

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PERSONAL PROTECTIVE EQUIPMENT (PPE) POLICY AND PROCEDURE

I. **PURPOSE:**

To ensure that the Saratoga County nurses, coordinators and contract staff are protected from infectious diseases as they perform the care of their patients. This is based on the Center for Disease Control and Prevention's guidance.

II. **POLICY:**

To ensure proper technique when putting on and removing (donning and doffing) Personal Protective Equipment (PPE) for standard precautions (to include contact, droplet, and airborne).

III. **EQUIPMENT:**

Gown
Mask (Surgical/Procedure or N-95)
Face shield or Goggles
Gloves

IV. **PROCEDURE:**

- A. The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection control precautions. Selection of PPE should be tailored to the infectious disease that will be encountered and its mode of transmission.
- B. Use safe work practices to protect yourself and limit the spread of contamination:
 1. Keep your hands away from your face
 2. Limit surfaces touched
 3. Change gloves when torn or heavily contaminated
 4. Perform hand hygiene before and after care of your patient (i.e. before donning and after doffing the PPE)
- C. See Attachment A for instructions for putting on and removing PPE*.

***Please Note:** There are certain infectious diseases (especially Ebola) that require Level II PPE and will require a witness to observe and assure that the sequence of donning and doffing is followed completely and properly.

SOURCE: The Center for Disease Control and Prevention's Guidance 2014

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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 Progresa 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 HHRG 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\c 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\c to tsclient\\tsclient\c pdf file and click save again. Make sure you are saving in the pdf file folder. The heading should read Network tsclient\\tsclient\c 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.

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.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

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 2015

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	Was 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		YES	NO	N/A	COMMENTS
1	Is 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		YES	NO	N/A	COMMENTS
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 "Vitals" 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.

SUBJECT: WALK-IN BLOOD PRESSURE CHECKS POLICY AND PROCEDURE

I. PURPOSE:

To provide blood pressure assessment and education regarding hypotension and hypertension, and the need for physician follow up, when any person 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 person 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 nursing supervisor or assigned staff nurse will assess the person's blood pressure while the person 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, using guard assist with the patient.
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 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) Name: _____ Office Location: _____ Phone: _____ Fax: _____	CARDIOLOGIST Name: _____ Office Location: _____ 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: _____



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 www.saratogacountyny.gov

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. DelGiaccio, 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 DelGiaccio
 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.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: IMMUNIZATION CLINIC POLICY AND PROCEDURE

I. POLICY:

To ensure proper administration and documentation of vaccines administered to adults and children at all Saratoga County Public Health Nursing Service Clinics (including mass flu clinics and any other clinics).

II. PURPOSE:

To promote the health of Saratoga County residents by reducing the spread of preventable communicable diseases and ensure compliance with the Center for Disease Control (CDC) recommendations and the Advisory Committee on Immunization Practices (ACIP) guidelines.

III. PROCEDURE:

1. Parent/Guardian/Patient will access immunization clinic services either through designated walk-in clinic hours, calling to make an appointment or self-scheduling for select clinics through e-health.
 - a) If appointment is pre-scheduled, reminder call is made and insurance information is collected.
 - b) Parent/guardian/patient is reminded at that time to bring current insurance card with them to the appointment.
 - c) Parent/guardian/patient is informed of fees that will be charged at time of visit payable by cash, check or credit card.
 - d) If parent/guardian/patient indicates they are unable to pay the fees associated with the visit, they will be advised of the sliding fee policy available and instructed what documentation to bring with them to the appointment.
 - e) Parent/guardian/patient is advised of immunizations that require a prescription from MD at time of visit.
2. Parent/Guardian is instructed to bring a minor child's immunization records when the appointment is scheduled. Immunization records faxed from the doctor's office or schools will be accepted. Immunization records must be verified with the vaccinator's signature. If these records are not available and the child's record is in NYSIIS that may be used as an accepted record if all other methods are exhausted.
3. Adults seeking immunizations will be asked to provide immunization records if available at time of visit. Verbal consent for NYSIIS input will be obtained at time of visit.
4. Upon arrival at clinic site Parent/Guardian/Patient will sign in.
5. Consent for Treatment, Payment and Healthcare Operations (Prevention Services Division~Clinic Services) will be completed and signed for patients that present for services that will be billed directly to insurance providers.
6. Parent/Guardian/Patient will be given the Saratoga County Public Health Nursing (SCPHN) Notice of Privacy Practices and D & T Patient's Bill of Rights.
7. Parent/Guardian/Patient completes the appropriate patient record(s) and/or screening checklist and billing information as determined by clinic type.
8. The nurse is responsible for:
 - a) Ensuring the correct forms have been filled out accurately and completely and that Parent/Guardian/Patient has a prescription from MD, if applicable.
 - b) Review and verify accuracy of valid prescription is applicable.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: IMMUNIZATION CLINIC POLICY AND PROCEDURE

- c) Reviewing and documenting on the screening checklist for contraindications.
- d) Ensuring the Pregnancy Risk form has been reviewed and signed when MMR, Varivax or HPV is to be administered to females aged 10 or older.
- e) Collection of insurance information and/or fees or refer to clerical staff if available.
- f) If uninsured, document that the parent/guardian/patient has been offered medical insurance information. If applicable, sliding fee is completed and reviewed for non-publicly funded vaccines and/or administration fees. (Travel vaccines are excluded from sliding fee).
- g) Reviews with parent/guardian/patient immunizations needed at this visit, reviews and discusses current VIS form for each immunization to be administered and provides a copy.
- h) Obtains signature from parent/guardian/patient for immunizations to be administered.
- i) Administering vaccines determined to be necessary based on record review and/or nursing assessment noted above in #6. If nurse is screener, takes completed records to immunizing nurse for verbal review.
- j) Document vaccines given per SCPH Adult or Children Immunization Record and Signature Card or other designated vaccine consent form
- k) Provides parents/guardians/patients with documentation of immunizations administered.
- l) Explain and obtain verbal consent for NYSIIS input for adult patients 19 and older and document verbal consent obtained on patient records. Immunization information will be entered into NYSIIS for all patients up to age 19 years of age or verbally consented adults 19 years and older within 2 weeks.
- m) A Vaccine Adverse Event Reporting System (VAERS) will be completed by a SCPH nurse when there is a report of an adverse reaction to a vaccine given by a SCPH nurse. Reports of adverse reactions to vaccines given at another provider will be referred back to the vaccinating provider for reporting.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PROCEDURE FOR PROCESSING OF REGULATED MEDICAL WASTE

I. PROCEDURE:

1. All sharps containers (filled to manufacturer's designated fill line, approximately 3/4 full), will be returned by nursing staff to the office and stored in a locked cabinet in the Prevention unit. The keys are kept in the Prevention office.
2. As needed, all filled sharps containers are sealed securely and placed in a corrugated cardboard box for transport by a Prevention staff member in assigned duty.
3. All sharps containers have a waterproof label placed on each, identifying the source of the waste as "Saratoga County Public Health Nursing Service."
4. The box is securely taped with clear tape and the box itself is labeled as follows:

Regulated Medical Waste
Shipped xx/xx/xx Box x of x

Saratoga County Public Health Nursing Service
31 Woodlawn Avenue, Suite 1
Saratoga Springs, NY 12866-2198

The label is covered with clear tape to waterproof it.

7. DEC form 47-15-21 is completed, sending copies #1 and #2 with the shipment. Copy #3, the transporter copy, is retained by the Saratoga County Buildings and Grounds Department. Copy #4 is retained at the Public Health Office.
8. A work order must be completed and submitted to Buildings and Grounds for transfer of regulated waste material. The request for replacement empty boxes is to be made with transfer request.
9. The regulated medical waste is shipped via authorized county employees to the County Animal Shelter for disposal.
10. Copy #1 of form 47-15-21 is signed and returned to us by the County Animal Shelter, and copy #2 is retained by the County Animal Shelter in their files.
11. All files pertaining to the above will be kept in the Prevention office in a binder marked "Regulated Medical Waste".

SUBJECT: STORAGE/MAINTENANCE AND DISPOSAL OF SYRINGES

I. STANDARDS OF PRACTICE:

A. Storage and Maintenance

1. All syringes, needles, and hypodermic units are to be stored in a secure, locked place.
2. During a clinic, syringes are to remain in a secure place at all times. Syringes are not to be stored at outreach clinic sites.
3. It is the responsibility of all nurses to keep nursing bags in a secure place, at ALL times. The bag **SHOULD NOT** be left in an unlocked or unattended vehicle at any time.

B. Destruction of Syringes

To prevent needlestick injuries, only retractable syringes with needles are to be used. They should be promptly placed in a prominently labeled puncture resistant container used solely for such disposal.

