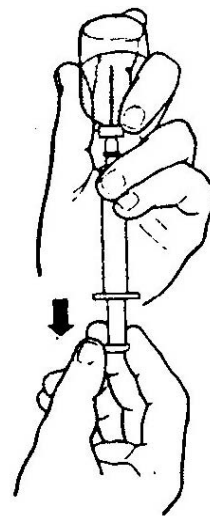


Figure 3

Withdrawing medication with vial inverted.

- j. Clear the syringe of air bubbles.
 - i. Hold syringe with the needle pointing up.
 - ii. Pull back on the plunger lightly to clear all medications from the shaft of the needle.
 - iii. Flick the barrel lightly with your finger to force air bubbles to the top of the barrel.
 - iv. Pull the plunger back slightly and push forward until the solution is in the needle hub, clearing it of bubbles.
 - v. Continue pushing the plunger forward until the proper amount of medication remains in the syringe. (The excess medication is expelled.) (See figure 4.)

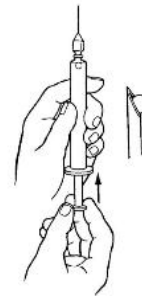


Figure 4 Clearing bubbles from barrel.

- vi. Verify the correct dosage.
- vii. Cover the needle with the plastic protective cover to maintain sterility until the injection is performed. **Take care when recovering the needle to prevent puncturing your skin.**

- 4. Ampule-Follow this procedure for the medications in an ampule.
 - a. Lightly tap the top of the upright ampule to force trapped medication back from the bottle neck. (See figure 5.)

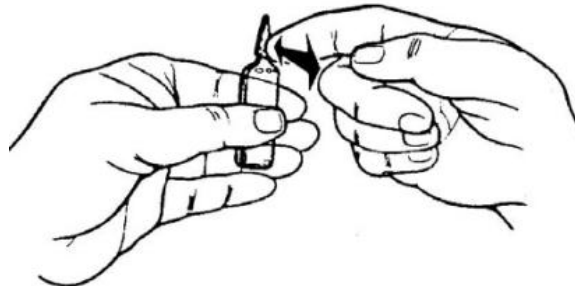


Figure 5

- b. Cleanse the neck of the ampule with an alcohol swab.
- c. Wrap the neck of the ampule with the sponge and leave for 30 seconds.
- d. Grasp the ampule with both hands, covering the neck with a sterile piece of gauze. Snap the neck of the ampule by bending away from the

breakline. The ampule should be snapped away from any person to prevent injury from flying glass. (See figure 6.)

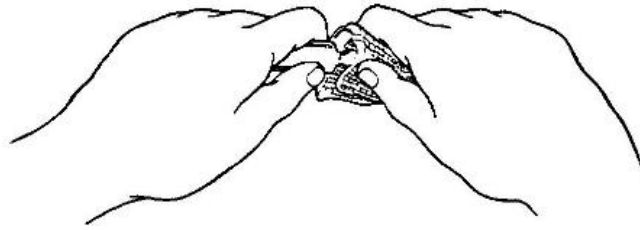


Figure 6

- e. Inspect the ampule for minute glass particles. ~~If any glass particles are observed, discard the ampule and obtain another or use a filter needle.~~ **Always use a filter needle when withdrawing medication from an ampule.**
- f. Pick up the assembled needle and syringe in **your** dominant hand and remove the protective cover. Regardless of **the** method used, care must be exercised not to contaminate the needle.
- g. Insert the needle and withdraw the medication in either of the following **two ways (as described in i and ii immediately following):**
 - i. Holding the ampule horizontally in the nondominant hand and the syringe in the dominant hand, insert the needle into the medication: **OR**
 - ii. Placing the ampule upright on a flat surface and stabilizing it with the nondominant hand, insert the needle to withdraw the medication.
 - iii. The prescribed amount of medication plus 0.2 cc is withdrawn while keeping the needle immersed in solution. (see figure 7)

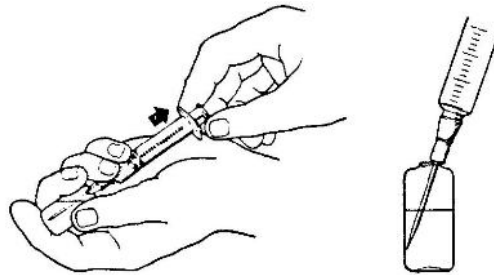


Figure 7

- iv. Withdraw the needle.
- v. Verify the correct dosage. Refer to the doctor's orders.
- vi. Clear the syringe of air bubbles.

5. Injection Details

- a. **Prior to injection, you must verify the specific medication/vaccine, dose, and route by taking the injection tray to the ordering provider. The provider must inspect the medication/vaccine vial for the name and the expiration date. The provider must also verify that the correct amount of medication/vaccine has been drawn into the syringe, and that the injection site can accommodate the amount of medication/vaccine to be injected into the site selected.**
- b. **If injecting a vaccine, you must assure that the patient has received the appropriate vaccine information statement (VIS), and has had all questions answered by the provider.**

- c. Identify the patient by two methods.—(Name, Birthdate etc); e.g., name, birthdate.
- d. Ask the patient about any known allergies before you administer any medication. You should ask about specific allergic reactions such as penicillin, eggs, or horse serum to refresh his/**her** memory. You should refer to his/**her** chart to see if any allergies are listed. If the patient is a young child or an older person, ~~they~~ **he/she** may not be able to tell you. If there is a known allergy, consult the senior medical person in the area for guidance. Do not administer the injection if you are not sure there are no allergies. Allergic reactions can make the patient very sick or even cause death.
- e. Ask females about the possibility of a current pregnancy. Some medications can cause severe birth defects if given to the mother during pregnancy. If there is a possibility of pregnancy, do not administer the injection. Refer the patient to the physician or senior medical person.
- f. Provide privacy for the patient if injecting in the buttocks or lateral thigh. ~~Be sure to abide by a local SOP.~~ **Assure the privacy of the patient by closing the exam room door or using the portable opaque screen.**
- g. Tell the patient about the injection procedure. Be sure to wake up a patient if **he/she** has been sleeping. If a patient is unconscious and you think **he/she** cannot understand what you are telling him/**her**, tell the patient anyway. A patient may be frightened and/or violent. If this is the case, you must seek assistance.
- h. Select **the** Injection Site and Position **the** Patient. An intramuscular injection is usually given in the buttocks, thigh, or the upper arm area. If the medication is more than 1 cc, give the injection in the buttocks. The amount of medication determines the selection of the site.
- i. **Buttocks**. The buttocks are the preferred site for administration of the intramuscular injection. The muscles (gluteal) of this area are thick and are utilized frequently in daily activities, thus causing complete absorption of medications.

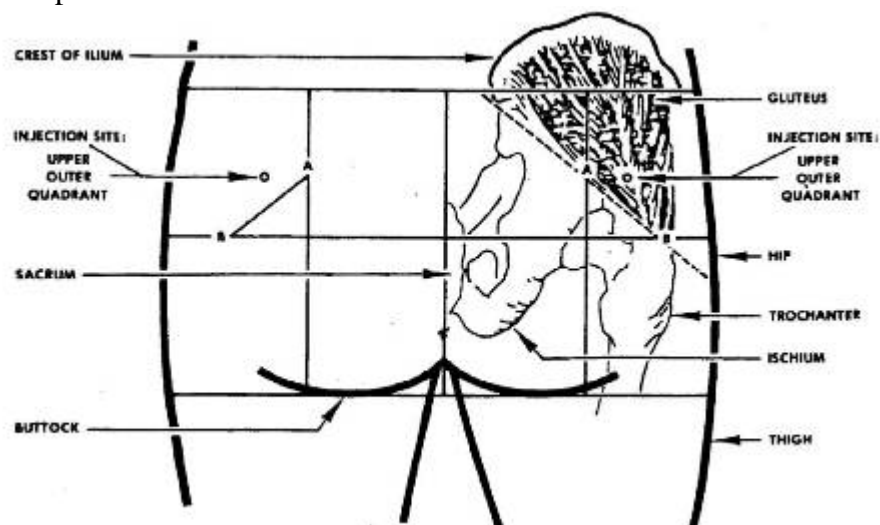


Figure 8 Intramuscular injection site in the buttocks (upper, outer quadrant)

- Using care in choosing the location for administering the injection will minimize the possibility of hitting a bone, large blood vessel, or the sciatic nerve.
- To identify the injection site, draw an imaginary horizontal line across the buttocks from hip bone to hip bone. Then divide each buttock in half with an imaginary vertical line (See figure 8.). The four imaginary sections of the buttock are referred to as quadrants. The proper location for an injection is in the upper outer quadrant of either buttock.
- Remember, if an injection is given outside of the upper outer quadrant, irreparable injury may be done to the sciatic nerve or the needle may penetrate the gluteal artery and this can cause significant bleeding from the vessel.
- If 5 cc is to be given, the medication should be divided into 2 doses and injected into separate sites with a maximum of 2.5 cc per dose.
- The needle length should not exceed one and one-half inches. A one and one-fourth inch needle is commonly used.
- If the patient is receiving a number of intramuscular injections over a prolonged period, the site of injection should be rotated. A record in sites must be kept on the patient's chart for this purpose.
- Expose the buttocks to make sure you do not make an error in determining the location of the injection. The patient will lie face down with toes together and heels apart. This position relaxes the muscles of the buttocks (See figure 9.)

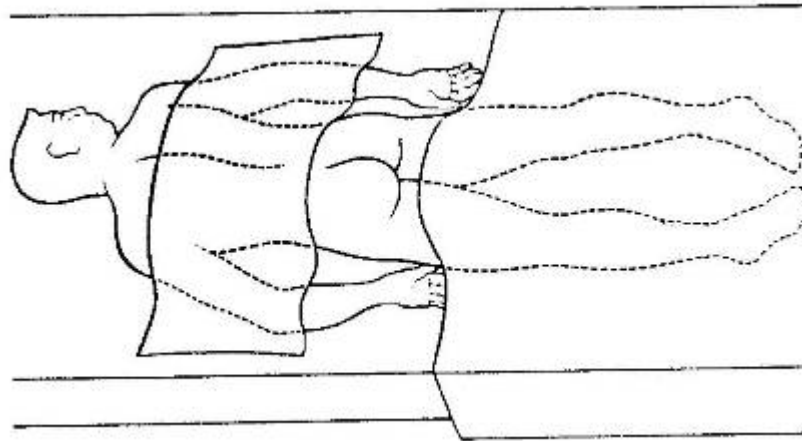


Figure 9 Patient in Prone position for intramuscular injection in the buttocks

- If no bed, cot, or table is available for the patient to lie on, the patient may be instructed to support himself/herself with a nearby object (such as a chair). Be sure you can visualize the entire buttocks to assure identification of the injection site. The patient will lean over and shift his weight to **one the leg opposite to the side being injected**. In this position, the buttock muscles will relax in the hip not bearing the body weight. You will be

able to give an injection in the gluteus medius muscle with minimal discomfort to the patient.

