



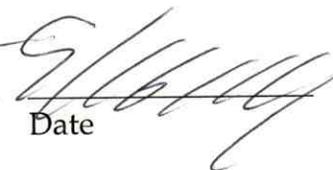
SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE
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The following policies and procedures have been presented to me for approval and my signature ensures that they are deemed appropriate:

- Medicare PPD Billing Policy and Procedure
- Medication Reconciliation Policy for Therapy Only Patients (revised)
- Peer Review Audit Policy and Procedure (revised)
- Utilization Review Pain Management Audit Tool
- Code of Ethics for Nurses
- Walk in Blood Pressure Checks Policy and Procedure with Appendix A & B
- Annual Employee Health Assessment (revised)
- Patient Transfer Procedures for Emergency Situations (revised)

Approved by Medical Director:


Desmond R. DelGiacco, MD


Date

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Our mission: To assess, improve and monitor the health status of our community.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: MEDICARE PPS BILLING POLICY AND PROCEDURE

I. **POLICY:**

Saratoga County acting through its dba: Public Health Nursing Service will bill Medicare within one calendar year for services that meet Medicare requirements (Medicare eligible services), rendered to patient's in the Certified Home Health Agency (CHHA) and the Long Term Home Health Care Program (LTHHCP) who are Medicare recipients.

II. **PURPOSE:**

Saratoga County acting through its DBA Public Health Nursing Service will receive payment according to Medicare Regulations and Guidelines for Medicare services rendered to Medicare eligible patients in the CHHA and LTHHCP.

III. **PROCEDURE:**

➤ **COMPLETION OF THE INITIAL RAP**

A. **Oasis Export Report**

The Senior Account Clerk obtains the Oasis Export Report from the CHHA/LTHHCP Information Processing Specialist. The CHHA/LTHHCP Information Processing Specialist runs this report at the end of every work day. The report shows the patient name, record number, date oasis was completed, clinician that completed the oasis, and type of OASIS for all.

B. **Print Episodes without RAP Report**

1. The Senior Account Clerk then logs in to Progres HCMS, clicks on the **Report tab**, then clicks on **Report button**, then arrow down under **Report Types** and click on **PPS Management**, then go to section labeled **Report Titles** and click on **Episodes without RAP**, click **select**, go to **parameters section** and click in empty box next to **Episode from Date**, this highlights the **Episode from Date**, type in the **from date 01/01/90**, and the **to date** which would be the date you are running the report.

That is the only criteria you select, click on the spy glass icon, the report will appear on the screen. This Report shows patients with initial episodes that need a RAP, and patients with recertification episodes that need a RE RAP.

C. **Review Episodes without RAP REPORT**

1. **Medicare Not Primary**

The Senior Account Clerk reviews the **Episodes without RAP** report and compares it to the **Oasis export** report to see that all patients without HHRG codes pulled over to the report and the calculator. The report is also reviewed to see if any patients pulled over that have Medicare **but Medicare is not the primary** billing source.

The primary billing source can be verified by going to the patient's admit screen in HCMS. First exit out of the report tab, click on the Task tab, then click on the Patient Information Button, type in the first 3 letters of patient's last name or the patient record number, then go to the bottom of the screen and click the Find button. This will bring up the patients demographic information. Move sideways from the Patient tab to the Admit tab. This screen will show the primary payer.

The patients that are identified as **not Medicare primary** must be deleted. To delete these patients you must go to the HHRG finder. Look at the main tool bar on the screen and click on the Invoice Processing button. This opens a drop down box, click on HHRG finder. The RAP Claim Calculator box will open up. Type in patients last name and hit enter. A **not Medicare primary** patient (this would include a PRI patient that has Medicare but it is not primary) will show no expected reimbursement, hit the delete key on your keyboard. Repeat this process for each patient that wasn't **primary Medicare**. In addition, a

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patient that a recertification shell was created for but we didn't recertify them because they were discharged would also show no expected reimbursement on the **Episodes without RAP** report (usually empty shells are deleted when the discharge slip is processed by the information processing specialist). These patients would be deleted as well.

2. No Visit and NO HHRG on Episodes without RAP report

If there is no visit and no HRRG listed for the patient on the Episodes without RAP report, the note has probably not been processed yet. Notify a supervisor if a week has gone by since SOC. If it hasn't been a week, check the frequency on the 485. To check the frequency on the 485 in HCMS, go to tasks, certification, enter patient's medical record number or last name, patient names will pop up in a box, click on correct patient name to highlight, then click select button. A box with all the certification periods for the patient will pop up, select the correct certification period, click the "preview/print 485" button. The 485 will appear so you can view the frequency of visits for each discipline in box 21. If the frequency is in compliance with the 485 just wait until the visit is made and processed. If it is a recertification episode, look for the recert OASIS visit prior to the episode. If the recertification OASIS visit is processed then the HHRG should populate. Exit out of HHRG finder screen and check the clinical documentation system (clindoc) for the note. Log in to Clindoc. The main screen will open, click on the patient details icon, type in the patient's last name, click the select button, click on the activities tab, this brings up the notes, arrow through the notes, by note date. If the visit was done and the HHRG didn't populate, look to see the status of the note. If the note is not processed the HHRG cannot be imported. You must wait until the note is processed. If the note was processed and the date that the note was processed is before the date of the OASIS export report, go to tools and then click on the HHRG viewer, then click on the HHRG tab, then click on the calculate button this calculates the HHRG. Press screen print and print it. Now go back to HCMS to the HHRG finder; click on tasks, then click on invoice processing button, then click on HHRG finder, type the first 3 letters of last name, press enter, type in initial of 1st name, press enter, highlight patient, then click select, patient will populate the screen. This will bring up RAP claim calculator screen, click on HIPPS code drop down box arrow, select code from the menu that is also on your screen print. Print it. The HHRG will automatically populate when you click in the HHRG column. Then enter the original OASIS SOC date (date they were admitted and haven't been discharged since, then enter assessment date which is your visit date, then click on oasis reason drop down box arrow, select reason and click line underneath it to save the line, click on the oasis claim key box and click delete, then enter the OASIS claim key number from your screen print, then click save.