1. At clinic operations, sharps containers are to be readily accessible in EACH patient care area where needles and syringes are utilized. The entire syringe is to be dropped into the sharps container. You must retract the needle.
2. Sharps containers are to be used until filled to manufacturer's designated fill line, approximately $\frac{3}{4}$ full, and then sealed.
3. Sharps containers are to be returned to the office and placed in the designated area for disposal per the Procedure for Processing of Regulated Medical Waste.

SUBJECT: BILIARY TUBE FLUSH PROCEDURE

I. PURPOSE:

To maintain the patency of the biliary drain tube. A biliary drain is placed when there is a blockage in the biliary duct that won't allow bile to flow from the liver to the gallbladder. This blockage can result in a back flow of bile in to the liver causing yellow skin color (jaundice), dark urine, light stools, nausea, poor appetite and sometimes itching, and liver damage. The biliary drain will allow the bile to drain from the liver.

II. POLICY:

When Saratoga County Public Health Nursing Service provides nursing care to a patient with a biliary drain, and a physician order to flush the drain, the nurse will follow this policy and procedure. Saratoga County Public Health Nursing Service will ensure that patency of the drain is maintained, aseptic technique is followed, and no harm is done to the patient.

III. SUPPLIES

Non-sterile gloves
(2) Sterile drapes
Sterile gloves
10 ml syringe (appropriate size and type to fit drain tube, port or stop cock)
(1-2) Sterile Cup(s)
Prescribed solution
(2) Alcohol pads
(1) 3 x 3 Sterile Gauze Pad

IV. PROCEDURE:

1. Obtain a physician's order to flush the biliary drain including type and amount of fluid to be used.
2. Wash your hands per agency policy.
3. Don a pair of non-sterile gloves.
4. Assess the patient for fever, severe pain or swelling around the drain site, dislodged or broken drain, or leakage around the drain, drainage with foul odor. If noted report to physician immediately and proceed according to any new physician orders. If none of the above is noted proceed as per procedure.
5. Empty the drainage bag taking note of amount, color, odor and consistency of drainage.
6. Remove non sterile gloves and discard.
7. Wash hands per agency policy and procedure.
8. Gather your supplies as listed above.
9. Open and place sterile field on a clean surface close to the drain tube.
10. Open sterile cup and set off to the side of the sterile field.
11. Pour prescribed solution into the sterile cup.
12. Open 10cc syringe and gently drop on sterile field.
13. Open 2 alcohol wipes using aseptic technique.
14. Open a second sterile drape and place on patient's body near the biliary drain.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: BILIARY TUBE FLUSH PROCEDURE

15. Stop the flow of fluid to the drainage bag by:
 - a. Clamping the biliary drain tube below the injection port site
OR
 - b. If there is no port, disconnect the drain tube from the drainage bag and maintain aseptic technique for the end of the tubing, and the connector on the tubing to the drainage bag
OR
 - c. If there is a stop cock, turn the stop cock to the off position
16. Don a pair of sterile gloves.
17. Clean the injection port, or the end of the tubing or the stop cock, with an alcohol wipe.
18. Pick up the syringe from the sterile field and draw up the prescribed amount of the prescribed solution into the syringe.
19. Insert the tip of the syringe containing the prescribed solution into the injection port, or the end of the drain tube, or the stop cock port.
20. Push the plunger of the syringe slowly and evenly to put all of the saline into the drain tube. If any pressure or resistance is felt, **STOP. NEVER** pull back on the syringe plunger as this could damage the liver.
21. Assess the patient for any discomfort during the flush and **STOP** if any adverse effects noted.
22. Unclamp the biliary drain tubing or if there is a stop cock, turn the stopcock to the open position **BEFORE** removing the syringe.
23. Remove the syringe from the tubing port, or the tubing, or the stopcock port.
24. Assess for drainage return into the drainage bag taking note of amount, color, consistency of drainage.
25. Discard supplies.
26. Wash hands per agency policy and procedure.
27. Assist patient as needed in adjusting clothing and positioning.
28. Call the physician if resistance was met or any adverse effects occurred during the flush, and you were unable to finish the normal saline flush.
29. Document the care you provided, the patient's condition during and after the flush, any findings, and any phone calls to the physician.

REFERENCES:

Dawood, A. (2014,-November-11).Percutaneous Biliary Drainage. *Medscape Reference Drug, Diseases, and Procedures*. "Retrieved from" <http://emedicine.medscape.com/article/1828052-overview>

The Ohio State University Medical Center,Radiology. (2012,-January-27).Biliary drain. "Retrieved from" <http://patienteducation.osumc.edu/documents/biliarydrain.pdf>

University of Michigan Health Systems. (2015). Flushing Your External Biliary Tube. "Retrieved from" <http://www.med.umich.edu/1libr/aha/umliver11.htm>

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: AED (AUTOMATED EXTERNAL DEFIBRILLATION) POLICY AND PROCEDURE

I. **PURPOSE:**

To provide guidance to agency nursing staff in the use of an Automatic External Defibrillator (AED) and enable them to perform defibrillation when indicated, to cardiac arrest victims. An AED is used to defibrillate the heart and restore a normal cardiac rhythm in a person suffering a cardiac arrest and ventricular fibrillation. Only qualified personnel who have undergone CPR and AED training should utilize an AED when indicated during cardiopulmonary resuscitation efforts.

II. **POLICY:**

Saratoga County Public Health Nursing Service (SCPHNS) will maintain an AED unit in a locked cabinet, mounted on the wall next to the pull down fire alarm in the hallway, on the lower level of the Public Health building near the base of the Woodlawn Ave end stair well. Saratoga County Public Health Nurses (SCPHNs) are required to maintain CPR and AED training certification by the American Heart Association. SCPHNs will utilize the AED during cardiopulmonary resuscitation, when indicated by the AED following heart rhythm analysis, in order to restore a normal heart rhythm to a cardiac arrest victim. SCPHNs will follow the guidance in this policy and the guidance provided by the AED when utilizing the AED. This policy must be reviewed every year.

III. **TRAINING:**

- A. The DPH\DPS is responsible for overseeing: the scheduling of CPR/AED training, maintaining a list of all trained emergency response staff and maintaining a copy of training certification cards.
- B. The Prevention SPHN or designee will serve as AED Coordinator and oversee the equipment, AED events, post event follow-up, AED unit follow up, after use, and regular maintenance of the AED equipment.
- C. All nursing staff and EI Service Coordinators will receive CPR and AED training every two years.
- D. All CPR/AED trained staff will receive training on how to make a 911 call. The following information must be conveyed when calling 911:
 1. Name of victim (if known)
 2. Approximate age of victim
 3. Location
 4. Reason for the call

IV. **EQUIPMENT**

- A. Heartstart Frx Defibrillator
- B. Defibrillator cabinet (wall mounted, locking)
- C. Blue Zipper Pouch
 1. Contents blue zipper pouch:
 - ✓ Pocket mask face shield
 - ✓ Disposable gloves
 - ✓ Disposable razors
 - ✓ Scissors
 - ✓ Towel or absorbent wipes
- D. Red First Responder Emergency Bag
 1. Contents of red AED emergency bag:
 - ✓ Pocket mask face shield to protect user
 - ✓ Disposable gloves to protect user
 - ✓ Disposable razors ~ to shave chest if necessary
 - ✓ Scissors ~ to cut victims clothes if necessary
 - ✓ Towel or absorbent wipes ~ to dry victim's skin
 - ✓ Note pad and pen ~ to record time CPR was started, time EMS arrived and outcome

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: AED (AUTOMATED EXTERNAL DEFIBRILLATION) POLICY AND PROCEDURE

V. LOCATION OF EQUIPMENT:

- A. AED Heartstart Frx Defibrillator will be kept in a wall-mounted defibrillator cabinet
- B. Defibrillator wall-mounted cabinet will be on the hallway wall on the lower level at the bottom of the main entrance stairwell next to the pull down fire alarm
- C. Blue zipper pouch will be kept in the Defibrillator cabinet
- D. Key to the AED wall-mounted, locking cabinet will be kept on a lanyard in the Red First Responder Emergency bag. However, the cabinet will not be kept locked.
- E. Red First Responder Emergency Bag will be kept in the Prevention office