- ii. **Lateral thigh** (vastus lateralis muscle). The vastus lateralis muscle, part of the quadriceps group of four muscles of the upper leg, is located on the outer, lateral thigh. The injection site is about a hand's width above the knee to a hand's width below the groin (or hip joint). (See figure 10.) Injections outside this area may hit a bone, a nerve, or blood vessel.

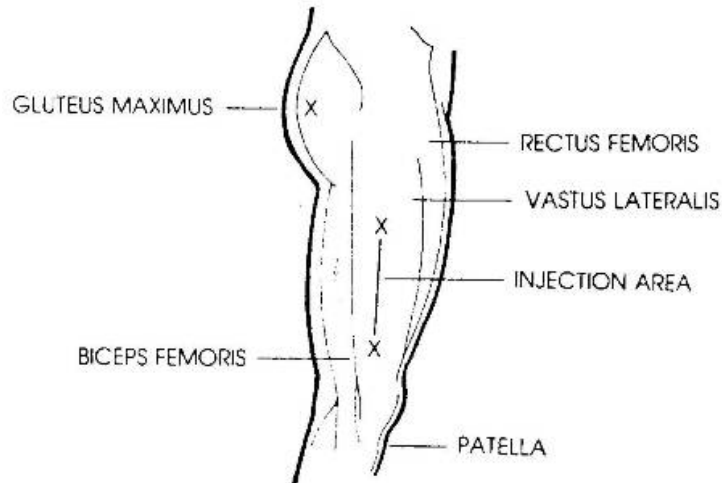


Figure 10 -Location for Thigh injection

- The volume of medication given in this site can be up to two milliliters injection in an adult.
 - The needle length must not be less than one inch and should not exceed one and one-half inches for adults. A one and one-fourth inch needle is commonly used.
 - To administer an injection, make sure the patient's lateral thigh is completely exposed so you can visualize the injection site. The patient should be lying on his/**her** back (supine) or seated.
 - Do not inject into ~~the~~ areas close to the knee or hip bone.
 - There are no main blood vessels or nerve trunks in the lateral thigh injection site. There is a cutaneous nerve (lateral femoral) superficially located and sometimes damage to these nerves is reported.
- iii. **Upper arm** (deltoid muscle). The injection site in this area is a rectangular area bounded on the top by the lower edge of the shoulder bone (the acromion process), on the bottom by the armpit (the axilla), and by the lateral one-third of the arm (See figure 11.).

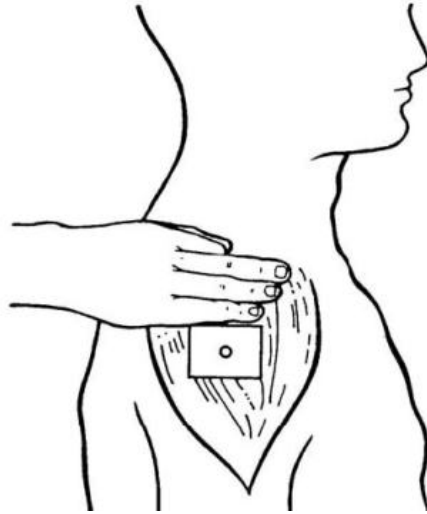


Figure 11 Location for upper arm injection

- The safe area for injection is generally defined as about three fingers below the shoulder joint.
 - The needle length of one inch is normally used because of the size of the deltoid muscle.
 - The volume of medication given in this site can be up to a maximum of one milliliter per injection for an adult. A volume of 0.5 milliliter or less is more commonly used.
 - The shoulder should be completely exposed so you can determine the exact location of the injection. The clothing should not be rolled up to attempt to administer an injection.
 - Ensure that the patient is in a standing or sitting position, with the arm at side and muscles relaxed. Direct the patient to hang the arm loose.
- i. Prepare the Injection Site. Clean the skin at the injection site thoroughly with an antiseptic pad (sponge with alcohol or Betadine). Use a circular motion from the center of the injection site outward. Place the antiseptic pad between the last two fingers for use later when you complete the injection.
 - j. Remove the Needle Guard or Cover. Pull the cover straight off, rather than using a twisting motion or a sideward motion because you may bend the needle.
 - i. ~~Avoid bending or touching~~ **Do not bend or touch** the needle.
 - ii. Place the needle cover on a clean, flat surface.
 - k. Stabilize the Injection Site. Firm the tissue at the injection site with the hand that is free by pinching the skin with the thumb and forefinger so that it is taut.
 - i. The cushion of tissue formed by grasping the skin makes it easier to inject the needle in exactly the right place.
 - ii. The needle enters more easily into taut or firm skin than into loose skin.
 - iii. Help the patient relax his/**her** muscles by distracting his/**her** attention by asking a question or having the patient do something like blow a breath out or look at an object on the wall.
 - l. Insert the Needle Into the Patient at **the Site Selected for Injection**. When inserting the needle, remember the following guidelines:

- i. Hold the barrel of syringe firmly between the thumb and index finger of the dominant hand (See figure 12.).

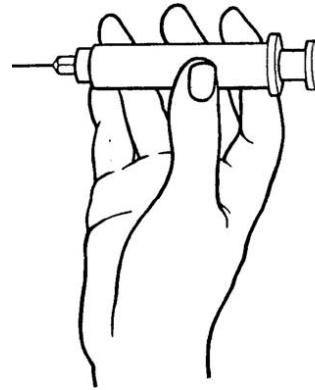


Figure 12 Hold the barrel of syringe between thumb and index finger.

- ii. Move the needle tip to about one-half inch from the injection site, with the bevel up, and position the needle at a 90-degree angle to the skin surface. (All intramuscular injections are inserted at a 90-degree angle into the muscular layer below the skin.)
 - iii. Plunge the needle firmly and quickly into the muscle to the depth of the needle with a steady straightforward motion. A quick insertion of the needle will minimize the pain for the patient.
- m. Aspirate the Syringe. Aspirate the syringe as follows (See figure 13.).

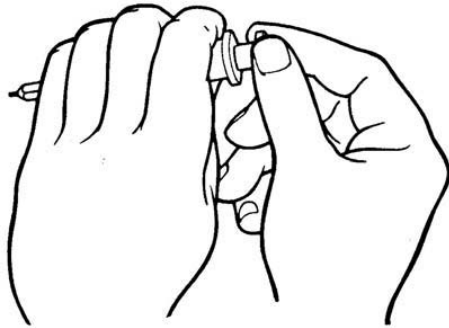


Figure 13 Aspirate the Syringe

- i. Release the hold on the skin.
- ii. Move the free hand to the plunger of the syringe.
- iii. Pull back the plunger until slight resistance is felt.
- iv. Check for blood entering the syringe. If blood appears in the syringe, do not administer the medication. Proceed as follows:
 - Withdraw the needle from the skin at a 90-degree angle.
 - Dispose of the needle and syringe (see procedures for accomplishing this at the end of this lesson).
 - Explain your actions to the patient.
 - Obtain another (sterile) needle and syringe.
 - Select another injection site.

- Start the injection procedure over, following the instructions already provided.
 - CAUTION: Failure to aspirate for blood before injecting could result in administering medication into a blood vessel, which would endanger the life of the patient. This is because the entire amount is instantly available for the body to use.
- n. Inject the Medication. To inject the medication, **perform** the following procedures:
- i. Stabilize the syringe with the nondominant hand.
 - ii. Place the thumb of the dominant hand on the plunger and the index and middle fingers under the hook of the syringe barrel.
 - iii. Push the plunger into the syringe barrel with a slow, continuous downward movement as far as the plunger will go.
 - iv. Make sure that all the medication is injected. Any medication that is left in the needle at the end of the injection may dribble into the subcutaneous tissue as it is withdrawn. Tissue injury may result.
- o. Withdraw the Needle. To withdraw the needle:
- i. Place the alcohol pad you are holding just above the injection site with the nondominant hand.
 - ii. Remove the needle straight out in same direction as the injection with a quick, outward motion.
- p. Engage the safety feature of the needle.
- q. Dispose of the Expended Needle and Syringe. Place the needle and syringe in a ~~non-permeable container in accordance with local policy~~ sharps container. Proper disposal of equipment prevents cross contamination, drug abuse, and injury by needles. **[THIS SECTION WAS MOVED UP TWO LEVELS DURING REVISION.]**
- r. Cover the Injection Site. Place an adhesive bandage over the injection site to protect clothes from possible bloodstains and **to** protect the injection site from possible infection.
- s. Perform Postinjection Patient Care. Perform as follows:
- i. Observe the patient for unusual reactions. Any medication can cause anaphylactic reactions.
 - ii. Give appropriate information regarding the medication and required waiting time to the patient in accordance with local guidelines.
- t. Record Administration of the Injection. Record the information in the patient's medical record (EHR). **Prompt recording prevents other personnel from administering the same medication. [THIS SENTENCE WAS MOVED TO THE BODY OF THE INSTRUCTION DURING REVISION.]**

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- § 2500(b) It shall be the duty of every health care provider, knowing or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- § 2500(c) The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- § 2500(a)(14) "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

- Ⓞ ! = Report immediately by telephone (designated by a ♦ in regulations).
- † = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations)
- FAX Ⓞ ☒ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
- = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(i)(1)

- Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
- FAX Ⓞ ☒ Amebiasis
- Ⓞ ! Anaplasmosis/Ehrlichiosis
- FAX Ⓞ ☒ Anthrax, human or animal
- Ⓞ ! Babesiosis
- Ⓞ ! Botulism (Infant, Foodborne, Wound, Other)
- Brucellosis, animal (except infections due to *Brucella canis*)
- Ⓞ ! Brucellosis, human
- FAX Ⓞ ☒ Campylobacteriosis
- Chancroid
- FAX Ⓞ ☒ Chickenpox (Varicella) (only hospitalizations and deaths)
- Chlamydia trachomatis* infections, including lymphogranuloma venereum (LGV)
- Ⓞ ! Cholera
- Ⓞ ! Ciguatera Fish Poisoning
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- FAX Ⓞ ☒ Cryptosporidiosis
- Cyclosporiasis
- Cysticercosis or taeniasis
- Ⓞ ! Dengue
- Ⓞ ! Diphtheria
- Ⓞ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- FAX Ⓞ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- Ⓞ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
- † FAX Ⓞ ☒ Foodborne Disease
- Giardiasis
- Gonococcal Infections
- FAX Ⓞ ☒ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
- Ⓞ ! Hantavirus Infections
- Ⓞ ! Hemolytic Uremic Syndrome
- FAX Ⓞ ☒ Hepatitis A, acute infection
- Hepatitis B (specify acute case or chronic)
- Hepatitis C (specify acute case or chronic)
- Hepatitis D (Delta) (specify acute case or chronic)
- Hepatitis E, acute infection
- Influenza, deaths in laboratory-confirmed cases for age 0-64 years
- Ⓞ ! Influenza, novel strains (human)
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- FAX Ⓞ ☒ Listeriosis
- Lyme Disease
- FAX Ⓞ ☒ Malaria
- Ⓞ ! Measles (Rubeola)
- FAX Ⓞ ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- Ⓞ ! Meningococcal Infections
- Mumps
- Ⓞ ! Paralytic Shellfish Poisoning
- Pelvic Inflammatory Disease (PID)
- FAX Ⓞ ☒ Pertussis (Whooping Cough)
- Ⓞ ! Plague, human or animal
- FAX Ⓞ ☒ Poliovirus Infection
- FAX Ⓞ ☒ Psittacosis

- FAX Ⓞ ☒ Q Fever
- Ⓞ ! Rabies, human or animal
- FAX Ⓞ ☒ Relapsing Fever
- Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- FAX Ⓞ ☒ Salmonellosis (Other than Typhoid Fever)
- Ⓞ ! Scombroid Fish Poisoning
- Ⓞ ! Severe Acute Respiratory Syndrome (SARS)
- Ⓞ ! Shiga toxin (detected in feces)
- FAX Ⓞ ☒ Shigellosis
- Ⓞ ! Smallpox (Variola)
- FAX Ⓞ ☒ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
- FAX Ⓞ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
- FAX Ⓞ ☒ Syphilis
- Tetanus
- Toxic Shock Syndrome
- FAX Ⓞ ☒ Trichinosis
- FAX Ⓞ ☒ Tuberculosis
- Tularemia, animal
- Ⓞ ! Tularemia, human
- FAX Ⓞ ☒ Typhoid Fever, Cases and Carriers
- FAX Ⓞ ☒ *Vibrio* Infections
- Ⓞ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
- FAX Ⓞ ☒ West Nile virus (WNV) Infection
- Ⓞ ! Yellow Fever
- FAX Ⓞ ☒ Yersiniosis
- Ⓞ ! OCCURRENCE of ANY UNUSUAL DISEASE
- Ⓞ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and <http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx>

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800-2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the Cervix) (§2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty (\$250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrca.org.