3. HHRG present but No visit date on Episodes without RAP report

If HHRG is present but no visit date is listed for the patient on the Episodes without RAP Report it means that a billable visit has not been done since the start of the episode. If date that note was processed is after the date of the Oasis export report, then wait for the next OASIS report from the CHHA Information Processing Specialist.

4. Both the HHRG and the visit date are present on the Episodes without RAP report

Run the "Episode without RAP Report". Go to Reports in HCMS, click on report tab, then click on report button, click on PPS Management under report types, and then click on Episodes without RAP under report titles, then click the select tab. This will bring up the report criteria that you can select. Click in the small empty box next to Episode to Date. Type in 01/01/1990 for the from date and type in the present Date for the to date. Click on the spyglass icon and the report will appear on the screen. Review the report for Patients with HHRG and 1st billable visit. **Check for signed and dated face to face.** Return to the main screen in HCMS, click on patient information button, type in patient's last name, click the find button, then click on and highlight patient's name from the list of names, click the select button, then click on the small **admit tab**, then click on the **documents tab**, the patient's SOC and any previous SOC will appear, click on and highlight the **SOC that you need**, then click on **referral packet** in the box above and **highlight the entire line**, then click on the **view button** mid screen. This opens the referral document.

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Locate the **face to face statement** on the scanned referral form, check the **date** to be sure it is for the **correct SOC**. If patient was referred from a nursing home or community physician, SCPHN uses our own face to face form. **Check the patient's location**. Verify if patient resides in their home or an adult home. While you are on the admit tab, click on the location button on the bottom of the screen. The information should be there. If not, click on the add button and type in the "from date" (SOC), choose location home or assisted living. Then click the save button. If you believe that a patient lives in an Adult Home, refer to the List of Adult Care Facilities so that you can verify the address needed.

D. Calculate RAP (Initial or Recert), Assign Invoice, and Build EMC file**1. Calculate RAP**

Log into HCMS, from the main tool bar on the screen, click on the Invoice Processing button. Select HHRG finder. Type in Patient ID and press enter to open appropriate Episode to be calculated from the "Episode without RAP Report" Select Invoice and press Calculate RAP button. Once the Expected Reimbursement amount appears in the appropriate column go to next step Assign Invoice.

2. Assign Invoice

From the Tool bar select Invoice Processing, Assign Invoice. Select Individual Patients, select Program CHHA and Payer PPS from the dropdowns. Enter the From and To Dates of the Episode from the Episodes without RAP report (the "to" date is the same) and enter the Patient ID. Add to List by pressing the Add button on the screen. "Invoice process complete" will appear on the screen. Press OK and an invoice number will be assigned. Press the red VIEW button to find the Invoice Number that was assigned to the claim. The view options will appear. Record the number without the letter F on the **Episode without RAP report**. Then click on the Bill button. This shows you the billed amount. Look at the billed amount to make sure there is a calculation. Press Accept and then Yes to accept assigned invoices.

3. Build EMC file

The EMC file is built in order to bill the claim electronically. From the Tool bar select Interface, click on Billing tab, then click on Export EMC. Click on the selected Invoice Number, press enter and it adds the invoice # to the screen. Repeat until you have invoiced all RAPs and then click on export button. Next you need to name the file. To save the file, first make sure you are at network tsclient\tsclient\billing_export. Give it a name Example: NGS_Medicare_date.txt and press the SAVE key. A graph will appear and the file will build. Once file is completed and saved you need to view and print report. Click on the printer icon, click on properties, click on portrait, choose **Flip on long Edge or None**. Press Ok, then press Ok again the report prints. Close Report Builder. Click Save and change tsclient\tsclient\ to tsclient\tsclient\pdf file and click save again. Make sure you are saving in the pdf file folder. The heading should read Network tsclient\tsclient\pdf file. Name the file the same as the just built file name but use .pdf at the end. Click save.

E. Electronic Submission of claim and Receipt of Revenue**1. Payer Link is used to send the file to NGS Medicare.**

Get on the internet and then log on to payerlink.com. Billing staff is to use their designated email address and password to log on to payer link. If billing staff forgets their password they should request that the Director of Public Health (DPH)/Director of Patient Services (DPS), or the Fiscal Manager to retrieve their password for them. The passwords are kept on a master list in the billing reference notebook which is kept in a locked safe on the Public Health building premises. Select File Transfer. Select Upload 837 Files. Click on the drop down box arrow and scroll to Submitter ID HM52930 with Claim Type Institutional, click on to select. Click Browse and go to Computer OS(c). Find your export billing folder. Double click to open and scroll to the file you just named and created. Highlight it and it will appear in File Name Box. Click OPEN. Click Upload File. After it uploads go to the gauge, click on the gauge button between the T and I buttons. Now you will see the Claim File Reconciliation

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screen. This file gets picked up by the payer link system. The payer link system checks every half hour. Log out of Payer Link. Log back in to payer link at a later time and go to Claim File Reconciliation to see if the file was accepted.

2. Checking for Revenue

Each day you should log on to payer link to see what we have been paid or to correct denials. Download an EOB. From the File Transfer button look for the line with the number that begins with a 5. Refer to the written log of downloads as a reference. Check the date to see that it has not been downloaded previously. If it has not been down loaded then select it and click on save. Then click on SAVE AS to save it to the Report Folder on the C drive. Record the EOB number on the written log of downloads so you can transpose the EOB number onto the printed EOB. Log off of Payer link. To Print the EOB go to the PC Print icon. Double click to open. Click yes to open from an unknown user. Select X12 from the Tool Bar. Look in the Reports folder where you just saved the file on your C drive and highlight the file. Click on open to open the the file. Click on the PS, and click Print. Click on BS, and click Print. Click on AC, then you will need to click on file, go to print set up and change to landscape. Click OK, then click print. Once the report prints you will need to write the file name on it. Repeat if more than 1 file was downloaded. Close out of PC Print when finished.