VI. PROCEDURE:

- A. The first responder at the scene assesses the situation (victim and the scene) and initiates the emergency response according to the current American Heart Association Guidelines.
See <http://www.cprcertificationonlinehq.com/aha-cpr-guidelines-latest-jan-2014/>¹
- B. When second responder arrives send them to:
 - 1. Call 911 (the responder should provide the name of the victim if known, approximate age of the victim, reason for the call, and location of the victim.
 - 2. Retrieve the Blue Zipper Pouch
 - 3. Retrieve the AED.
- C. If there is a bystander have them take notes of events and the time. If there is no bystander, document when the event is over or when EMS has arrived and assumed care for the victim.
- D. When AED is brought to the scene open the case.
- E. Turn on the unit by pressing the green on/off button located on the top right corner of the AED unit.
- F. If the victim is an infant or child under 55lbs or under 8 years old, remove the infant /child key from the clear plastic pocket on the left side of the AED case. Insert the Infant/Child key into the slot on the front of the AED unit at the top. This key automatically reduces the defibrillation energy from 150 joules to 50 joules. If you are not sure of the exact age or weight, turn on the AED without inserting the key and follow instructions.
- G. The unit will tell you to remove all clothing items from the person's chest. Rip the person's clothing if necessary. In the emergency bag there is scissors to use if needed.
- H. On the left side of the AED case, pull the grey velcro tab up to open the compartment that contains the Smart Pads which are in a grey plastic case.
- I. Remove one Smart pad at a time from the grey case plastic case and place the pad on the person's bare skin per the diagram, on the pad, on the flashing icon on the AED unit, or on the Infant /child key if the person is an infant or child. Before placing the pad, remove any moisture from the skin with a cloth, remove excessive hair on the chest with a razor, remove any medicine patches, or residual adhesive. Do not place pad over a pacemaker or defibrillator (lump with a surgical scar would indicate location of device). Press the adhesive portion of the pad down firmly. If the adhesive gel is not sticky to the touch, replace the pads with a new set. A spare set of Smart pads is in the bottom compartment on the left side of the case.
- J. The AED unit pad icons will stop flashing when the pads are attached to the patient.
- K. The unit begins analyzing the patient's heart rhythm. The AED unit will tell you that no one should be touching the patient, and the caution light with the hand icon begins flashing.
- L. Make sure no one is touching the patient.

¹ American Heart Association 2014

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M. If a shock is *needed*:

1. The caution light with the hand icon, on the mid to lower right side of the AED unit, will stop flashing and will remain on. The orange shock button on the lower right side of the AED unit will start flashing. The AED unit will tell you to press the flashing orange button.
2. Make sure no one is touching the patient and press the flashing orange shock button. The AED unit will tell you that the shock was delivered. The defibrillator will tell you that it is safe to touch the patient.
3. The blue “i” button comes on solid to tell you that it is safe to touch the patient. The AED unit tells you to begin CPR, invites you to press the flashing blue “i” button on the upper right side of the AED unit for CPR coaching if needed. (CPR coaching will be for infant/child if the infant/child key was inserted in the AED unit during step 8.)

N. If a shock is NOT needed:

1. The blue “i” button comes on solid to show that it is safe to touch the patient.
2. The AED unit will tell you to perform CPR if needed. The AED unit will invite you to press the flashing blue “i” button for CPR coaching if needed. (CPR coaching will be for infant/child if the infant/child key was inserted in the AED unit during step 8.) If the person is moving or regaining consciousness and CPR is not needed, continue to monitor the person until EMS provider(s) arrive.
3. Care of the victim is transferred from responders to EMS provider(s) when they arrive and the following information should be given to EMS providers if known:
 - ✓ Victim’s name
 - ✓ Known medical problems, allergies or medical history
 - ✓ Time the victim was found
 - ✓ Initial and current condition of the victim
 - ✓ Information from the AED: number of shocks delivered and length of time that the defibrillator was used

VII. **POST EVENT FOLLOW UP** (to be completed by the AED Coordinator)

- A. When the event is over and/or the EMS have arrived, responders should document the event immediately or within 24 hours.
- B. Responders must complete a REMO Public Access Defibrillation QI Report (see appendix A) and an SPHN Incident Report (see appendix B) and submit to their Nursing Supervisor and/or the DPS/DPH within 24 hours.
- C. The AED Coordinator or designee will download the AED data. (Be sure that data is downloaded before the post use battery test is done. Removing the battery erases the summary data.) To download the AED data see Appendix C.
- D. Provide a copy of the downloaded AED data and a copy of completed documentation to the EMS provider, the Saratoga County Public Health Medical Director, the Saratoga County Director of Public Health, and the REMO EMS Council.
- E. A post event meeting should be held with the responder(s), their Supervisor and the Director of Patient Services/Director of Public Health to review the incident.

VIII. **AED UNIT FOLLOW UP AFTER AED USE** (to be completed by the AED Coordinator)

- A. Check the outside of the AED and carry case for any damage, dirt or contamination. If any damage is found, contact the local Phillips distributor or go on line to www.philips.com/productdocs in the “HeartStart Frx Defibrillator Technical Reference Manual” for technical support. (Appendix F). If the AED is dirty or contaminated it may be cleaned with a soft cloth and soapy water, chlorine bleach (2tbsp per quart or liter of water), ammonia-based cleaners, or 70% isopropyl (rubbing) alcohol. The carry case should be cleaned with a soft cloth dampened in soapy water.

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SUBJECT: AED (AUTOMATED EXTERNAL DEFIBRILLATION) POLICY AND PROCEDURE

- B. Replace the Smart pads. Remove the package of replacement Smart pads from the compartment in the carry case. Open the foil package and take out the grey plastic container that contains the pads. Check expiration date on the cover of the grey plastic case. Plug the connector cord into the plug at the top left hand corner of the AED unit. Place the grey plastic case in the left side of the carry case and secure the Velcro tab.
- C. Remove the battery from the compartment on the back of the AED, for 5 seconds. Reinstall the battery by placing the bottom end of the battery in to the bottom of the compartment and then firmly press down the top (latch) end of the battery into the compartment until it clicks.
- D. The AED will automatically run a self-test once the battery is inserted. Press the shock button and the on/off button when instructed. Let the self-test run all the way to completion. When the self-test is completed the AED will report the result and tell you to press the green on/off button in case of an emergency. **DO NOT PRESS THE ON/OFF BUTTON** unless it is an actual emergency. The AED will turn off and go to standby mode. The green Ready light will be blinking to show that the AED is ready for use.
- E. Return the AED to the carry case and to the wall storage cabinet. Place the updated inspection log /maintenance booklet in the wall cabinet.

IX. REGULAR AED MAINTENANCE (to be completed by the AED Coordinator)

- A. The AED unit will be checked **monthly** by assigned prevention staff for the following items:
 - 1. Verify that the green ready light is blinking. If it is not blinking refer to chapter 5 in the Heartstart Frx Defibrillator Owner's Manual. (Appendix E)
 - 2. Check the supplies expiration dates and replace any expired supplies.
 - 3. Check the outside of the AED unit and the carry case for cracks or any signs of damage. If any damage is found, contact the local Phillips distributor or go on line to www.philips.com/productdocs in the "HeartStart Frx Defibrillator Technical Reference Manual" for technical support. (Appendix F)
- B. Record the findings in the Inspection log which is kept inside the owner's manual and inside the AED storage wall cabinet.

X. QUARTERLY REPORT

- A. AED Coordinator or designee will complete the Public Access Defibrillation Program Agency Quarterly Report form and fax to REMO. (See Appendix D)

XI. ANNUAL REVIEW

- A. Once each calendar year, the director of Public Health /DPS shall conduct and document a system readiness review to include the following:
 - 1. Review training records
 - 2. Review Equipment operation and maintenance records

REFERENCES:

American Heart Association. (2014) American Heart Association CPR Guidelines. Retrieved 02.15, from <http://www.cprcertificationonlinehq.com/aha-cpr-guidelines-latest-jan-2014/>

Koninklijke Philips N.V. (2014). *Heartstart Frx Defibrillator: Technical Reference Manual*, Edition 3. Bothell, WA: Koninklijke Philips N.V.

Philips Electronics Corp. (2013) . *Heartstart Frx Defibrillator: Owner's Manual*, Edition 2. Bothell, WA: Philips Electronics North America.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: MEDICARE OTHER PPS BILLING POLICY AND PROCEDURE

I. **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.

II. **POLICY:**

Saratoga County acting through its dba: Public Health Nursing Service will bill Medicare Other PPS 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.

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 Progresa HCMS, clicks on the Report tab, then clicks on Report button, then arrows down under Report Types and clicks on PPS Management. 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 Other PPS**

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 Medicare Other PPS patients have pulled over. 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.

In addition, a 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.