California Labor Law Regarding Occupational Injuries
Workers' Compensation

(Downloaded from California Labor Codes section on 8/7/2014 at
<http://www.leginfo.ca.gov/cgi-bin/displaycode?section=lab&group=06001-07000&file=6400-6413.5>)

6409. (a) Every physician as defined in Section 3209.3 who attends any injured employee shall file a complete report of every occupational injury or occupational illness to the employee with the employer, or if insured, with the employer's insurer, on forms prescribed for that purpose by the Department of Industrial Relations. A portion of the form shall be completed by the injured employee, if he or she is able to do so, describing how the injury or illness occurred. The form shall be filed within five days of the initial examination. Inability or failure of an injured employee to complete his or her portion of the form shall not affect the employee's rights under this code, and shall not excuse any delay in filing the form. The employer or insurer, as the case may be, shall file the physician's report with the department within five days of receipt.

Each report of occupational injury or occupational illness shall indicate the social security number of the injured employee. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall also file a complete report, which need not include the affidavit required pursuant to this section, with the department, and within 24 hours of the initial examination shall file a complete report with the local health officer by facsimile transmission or other means. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall not be compensated for the initial diagnosis and treatment unless the report is filed with the employer, or if insured, with the employer's insurer, and includes or is accompanied by a signed affidavit which certifies that a copy of the report was filed with the local health officer pursuant to this section.

(b) As used in this section, "occupational illness" means any abnormal condition or disorder caused by exposure to environmental factors associated with employment, including acute and chronic illnesses or diseases which may be caused by inhalation, absorption, ingestion, or direct contact.

6409.1. (a) Every employer shall file a complete report of every occupational injury or occupational illness, as defined in subdivision (b) of Section 6409, to each employee which results in lost time beyond the date of the injury or illness, or which requires medical treatment beyond first aid, with the Department of Industrial Relations or, if an insured employer, with the insurer, on a form prescribed for that purpose by the department. A report shall be filed concerning each injury and illness which has, or is alleged to have, arisen out of and in the course of employment, within five days after the employer obtains knowledge of the injury or illness.

Each report of occupational injury or occupational illness shall indicate the social security number of the injured employee. In the case of an insured employer, the insurer shall file with the division immediately upon receipt, a copy of the employer's report, which has been received from the insured employer. In the event an employer has filed a report of injury or illness

pursuant to this subdivision and the employee subsequently dies as a result of the reported injury or illness, the employer shall file an amended report indicating the death with the department or, if an insured employer, with the insurer, within five days after the employer is notified or learns of the death. A copy of any amended reports received by the insurer shall be filed with the division immediately upon receipt.

(b) In every case involving a serious injury or illness, or death, in addition to the report required by subdivision (a), a report shall be made immediately by the employer to the Division of Occupational Safety and Health by telephone or telegraph. An employer who violates this subdivision may be assessed a civil penalty of not less than five thousand dollars (\$5,000). Nothing in this subdivision shall be construed to increase the maximum civil penalty, pursuant to Sections 6427 to 6430, inclusive, that may be imposed for a violation of this section.

6409.2. Whenever a state, county, or local fire or police agency is called to an accident involving an employee covered by this part in which a serious injury or illness, or death occurs, the responding agency shall immediately notify the nearest office of the Division of Occupational Safety and Health by telephone. Thereafter, the division shall immediately notify the appropriate prosecuting authority of the accident.

6409.3. In no case shall the treatment administered for pesticide poisoning or a condition suspected as pesticide poisoning be deemed to be first aid treatment.

6409.5. (a) Whenever any local public fire agency has knowledge that a place of employment where garment manufacturing operations take place contains fire or safety hazards for which fire and injury prevention measures have not been taken in accordance with local fire and life safety ordinances, the agency may notify the Division of Occupational Safety and Health. This referral shall be made only after the garment manufacturing employer has been given a reasonable amount of time to correct violations.

(b) Whenever the Division of Occupational Safety and Health has knowledge or reasonable suspicion that a place of employment where garment manufacturing operations take place contains fire or safety hazards for which fire and injury prevention measures have not been taken in accordance with local fire and life safety ordinances, the division shall notify the appropriate local public fire agency.

(c) Whenever the Division of Occupational Safety and Health receives a referral by a local public fire agency pursuant to subdivision (a) which informs the division that a place of employment where garment manufacturing operations take place is not safe or is injurious to the welfare of any employee, it shall constitute a complaint for purposes of Section 6309 and shall be investigated.

(d) Whenever a local public fire agency receives a referral by the Division of Occupational Safety and Health pursuant to subdivision (b) which informs the local public fire agency that a place of employment where garment manufacturing operations take place is not safe or is injurious to the

welfare of any employee, the local public fire agency may investigate the referral at its discretion.

(e)(1) If the Division of Occupational Safety and Health acquires knowledge that the garment manufacturing employer is not currently registered, it shall notify the Division of Labor Standards Enforcement.

(2) Local public fire agencies may make referrals of individuals not registered as garment manufacturers to the Division of Labor Standards Enforcement.

(3) Whenever the Division of Labor Standards Enforcement is informed by the Division of Occupational Safety and Health or by a local public fire agency that a garment manufacturing employer is unregistered, the Division of Labor Standards Enforcement shall take measures it deems appropriate to obtain compliance.

6410. (a) The reports required by subdivision (a) of Section 6409 and Section 6413 shall be made in the form and detail and within the time limits prescribed by reasonable rules and regulations adopted by the Department of Industrial Relations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(b) Nothing in this chapter requiring recordkeeping and reporting by employers shall relieve the employer of maintaining records and making reports to the assistant secretary, United States Department of Labor, as required under the federal Occupational Safety and Health Act of 1970 (P.L. 91-596). The Division of Occupational Safety and Health shall prescribe and provide the forms necessary for maintenance of the required records, and shall enforce by citation and penalty assessment any violation of the recordkeeping requirements of this chapter.

(c) All state and local government employers shall maintain records and make reports in the same manner and to the same extent as required of other employers by this section.

6410.5. The reports required by subdivision (a) of Section 6409, subdivision (a) of Section 6409.1, and Section 6413 shall contain, prominently stated, the statement set forth in Section 5401.7.

6411. Every employer or insurer receiving forms with directions from the Department of Industrial Relations to complete them shall cause them to be properly filled out so as to answer fully and correctly each question propounded therein. In case of inability to answer any questions, a good and sufficient reason shall be given for such failure.

6412. No report of injury or illness required by subdivision (a) of Section 6409.1 shall be open to public inspection or made public, nor shall those reports be admissible as evidence in any adversary proceeding before the Workers' Compensation Appeals Board. However, the reports required of physicians by subdivision (a) of Section 6409 shall be admissible as evidence in the proceeding, except that no physician's report shall be admissible as evidence to bar proceedings for the collection of compensation, and the portion of any physician's report completed by an employee shall not be

admissible as evidence in any proceeding before the Workers' Compensation Appeals Board.

6413. (a) The Department of Corrections and Rehabilitation, and every physician or surgeon who attends any injured state prisoner, shall file with the Division of Occupational Safety and Health a complete report, on forms prescribed under Sections 6409 and 6409.1, of every injury to each state prisoner, resulting from any labor performed by the prisoner unless disability resulting from such injury does not last through the day or does not require medical service other than ordinary first aid treatment.

(b) Where the injury results in death a report, in addition to the report required by subdivision (a), shall forthwith be made by the Department of Corrections and Rehabilitation to the Division of Occupational Safety and Health by telephone or telegraph.

(c) Except as provided in Section 6304.2, nothing in this section or in this code shall be deemed to make a prisoner an employee, for any purpose, of the Department of Corrections and Rehabilitation.

(d) Notwithstanding subdivision (a), no physician or surgeon who attends any injured state prisoner outside of a Department of Corrections and Rehabilitation institution shall be required to file the report required by subdivision (a), but the Department of Corrections and Rehabilitation shall file the report.

6413.2. (a) With regard to any report required by Section 6413, the Division of Occupational Safety and Health may make recommendations to the Department of Corrections and Rehabilitation of ways in which the department might improve the safety of the working conditions and work areas of state prisoners, and other safety matters. The Department of Corrections and Rehabilitation shall not be required to comply with these recommendations.

(b) With regard to any report required by Section 6413, the Division of Occupational Safety and Health may, in any case in which the Department of Corrections and Rehabilitation has not complied with recommendations made by the division pursuant to subdivision (b), or in any other case in which the division deems the safety of any state prisoner shall require it, conduct hearings and, after these hearings, adopt special orders, rules, or regulations or otherwise proceed as authorized in Chapter 1 (commencing with Section 6300) of this part as it deems necessary. The Department of Corrections and Rehabilitation shall comply with any order, rule, or regulation so adopted by the Division of Occupational Safety and Health.

6413.5. Any employer or physician who fails to comply with any provision of subdivision (a) of Section 6409, or Section 6409.1, 6409.2, 6409.3, or 6410 may be assessed a civil penalty of not less than fifty dollars (\$50) nor more than two hundred dollars (\$200) by the director or his or her designee if he or she finds a pattern or practice of violations, or a willful violation of any of these provisions. Penalty assessments may be contested in the manner provided in Section 3725. Penalties assessed pursuant to this section shall be deposited in the General Fund.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Quality of Care Provided	Policy #: 04-006-200	Policy Title: Legally Mandated Reporting
Tribal Chairman: Date: September 8, 2011 Signature: Supersedes Policy 04-006-200 dated 09/10/09	Medical Director: Date: August 16, 2011 Signature:	Cross References: California Labor Code (6409. – 6413.5) CA Reportable Diseases and Conditions (CCR Title 17.)