3. Notify Treasurer's office

Log on to computer, Go to PH2003sys, then go to Users, then click on Billing Shared Folder, then to Cash Memos and Reconciliation Folder (current year), then click on the Year of EFT , then select the month of the EFT, then click on the ACH Summary. Use the current deposit # and date from the card that is updated each Thursday. Write it on the EOB from the Insurance Company. On the current Month ACH Summary spreadsheet, record the Remit Date/EOB date, Deposit #, Deposit Date, Reduction Amount if any, Payee, ACH Total and record the amount of the EOB in the correct Account listed on the spreadsheet. See Budget to Actual Report in AS400 if needed. Attach this sheet to an Email with a cover letter to the Senior Revenue Account Clerk, Deputy Treasurer, and Tax Collection Specialist in the Treasurer's Office. Once this has been done you need to check the Insurance folder /binder containing the copy of the sent UB04 or EMC file. Mark them paid. Discard EMC report and episode reports when all items on the EMC report are paid.

4. Post Cash to Open Accounts Receivable

Now you can add this EOB to the Deposit tape. To get to the Cash screen go to Task on the tool bar and Cash to open the Application. Add or update a previous Deposit. Enter deposit number and click find, or if a new deposit click add. Enter a dollar amount of the new deposit. Click on company drop down box, select corporation. Enter deposit date and save. Make sure you balance with your Deposit tape. To enter Cash go to Cash on the Tool Bar to open the Application. Click add in the check information section of the screen. Enter Check #, posting date, Check date and amount being entered. And Save. Go back to Deposits on the Tool Bar and type in Deposit #. Click Find. Deposit will appear. Click "show available checks" and click on "include" button to include the check/EOB information just entered. Go back to Cash Application , Enter patient ID, click Find, and click Add. If this is Medicare PPS, Medicaid, or Pay span transaction continue to enter the complete EOB. Go to Cash Application Screen and type in patient ID, uncheck the (Hide zero balance invoices) box, click Find. Any unpaid A/R will show on the screen. Select the appropriate invoice that is being paid. Click Add and choose the appropriate A/R code from the dropdown box, (AR code 1 is for cash receipts/accrual Medicare payments; AR code 8 is for Medicare recoupments; AR code 22 is for PPS penny adjustment, and also for reductions on final payments). Enter in comment box "payer initiated reduction". Enter payment amount, press enter so the covered amount will populate in the payment box below the payment box. Click Save then click Yes. Click on the Service key and follow the prompts to record the amount paid. If the amount remaining is zero the check has been posted. If a balance is shown then press the adjustment key to allowance or transfer the balance to other insurance or self-pay.

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If allowed off go to the adjustment button on the cash application screen click add and enter appropriated A/R code from dropdown box and enter payment of zero and enter payment amount of what is being allowed off. Press Save. **If billing the balance to the patient (self pay)**, go to the patient information screen, then click on payor tab. Once on the payer screen click add new (green cross), Select self-pay, enter a from date (1st billable visit) click on drop down arrow and select a plan code from the menu. Click on the disc icon to save. Click yes to confirm. Click on the "Bill to" tab, type in address of patient or responsible party. (Refer to contact screen as needed), Click save. Go to admit screen under secondary payer, open the drop down box menu, choose self pay and click save. Click yes to confirm. Go to tasks, click on invoice processing, click on transfer reverse. Type in invoice number (can be found in the cash screen) for the patient that you are doing the transfer on. Click enter, the invoice will populate on the screen. Click on the drop down box menu, select a new payer (self-pay). Enter the adjusted charge which may be the full amount or a lesser percentage of the amount depending on the patient responsibility. Do this for each line if more than one line. Click OK, click transfer and scroll to the right to view the new invoice number. Click accept and then print the invoice by going to invoice processing. Click on the invoice processing tab, click on drop down box arrow and select print invoice, click on the invoice number button, click on the drop down box for "form type" and select plain paper. Type in the new invoice number that was just assigned, click on "add to list" button and it will populate below. Click print, the invoice will appear. Click on the printer icon. Check printer properties to be sure "portrait" and "print on one side only" are selected, click the number of copies that you want (2), Click OK, then click OK again.

If billed to a secondary insurance, go to patient information screen, enter patient ID number, click find, go to admit screen and see what the secondary payor is. If not filled in add the secondary payor to the payor screen. Transfer the services to the new payor, get the new invoice number. Print the UB04, submit to appropriate carrier (see guidance document in billing office as needed). Mail one copy with EOB to patient or responsible party, stamp patient copy "payable to SCPHN", stamp SCHN copy with "mail stamp, file our copy, mail patient copy in window envelope, update collection screen as "First Bill" and with any additional comments.

F. Medicare PPS Chart Review

1. Run Episodes without Claim Report. Go to the Task bar for Reports, PPS Management, Episodes Without Claims report. Select dates 1/1/90 to the time period you would like to review.
2. Run Services by Patient by Service Date Report for the Episode you would like to review. Go to report on the Task Bar select Financial, Services by Patient by Service Date. Enter the dates of the Episodes from the Episodes without claim report. Enter the From and to Press Select. Enter the Patient Name (3 letters of the last name and press Enter) scroll down and highlight the name of the patient. Click on the to line to capture. View and Print. Mark the Weeks on the Services by Patient report.
3. Pull the charts that go with the services report. Sign it out if necessary.
4. Run the Processed and Unprocessed note report. Go to Reports Clinical Documentation, Processed Note listing. Enter visit date from and to Enter Patient Name, highlight and click on the line. View. Count visits by Discipline. Make a note on the Services by Patient Report. View unprocessed note report. From Clinical Documentation Choose Unprocessed Patient Note listing. Select and enter dates and patient name. View and note any unprocessed notes for this patient or print the report.
5. Look for the signed 485. If a recertification, check box 23 for signature and date. For initial 485 or recertification 485 look for MD signature. Date in Box 25 when 485 was returned. Make note of frequency and disciplines on the services Report, then .Look at Frequency and Duration on 485 and indicate it on the Services Report. Look for supplies. If any of this information is missing, make a note and report it to Nursing Supervisor and Nurse/Therapist by completing form for missing information (see attached sheet).