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SUBJECT: MEDICARE OTHER PPS BILLING POLICY AND PROCEDURE

2. No Visit and NO HHRG on Episodes Without RAP Report

If there is no visit and no HHRG 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 the SOC (start of care). If it hasn't been a week, check the frequency on the 485. To check the frequency on the 485 in the Home Care Management System(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. 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 and click on the activities tab. This brings up the notes. Choose 60 days or all to bring up the notes that you need. Arrow through the notes, by note date, in order to find SOC or recert visit. If the visit was done, and the HHRG did not populate, look to see the status of the note. If the note is not processed then the HHRG cannot be imported. You must wait until the note is processed. If the date that the note was processed is before the date of the OASIS export report, go to the note, then to tools and then click on the HHRG viewer, then click on the HHRG tab. Click on the calculate button, this calculates the HHRG. Press the screen print button and print it. Now go back to HCMS to the HHRG finder, click on tasks, then click on invoice processing button. Click on the 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. The HHRG will automatically populate when you click in the HHRG column. 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. Click on the OASIS reason drop down box arrow, select reason which is start of care (SOC) or recertifications (follow up assessment), and click the line underneath it to save the line. Click on the OASIS claim key box and click delete in order to delete the 99xx99xx99xxxxxxxx , then enter the OASIS claim key number from your screen print and save.

3. HHRG Present but No Visit Ddate 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 the date of the note 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. Print if new patients can be calculated. Review the report for Patients with HHRG and 1st billable visit. **Check the patient's location by going to the patient information screen and looking at the patient's address.** Verify whether the patient resides in their own home/home of a family member, or in an adult home. Then go to the admit tab. While you are on the admit tab, click on the location button on the bottom right side of the screen. The service location information should be there. If it is not there, 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 if needed. (See list in the billing office.)

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: MEDICARE OTHER PPS BILLING POLICY AND PROCEDURE

D. Calculate RAP (Initial or Recert), Assign Invoice**1. Calculate RAP**

Log into HCMS and 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 you will need to assign the 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" date from the Episodes without RAP report, the "TO" date as it is the same. Also enter the Patient ID. Add to list by pressing the Add button on the screen, then press the OK button. "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. 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. Hold on sending RAP until ready to send Final.

E. Medicare Other PPS Chart Review

1. Run Episodes without Claim Report. Go to the Task bar for Reports, PPS Management, Episodes Without Claim report. Click the select button. Enter the date 1/1/90 to the end date of the time period that you would like to review. View and print report.
2. Run Services by Patient by Service Date Report for the Episode you would like to review. Go to Reports 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.
3. Pull the charts that go with the services report. Sign CHHA/LTHHCP charts out if necessary. Sign active charts out on the clipboard kept on the side of the chart cabinet in the front of the CHHA office. Sign discharge charts out on the sheet kept on the front face of the discharge chart box in the front of the CHHA office.
4. Mark the Weeks on the Services by Patient report. (Sunday to Saturday)
5. 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, click on the line and 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.
6. Look for the signed 485. If a recertification, check box 23 for signature and date. For initial 485 or Recertification 485, look for the physician signature, the date in Box 25 which is when the 485 was signed and returned. Look at the 485 and write the disciplines and frequencies from the 485 on to the Services Report. Look to see if supplies were listed on the 485. If any of this information is missing, make a note and report it to Nursing Supervisor and Nurse/Therapist by completing the billing department form for missing information. (See attachment A.)
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 indicates that we have a patient signature on the Welcome Letter.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: MEDICARE OTHER PPS BILLING POLICY AND PROCEDURE

8. If multiple disciplines saw the patient, you will need to compare signature pages to visits on the Services Report. If a signature page is not on the chart, compare visits on the Services Report to visits listed on the Processed and Unprocessed Note report. Make a check mark next to each visit if a signature on the signature sheet is present for that visit. If not circle the hours of the visit and fill out an attachment A form and give to the appropriate CHHA Supervisor.
9. Make sure visits are Like kind (LK) and the correct Employee did the visit. All patients that have Medicare are considered LK and should be coded as such. Sometime services get entered as a different Employee. Verification needs to be done as to the employee that actually did the visit appears.
10. Look for signed discharge summary order if the patient has been discharged.
11. If any of the above information is missing, **do not continue** until all the information is present. You may need to issue a memo requesting the missing information be found and returned before releasing the Final Claim.

➤ **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.

If when calculating the Final, a Therapy Upcoding or Downcoding message appears, you will need to screen print this so you can correct the RAP and Final prior to sending. You need to correct the Invoice once it is Assigned. The Final Reimbursement amount will now appear as well as Final Claim type. (LUPA, PEP, Outlier, Normal)

B. Assigning the Invoice

1. Assign Invoice by going to Invoice Processing. Highlight assign invoice, and press enter. Enter the date of the Episode from the Services Report (60 day certification period). Choose Individual type. Enter 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.
2. 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. Click Accept. It will ask if you are sure you want to accept assigned invoices. Press Yes.

C. Print and send RAP & Final claim (Invoice)

1. From the Cash screen note the Invoice number of the RAP and Final you are sending.
2. If the final is not a LUPA. (which is more than 4 visits) The RAP and Final are printed and sent.

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SUBJECT: MEDICARE OTHER PPS BILLING POLICY AND PROCEDURE

3. If the Final is a LUPA (less than 4 visits) both are printed but only the Final is sent.
4. If the Therapy upcoding/downcoding message appears you will need to print the RAP and Final and then manually correct the HIPPS code on the invoice by whiting out the code on the claim and typing the correct code on the invoice (by using the typewriter), prior to sending the RAP and Final.
5. To print the invoice, go to Task, Invoice Processing, Print Invoice. Select Invoice Number at the bottom of the screen. Select Form Type, UB04 Laser #1. Type Invoice # to be printed and press add to list. Patient name will appear on the screen. Select Print. Select the Printer key when ready to print. Make sure the correct form and number of forms is in the printer when you press yes to print. (UB04)
6. If HIPPS code is altered then make a copy prior to sending.
7. If HIPPS code is not altered then print 1 copy of RAP and Final on plain paper.
8. Prepare Envelope and enclose RAP and Final.

D. Receipt of Explanation of Benefits (EOB)

1. Sr. Account Clerk will receive determination/payment in the mail or via Electronic Fund transfer. If payment is in the form of a check, make a copy of the check. If the EOB indicates a patient responsibility, make a copy of the EOB to be included with the Self Pay bill to the patient.
2. If payment is by check, report payment to the Treasurer by including it on the weekly cash memo #1. This is normally done every Thursday morning. Enter the check on the appropriate cash and check log number 1. Enter the amount of the check in the correct account which is 1-40-1610PI. Enter the name of where the check is from (payer).
3. If payment is by electronic fund transfer, then download the EOB from the insurance website. Record the spreadsheet in the appropriate account and attaché the spreadsheet to the email going to the treasurer's office at the time of receipt.

E. Process for Weekly Deposit

1. On Thursday of each week the Senior Account Clerk reviews the checks and cash received since the prior Thursday by going to p/admins/adminoffice/billing/billingshared/cashmemosandrecon/currentyear Click on the file (year check and cash log #1). Review the document for accuracy, sort column B alphabetically, save and print it. Go to the master document, move it to the end of the sheet, copy it, and rename it for the next Thursday.
2. In the same folder of cash memo #1, go to the 2014 cash memo #1. Refer to printed check and cash log #1 report. Make 3 tapes of the cash and checks that are kept in the collection envelope. Verify that it agrees with the check and cash log. If they do not agree, review the check amounts on the tape to each check amount on the check and cash log. If they still don't agree you may have to go back to the source of what was received (example: clinic). If cash agrees, enter the amount of cash on the total cash line. Enter the dollar amounts for each account code. Compare the total check column to the total of check amount on the tapes.
3. One tape is secured to the cash, one tape is secured to the checks, and one tape is kept by the Senior Account Clerk.
4. Print 2 copies of the cash memo #1, one copy goes to the treasurer and one copy is kept by the Senior Account Clerk.
5. Select the appropriate master, move to the end and rename for the next Thursday. Date the top of the memo with the date of the next Thursday.