Exposure to Blood:

Any employee sustaining a significant blood exposure shall contact his/her supervisor and shall generate an incident report, which shall be sent to the Quality Management Department who will notify the Infection Control Officer. The employee shall have immediate medical evaluation and appropriate medical care.

Pesticide Related Illnesses:

The Karuk Tribal Health and Human Service program shall comply with the Health and Safety Code and shall report suspected cases of pesticide related illnesses to either the Siskiyou or Humboldt County Public Health Department.

Communicable Disease:

The Karuk Tribal Health and Human Services program will comply with Title 17, California Code of Regulation, Sec. 2500, and shall report known or suspected cases of any communicable disease to the local jurisdiction within the required time frame. The local jurisdictions for the Karuk Health and Human Services program are Siskiyou and Humboldt County Public Health Departments.

Child, Elder and Domestic Abuse or Neglect:

Known or suspected cases of either child, elder, or domestic abuse or neglect shall be reported as mandated by law.

Other:

Motor vehicle accidents with injury, rape or assault shall be reported to the law enforcement agency with primary investigative authority. **Any animal bites will be reported to city or county officials, depending upon the location at which the animal bite occurred.**

Occupational Injury or Illness:

The Karuk Tribal Health and Human Service program shall comply with Labor Code 6413.5 and shall report any occupational related injury or disease to the State Compensation Insurance Fund, to the Worker's Compensation carrier of the employer, and the Division of Labor Statistics and Research.

In the event the employer does not carry Worker's Compensation Insurance, the Department of Labor will be notified.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 (X) 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Infection Prevention and Control	Policy #: 07-001-111	Policy Title: Annual Employee Flu Immunization Policy
Tribal Chairman: Date: 05/10/2012 Signature:	Medical Director: Date: 05/09/2012 Signature:	Cross References: Influenza Immunization Forms
New Policy 2012		

Background:

Unvaccinated health care personnel may be the cause of spreading the highly contagious influenza virus, which places ~~vulnerable~~ patients at risk. Especially ~~vulnerable are~~ those 65 years or above, those with chronic conditions, ~~and those who are pregnant women,~~ ~~and young children~~. In addition to placing their patients at risk, they are putting their ~~fellow~~ staff members, their families, and themselves at risk.

~~Flu~~ **Influenza** vaccinations are the number one vaccine-preventable cause of death, and the public health goal is to vaccinate individuals working in all healthcare settings. Healthcare employers are asked to launch annual ~~immunization~~ **vaccination** and educational programs.

Purpose:

~~To provide an easily accessible avenue for healthcare personnel to be annually immunized and educated, regarding the flu vaccination, benefits, and associated risk.~~ **To provide healthcare workers with easy and cost-free access to annual influenza vaccinations, and to education regarding the benefits of immunization and the risks associated with not being vaccinated.**

Policy:

The Karuk Tribal Health and Human Service Program (**KTHHSP**) will offer free annual influenza ~~flu immunizations~~ **vaccinations** to all healthcare personnel, volunteers, and students, who have close patient contact or frequently visit the clinic for administrative or other ~~technical maintenance~~ **official responsibilities**. Those ~~workers~~ **staff members**, who decline influenza vaccination for other than medical contraindications, must sign a **Declination of Influenza Vaccination** form.

This policy may be superseded in the event a regulating organization, with the legal authority to overrule KTHHSP influenza immunization policy, mandates changes that exceed KTHHSP requirements.

~~Flu vaccination clinics will be held in a meeting room of each facility during the months of October, November and December (schedule will be attached below). Vaccinated employees will be given a (sticker, clip or button) to wear as a sign of being vaccinated.~~

Procedure:

1. ~~Flu vaccinations~~ **Influenza vaccination** will be offered to employees at **the** time of **their** initial employment physical and annually thereafter.
2. ~~The Public Health Nurse and/or a provider will set up a clinic at each facility in a room accessible to all staff at all times i.e. conference room or break room.~~
3. A screening questionnaire will be completed on **by** adult patients and parents of children to be vaccinated. **Employees who have been immunized shall receive a token of immunization, which will be worn on their name badge during the influenza season.** ~~Employee getting the flu vaccination will receive a sticker, clip or button as an indication of being vaccinated, which shall be worn with their name badge during the months of October through April.~~
4. Employees refusing ~~the flu~~ **influenza** vaccination shall sign a Declination of **Influenza Vaccination** form, see attached.
5. Employees ~~with a fever~~ **with a temperature exceeding 100°F** may not enter the **clinic while febrile.** ~~must stay home from work.~~
6. **Employees with respiratory symptoms, but whose temperature does not exceed 100°F, may work at the clinic, but must wear an A-95 face mask while in the clinic.** ~~Personnel, who have respiratory symptoms but no fever, may work but they must wear a mask.~~
7. **Patients entering the clinic with respiratory symptoms will be asked to wear a face mask while in the clinic, and to apply anti-bacterial hand sanitizer, at the earliest possible moment. These products will be available at each clinic's entryway at no cost to the patient.**

Declination of Influenza Vaccination

My employer or affiliated health facility, _____, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- ◆ Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- ◆ Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- ◆ If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- ◆ If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- ◆ I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- ◆ I understand that I cannot get influenza from the influenza vaccine.
- ◆ The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
 - all patients in this healthcare facility
 - my coworkers
 - my family
 - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines—
Recommendations of ACIP at www.cdc.gov/flu/professionals/acip/index.htm

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____
 Form reviewed by: _____ Date: _____

Technical content reviewed by the Centers for Disease Control and Prevention

Information for Health Professionals about the Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the sources listed at the bottom of this page.

1. Is the person to be vaccinated sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with an acute febrile illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

2. Does the person to be vaccinated have an allergy to eggs or to a component of the vaccine?

Allergic reactions to any vaccine component can occur. The majority of reactions probably are caused by residual egg protein. Although most current influenza vaccines contain only a limited quantity of egg protein, this protein can induce immediate allergic reactions among people who have severe egg allergy.

An egg-free recombinant hemagglutinin vaccine (RIV) may be used in people age 18 through 49 years with egg allergy of any severity who have no other contraindications. People who do not meet the age criteria for RIV who have experienced a serious systemic or anaphylactic reaction (e.g., hives, swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs should consult a specialist for appropriate evaluation to help determine if vaccine should be administered. People who have documented immunoglobulin E (IgE)-mediated hypersensitivity to eggs, including those who have had occupational asthma or other allergic responses to egg protein, might also be at increased risk for allergic reactions to influenza vaccine. Protocols have been published for safely administering influenza vaccine to people with egg allergies (see source 3).

Some people who report allergy to egg might not be egg-allergic. If a person can eat lightly cooked eggs (e.g., scrambled eggs), they are unlikely to have an egg allergy. However, people who can tolerate egg in baked products (e.g., cake) might still have an egg allergy. If the person develops hives only after ingesting eggs, CDC recommends they receive either inactivated influenza vaccine (IIV) or, if age-eligible, RIV (not LAIV). If IIV is to be administered, CDC further recommends 1) the vaccine be administered by a healthcare provider familiar with the potential manifestations of egg allergy and 2) the vaccine recipient be observed for at least 30 minutes after receipt of the vaccine for signs of a reaction.

Fluzone (sanofi pasteur) contains gelatin as a stabilizer; therefore a history of anaphylactic reaction to gelatin is a contraindication. Some inactivated influenza vaccines contain thimerosal as a preservative. Most people who had sensitivity to thimerosal when it was used in contact lens solution do not have reactions to thi-

merosal when it is used in vaccines. Check the package insert at www.immunize.org/packageinserts for a list of the vaccine components (i.e., excipients and culture media) used in the production of the vaccine, or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

Some vaccines also contain latex in the prefilled syringe cap which may cause allergic reactions in latex sensitive people. Check the package inserts at www.immunize.org/packageinserts for information on which vaccines are affected, or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf.

3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?

Patients reporting a serious reaction to a previous dose of inactivated influenza vaccine should be asked to describe their symptoms. Immediate—presumably allergic—reactions are usually a contraindication to further vaccination against influenza.

Fever, malaise, myalgia, and other systemic symptoms most often affect people who are first-time vaccinees. These mild-to-moderate local reactions are not a contraindication to future vaccination. Also, red eyes or mild upper facial swelling following vaccination with inactivated injectable influenza vaccine is most likely a coincidental event and not related to the vaccine; these people can receive injectable vaccine without further evaluation.

4. Has the person to be vaccinated ever had Guillain-Barré syndrome?

It is prudent to avoid vaccinating people who are not at high risk for severe influenza complications (see source 3) but who are known to have developed Guillain-Barré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination. As an alternative, physicians might consider using influenza antiviral chemoprophylaxis for these people. Although data are limited, the established benefits of influenza vaccination for the majority of people who have a history of GBS, and who are at high risk for severe complications from influenza, justify yearly vaccination.

Sources:

1. CDC. *Epidemiology & Prevention of Vaccine-Preventable Diseases*, WL Atkinson et al., editors, at www.cdc.gov/vaccines/pubs/pinkbook/index.html.
2. CDC. *General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)* at www.cdc.gov/vaccines/hcp/acip-recs.
3. CDC. Summary* Recommendations: Prevention and Control of Influenza with Vaccines: Recommendations of ACIP—United States, 2013-14: at www.cdc.gov/flu/professionals/acip/2013-summary-recommendations.htm.

Patient name: _____ Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you or your child live attenuated intranasal influenza vaccine (FluMist) today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the person to be vaccinated sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you the child had wheezing or asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Is the person to be vaccinated receiving antiviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the person to be vaccinated ever had Guillain-Barré syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Information for Health Professionals about the Screening Checklist for Contraindications to Live Attenuated Intranasal Influenza Vaccination

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the sources listed at the bottom of this page.

1. Is the person to be vaccinated sick today?

There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. People with an acute febrile illness usually should not be vaccinated until their symptoms have improved. Minor illnesses with or without fever do not contraindicate use of influenza vaccine. Do not withhold vaccination if a person is taking antibiotics.

2. Does the person to be vaccinated have an allergy to eggs or to a component of the influenza vaccine?

A history of anaphylactic or non-anaphylactic reaction—such as hives, wheezing, or difficulty breathing, or circulatory collapse or shock (not fainting)—after eating eggs or receiving any component of the intranasal live attenuated influenza vaccine (LAIV; tradename FluMist) is usually a contraindication for further doses. An egg-free recombinant hemagglutinin vaccine (RIV) may be used in people age 18 through 49 years with egg allergy of any severity who have no other contraindications. People with egg allergies who do not meet the age criteria for RIV can usually be vaccinated with inactivated influenza vaccine (IIV); consult ACIP recommendations (see source 3). For a complete list of vaccine components (i.e., excipients and culture media) used in the production of the vaccine, check the package insert (at www.immunize.org/packageinserts) or go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/b/excipient-table-2.pdf.

3. Has the person to be vaccinated ever had a serious reaction to intranasal influenza vaccine (FluMist) in the past?

Patients reporting a serious reaction to a previous dose of LAIV should be asked to describe their symptoms. Immediate—presumably allergic—reactions are usually a contraindication to further vaccination with LAIV.