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6. If SOC is after 4/1/11 need to look for signed "Face to Face" Sheet.
7. Look for signed welcome letter on SOC to make sure date is the same as first visit. Place a check mark next to visit on services report which means we have a patient signature on Welcome Letter.
8. If multiple disciplines saw the patient you will need to compare signature page to visits on services report. If signature page is missing compare to process and unprocessed report. Make a check mark next to each visit.
9. Make sure visits are LK and the correct Employee did the visit.
10. Look for signed D/C Summary/order if Patient is D/C.
11. If any of the above is missing **Do Not Continue** until all the information is present.

➤ **FINAL CLAIMS****A. Calculate Final Claim**

Log into HCMS and Calculate Final Claim by going to Tasks, Click on Invoice Processing, then click on HRG Finder. Type in Patient ID # and press enter. The screen will populate. Select the correct Episode in the lower part of the screen. If supplies were not taken in, you need to change the HIPPS code. To do that, click on Oasis HHRG, then click on HIPPS column, un-highlight and back off the last letter of the code. If the last letter is an S then change it to 1 and click on line below code to save. If the last letter is a T then change it to a 2, if the last letter is a U then change it to a 3, if the last letter is a V then change it to a 4, if the last letter is a W then change it to a 5, and if the last letter is an X then change it to a 6. Click on Invoice at the bottom of the screen. Click on calculate claim. The attached message will appear. **"Supply services are not found for the selected episode. Do you want to reset the HIPPS code to indicate no supplies used?"** Click Yes. The Final Reimbursement amount will now appear as well as Final Claim type. (LUPA, PEP, Outlier, Normal)

B. Assign the Invoice

Assign Invoice by going to Invoice Processing, highlight assign invoice, and press enter. Enter the date of the Episode from the Services Report, click add to list. Choose Individual type patient ID, press enter. Choose program, CHHA, choose payer (PPS), click add to list, patient ID and name will appear below. Press OK. "Invoice process complete" will appear. Press OK Click on Red View button. Make note of Invoice # without the F next to it and write it on "Episode without claim report", next to the patient name. Click on bill to see dollar amount. Amount will be in parenthesis. Click Accept. It will ask if you are sure you want to accept assigned invoices. Press yes.

C. Build the EMC File

Once all invoices are assigned you can now build the EMC File. Click on Interfaces, from the Tool Bar. Go to "Billing" arrow down to Export EMC from the dropdown menus. Click on Invoice #, enter Invoice #, click add to list. Click Export. Make sure you are saving to the billing export folder on your c drive thru the TS client folder. Give the file a name so you can find it when you log in the payer link to release it for processing. (example: NGS_Medicare_00-00-0000). Press Save. File builds, print report, save as a pdf file in your pdf folder.

D. Electronic Submission of the Claim

1. File is sent through Payer Link to NGS Medicare (follow same process as for initial)
2. Checking for Revenue (follow same process as for initial)
3. Notify Treasurer's Office (follow same process as for initial)
4. Post Cash to Open Accounts Receivable (follow same process as for initial)
5. Overpayment - If over payment is identified, repayment should occur within 60 days that the overpayment is identified.

SUBJECT: MEDICATION RECONCILIATION POLICY FOR THERAPY ONLY PATIENTS

I. PURPOSE:

One of the Conditions of Participation requires that the comprehensive assessment done on an a Start of Care (SOC) and Resumption of Care (ROC) includes a review of all medications the patient is currently taking. The reason for review is to identify any potential adverse effects and drug reactions. This includes ineffective drug therapy, side effects, drug interaction, duplicated drug therapy, omissions, dosage errors, and noncompliance with drug therapy.

II. PROCEDURE:

A. CHHA/Therapy Supervisor Role

1. CHHA Nursing/Therapy Supervisor receives a referral and reviews the list of medications and patient comorbidities. The supervisor may make an immediate determination that a skilled nursing visit medication reconciliation is required or a nursing SOC.

B. Therapist's Role

1. The therapist will obtain the SOC/ROC referral information including the high risk medication teaching sheets prior to the initial home assessment visit. The high risk medication teaching sheets **MUST** be kept in the welcome folder in the patient's home for the patient and/or family/caregiver to refer to during medication discussion/teaching with the RN.
2. Prior to going to the patient's home, the therapist will enter only the medications on the discharge orders of the referral into the patient's Medication Profile, to include dosage, frequency, route and duration. This information **MUST** be synchronized within 24 hours by the therapist.
3. The therapist will call the patient's home and ask that all of the prescribed medications, and any over the counter medications including supplements, vitamins and herbals that the patient is currently taking, be placed on a table for the therapist to review during the home visit.
4. In the patient's home, the therapist will write on the "Therapy SOC/ROC List of Medications in the Home" form Attachment A, all of the prescribed medications, and any over the counter medications including supplements, vitamins, and herbals that the patient and or family/caregiver states that the patient is currently taking.
5. The evaluating therapist will call the therapy supervisor at the conclusion of the initial evaluation visit to discuss the comparison of the "Therapy SOC/ROC List of Medications in the Home" form to the discharge medication list.
6. The evaluating therapist will fax or deliver the "Therapy SOC/ROC List of Medications in the Home" form to the SCPHN office by 5 pm that day.
7. The therapy supervisor will write the name of the appropriate CHHA nursing supervisor, and the date, on the "Therapy SOC/ROC List of Medications in the Home" form. The therapy supervisor will then give the form to the appropriate CHHA nursing supervisor.
8. The CHHA nursing supervisor will decide whether a phone medication reconciliation or an in home medication reconciliation will be completed. The nursing supervisor will indicate her decision on the form and assign a nurse to complete the medication reconciliation.
9. The CHHA nursing supervisor will obtain the 1w1 skilled nursing order and insurance authorizations as applicable.
10. The CHHA nursing supervisor will give the "Therapy SOC/ROC List of Medications in the Home" form and a copy of the referral with discharge medications to the assigned nurse, to complete the medication reconciliation.