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F. Post Cash to Open Accounts Receivable

1. Add the check(s) that came with the EOB to the tape attached to the 3X5 card with the Deposit # and Date located on Sr. Account Clerks Desk.
2. Write the Deposit # and date in the top right corner on the EOB.
3. To add the check to the deposit, go to the cash screen. To get to the Cash screen, go to Task on the tool bar and click on cash to open the application. Click Add to enter the check information on the cash screen and save once the information is entered. Enter the check number, posting date, check date, the amount being entered and click save.
4. Go back to the tool bar and click on deposits. Type in the deposit number and click find. The deposit will appear. If this is the first time you are entering this deposit number then you must press add. Enter or update the dollar amount and click save.
5. Click on “show available checks” and then select and include the check/EOB information that was just entered. Go back to the cash application and enter the patient ID number. Click find, click add, and continue to enter the complete EOB.
6. Now go to the Cash Application Screen and type in the patient ID number. Uncheck the “Hide zero balance invoices” box and click find. Any unpaid accounts receivable will show on the screen. Select the appropriate invoice that is being paid. Click add and choose the appropriate accounts receivable code from the dropdown box (1- Cash receipt accrual), enter the payment amount, press enter so the covered amount will populate in the payment box. Click save and then click yes.
7. If the amount remaining is zero the check has been posted. If a balance is shown then follow the steps in number 8 to allowance off any payer initiated reduction amount.
8. If the balance needs to be allowed off go to the adjustment button on the cash application screen click add, and enter appropriate accounts receivable code from the dropdown box (22- PPS Penny Adjustment). Enter a payment of zero and enter the amount of what is being allowed off. In the remarks box type “payer initiated reduction”. Then click save.
9. In some cases a balance bill is needed and the balance is billed to the patient. If billing the balance to the patient, you will need to print a statement for the patient. Do this by going to Reports, and then to Financial, Statement. Enter the aging date (aging date must be at least the Thursday you are entering the deposit). Select the Patients Name and click enter. View the report and select the printer key to print.
10. Keep one copy for our records and mail one to patient with the EOB. Highlight the Patients Name and Amount due. Use the stamp to indicate “Make payable to Saratoga County PHNS”. Record on Collection Screen. Include slip explaining we now take Debit/Credit cards.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PROCEDURE FOR DRY STERILE DRESSING

I. DEFINITION:

Application of dry sterile materials to wound.

II. PURPOSE:

1. To cover and protect an area or wound from injury or contamination.
2. To absorb any drainage.
3. To contain an infection already present.

III. EQUIPMENT:

Varies with each dressing. Typical: clean gloves (disposable); plastic bag for disposal of wastes; sterile normal saline and/or antiseptic solution per Doctor's orders; sterile suture set; 3-6 gauze squares; 1-2 surgical pads; tape; sterile gloves.

IV. PROCEDURE:

1. Wash hands
2. Explain procedure to patient
3. Place patient in comfortable position
4. Loosen tape securing old dressing by pulling tape toward wound. Leave dressing covering wound.
5. Establish a sterile field where appropriate
6. Open packages (gauze squares, applicators, pads, etc.) and drop each onto sterile field. Avoid reaching over sterile field.
7. Tear off anticipated amount of tape needed and place within reach.
8. Open disposal bag (for soiled dressing and gloves)
9. Put on clean glove(s), remove old dressing, discard gloves and dressing in disposal bag.
10. Assess wound and surrounding skin, measure wounds and take wound photographs per agency policy.
11. Wash hands; or cleanse with antimicrobial hand rinse if hands are not visibly soiled.
12. Don sterile gloves.
13. Cleanse wound per physician plan of care.
14. Apply dressing according to physician's orders
15. Secure dressing
16. Remove gloves/wash hands
17. Reposition patient to make comfortable.
18. Discard disposal bag

V. CHARTING:

Record date, time dressing was changed, any change in appearance of wound, drainage or odor and how patient tolerated procedure. If wound was measured and photographed, document per agency policy.

SOURCE: Wilkinson, Judith M., Treas, Leslie S. (2011). *Fundamentals of Nursing* (2nd ed). Philadelphia, PA: F.A. Davis Company.

Revised: 6/12/15, 11/6/13

SUBJECT: PROCEDURE FOR WET TO DRY DRESSING

I. PURPOSE:

1. To cover and protect an area or wound from injury or contamination.
2. To absorb any drainage.
3. To remove any devitalized tissue or mechanically debride the wound.
4. To contain an infection already present.

II. EQUIPMENT:

Varies with each dressing. Typical: clean gloves (disposable); sterile gloves; plastic bag for disposal of wastes; sterile cup; prescribed solution; sterile drape; gown; sterile suture set; 3-6 gauze squares; 1-2 surgical pads; tape.

III. PROCEDURE:

1. Wash hands, don gown
2. Explain procedure to patient
3. Place patient in comfortable position
4. Loosen tape securing old dressing by pulling tape toward wound. Leave dressing covering wound.
5. Establish a sterile field where appropriate
6. Open packages (gauze squares, applicators, pads, etc.) and drop each onto sterile field. Avoid reaching over sterile field.
7. Pour prescribed solution into a sterile cup or onto gauze squares that will be placed in the wound bed. Initial and date solution bottle if newly opened.
8. Tear off anticipated amount of tape needed and place within reach.
9. Open disposal bag (for soiled dressing and gloves)
10. Put on clean glove(s), remove old dressing, discard gloves and dressing in disposal bag. May moisten to dressing prior to removal with physician order.
11. Assess wound and surrounding skin, measure wounds and take wound photographs per agency policy.
12. Wash hands; or cleanse with antimicrobial hand rinse if hands are not visibly soiled.
13. Don sterile gloves.
14. Cleanse wound per physician order.
15. Apply dressing according to physician's orders
16. Wring some solution out of the gauze pads before applying to the wound bed. Do not allow wet gauze to touch surrounding tissue.
17. Apply dry gauze over wet gauze.
18. Secure dressing
19. Remove gloves/wash hands
20. Reposition patient to make comfortable.
21. Discard disposal bag

IV. CHARTING:

Record date, time dressing was changed, any change in appearance of wound, drainage or odor and how patient tolerated procedure. If wound was measured and photographed, document per agency policy.

SOURCE: Wilkinson, Judith M., Treas, Leslie S. (2011). *Fundamentals of Nursing* (2nd ed). Philadelphia, PA: F.A. Davis Company.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HOME HEALTH AIDE POLICIES

I. GENERAL POLICIES**A. Availability of Home Health Aide Services**

Home Health Aide service is available when agency nurses can provide adequate supervision in their home or boarding homes in accordance with the orders and plan of treatment of patient's physician.

B. Qualification for Home Health Aide

Applicants for home health aide training are accepted after careful screening and personal interviews. To qualify as a home health aide, the applicant must satisfactorily complete a training program approved by the New York State Department of Health.

C. In-Service for Home Health Aide Services

All home health aides must complete 12 hours of in-service yearly.

D. Contract Aides

Contract Agency is responsible for satisfactory training program, health status, and in-service for their personnel.

E. In accordance with title 10 NYCRR sections 763.13, 766.11 and 400.23, Saratoga County Public Health Nursing Service (SCPHNS) will require all prospective non-licensed home care staff who are employed or used to provide direct care or supervision to patients to undergo a criminal history record check from the Federal Bureau of Investigation (FBI). (Persons licensed pursuant to Title 8 of the Education Law or Article 28-D of the Public Health Law are excluded from the meaning of employee).

II. SUPERVISION OF HOME HEALTH AIDE

A. The public health nurse or registered nurse will be responsible for the supervision of the home health aide.

B. The aide's written assignment and patient care plan will be the responsibility of the public health nurse and registered nurse assigned to the area in which the aide is functioning.

C. It is mutually understood by the Public Health Nursing Service that, if problems arise as a result of an aide's performance, the supervising nurse for the Public Health Nursing Service will be responsible for determining what action is necessary to resolve the problem.

D. The nurse will supervise the aide's performance at the time of the first visit, and supervise the aide every two weeks, or more often, thereafter.

E. The nurse will conduct an ongoing review of the services provided by the aide by thoroughly reviewing the aide activity sheets that are submitted weekly by the SCPHNS aide and monthly by contract agency aide. The nurse will provide verification of activities reviewed as compared to the HHA Care Plan by initialing each activity sheet that is submitted.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HOME HEALTH AIDE POLICIES

- F. When an aide assists with self-administered medication, the public health nurse will prepare a written schedule that the aide will follow.
- G. The aide will not perform any procedure unless authorized by the physician and the Public Health Nursing Service.