4. Is the person to be vaccinated younger than age 2 years or older than age 49 years?

LAIV is not licensed for use in people younger than age 2 years or older than age 49 years.

5. Does the person to be vaccinated have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes), or anemia or another blood disorder?

People with any of these health conditions should not be given LAIV. Instead, they should be vaccinated with the inactivated injectable influenza vaccine.

6. If the person to be vaccinated is a child age 2 through 4 years, in the past 12 months, has a healthcare provider told you that the child had wheezing or asthma?

LAIV is not recommended for a child this age if their parent or guardian answers yes to this question or if the child has a history of asthma or recurrent wheezing. Instead, the child should be given the inactivated injectable influenza vaccine.

7. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months, have they taken medications that weaken the immune system, such as cortisone, prednisone, other steroids, or anticancer drugs; or have they had radiation treatments?

People with weakened immune systems should not be given LAIV. Instead, they should be given the inactivated injectable influenza vaccine.

8. Is the person to be vaccinated receiving antiviral medications?

Receipt of certain influenza antivirals (e.g., amantadine, rimantadine, zanamivir, oseltamivir) could reduce LAIV vaccine efficacy; therefore, providers may want to defer vaccination with LAIV in people who took these antivirals within the previous 48 hours and to advise avoiding use of these antivirals for 14 days after vaccination, if feasible.

9. Is the child or teen to be vaccinated receiving aspirin therapy or aspirin-containing therapy?

Because of the theoretical risk of Reye's syndrome, children and teens on aspirin therapy should not be given LAIV. Instead they should be vaccinated with the inactivated injectable influenza vaccine.

10. Is the person to be vaccinated pregnant or could she become pregnant within the next month?

Pregnant women or women planning to become pregnant within a month should not be given LAIV. All pregnant women should, however, be vaccinated with the inactivated injectable influenza vaccine.

11. Has the person to be vaccinated ever had Guillain-Barré syndrome?

It is prudent to avoid vaccinating people who are not at high risk for severe influenza complications but who are known to have developed Guillain-Barré syndrome (GBS) within 6 weeks after receiving a previous influenza vaccination. As an alternative, physicians might consider using influenza antiviral chemoprophylaxis for these people. Although data are limited, the established benefits of influenza vaccination for the majority of people who have a history of GBS, and who are at high risk for severe complications from influenza, justify yearly vaccination.

12. Does the person to be vaccinated live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?

Inactivated injectable influenza vaccine is preferred for people who anticipate close contact with a severely immunosuppressed person during periods in which the immunosuppressed person requires care in protective isolation (e.g., in a specialized patient-care area with a positive airflow relative to the corridor, high-efficiency particulate air filtration, and frequent air changes). Either the inactivated injectable influenza vaccine or LAIV may be used in people who have close contact with people having lesser degrees of immunosuppression.

13. Has the person to be vaccinated received any other vaccinations in the past 4 weeks?

People who were given an injectable live virus vaccine (e.g., MMR, MMRV, varicella, zoster, yellow fever) in the past 4 weeks should wait 28 days before receiving LAIV. There is no reason to defer giving LAIV if people were vaccinated with an inactivated vaccine or if they have recently received blood or other antibody-containing blood products (e.g., IG).

Sources:

1. CDC. *Epidemiology & Prevention of Vaccine-Preventable Diseases*, WL Atkinson et al., editors, at www.cdc.gov/vaccines/pubs/pinkbook/index.html.
2. CDC. *General Recommendations on Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)* at www.cdc.gov/vaccines/hcp/acip-recs.
3. CDC. "Summary* Recommendations: Prevention and Control of Influenza with Vaccines: Recommendations of the ACIP—United States, 2013–14" at www.cdc.gov/flu/professionals/acip/2013-summary-recommendations.htm.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 (X) 21 () 22 ()
Function: Pathology and Medical Laboratory Services	Policy #: 12-000-685	Policy Title: Laboratory Services Policy
Tribal Chairman: Date: 07/13/2011 Signature:	Medical Director: Date: 07/13/2011 Signature:	Cross References: <p style="text-align: center;">Lab Procedure Manual</p>

Purpose:

To establish a system for providing quality laboratory services in an environment where CLIA-waived and physician-performed microscopy are performed.

Policy:

The Karuk Tribal Health and Human Services medical departments shall maintain a Certificate of Registration for CLIA-waived testing and physician-performed microscopy services at each clinic. The Orleans Medical Clinic is certified under the Yreka Clinic's CLIA registration.

Personnel authorized to perform CLIA-waived test are the Physicians, Family Nurse Practitioners, Physician Assistants, RNs, and LVNs, and Medical Assistants. Annual laboratory proficiency testing will be completed on each employee performing **CLIA-waived** tests. ~~(A separate Laboratory Procedure Manual is available for staff reference.~~

Employees will adhere to KTHHSP infection control policies and will comply with the Universal Precautions.

~~Onsite test include urinalysis, automated urine micro-albumin, blood glucose, HA1c, urine pregnancy, fecal occult blood, pro time, automated hemoglobin, group A strep, screen (throat), KOH preparations, wet mounts and microscopic test.~~

Onsite CLIA-waived tests include the following:

- Automated Hgb A1c
- Automated urinalysis (10 tests)
- Blood glucose
- Hemoglobin
- INR
- Fecal occult blood
- Group A β-hemolytic streptococcus (25 tests)
- Hcg (50 tests)
- HIV antibody

~~Outgoing test shall be logged into a book requesting the name of the patient, date of service, and names of test. Incoming test reports shall be logged into the book by writing in the date the test was received. Then the report is sent to the provider to review, date and initial prior to filing in the patient record.~~

Test required beyond our scope shall be provided by Quest Laboratories, which meets all assurances. Specimens are collected in the appropriate Quest-provided, container, and stored until collection at the appropriate temperature: room, refrigerated, or frozen. All specimen containers are appropriately marked for test requested, patient identification, and date of collection. Specimens are collected daily by the Quest courier. Outgoing Quest tests are entered into an automated bi-directional system, with results automatically entered into the EHR, for the provider to review and to sign electronically. Results out of range generate a specific notification on the ordering provider's EHR.

Panic values require immediate telephone notification by the laboratory performing the test. The employee receiving the report must repeat the information back to the laboratory for confirmation. The provider shall be notified of the test results immediately. It is preferred that the provider should receive the results directly, when available. **If the ordering provider is not in the clinic for the day, the Medical Director will be notified.**

At the Yreka clinic, tests which require immediate results and cannot be performed within the clinic, are performed by the Fairchild Medical Center (FMC) lab. All specimen containers are appropriately marked for test requested, patient identification, and date of collection. Specimens are immediately transported to the FMC lab in the appropriate container, in an appropriate temperature-controlled environment. Tests results are requested STAT, and results are telephoned and faxed to the clinic. The results are immediately reported to the ordering provider.

Other tests and consult results are scanned into the EHR for the provider to review and to sign electronically.

External quality controls shall be monitored for all waived testing and shall follow the guidelines set forth by the manufacturer. A log of all controls shall be maintained and reviewed by the clinic physician, **or designee**, who will evaluate unexpected results ~~are~~ **and** suspected discrepancies. Contract laboratories perform internal quality controls as specified in their reference manuals.

The following section should be replaced by the Laboratory Procedure Manual.

Procedures

Collection of Venous Blood Specimens:

Equipment:

Vacutainer holder

Needle or syringe

~~21 gauge needle or 21 gauge butterfly apparatus~~

Gloves
Tourniquet
Skin preparation pads
Cotton balls
Specimen tubes
Tape or band-aid

Procedure:

1. Identify the patient by full name and birth date
2. Record on lab requisition provider name, fasting/non-fasting
3. Obtain blood from antecubital vein if possible. However, veins in other sites may be used.
4. Position the patient sitting in a chair or lying on the table.
5. Place and tighten a tourniquet on the upper arm to cause venous congestion and prevent venous return.
6. Prepare and clean the sight prior to collecting the specimen by briskly rubbing the area with alcohol or betadine. Allow the air to dry. Do not re-palpate the site.
7. Don gloves and perform venipuncture, observe for a rapid return of blood.
8. Vacutainer tubes, if used are drawn in the following order:
 - Yellow— blood culture
 - Light blue
 - Red/tiger top
 - Green
 - Lavender
 - Pink
 - Gray
 - Dark blue
9. When hemostasis has been achieved, cover the puncture site with a band-aid or other sterile dressing.
10. The volume of specimen needed is 4.5 to 10 ml (fill tube completely). If an insufficient specimen was obtained; note this on the lab form with the reason (i.e., difficult draw, etc.)
11. These procedures are reviewed annually and revised as needed. Relevant staff will be notified of revisions at staff meetings.

Clinical decisions:

1. If difficulty is encountered in obtaining blood:
 - a. — Warm the extremity
 - b. — Allow extremity to remain in a dependant position.
2. Hematomas can be prevented by:
 - a. — Releasing the tourniquet before blood is aspirated.
 - b. — Applying sufficient pressure over puncture site after completion of the procedure.
3. Prolonged use of the tourniquet causes stasis of blood, produces hemoconcentration and causes changes that make the blood unsuitable for a blood count.

4. ~~If oozing from the puncture wound is difficult to stop, elevate the area and apply a pressure dressing. Stay with the patient until the bleeding stops.~~

A. Preparation of Specimens for Transport:

1. ~~Fasting samples are often the specimens of choice, especially for chemistry profiles.~~
2. ~~Hemolysis and lipemia interfere with many procedures. Provide serum or plasma free from hemolysis and lipemia if at all possible.~~
3. ~~Do not use expired tubes or media for specimen collection.~~
4. ~~Whenever possible obtain specimens prior to the administration of antibiotics.~~
5. ~~Sterile containers must be used for any culture.~~
6. ~~Collection containers should be closed securely and precautions taken to prevent leaking of sample drug during transport. These specimens may constitute a biohazard.~~
7. ~~Refer to the contract laboratory manual for appropriate tube selection.~~

B. Serum:

- b.1. ~~Red stopper tube (no anticoagulant or separating gel)~~
 1. ~~One full 10 ml tube is recommended for every 4 ml of serum needed.~~
 2. ~~Allow the blood to clot, then centrifuge within 45 minutes of venipuncture. Centrifuge for appropriately 5 to 10 minutes. (Caution: prolonged centrifugation may cause hemolysis and evaporation).~~
- b.2. ~~Mottled red/grey or cherry red stopper tube:~~
 1. ~~Follow the same venipuncture technique for serum separator tubes as for red stopper tube.~~
 2. ~~Gently invert the serum separator tube six times to mix the clot activator and blood.~~
 3. ~~Allow blood to clot for about 30 minutes. Centrifuge at full speed for 5 to 10 minutes. A barrier will form between the serum and the cells. If a complete barrier is not formed above the cells, either re-spin immediately for five minutes or transfer serum to a plastic transfer tube. Do not re-spin if more than an hour has lapsed since venipuncture.~~

C. Plasma:

1. ~~Draw blood into a tube containing the appropriate anticoagulant such as EDTA, heparin or sodium citrate. When using a syringe to draw the specimen, transfer the blood immediately to a tube containing anticoagulant. To prevent hemolysis, puncture the rubber stopper with syringe needle at an angle so the blood is drawn down the side of the tube. Allow the blood to be drawn into the tube. Do not force the blood from the syringe into the tube. Overfilling may cause hemolysis, alter the blood/anticoagulant ratio, or cause the stopper to become loose.~~

2. Promptly invert the tube gently (do not shake) about six (6) times to mix the blood anticoagulant.

D. Whole Blood:

1. Draw blood into a tube containing the appropriate anticoagulant such as EDTA, heparin, or sodium citrate. When using a syringe to draw the specimen, transfer blood immediately to a tube containing anticoagulant. To prevent hemolysis puncture the rubber stopper with the syringe needle at an angle so the blood is drawn down the side of the tube. Allow the blood to be drawn into the tube. Do not force the blood from the syringe into the tube.
2. Promptly invert the tube gently (do not shake) about six (6) times to mix the blood anticoagulant.