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C. Medication Reconciliation performed:**1. Phone Medication Reconciliation:**

- a. The RN will compare the "Therapy SOC/ROC List of Medications in the Home" form to the medications listed in the patient's medication profile in order to identify discrepancies.
- b. The RN will call the patient and/or family/caregiver to discuss the prescribed medications, and any over the counter medications including supplements, vitamins, and herbals, and question the patient and or family/caregiver regarding any clinically significant medication issues, and effectiveness of the patient's medications.
- c. The RN will contact the physician via telephone, to discuss medication discrepancies, and any clinically significant medication issues. RN will request a response if physician is not available.
- d. The RN will document the coordination with the physician and the *specific medications* that were reconciled.
- e. The RN will contact the patient and/or family/caregiver to review the medication changes and the entire med regime utilizing the high risk medication teaching sheets as applicable. The RN will also teach the patient and/or family/caregiver regarding proper administration, desired effects, potential side effects, risks and possible interactions.
- f. The RN will contact the therapist with any medication changes and the date of MD medication reconciliation. That date will be entered as the M0090 Date Assessment Completed on the OASIS. If the date of reconciliation is greater than 5 days from the initial assessment then enter the date of the 5th day. The therapist will document the report of reconciliation findings from the RN.
- g. The RN will create a 912 note and the following items **MUST** be included in the note.
 - ✓ RN completed the medication reconciliation and medication education by telephone.
 - ✓ Synopsis of the phone conversation to include teach back.
 - ✓ Statement regarding whether any nursing visits are needed, and if needed, the reason(s).
 - ✓ Statement that coordination with the physician was completed and the specific medication(s) that were reconciled.
 - ✓ Statement that the patient was encouraged to be compliant with all future medical direction and follow up appointments with physician. Document patient's response.
 - ✓ Statement about what services are being provided in the home.
 - ✓ Enter medication changes in the patient's Medication Profile, as applicable.
- h. If the nurse feels that a nursing visit is needed, the nurse will telephone the physician to obtain an order.

2. Nursing Visit Medication Reconciliation:

- a. The RN will compare the "Therapy SOC/ROC List of Medications in the Home" form to the medications listed in the patient's medication profile, to identify discrepancies.
- b. The RN will call the patient and/or family/caregiver to schedule a home visit.
- c. During the home visit the RN will discuss prescribed medications, and any over the counter medications including supplements, vitamins and any herbals and question the patient regarding any clinically significant medication issues, and effectiveness of the medications.
- d. The RN will make every effort to contact the physician from the patient's home to discuss medication discrepancies and any clinically significant issues. The nurse will request a response if physician is not available.

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- e. The RN will document the coordination with the physician, and the *specific medications* that were reconciled.
- f. The RN will review the medication changes and entire medication regime with the patient and/or family/caregiver utilizing the high risk medication sheets. The RN will also teach the patient and/or family/caregiver regarding proper administration, desired effects, potential side effects, risks and possible interactions.
- g. The RN will contact the therapist with any medication changes and the date of the MD medication reconciliation. That date will be entered as the M0090 Date Assessment Completed on the OASIS. If that date is greater than 5 days from the initial assessment then enter the date of the 5th day as your date assessment completed. The therapist will document the report of the reconciliation findings from the RN.
- h. The RN will provide the answers to OASIS Medication questions M2000, M2002, M2010, M2020, M2030, and M2040. See Attachment B. The answers will be provided to the therapist by Clindoc, email or phone.
- i. The RN will create a 012 (LK) or 019 (NLK) visit note and the following items **MUST** be included in the note:
 - ✓ RN made one skilled nursing visit to complete medication reconciliation and medication education.
 - ✓ Synopsis of visit findings including teach back.
 - ✓ Statement regarding whether any further nursing visits are needed, and if needed the reason(s).
 - ✓ Statement that coordination with the physician was completed and the specific medications that were reconciled.
 - ✓ Statement that the patient was encouraged to be compliant with all future medical direction and follow up appointments with physician. Document the patient's response.
 - ✓ Statement about what services will continue in the home.
 - ✓ Enter medication changes in to the Medication Profile, as applicable.
 - ✓ Discontinue the 1wk 1 order.
 - ✓ Discontinue the evaluation and treat order.
 - ✓ A one-time Medication Management physician order and that contains all the above components by copying and pasting them from the note into the order.
- j. If the nurse feels further visits are needed the nurse will telephone the physician.

MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- 0 - Not assessed/reviewed [Go to M2010]
- 1 - No problems found during review [Go to M2010]
- 2 - Problems found during review
- NA - Patient is not taking any medications [Go to M2040]

(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- 0 - No
- 1 - Yes

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

- 0 - No
- 1 - Yes
- NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
 - (a) individual dosages are prepared in advance by another person; OR
 - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3 - Unable to take medication unless administered by another person.
- NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

- 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take injectable medication(s) at the correct times if:
 - (a) individual syringes are prepared in advance by another person; OR
 - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- 3 - Unable to take injectable medication unless administered by another person.
- NA - No injectable medications prescribed.

(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral Medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PEER REVIEW AUDIT POLICY AND PROCEDURE

I. PURPOSE:

Saratoga County Public Health Nursing will monitor patient care and documentation of patients in the Certified Home Health Agency (CHHA) and Long Term Home Health Care Program (LTHHCP) to ensure compliance with Federal, and State regulations, and agency policies, procedures and standards.