III. FUNCTIONS OF THE HOME HEALTH AIDE**A. Routine functions of home health aide:**

1. Prepare and serve regular diets.
 2. Assist with care of teeth and mouth.
 3. Assist with grooming, care of hair including shampoo, shaving, and the ordinary care of nails.
 4. Bathe patients confined to bed.
 5. Assist patients with tub bath or shower **only** when special permission has been given by the nurse.
 6. Assist patients on and off bedpan, commode, and toilet; with use of urinal.
 7. Assist patient in moving from bed to chair, wheelchair, and in walking; perform Hoyer lift transfers after being taught and/or supervised by nurse or physical therapist.
 8. Assist patient with feeding, as necessary.
 9. Assist with dressing of patient.
 10. With guidance from the nurse, arranges schedule so that patient follows medical recommendations such as bed rest, increased physical activities or assuming more responsibility for self-care.
 11. Take temperature, pulse, respirations when advised, and keep written record of same.
 12. Discuss any problem that concerns the care of the patient with the public health nurse supervising the care.
 13. Promote interest in meaningful living.
 14. Assist patient in taking self-administered prescribed medication only when no family member is available to do this; nurse provides written instruction for the aide to follow.
 15. Perform incidental household tasks essential to the patient's health needs.
 - a. Light housekeeping including: making and changing beds, dust and vacuum rooms used by the patient, care of dishes, tidying kitchen, tidying bathroom.
 - b. Listing needed supplies.
 - c. Take care of patient's personal laundry if no able family member is available.
- B. Under special circumstances, if no family member is present or capable of providing care, the HHA may perform the assigned tasks. Tasks permissible under special circumstances may only be performed for a patient whose characteristics and case situation meet all of the following criteria:

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SUBJECT: HOME HEALTH AIDE POLICIES

1. The patient is self-directing. A self-directing patient has the capability to make choices about activities of daily living, understands the impact of these choices, and assumes responsibility for the results of the choices.
2. The patient has a need for assistance with the task or activity for routine maintenance of his/her health.
3. The patient cannot physically perform the task or activity because of his/her disability.
4. The patient has no informal caregiver available at the time the task or activity must be performed; or the caregiver is available but is unwilling or unable to perform the task; or the caregiver's involvement is unacceptable to the patient.

IV. PROCEDURE**A. Prior to the HHA's performing any of the following activities:**

1. The public health nurse must discuss the case with a supervising public health nurse.
2. The public health nurse must identify and document, in the patient's clinical record, the patient's needs and any special circumstances involved.
3. The public health nurse must instruct and demonstrate to the HHA the activity to be performed as well as any untoward signs and symptoms to watch for. Initial and subsequent instruction outlining the steps for the procedure will be available to the HHA in a written care plan in the home. The public health nurse will document all instructions in the clinical record on the Home Health Aide Care Plan form, patient narrative and documents the HHA's ability to comprehend and perform the activity in a competent manner.
4. The HHA must explain and demonstrate to the health professional, in a safe and competent manner, the activity to be performed as well as his/her understanding of untoward signs and symptoms to watch for and appropriate actions to take.

V. HOME HEALTH AIDE ACTIVITIES ALLOWABLE UNDER SPECIAL CIRCUMSTANCES**A. The following activities can be performed by a HHA under special circumstances after the above mentioned steps have been taken. These activities can be performed only with the particular patient for whom the HHA has received instruction and returned a competent demonstration.**

1. * *Assist with prescribed skin care.*
2. * *Application of prescription or non-prescription topical medications to stable skin surfaces. (Antianginals and Vasodialators are not permitted.)*
3. * *Reinforce dressings/apply non-sterile dressing to stable wound surface.*
4. * *Changing a colostomy or ureterostomy or ileostomy appliance to a mature and stable ostomy.*
5. * *Urine testing for sugar, acetone, or albumin.*

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SUBJECT: HOME HEALTH AIDE POLICIES

6. Using a hydraulic lift; electric lift chair. (In this instance, the patient does not need to be self-directed).
7. Assisting with prescribed exercises including passive range of motion or assisted range of motion (may be taught by public health nurse, physical therapist or occupational therapist).
8. **Instill/apply/spray intra-aural, nasal and ocular medications (excluding patients less than seven days post-op).*
9. **Preparing meals for modified diets.*
10. Applying/removing braces, splints, slings, and artificial limbs.
11. Applying ace bandage.
12. Assisting with TENS treatment, after instructed by public health nurse or physical therapist.
13. Changing a Foley catheter bag.
14. ** Assistance with G-tube feedings (excluding instillation of feeding).*
15. ** Insertion of rectal/vaginal creams and suppositories (excluding narcotics).*
16. ** Suctioning the oral cavity with a bulb syringe.*
17. Soaks of all types.
18. Applying or removing a male external catheter.

**** IN ORDER FOR ANY ASTERISKED ACTIVITIES TO BE PERFORMED, THE ACTIVITY MUST BE SUPERVISED BY A REGISTERED NURSE (both initially and on an ongoing basis).***

B. The Home Health Aide will not be permitted to perform the following:

1. Injecting insulin.
2. Cutting toenails.
3. Irrigating a Foley catheter.
4. Irrigating a colostomy.
5. Administering enemas or douches.
6. Tracheostomy care.
7. Participating in administration of TPN.
8. Participating in working with mechanical ventilators.
9. Obtaining chemstrip results.
10. Administering nebulized medication.
11. Application of prescribed heat or cold.
12. Assisting a patient with oxygen administration as prescribed.
13. Perform any personal care item not included in the plan or care prepared by the public health nurse.
14. Make judgments or give advice on medical or nursing problems.
15. Discuss the patient's illness/condition with anyone except appropriate health personnel.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HOME HEALTH AIDE POLICIES

VI. RECORDS AND OBSERVATIONS PERTAINING TO HOME HEALTH AIDE SERVICE

- A. A copy of the patient care plan, including the plan for home health aide services will be inserted in the family folder of the nursing service records. The written plan will be modified as determined by the physician's plan for care and the patient's needs.
- B. The home health aide will maintain written records of her work in the home as requested by the public health nurse. These records **will not** include judgments related to the patient's condition. They may include:
 - 1. Record of intake and output.
 - 2. Record of elimination.
 - 3. Record of diet and eating pattern.
 - 4. Record of specific personal care rendered for each day in the home.
 - 5. Record of temperature, pulse, respirations.
- C. When the aide's services in a home are terminated, these written records will be submitted to the nursing service. The nurse will collect the aide's report of nursing care at least every two weeks, or more often if the nurse makes frequent visits to give skilled care during the two-week intervals.
- D. The aide's observations of a patient's appearance and gross behavioral changes will be reported verbally to the public health nurse who provides direct supervision in the home.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HOME CARE REGISTRY

I. POLICY:

Saratoga County Department of Health will maintain, update, and consult, as needed, the Home Care Registry (HCR) as it pertains to home health aides (HHA's) employed, or contracted by the county.

Additional Info: Effective September 25, 2009, the HCR is a web-based registry of all personal care and home health aides who have successfully completed a personal care or home health aide training program approved by either the New York State Department of Health or State Education Department. The goal of this statute is to protect vulnerable New Yorkers by ensuring that only properly trained and certified individuals who are suitable for employment in health care are employed by home care service agencies to provide home care.

II. PROCEDURE:

- A. The HPN Coordinator (Emergency Preparedness Coordinator) will assign agency staff various roles (HCR Agency Viewer, HCR Agency Updater, etc.) on the Health Provider Network (HPN).
- B. The agency HPN Coordinator (Emergency Preparedness Coordinator) will update these users onto the site.
- C. Agency requirements:

Home Care Agency Requirements: Home care agencies have the following responsibilities with respect to personal care and home health aides who began training on or after September 25, 2009 and successfully completed the training program:

1. Access the aide's HCR information prior to the aide beginning to provide home care services for that agency.
2. Ensure that aides do not provide home health aide services unless the aide's training information has been posted to the HCR by the training program. Employers may not post this information for the aide.
3. For all personal care and home health aides who successfully completed training before September 25, 2009, prior to the aide beginning to provide services, the agency must access the aide's registry information. If the aide is not yet listed in the HCR, the agency must, prior to the aide beginning to provide services:
 - a) Obtain a copy of the certificate issued to the prospective employee by the training program and verify that it is valid: and
 - b) Obtain and enter on the HCR the following information for the aide:
 - Full name, including pre-marital name and any other names currently or previously used;
 - Current home address;
 - Gender;
 - Date of birth;
 - Name of each state approved education or training program successfully completed, the name of the entity providing the program, and the date on which the program was completed; and
 - History of work in home care services through any home care services entity, including dates of employment and name of entity providing the employment.

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SUBJECT: HOME CARE REGISTRY

- c) Maintain compliance with the following with respect to personal care and home health aides employed on or after September 25, 2009:
- Within 5 business days after the aide begins to provide services, update the aides' information on the HCR to show the aide's employment with the agency, including the start date.
 - Within 5 business days after receiving information from an aide who is not in the HCR, update the HCR to include the aide's information. If the information is a change of name, obtain and retain documentation of the change. Acceptable documentation of name change is a copy of a certificate of marriage, decree of divorce, or other court order authorizing a person to change his or her name.
 - Within 5 business days after an aide's employment with the agency is terminated, update the HCR with the date on which the aide's employment with the agency was terminated.
 - Upon request of any aide currently employed by the agency, provide access to complete HCR information relating to the aide, including a printed report if requested.
 - Within 5 business days after a request by an aide, correct information in the HCR that was entered incorrectly by the agency. An agency must request verification from the aide supporting the correction. If the correction involves a change of name, obtain and retain documentation of the change. Acceptable documentation of name change is a copy of a certificate of marriage, decree of divorce, or other court order authorizing a person to change his or her name.