Hemoglobin A1c:

Equipment:

Hemoglobin A1c reagent kit

Laboratory sheet

Gloves

Patient samples

Lint-free tissue

Timer

Lancets for capillary blood collection

Sharps container

Band-Aid

Procedure:

1. Identify the patient
2. Open reagent cartridge package, do not touch optical window
3. Don gloves
4. Collect blood sample; touch the tip of the capillary to a small drop of blood until capillary is filled.
5. Wipe the side of the capillary with lint-free tissue.
6. Inspect the capillary for bubbles; if bubbles are obvious discard and repeat procedure.
7. Carefully insert the capillary holder into the reagent cartridge (flat side toward cartridge) until the holder snaps into place.
8. Hold the cartridge so that the barcode faces to the right.
9. Insert the barcode into the track above the dot.
10. Quickly and smoothly, slide the cartridge down. A beep and display change indicate a successful scan; repeat if not successful.
11. Hold the barcode so the barcode faces to the right.
12. Open the door and insert the cartridge into the compartment until a click is heard.
13. Slowly and firmly pull to remove the flexible tab.
14. Close the door to start the test.

15. Wait until the test is complete (approximately 6 minutes)
16. Select print to print results
17. Secure results to laboratory sheet
18. Select next, then open the door
19. Push and hold down the button on the right side.
20. To unlock gently push the tab on the cartridge to the right
21. Pull out the cartridge
22. Discard the cartridge into biohazard container.

Quality control checks are recommended on a monthly basis and with a new lot of reagents or a new shipment of reagents.

Hemoglobin Meter:

Equipment:

Hemoglobin Meter
 Laboratory sheet
 Disinfectant wipes
 Sharps container
 Lancets for capillary blood collection
 Hemoglobin test card
 Gloves
 Band Aid

Procedure:

1. Identify patient
2. Explain the procedure to patient and/or guardian
3. Wash your hands
4. Turn on the power
5. Insert test card into card holder until it locks into place when symbol flashes
6. Don gloves
7. Perform a finger stick or heel stick and wipe away the first drop of blood.
8. Position a free flowing drop of blood over the center of the test card, touch drop of blood to the reagent pad into the center of the test card.
9. After applying the sample to the center of the test card, the countdown to the test results will begin. The test may finish before reaching zero.
10. Record the results on the laboratory sheet.
11. The meter will automatically shut off after 2 minutes.
12. To retrieve the last test, turn the meter on and press the up button.

Quality control shall be done with each new lot of test cards, once for each test kit and monthly.

Urinalysis with Clinitek Analyzer:

Equipment:

Gloves
 Laboratory sheet

Paper Towel

Test strip

Patient strip

Tissue

Procedure:

1. Identify the patient/sample
 2. Don gloves
 3. Turn on analyzer
 4. Select strip test on screen
 5. Remove reagent strip from the bottle
 6. Replace the bottle cap
 7. Touch start on the prepare test screen
 8. Within 8 seconds
 - a. Dip strip in urine sample
 - b. Drag edge of strip against side of sample container as you remove it.
 - c. Blot edge of strip to paper towel to remove excess urine
 - d. Place strip in channel, with test pads facing up.
 - e. Slide strip to end of channel. Do not touch the pads on the strip.
 9. After 8 seconds, test table will automatically be pulled into analyzer
 10. When analysis is complete, the results screen will display.
 11. Touch MORE to view the second results screen
 12. Discard reagent strip
 13. Wipe table insert with damp tissue between tests to remove urine residue.
 14. Print results, add patient ID and attach to laboratory sheet.
- Quality control test should be done with each reagent bottle.

v.) Dental Emergency Care

1. Includes those dental services which are necessary to relieve or control acute oral conditions, such as; a potentially life threatening difficulty, maxillo-facial fractures, swelling and severe pain, or other signs of infection. (This will not cover periodontal services)

Delete- or other and add: So it reads like so:

Includes those dental services which are necessary to relieve or control acute oral conditions, such as: a potentially life threatening difficulty, such as swelling, severe pain , signs of infection, or removal of Tori (bony growth on the mandible or maxilla) prior to partial or full denture placement.

RPMS
Karuk Tribal Health and Human Services Program
Health Board Meeting-Orleans
October 9, 2014
Patricia White, RPMS Site Manager



Action Items:

I have no action items for this month.

User Assistance and requests

During September there were 24 documented items for user support and program issues. 12 were assigned to Amy Coapman and 12 were assigned to me. I still have 4 open tickets from previous months.

Workload reports

Attached is the August 2014 "Operations Summaries" including Tribal Statistics. During August there were 1,883 visits at all locations. This is an increase of 168 visits over July numbers. Visits are up at all locations. 923 of these visits were for Native American Patients (49%).

Meeting / Conference Calls and other Activities August 2014

- 09/08 – Clinical Key Webinar (a medical reference website for provider use)
- 09/10 – ACQI Monthly Committee Meeting
- 09/11 – Health Board Meeting-Orleans
- 09/17 – Front Office/Billing Quarterly Meeting
- 09/18 – RPMS/EHR Office Hours Web Call
- 09/25 – RPMS/EHR Office Hours Web Call

Projects in process

- **BMW**- Practice Management Application-A graphical user interface (GUI) to handle Patient Registration and Scheduling. Since the last meeting I have been in touch with IHS regarding this program. I started a new ticket with California Area Office which stated that we had a ticket from July 2013 that had not been responded to. I also said that numerous emails and calls from Dale and I had not been answered. Long story short, I am now working with Marcella from CAO to get this program up and running. IHS is making it a priority to get us operational with this program.
- **Immunization Package version 8.5 Patch 8** –We have completed the install of this patch and version. This version/patch was needed for EHR certification and/or Meaningful Use. The program is working as it should.
- **VistA Imaging**- Amy and I continue to audit the scans done by staff and give ongoing support to those people. We are planning on adding scanners to Dental and Adult and Family Children departments so that they can scan in administrative document such as patient registration forms insurance cards, photo ID's etc. We are also training additional staff at the medical clinics how to scan in order to provide a back up to the Medical Records clerks. I have gone down to Orleans a few times to assist Babbie with Orleans' scanning.

RPMS Budget:

For period ending September 30, 2014 we ended the fiscal year under budget at 87.32%.

Program	RPMS
Budget Code	3000-75
Program Year	2014
Appropriation	\$230,739.83
Expenses to Date	\$201,481.00
Balance	\$29,258.83
Percent used	87.32%

Respectfully Submitted,

Patricia C White, RPMS Site Manager

OPERATIONS SUMMARY FOR KARUK TRB HP Service Unit
FOR AUG 2014
Prepared for the October 9, 2014 Health Board Meeting
Yreka, CA

(Note: In parentheses following each statistic is the percent increase or decrease from the same time period in the previous year. '**' indicates no data is present for one of the two time periods.)

PATIENT REGISTRATION

There are 18,586 (+3.9) living patients registered at this SU. This number does not represent the 'Active User Population' which is found elsewhere in PCC Reports. There were 65 (-30.1) new patients, 1 (**) births, and 4 (+300.0) death(s) during this period. Data is based on the Patient Registration File.

THIRD PARTY ELIGIBILITY

There were 2,801 (+0.3) patients enrolled in Medicare Part A and 2,682 (+0.5) patients enrolled in Part B at the end of this time period.

There were 101 (+5.2) patients enrolled in Medicare Part D.

There were also 6,714 (+6.5) patients enrolled in Medicaid and 5,757 (+25.7) patients with an active private insurance policy as of that date.

CONTRACT HEALTH SERVICES

Total CHS expenditures (obligations adjusted by payments) for this period were 58,919.21 (+16.1). The number and dollar amount of authorizations by type were:

57 - DENTAL	4	1359.35
64 - NON-HOSPITAL SERVICE	1221	57559.86

DIRECT INPATIENT

[NO DIRECT INPATIENT DATA TO REPORT]

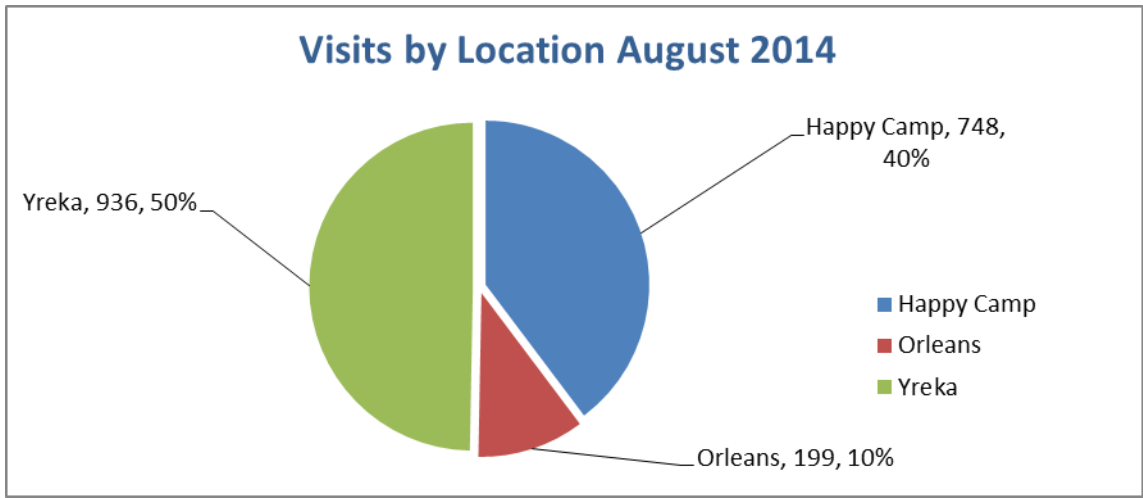
AMBULATORY CARE VISITS

There were a total of 1,883 ambulatory visits (-1.1) during the period for all visit types except CHS.

They are broken down below by Type, Location, Service Category, Clinic, Provider Discipline and leading Diagnoses. These do not equate to 'official' APC Visits which are identified in other PCC Reports.