II. POLICY:

Peer Review Committee will be held monthly to audit active and discharged CHHA and LT patient records. Peer Review Committee will consist of Team A and Team B. Each team will have 4-5 members from the CHHA and LTHHCP. Each team will meet every other month on different months. The Peer Review Committee Meetings, patient record reviews, and processing of completed record review tools will be overseen by the Supervisor for Quality Assurance and Compliance. The Supervisor of Quality Assurance (QA) and Compliance will report on Peer Review Committee to the Medical Director, the Director of Public Health and the Director of Patient Services.

III. PROCEDURE:

1. All CHHA and LTHHCP nurses are assigned to Team A or Team B and are notified of their assignment.
2. Each team consists of 2 north team CHHA nurses and 2 South team CHHA nurses and one team will include the LT nurse. This will allow adequate staffing for each CHHA team on the afternoon of Peer Review meetings.
3. Peer Review Meetings are scheduled on the conference room meeting schedule for the year by the Supervisor of QA and Compliance.
4. Each team of nurses is given a list of meeting dates and times for the current calendar year.
5. The Supervisor of QA and Compliance will Run an active admissions report and a discharged admissions report and select 1 record per nurse to be reviewed.
6. The CHHA Medical Secretary will pull the selected charts and complete the header section of each audit tool.
7. The Supervisor of QA and Compliance will assign the charts to each nurse so that no nurse reviews her own charts.
8. The Supervisor of QA and Compliance will review the audit tools for completion, signature and date of reviewer, and tally the results on a percentage grid, following each meeting.
9. The Supervisor of QA and Compliance will give the completed audit tools to the respective case manager with a memo containing directions to review the completed audit tool, make corrections as applicable, sign, date, and return the audit tool to their nursing supervisor within the specified time frame.
10. The CHHA/LTHHCP Nursing Supervisors will review the audit tools to see how their staff is performing.
11. The CHHA/LTHHCP Nursing Supervisors will return the audit tools to the Supervisor of QA and Compliance.
12. The Supervisor of QA and Compliance will report the findings to the Director of Public Health, and the Director of Patient Services following each Peer Review Meeting.

SUBJECT: PEER REVIEW AUDIT POLICY AND PROCEDURE

13. The Supervisor of QA and Compliance will report the findings from Peer Review Meetings quarterly to the Quality Assurance Committee, and the Professional Advisory Committee.

Approved by Medical Director:

Signature

Date

UTILIZATION REVIEW PAIN MANAGEMENT AUDIT TOOL 2014

Program: CHHA / LTHHCP Services: SN PT OT SLP MSW RD HHA PCA RT Payor Source: _____
 Patient Record #: _____ DOB: ____/____/____ Sex: M F Referral Source: _____
 SOC Date: ____/____/____ Discharge Date (if applicable): ____/____/____ Surgery and Dates: _____
 Primary Diagnosis: _____ Secondary Diagnosis: _____

PHYSICIAN ORDERS

	YES	NO	N/A	COMMENTS
1 Were the frequency and duration of visits on 485 followed?				
2 If not, was physician contacted and was interim order done?				
3 Were 485 and interim orders returned within 30 days?				
4 If patient has pain, do the physician orders contain interventions that address assessment of pain, education of patient regarding pain relief measures including pain medications, and reporting unmanaged pain to the physician?				

CARE PLAN

1 Is pain medication teaching listed and addressed in the care plan?				
2 If patient has pain, is type and location of pain documented in "Indicator" section of care plan?				
3 If the patient has pain, does the care plan contain interventions that address assessment of pain, education of patient regarding pain relief measures, including pain medications, and reporting unmanaged pain to the physician?				
4 Is patient's response to pain management measures documented in the Response section of the care plan?				

MEDICATION PROFILE

1 Does the medication profile indicate patient allergies or NKA?				
2 Does each medication listed include dosage, frequency, and route?				
3 Do prn medications on medication profile state purpose for use?				
4 During the course of care, if new medications were ordered, were they documented on the medication profile?				

DOCUMENTATION REQUIREMENTS

	YES	NO	N/A	COMMENTS
1 Does pain scale in vital sign section agree with OASIS pain assessment and M1240?				
2 Is coordination of services evident in documentation?				

DOCUMENTATION REQUIREMENTS (cont.)					YES	NO	N/A	COMMENTS
3	Is patient's condition and clinical course evident in the documentation?							
4	Were changes in patient's condition reported to physician and documented?							
5	If patient has poor pain control, is there documentation indicating communication with the physician?							
6	If physician gave new pain management orders, is there documentation indicating follow-up and teaching with patient?							
7	If changes in pain medications or new medication(s) are ordered during the course of care, is there documentation of medication teaching with patient/family and/or caregiver?							
8	Is there a patient signature sheet for every nursing and therapy visit?							
DISCHARGE					YES	NO	N/A	COMMENTS
1	Was patient discharged from services?							
2	If yes, is there documentation that physician was contacted to discuss discharge?							
3	Was patient agreeable to discharge?							
4	If not, was it documented in clinical note?							
5	Do M2250 and M2400 match?							
6	Within discharge summary order, is there documentation of the following:							
	a) A summary of patient care provided?							
	b) A summary of patient teaching?							
	c) A summary of patient teach back?							
	d) Reference to items answered YES in M2250/M2400?							
	e) Patient's status at discharge?							
	f) Primary caregiver, if any?							
	g) Community supports, if any?							
	h) Physician follow-up?							
7	Is notice of non-coverage in chart and signed? (Medicare and Managed Medicare patients only)							

CONCLUSIONS:

Were services coordinated and documented at least once a certification period? (each discipline must communicate with each other and the physician at least once a certification period) _____

Were all identified patient needs addressed? _____

Reviewer's decision on relationship of Care Plan and amount and kind of services as related to patient's condition and clinical course:

- Appropriate
- Over use
- Under use
- Lacking Information

Committee member signature and title: _____ TITLE _____ DATE REVIEW DONE _____

FOLLOW-UP RESPONSE/CORRECTIVE ACTION:

CLINICIAN SIGNATURE _____ DATE _____ SUPERVISOR SIGNATURE _____ DATE _____

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: CODE OF ETHICS FOR NURSES

I. POLICY:

Saratoga County Public Health will maintain a Code of Ethics for Nurses. All nurses employed by Saratoga County Public Health will abide by the Code of Ethics for Nurses.