Home Care Agency Requirements: For every personal care or home health aide who is employed by an agency on September 25, 2009, the agency must:

1. Check the registry to see if aide's information has already been entered. If so, update the aide's profile with current employment information.
2. Submit to the HCR on the HPN, according to the quarterly submission schedule shown below, all of the following information:
 - Full name, including pre-marital name and any other names currently or previously used;
 - Current home address;
 - Gender;
 - Date of birth;
 - Name of each state approved education or training program successfully completed, the name of the entity providing the program, and the date on which the program was completed; and
 - History of work in home care services through any home care services entity, including dates of employment and name of entity providing the employment.
3. The law requires all current aides to be entered into the Registry by September 25, 2010. The Department has provided the following quarterly schedule to enter this information.
4. Agencies are required to submit this information for all aides in their employment on September 25, 2009 even if the aide no longer works for the agency at the time the agency must submit the information in accordance with the schedule above.
5. Agencies are advised to collect this information for each aide in their employment on September 25, 2009 before the aide's employment ends.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HOME CARE REGISTRY

Personal Care and Home Health Aide Requirements: Personal care and home health aides also have specific responsibilities in regard to the HCR.

1. Aides who begin training on or after September 25, 2009, and successfully complete such, have the following responsibilities:
 - The aide must retain in good order the certificate of successful completion of training and display it to a prospective employer when requested;
 - If an aide discovers that the training program incorrectly entered information regarding her or himself in the HCR, the aide must provide corrected information, including any verification of the name change to the employer;
 - If any information required for the HCR changes, the aide must inform the employer of the changes and provide verification of the change as requested by the employer;
 - If an aide changes his or her name, the aide must provide proof of the name change to the employer. The employer will change the aide's name in the HCR and must retain a copy of the proof submitted in its permanent records. Appropriate proof of name change includes a copy of a certificate of marriage, decree of divorce, or other court order authorizing a person to change his or her name.
2. Aides employed by a home care agency on September 25, 2009, must provide their employer with the following information no later than 5 business days before September 25, 2009 or date of hire if date of hire is after September 18, 2009:
 - Full name, including pre-marital name and any other names currently or previously used;
 - Current home address;
 - Gender;
 - Date of birth;
 - Name of each state approved education or training program successfully completed, the name of the entity providing the program, and the date on which the program was completed; and
 - History of work in home care services through any home care services entity, including dates of employment and name of entity providing the employment.
3. If an aide discovers that an employer incorrectly entered information regarding the worker in the HCR, the aide must provide corrected information, including any verification of the information that may be requested, the employer.
4. If any information required for the HCR changes, the aide must inform the employer of the changes and provide any verification of the change requested by the employer.
5. If an aide changes his or her name, the aide must provide proof of the name change to the employer. The employer will change the aide's name in the HCR and must retain a copy of the proof submitted in its permanent records. Appropriate proof of name change includes a copy of a certificate of marriage, decree of divorce, or other court order authorizing a person to change his or her name.

DRAFT: 9/18/12
Quality Assurance Committee Review: 9/19/12
PAC Review: 10/10/12
Board of Supervisors to Review: November 2012

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: URETHRAL CATHETERIZATION PROCEDURE

I. DEFINITION:

The introduction of a catheter through the urethra into the urinary bladder.

II. PURPOSE:

1. To relieve retention
2. To provide a means for periodic instillation
3. To manage incontinence

III. EQUIPMENT:

Disposable catheterization set
Closed urinary drainage set
Foley catheter in prescribed size (including balloon size)
Sterile water or saline
Adequate lighting

IV. PROCEDURE:

1. Wash hands and don appropriate PPE to prevent infection.
2. Explain the procedure and need for procedure. This will help alleviate apprehension.
3. Place patient supine on bed.
4. Drape the patient to insure privacy.
5. Remove disposable bed protector, unfold and place under the patient's buttocks, and position patient. For the male, the legs are kept straight and slightly abducted. For females, if able, the knees are flexed sharply and spread wide apart to expose the perineum.
6. Set up sterile field.
7. Open catheter package and place contents on sterile field.
8. Don sterile gloves.
9. Inflate balloon with 10 cc sterile H₂O to ensure there are no defects, then deflate the balloon.
10. Lubricate tip of catheter well with lubricant in the catheter kit. Leave the catheter tip in sterile lubricant in the catheter kit tray.

11. FEMALE:

- a) Separate labia with one hand.
- b) With other hand take Povidone swab, which is still sterile, and cleanse from front to back once and discard. Continue until swabs are depleted, washing area thoroughly.
- c) Keeping labia separated, slowly insert the catheter until urine is returned and then continue to advance catheter approximately 1" further.

MALE:

- a) With one hand, grasp the penis just below the head.
- b) With the other hand, take Povidone swab and cleanse in circles beginning with meatus and covering head. Discard swab after each circle.
- c) Holding penis, insert the catheter slowly until urine is returned and then continue to advance catheter approximately 1" further.

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SUBJECT: URETHRAL CATHETERIZATION PROCEDURE

12. Inflate balloon with prescribed amount of sterile water.
13. Attach catheter bag to catheter tubing using clean technique.
14. If more than 500 cc of urine should be obtained, clamp catheter for 5-10 minutes before continuing to drain the bladder. This will prevent bladder spasms.
15. Evaluate patient's tolerance to the procedure.
16. Secure catheter to thigh with tape, if no skin sensitivity.
17. Dispose of equipment appropriately.
18. Observe color, clarity, and amount of urine in drainage bag.

V. CHARTING

- 1) Record in Nurse's Notes any problems with the catheterization, size of catheter inserted, amount of sterile H₂O inserted into balloon, amount and character of urine, and patient's tolerance.
- 2) Record I & O if indicated.

REFERENCE:

Judith M. Wilkinson, Leslie S. Treas (2011), page 619-622, Fundamentals of Nursing: (2nd ed.). Philadelphia, PA: F.A. Davis Company.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PHYSICIAN ORDERS TRACKING POLICY AND PROCEDURE FOR MATERNAL CHILD, LEAD, TUBERCULOSIS, AND SYNAGIS PROGRAMS

I. PURPOSE:

To ensure timely signing and receipt of physician orders within the required 30 day time frame.

II. POLICY:

Saratoga County Public Health Nursing Service will track all Prevention physician orders from the time that they are created to the time that they are returned signed by the physician, and filed on the chart.

III. PROCEDURE:

A. Computer Generated 485 Orders

1. The nurse completes a 485 physician order work sheet and gives it to the Medical Secretary within two business days.
2. The Medical Secretary checks to see if the patient has been made active or was active/discharge for one visit in HCMS.
3. The Medical Secretary creates the 485 physician orders in HCMS within two business days.
4. The Medical Secretary prints **three** copies of the 485 physician orders, highlights the words "MD Signature" and "Date" on one copy of the orders. The Medical Secretary puts all three copies in the nurse's folder in the reception office (Prevention Nursing Supervisor's folder if nurse is on vacation).
5. The nurse or Prevention Supervisor reviews and signs two copies of the 485 physician orders.
6. The nurse keeps the 485 copy that is stamped "COPY" in a tickler file, and places the other 2 copies in the CHHA office outgoing mail bin.
7. The reception office Typist retrieves the orders from the CHHA office outgoing mail bin, enters the date that the orders will be mailed into the HCMS physician orders tracking screen, and then mails the orders.
8. The nurses will check their tickler file weekly to track the return of signed orders, and will begin calling the physician office if orders are not received back by day 15. The nurse will continue to call the physician office requesting the signed orders, until the signed orders are received.
9. If signed orders are not received by 21 days after the order date, the nurse will notify the Prevention Supervisor.
10. The reception office Typist receives the signed 485 orders returned by mail, or by fax, stamps them with the date of receipt, enters the date signed by the physician in to the HCMS orders tracking screen and then puts the signed orders in the nurse's folder in the reception office.