By Type:		
TRIBE-638 PROGRAM	1,883	(-1.1)
By Location:		
YREKA	936	(-8.9)
KARUK COMMUNITY HEALTH CLINIC	748	(-5.0)
ORLEANS	199	(+123.6)

Visits by Location August 2014



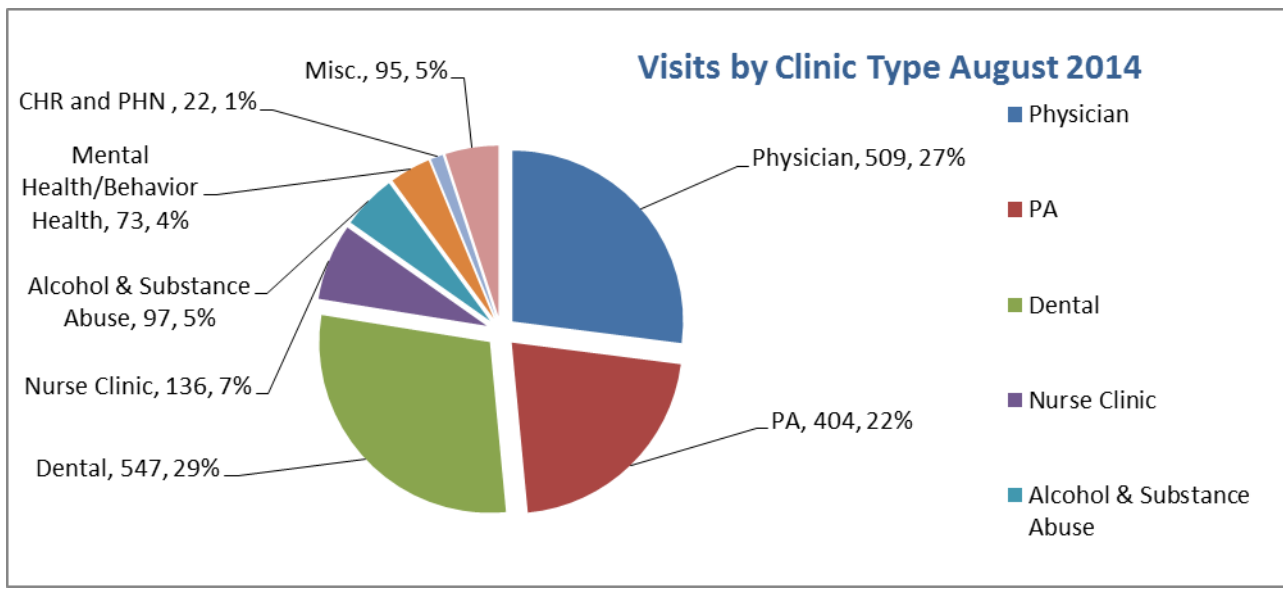
By Service Category:

AMBULATORY	1,822	(-1.6)
TELECOMMUNICATIONS	60	(+22.4)
TELEMEDICINE	1	(**)

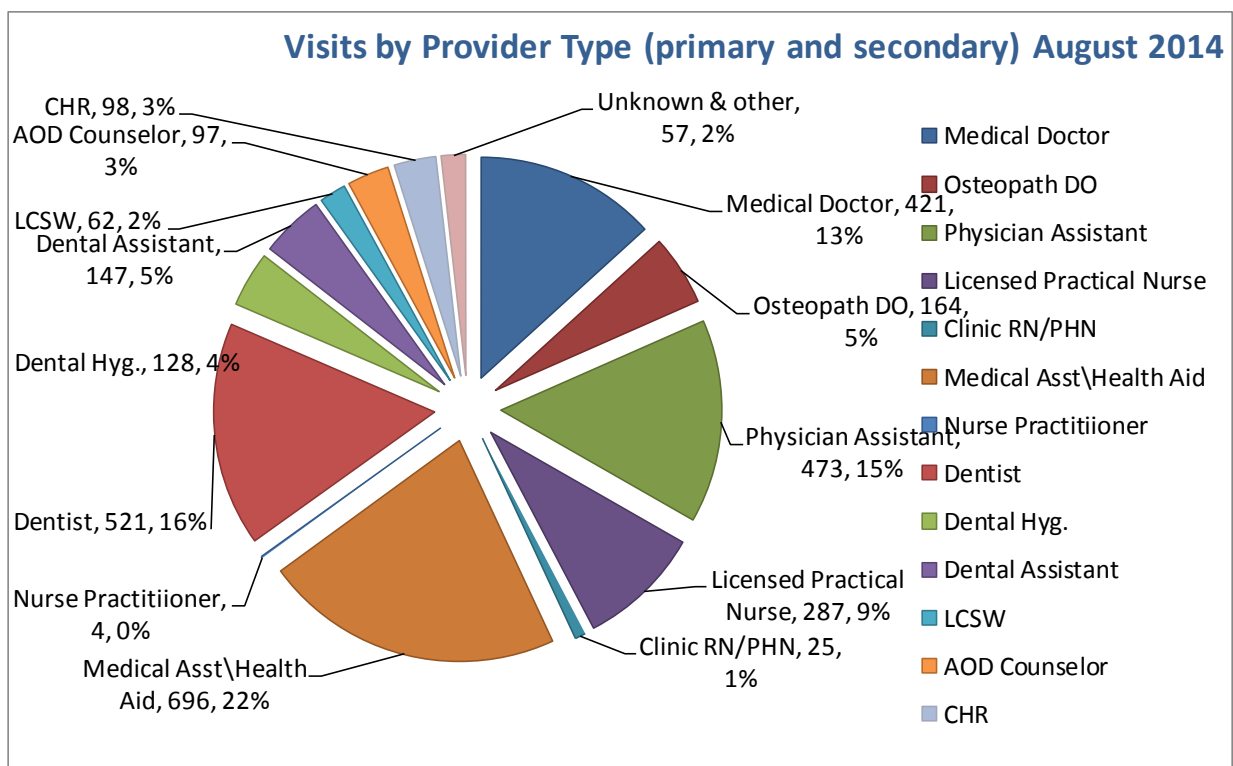
By Clinic Type:

DENTAL	547	(-10.5)
PHYSICIAN	509	(-6.4)
PHYSICIAN ASSISTANT	404	(+157.3)
NURSE CLINIC	136	(+20.4)
ALCOHOL AND SUBSTANCE	97	(-13.4)
TRANSPORT	77	(+2.7)
MENTAL HEALTH	73	(+92.1)
CHR	21	(-67.2)
TELEPHONE CALL	9	(-18.2)
TELEMEDICINE	5	(+150.0)
CHART REV/REC MOD	2	(+100.0)
PHARMACY	2	(-33.3)
PHN CLINIC VISIT	1	(-66.7)

Visits by Clinic Type August 2014



By Provider Type (Primary and Secondary Providers):		
HEALTH AIDE	634	(+23.3)
DENTIST	521	(-16.2)
PHYSICIAN ASSISTANT	473	(+84.0)
MD	421	(-26.1)
LICENSED PRACTICAL NURSE	287	(+62.1)
OSTEOPATHIC MEDICINE	164	(**)
DENTAL ASSISTANT	147	(**)
DENTAL HYGIENIST	128	(-11.7)
COMMUNITY HEALTH REP	98	(-27.9)
ALCOHOLISM/SUB ABUSE COUNSELOR	97	(-23.0)
LICENSED CLINICAL SOCIAL WORK	62	(+63.2)
MEDICAL ASSISTANT	62	(-74.5)
HEALTH RECORDS	57	(+5,600.0)
CLINIC RN	23	(+1,050.0)
NURSE PRACTITIONER	4	(-97.6)
PUBLIC HEALTH NURSE	2	(-60.0)



The ten leading purposes of ambulatory visits by individual ICD Code are listed below. Both primary and secondary diagnoses are included in the counts.

By ICD Diagnosis		
1). DENTAL EXAMINATION	511	(-15.4)
2). OTHER SPECIFD COUNSELING	110	(-26.2)
3). HYPERTENSION NOS	99	(+4.2)
4). LUMBAGO	77	(+24.2)
5). THERAPEUTIC DRUG MONITOR	67	(+59.5)
6). LONG-TERM USE ANTICOAGUL	62	(+37.8)
7). ROUTIN CHILD HEALTH EXAM	55	(+175.0)
8). OBESITY NOS	55	(-42.1)
9). DMII WO CMP NT ST UNCNR	52	(-13.3)
10). DEPRESSIVE DISORDER NEC	52	(+67.7)

CHART REVIEWS

There were 882 (-28.6) chart reviews performed during this time period.

INJURIES

There were 118 visits for injuries (+4.4) reported during this period. Of these, 26 were new injuries (+23.8). The five leading causes were:

1). NONVENOM ARTHROPOD BITE	4	(**)
2). FALL NEC	3	(**)
3). FALL NOS	3	(+200.0)
4). STAT OB W/O SUB FALL NEC	3	(**)
5). CAUGHT BETWEEN OBJECTS	2	(**)

EMERGENCY ROOM

[NO EMERGENCY ROOM VISITS TO REPORT]

DENTAL

There were 426 patients (-11.1) seen for Dental Care. They accounted for 547 visits (-10.5). The seven leading service categories were:

1). PATIENT REVISIT	368	(-22.5)
2). HYPERTENSION SCREENING	183	(-22.1)
3). INTRAORAL - PERIAPICAL FIRST RADIOG	132	(+2.3)
4). LOCAL ANESTHESIA IN CONJUNCTION WIT	122	(-33.3)
5). PREVENTIVE PLAN AND INSTRUCTION	112	(-18.2)
6). FIRST VISIT OF FISCAL YEAR	89	(-30.5)
7). TOPICAL APPLICATION OF FLUORIDE VAR	87	(-12.1)

IN-HOSPITAL VISITS

There were a total of 0 In-Hospital visits (**) during the period for all visit types, including CHS.

PHARMACY

There were 1,574 new prescriptions (+3.4) and 0 refills (**) during this period.

Tribal Statistics for August 2014

	Registered Indian Patients August 2014	Indian Patients Receiving Services August 2014	APC Visits by Indian Patients August 2014
Karuk	2085	425	534
Descendants residing in CA	1883	217	264
All other Tribes	2171	108	125
Total	6139	750	923

APRIL E. ATTEBURY
Interim Director, Child & Family Services
Report: Health Board Meeting October, 2014
Reporting Period: September 2014

ACTION ITEM: Possible Job Descriptions (meeting with HR Tuesday)

Project Title: **Alcohol & Other Drug (AOD) Service Program (2.0 Counselors)**

Deliverables:

Task One- Deliver AOD outpatient services including counseling for both individuals and groups.

- Support Services
- Referrals and Coordination for residential rehabilitation programs.

Progress: Yreka-Currently we have **09** clients attending our AOD groups which are the Red Road group and Relapse Prevention group.

Happy Camp-Reported by Robert Super there are **11** clients attending AOD groups

Orleans -Reported by Robert Super there are **5** clients attending AOD groups.

Task Two- Provide Batterer's Intervention Program

- Groups in all three communities

Progress: Yreka- We have **12** clients attending the men's Batterers Intervention Program. (2 graduated and 1 dropped out since last report period)

In the women's Batterer's Intervention Program there are **04** women attending group.

Happy Camp- Reported by Robert Super there is **1** client attending BIP group.

Orleans- Currently there are **0** clients enrolled in the BIP.