II. PURPOSE:

A code of Ethics is a set of standards and provides ethical and legal guidance for nursing practice. This guidance should be incorporated into the nursing practice of all Saratoga County Public Health Nurses to ensure that professional, respectful, compassionate, competent, and health promoting care is provided to the residents, their families, and the communities of Saratoga County.

CODE OF ETHICS FOR NURSES

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

REFERENCE:

Daley, Barbara PHD, RN, FAAN et al. (2001) Code of Ethics for Nurses with Interpretive Statements, American Nurses Publishing: Washington, D.C.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: WALK IN BLOOD PRESSURE CHECKS POLICY AND PROCEDURE

I. PURPOSE:

To provide blood pressure assessment and education regarding hypertension/hypotension, and the need for physician follow up, when any client walks in the building requesting a blood pressure check or states that they are not feeling well.

II. POLICY:

Saratoga County Public Health Nurse's (SCPHNs) will assess the blood pressure of any client who enters the building requesting a blood pressure check or states that they are not feeling well; and provide education regarding hypertension/hypotension, and the need for physician follow up when blood pressure is outside of normal parameters. If the client's blood pressure is found to be outside of normal parameters, SCPHNs will notify the client's physician of the abnormal findings.

III. PROCEDURE:

1. A nursing supervisor will speak with the client that is requesting the blood pressure check and make an assessment to be sure that a comprehensive approach is taken with the person.
2. The nursing supervisor will assign a nurse to talk with the client, discuss any history of hypertension/hypotension, blood pressure medications, and complete the first half of the "Walk-In Blood Pressure Record". (See Appendix A).
3. The nurse will ask for the client's consent to check their blood pressure and to follow up with the client's physician with any abnormal blood pressure findings.
4. The nurse will print the client's name in the declaration statement on the "Walk-In Blood Pressure Record". The client will sign where it says client signature, and write the date across from their signature. The nurse will sign name and title where it says witness signature and write the date across from their signature.
5. The nurse will assess the client's blood pressure while the client is sitting, on both arms unless contraindicated (AV fistula, history of lymph node dissection). If blood pressure reading is hypotensive, a standing blood pressure will also be taken.
6. The nurse will record the blood pressure reading(s) on the "Walk-In Blood Pressure Record". Any additional follow up or comments will also be recorded on the "Walk-In Blood Pressure Record".
7. The nurse will inform the client of their blood pressure reading and educate the person about normal blood pressure parameters according to the American Heart Association standards (see Appendix B), the health risks of hypertension/hypotension, and the need to follow up with their physician.
8. If the blood pressure reading is outside of normal parameters, the nurse will inform the client that their physician will be notified of the abnormal reading and the client should follow up with their physician.
9. The client will be given a copy of the form when completed, and the original will be filed in the "Walk-In Blood Pressure Notebook" kept in the both the CHHA and Prevention office.

Saratoga County Public Health Nursing Service
WALK-IN BLOOD PRESSURE RECORD

Date: _____
 Name: _____ DOB: _____
 Address: _____
 Home Phone No: _____ Cell Phone No: _____

PRIMARY CARE PROVIDER (PCP)		CARDIOLOGIST	
Name: _____		Name: _____	
Office Location: _____		Office Location: _____	
Phone: _____	Fax: _____	Phone: _____	Fax: _____

Health Insurance: Yes No Was a Health Insurance Navigator Program Referral Completed? Yes No

HISTORY OF:	YES	NO	COMMENTS
Hypertension			
Hypotension			
Medications			

 I, _____, give permission for Saratoga County Public Health Nursing Service to take my blood pressure, provide teaching, and release information to the above named physician(s) if necessary.

Client signature: _____ Date: _____
 Witness signature: _____ Date: _____

Sitting Blood Pressure		Standing Blood Pressure		Pulse	
Left arm	Right arm	Left arm	Right arm	Left arm	Right arm

- Educational material Provided: Yes No Comment: _____
- PCP notified by: **FAX** Yes No **PHONE** Yes No

Clinical Narrative: _____



What is the AHA recommendation for healthy blood pressure?

This chart reflects blood pressure categories defined by the American Heart Association.

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	less than 120	and	less than 80
Prehypertension	120 – 139	or	80 – 89
High Blood Pressure (Hypertension) Stage 1	140 – 159	or	90 – 99
High Blood Pressure (Hypertension) Stage 2	160 or higher	or	100 or higher
<u>Hypertensive Crisis</u> (Emergency care needed)	Higher than 180	or	Higher than 110

NOTE: Per Dr. DelGiacco, Medical Director for Saratoga County Public Health, if we check a client’s blood pressure and it is above 180/110 and they are not experiencing any symptoms, they are not treated as an emergency and should be encouraged to follow-up with their primary MD or Urgent Care Center. If a client with a blood pressure reading above 180/110 and experiencing symptoms of hypertensive crisis (i.e., blurred vision, dizziness, chest pain, numbness in extremities, headache, etc.) should be sent to ER.