Task Three- Provide DUI Program

- Groups in all three communities

Progress: Yreka- The DUI program has **3** client attending group in Yreka.(4 completed the program since last report period)

Happy Camp- Currently there are **4** clients attending DUI program in Happy Camp.

FUNDING SOURCE	Code	Total Budget	Expensed to date	Balance	% Expended
Outpatient Services AOD-CALWorks	6400-15-	\$53,950.00	\$4,503.01		
Term Dates	Total Months	Month # for report period	# Months Remaining	% Completed.	Extension Option Y/N
7/1/2014 to 6/30/2015	12	3	10		
Progress Report Due Date	Completed?	Date Completed.	Fiscal Report Due Date	Completed?	Date Completed.
Comments: The amounts reflected are for 1- AOD counselor, vehicle/travel/mileage/gas					
FUNDING SOURCE	Code	Total Budget	Expensed to date	Balance	% Expended
REVENUES: DUI	6400-10-		\$18,363.25	\$-390.06	102.17
REVENUES BIP	6400-05	\$6,226.05	\$148.70	\$6,077.35	2.39%
Comments: The DUI revenues pays for the IDCR associated with CALWORKS FUNDING SOURCE					
The DUI program revenue was charged the Tribes full IDCR associated with the CALWORKS grant, \$4,880.00.					

Project Title: Mental Health Services Program (3 LCSW's =2.0FTE)

Deliverables:

Task One- Deliver Mental Health Services

- LCSW Services Provided: 58

Task Two- Deliver Psychiatry Services

- Psychiatry Services Provided: 09

SUMMARY UPDATE BY: Mental Health Division, Clinical Supervisor

Program	Code	Total Budget	Expensed to date	Balance	% Expended
Mental Health-/BIA COMPACT-Travel Mileage Supplies	2130-56		\$1,023.34 \$1,918.00 \$2,161.61		144.44%
Term Dates	Total Months	Month # for report period	# Months Remaining	% Completed.	Extension Option Y/N
10/01/2013- 9/30/2014	12	11	1		
Progress Report Due Date	Completed?	Date Completed.	Fiscal Report Due Date	Completed?	Date Completed.
Comments: Travel, supplies and mileage/vehicle expenses are allocated from BIA Compact for the Mental Health Program. HERSA Grant funds the Salary and Fringe LCSW's however currently the BIA Compact pays 35 % of 1.0 FTE LCSW's salary and fringe.					
•					

Executive Director of Health and Human Services

Board Report

October 9, 2014

Lessie Aubrey, EDHHS

Community Board Recruiting in Rural Oregon

This was a Webinar I sat in on hosted by HANC which was very interesting and loaded with good information.

Collaboration and Partnerships is an essential element of recruitment. This is probably where the Community comes from. Good recruitment leads to retention!

Instead of the competitive community working apart, they all come together and work as one. They will even share the applicant for interviews. It's not based on need but on fit.

Whoever does the hiring pays for the visit.

"They hire a year before the start date; in their final year of residency". The majority of physicians are getting offers a year in advance. They connect the applicant to the community. The applicant loves baseball, so they introduce him to Buster. He is interested in stocks; you invite someone from the community who is also interested in stocks, etc.

The wife: her satisfaction is the # 1 driver of retention. Does she have children? Invite the principal, she likes to garden; invite a Gardner; she needs a nanny find one for her.

Even plan a play day for the children to get them used to the community.

Involve the community so they can meet people of interest. They attend a Church; invite the pastor or someone from that church, or the principal from the school to tell them about it.

During their visit it's best to keep them busy around the community.

Always plan a community diner and hold it at a residency. Invite about 12 people from the community with the same interest as the applicants. This should be a Social gathering.

Coordinate with other FQHC's or clinics in your area, as the applicant may fit them better and that's ok. Their applicant may fit us better, and referrals back and forth help each other.

Tell them about our loan repayments programs.

Go around the community and purchase gifts \$75.00 -\$100.00. Also get gift certificates to make them feel welcome. Provide maps as well.

After the applicant left she spoke with everyone the applicant saw to find out their opinion on the applicant. These people can pick up on behaviors and may tell you they don't like them. She said one applicant looked wonderful until they spoke with the hotel staff where they stayed and found them to be rude.

The Community Engagement Coordinator, is what this person is called, does not talk about wage scales, or contracts. The clinics do that. It's all about the FIT.

Apparently they use a recruiter. About march they begin talking with their recruiter to make sure the information is correct. He should know the successes of the communities.

Executive Director of Health and Human Services

Board Report

October 9, 2014

Lessie Aubrey, EDHHS

You should also ask the physicians or the resident who in their class should we also talk to.

Of course this is a hospital but one provider wanted privileges not granted at their health center. They found a center that did and was able to get that provider privileges there. They kept the physician and he was happy to have the privileges at another facility in town.

The key is to stay consistent.

Happy Camp and Orleans presents a much more difficult problem, but what community exists should work together. Yreka has more resources.

I thought this was very good and I hope we can use some of their ideas to our benefit.

HRSA Expanded Access Grant

We received funds from HRSA for Expanded Care of \$190,032.00. This will place another PA in the Yreka clinic and a part time medical assistant. This PA will see walk-in patients and new patients coming to the facility. Marketing will be done to notify the public of our accessibility.

The real problem now is the need for more space. I hope to discuss this with Buster sometime before the meeting.

Marketing Consultant
Abigail Yeager

Thank you, Margo Kerrigan and HRSA for your guidance in marketing our services and thanks

to the Blue Shield grant for the money to hire a consultant.

Abigail Yeager has opened my eyes to many new facts and ideas that I see has been missing for a while. For example, we may not be able to attract new patients in the down river areas, but we can beef up our services and provide more billable services. Abigail has been hired to develop our Marketing Plan, but we need to find funds to hire her to do the work.

I have asked her to do a presentation for you soon and she has agreed. It will amaze you what marketing can do for us.

Resignation

Mike Lynch our Yreka Clinic manager has resigned effective December 1, 2014. I'm truly sorry to see Mike leave he has been most helpful.

Evaluations

I have completed all but 2 evaluations for the 2014 evaluation period, which runs from October –December.

Action Item

Attached is the Veteran Contract Modification for your review and approval.

Dental Vacancies

We are hoping to have interviews soon to fill the 2 vacancies in Yreka. We are looking for one clinic dentist and a dental director.

We have one dentist that wants to come for just a trial. Rondi and I will discuss this with James next week.

Ebola Preparedness

With the first US Ebola patient, we are now being asked by the CDC, to begin preparing for more outbreaks.

CDC has sent out a checklist that we will begin working on soon. With the checklist there are links to guidance material that will be very useful. We will need to train staff, and have set aside an hour for the training on Ebola at the biannual health staff meeting as a beginning.

We will have to check our supplies for personal protective equipment, like gowns, mask, and gloves. Do we have the right mask? What do we do with contaminated medical waste, how do we isolate people, and many, many other things to consider. It may be similar to incident command,

but these are just my first thoughts. I just thought I'd share them with you.

Flu Shots

Have you received your flu shot yet? I hear they are available at all three clinics and I want to encourage you to get one. Annie is offering them to staff and may be dropping by to see you.

Yes, I have already received mine.



KARUK TRIBAL HEALTH PROGRAM
BUSINESS OFFICE HEALTH BOARD REPORT
OCTOBER 9, 2014

At this time the billers are learning to bill Beacon/Chipa (managed medical f) for the Behavioral Health visits and practitioners. I did manage to get them to agree to allow us to back bill from January 1st 2014 until now. We attempted to do that but found that they have denied all the claims. I am hoping the reason is that our contract is not yet signed and returned to them and they will allow us to again make this possible. Otherwise it is a loss to our Behavioral Health Department. The new Behavioral Health providers are finding it difficult to get the billing codes entered into RPMS so we can bill all their visits. I plan on asking Amy to again work with them and see if she could help them. We are unable to assist them since the Behavioral Health package is an enigma to us and nothing we have ever worked in before. In the past claims crossed over to billing complete and ready to bill.

The Data Analyst for Yreka is out on Medical Leave and will not be returning for some time. The other two ladies (April Spence and Sharon Meager) are trying to keep up on all three sites, but it has definitely slowed things down. It is not a loss, just slower, they are running about 3 weeks behind. Which is not bad at all. We understand there are going to be some documentation methods changing in EHR and this will also be time consuming for the Data Analysts. Everything always has a learning curve.

With all the reading of information from the insurance companies' things become more confusing at times and actually takes some time to truly STUDY some of the guidelines, not just read them. I may have to do some restructuring of tasks and job descriptions within the department to make thing run more smoothly. There is no longer even time for breaks any more and that is not a good thing.

We work a great deal with the receptionists from all sites and offices and at this time we seem to have a good group of ladies. They are willing and engaged in their positions and this definitely makes our lives less difficult and we appreciate them greatly.

Eileen will attempt to take the AAPC certified coder examination Saturday October 4th. These exams are NEVER simple. Her disadvantage is that with all her other departmental tasks she has not really had time to practice the art of coding on actual visits. It is very important that as many people in our department become certified coders as possible. In today's challenging medical world there are more and more offices, tribal and non-tribal, that demand their billers and accounts receivable staff are certified coders as well as the data analysts. It means cleaner, more accurate claims going out the door. What makes this exam difficult for us is that it includes many questions on outpatient services that we do not perform, i.e.: casting, heart catheterization services and cardiology, radiology, pathology, pulmonology, and same day services. I am certain glad I do not have to take it again. I have been certified since 2000.

Attached is the financial report.

Respectfully Submitted
Suzanna Hardenburger, CCS-P

	MONTHLY REVENUE REPORT			BUSINESS OFFICE	
	SEPTEMBER 2014	Happy Camp	Yreka	Orleans	KTHP
	Revenue Medical	\$70,584.53	\$62,863.78	\$12,072.24	\$145,520.55
	PHC Capitation	\$7,282.22	\$10,449.28	\$2,270.87	\$20,002.37
	HPSA Quarterly Incentive	\$0.00	\$0.00	\$0.00	\$0.00
	Revenue Dental	\$11,684.92	\$11,611.86	\$0.00	\$23,296.78
	Revenue Mental Health	\$17,145.34	\$22,651.51	\$2,906.26	\$42,703.11
	REVENUE TELEMED		\$698.23		\$698.23
	Revenue Total	\$106,697.01	\$108,274.66	\$17,249.37	\$232,221.04
		Happy Camp	Yreka	Orleans	KTHP
	Billing SEPTEMBER Medical	\$92,640.61	\$ 113,046.32	\$81,302.37	\$286,989.30
	Billing SEPTEMBER Dental	\$52,598.40	\$ 74,269.00		\$126,867.40
	Billing SEPTEMBER Mental Health	\$11,033.62	\$ 9,689.54	\$1,375.81	\$22,098.97
	Billed Grand Total	\$156,272.63	\$ 197,004.86	\$82,678.18	\$435,955.67
	BILLING DEPARTMENT BUDGET 2014				
					AVAILABLE %
PROGRAM	YEAR END ANNUAL	EXPENSES TO			Could be spent
YEAR	BUDGET	DATE	BALANCE	% USED	at this date
FY 2014	\$491,898.13	\$464,264.74	\$27,633.39	94.38%	100.00%