 Dr. Desmond DelGiacco
 Medical Director


 Date

Saratoga County Public Health Nursing Service
ANNUAL EMPLOYMENT HEALTH ASSESSMENT

Name: _____ Gender: M F Date of Birth: _____

Address: _____ Phone No.: _____

Position: _____

Family Physician: _____ Address: _____

Have you been seen by a Physician in the past year? Yes No If yes, date: _____

REVIEW OF SYSTEMS: Do you have or have you been treated for:

	Yes	No		Yes	No
➤ Skin: changes in color	<input type="checkbox"/>	<input type="checkbox"/>	➤ Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
rashes	<input type="checkbox"/>	<input type="checkbox"/>	➤ Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
bleeding	<input type="checkbox"/>	<input type="checkbox"/>	➤ Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
moles that have changed in			➤ Change in voice	<input type="checkbox"/>	<input type="checkbox"/>
color/size	<input type="checkbox"/>	<input type="checkbox"/>	➤ Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
➤ Enlargement of glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	➤ Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>
groin	<input type="checkbox"/>	<input type="checkbox"/>	pain	<input type="checkbox"/>	<input type="checkbox"/>
➤ Fractures of a bone	<input type="checkbox"/>	<input type="checkbox"/>	discharge	<input type="checkbox"/>	<input type="checkbox"/>
➤ Joint: swelling	<input type="checkbox"/>	<input type="checkbox"/>	➤ Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
pain	<input type="checkbox"/>	<input type="checkbox"/>	➤ Cough	<input type="checkbox"/>	<input type="checkbox"/>
weakness	<input type="checkbox"/>	<input type="checkbox"/>	➤ Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
➤ Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	➤ Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
➤ Back injury	<input type="checkbox"/>	<input type="checkbox"/>	➤ Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
➤ Back surgery	<input type="checkbox"/>	<input type="checkbox"/>	➤ Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
➤ Restrictions placed on lifting/bending	<input type="checkbox"/>	<input type="checkbox"/>	pressure	<input type="checkbox"/>	<input type="checkbox"/>
➤ Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	tightness	<input type="checkbox"/>	<input type="checkbox"/>
➤ Increasingly bothered by heat	<input type="checkbox"/>	<input type="checkbox"/>	➤ Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
cold	<input type="checkbox"/>	<input type="checkbox"/>	➤ Pain in legs	<input type="checkbox"/>	<input type="checkbox"/>
➤ Excessive eating	<input type="checkbox"/>	<input type="checkbox"/>	➤ High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
drinking	<input type="checkbox"/>	<input type="checkbox"/>	➤ Nausea	<input type="checkbox"/>	<input type="checkbox"/>
urination	<input type="checkbox"/>	<input type="checkbox"/>	➤ Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
➤ Headaches	<input type="checkbox"/>	<input type="checkbox"/>	➤ Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
➤ Fainting	<input type="checkbox"/>	<input type="checkbox"/>	➤ Constipation	<input type="checkbox"/>	<input type="checkbox"/>
➤ Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	➤ Black stools	<input type="checkbox"/>	<input type="checkbox"/>
➤ Double vision	<input type="checkbox"/>	<input type="checkbox"/>	➤ Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
➤ Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	➤ Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
➤ Change in hearing	<input type="checkbox"/>	<input type="checkbox"/>	➤ History of hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
➤ Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>
➤ Pain in ears	<input type="checkbox"/>	<input type="checkbox"/>	➤ Pain upon urination	<input type="checkbox"/>	<input type="checkbox"/>
➤ Discharge from ears	<input type="checkbox"/>	<input type="checkbox"/>	➤ Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
➤ History of mental/emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	➤ History of seizures	<input type="checkbox"/>	<input type="checkbox"/>
➤ Sores in mouth	<input type="checkbox"/>	<input type="checkbox"/>	blackouts	<input type="checkbox"/>	<input type="checkbox"/>
			weakness of arms or legs	<input type="checkbox"/>	<input type="checkbox"/>

Give details of "yes" answers: _____

Blood pressure: _____ / _____

Weight: _____ lbs

Pulse: _____ /per minute

Regular: Irregular:

MEDICAL HISTORY: (PAST YEAR)

Hospitalization (date, reason): _____

Surgery (date, type): _____

Daily medications: _____

Allergies: _____

Date of last Pap Smear? _____

PPD: date of last done _____ due _____

Chest x-ray: _____

Have you had any Worker's compensation or Disability claims in the past year? _____

Do you have any medical conditions that could affect your ability to perform your duties, or create a potential risk to patients, the public, or other personnel? _____

Smoking: # packs/day _____ # years _____

Alcohol: _____

Have you ever taken any habit forming drugs other than those prescribed by a physician? _____

Do you have any habituations such as alcohol, tobacco, stimulants, or narcotics that could affect your ability to perform your duties? _____

EMPLOYEE CERTIFICATION:

I hereby certify that the answers to the questions on this form are true and accurate to the best of my knowledge. I understand that any falsification or misrepresentation of my medical condition (if any) will result in withdrawal of my offer of employment and may be grounds for future discipline, up to and including termination.

Employee signature _____ Date _____

Director Public Health/Director Patient Services signature _____ Date _____

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PATIENT TRANSFER PROCEDURES FOR EMERGENCY SITUATIONS

I. POLICY:

In case of an emergency, a plan will be in place to transfer patients to another facility.

II. PURPOSE:

- A. To facilitate the continuity of home care services for patients who will be transferred from Saratoga County Public Health Nursing Service.
1. Director of Public Health (DPH) to notify the NYS DOH of emergency situation and request authorization for transfer of patients.
 2. The Supervising Public Health Nurse's (SPHN's) for CHHA/LTHHCP will identify the patients in need of transfer and provide a list of patients to the Director of Patient Services (DPS). (Priority Listing Form will be used to aid in the selection process, as well as the geographical location of the patients.)
 3. The DPS will be responsible for contacting the new agency to determine the number of patients they can accept for transfer (see Regional Home Care Provider List for contact numbers.)
 4. SPHN's will be responsible for gathering informational materials on each patient to be transferred, using the Patient Transfer Check List.
 5. Agency Medical Secretary of designee will fax the patient information to the Agency.
 6. DPH to notify the NYS DOH when emergency situation is over and patients may return to agency.
 7. When emergency situation is over, SCPHNS will notify the receiving agency, and they will transfer the patients back to SCPHNS, with accompanying information for each patient.