B. Nursing Interim Orders (NCR Handwritten)

1. The nurse completes the Interim order and places it in the CHHA office outgoing mail bin.
2. The reception office Typist makes a photocopy of the original NCR order and gives it to the nurse who files it in her tickler file.
3. The receptionist office Typist logs the order mailed date in the HCMS orders tracking screen and mails the original NCR order.
4. The nurse checks the tickler file weekly to track the return of signed orders and will begin calling the physician's office if orders are not received back by day 15.
5. The nurse will continue to call the physician office requesting the signed orders until the signed orders are received.
6. If signed orders are not received by 21 days after the order date, the nurse will notify the Prevention Supervisor.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: CHHA/LTHHCP PHYSICIAN ORDERS TRACKING POLICY AND PROCEDURE

I. PURPOSE:

To ensure timely signing and receipt of physician orders within the required 30 day time frame from the date the order was created.

II. POLICY:

Saratoga County Public Health Nursing Service will track all CHHA and LTHHCP physician orders from the time that they are created to the time that they are returned signed by the physician. SCPHNS will insure the timely signing and receipt of all CHHA and LTHHCP orders by flagging orders at the 15th day past the date that the order was created. SCPHNS will take immediate and repeated action to get the orders signed within the required 30 day time frame.

III. PROCEDURE:

A. Computer Generated 485 Orders

1. All CHHA/LTHHCP 485 physician orders created in the Clinical Documentation System (Clindoc) must be reviewed and processed by the CHHA Nursing Supervisor or the CHHA Therapy Supervisor.
2. The Medical Secretary prints the *Processed Note Report* daily to see if any Start of Care (SOC) note or Recertification note, have been processed because they will generate 485's that will need to be printed by the SCPHN Medical Secretary. (Interim orders, Resumption of Care (ROC) interim orders and discharge orders automatically print when the note is processed by a CHHA supervisor).
3. The Medical Secretary prints the *Unprocessed Note Report* weekly and highlights any unprocessed SOC notes, Recertification notes, notes containing interim physician orders, and discharge notes. Copies of this report will be distributed to the CHHA Supervisors. (Some unprocessed notes may be in field or office edit awaiting corrections by clinicians).
4. Three copies of every Physician order are printed.
5. The Medical Secretary retrieves the printed orders from the printer.
6. The Medical Secretary gives all three copies of 485 SOC orders and 485 recertification orders for nursing cases and therapy cases to the Nurse Case Manager (the CHHA Nursing Supervisor will review and sign if the nurse is on vacation) , and the CHHA Therapy Supervisor respectively, to review and sign.
7. The Nurse Case Manager and the Therapy Supervisor must also write the verbal order date on the 485 recertification orders.
8. The Medical secretary files one copy of the physician order in the orders tracking accordion file. The 485 physician orders are filed by the first date of the certification period.
9. The Medical Secretary highlights the physician "signature and date" on the second copy of **all** computer physician orders.
10. The Medical Secretary paper clips the second and third copy of the physician orders together and places them in the outgoing mail bin in the CHHA office.
11. The Reception office Typist retrieves the physician orders from the outgoing mail bin in the CHHA office and stamps "MD Copy" on one copy of the physician orders. The Reception office typist then enters the date that the physician orders are mailed or faxed to the physician, into the Home Care Management Computer system (HCMS) orders tracking screen. Some physician orders are faxed, not mailed per physician request.
12. Physician orders should be signed and returned within 30 days from the date that the order was created.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: CHHA/LTHHCP PHYSICIAN ORDERS TRACKING POLICY AND PROCEDURE

13. Signed physician orders returned by mail are received by the reception office Typist. The reception office Typist enters the date that the physician orders were signed, into the HCMS order tracking screen, and stamps the date of receipt on the orders.
14. Signed physician orders returned by fax are removed from the fax machine by the reception office Typist and the CHHA Information Processing Specialist. They enter the date that the physician orders were signed, into the HCMS order tracking screen and initial the order to confirm that it was entered into tracking.
15. **All** returned orders are given to the Medical Secretary. The Medical secretary pulls the copy of the physician orders from the accordion file and discards it in the confidential shredding bin. The Medical Secretary places a red check mark on the signed physician orders and places them on the chart or in the filing bin.

B. Computer Generated Interim Orders (Nursing and Therapy)

1. All CHHA/LTHHCP 485 interim orders created in the Clinical Documentation System (Clindoc) must be reviewed and processed by the CHHA Nursing Supervisor or the CHHA Therapy Supervisor.
2. The Medical Secretary prints the *Unprocessed Note Report* weekly and highlights any unprocessed notes, notes containing interim physician orders including discharge notes. Copies of this report will be distributed to the CHHA Supervisors. (Some unprocessed notes may be in field or office edit awaiting corrections by clinicians).
3. Interim orders, Resumption of Care (ROC) interim orders and discharge interim orders automatically print when the note is processed by a CHHA supervisor.
4. The Medical secretary retrieves the printed orders from the printer.
5. The Medical secretary files one copy of the Interim order in the orders tracking accordion file. The interim physician orders are filed by order date for tracking purposes.
6. The Medical Secretary highlights the physician "signature and date" on the second copy of **all** computer physician orders.
7. The Medical Secretary paper clips the second and third copy of the physician orders together and places them in the outgoing mail bin in the CHHA office.
8. The Reception office Typist retrieves the physician orders from the outgoing mail bin in the CHHA office and stamps "MD Copy" on one copy of the physician orders. The Reception office typist then enters the date that the physician orders are mailed or faxed to the physician, into the Home Care Management Computer system (HCMS) orders tracking screen. Some physician orders are faxed, not mailed per physician request.
9. Physician orders should be signed and returned within 30 days from the date that the order was created.
10. Signed physician orders returned by mail are received by the reception office Typist. The reception office Typist enters the date that the physician orders were signed, into the HCMS order tracking screen, and stamps the date of receipt on the orders.
11. Signed physician orders returned by fax are removed from the fax machine by the reception office Typist and the CHHA Information Processing Specialist. They enter the date that the physician orders were signed, into the HCMS order tracking screen and initial the order to confirm that it was entered into tracking.
12. **All** returned orders are given to the Medical Secretary. The Medical secretary pulls the copy of the physician orders from the accordion file and discards it in the confidential shredding bin. The Medical Secretary places a red check mark on the signed physician orders and places them on the chart or in the filing bin.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: CHHA/LTHHCP PHYSICIAN ORDERS TRACKING POLICY AND PROCEDURE

C. Therapy Interim Orders (NCR Handwritten)

1. Non-computer therapy clinician's complete a hand written physician order and places it in the outgoing mail bin in the reception office.
2. Senior Typist makes a copy of the interim order and stamps "COPY" on the photocopy and places in Medical Secretary's mailbox.
3. The Medical Secretary files the copy in the "order Tracking" accordion file by order date.
4. The Senior Typist gives the original white copy of the Interim order to Typist who enters it in the HCMS "Order Tracking" screen.
5. The Typist mails the original Interim order.

D. Nursing Interim Orders ((NCR Handwritten)

1. The PRI/UAS nurse completes the Interim order and places it in the CHHA office outgoing mail bin.
2. The reception office Typist makes a photocopy of the order and logs the order mailed date in the HCMS orders tracking screen and mails the order.
3. The receptionist office Typist gives a photocopy of the order to the Medical Secretary who files it in the "order tracking" accordion orders tracking file.

E. Outstanding Orders at 15 Days Post Order Date

1. The Medical Secretary checks the unreturned order copies (which are filed by order date) in the accordion file, twice weekly. When an order copy is noted in the file 15 days after the order date, the Medical Secretary checks the tracking screen to see if the physician order has already come back and was entered in to tracking without the Medical Secretary being informed or without the order copy being pulled from the accordion file. This will help prevent duplicate signed orders.
2. The Medical Secretary will pull the copy of the physician order, not returned by the 15th day, from the accordion file. The Medical Secretary will call the Physician's office, inform the office person that the orders must be signed and returned so that **SCPHNS is in compliance with regulations**.
3. The Medical Secretary will request that the physician office person check the patient's chart for a copy of the orders.
 - a. If there is a signed copy of orders in the physician's office patient chart, the Medical Secretary will request that the physician office person fax the orders that day to the attention of the Medical Secretary at the 583-1202 fax number.
 - b. If there is a copy of the unsigned order in the patient chart, the Medical Secretary will request that the orders be signed and returned within 1-2 days.
 - c. If there is no copy of the order in the patient chart, the SCPHN Medical Secretary will fax the order copy to the physician office person, requesting the order be signed and returned within 1-2 days. The Medical Secretary will record the name of the physician office person, the time and date of the conversation. The written record of the conversation will be attached to the fax sheet and order(s). This will be kept with a log sheet in a manilla folder on the Medical Secretary's desk.
 - d. This will be repeated until the signed order is returned. Following the receipt of the signed order the Medical Secretary will file the fax sheet(s), the written conversation(s) record and the order on the chart.
 - e. If no signed order is received by day 21, the Medical Secretary will alert the CHHA Nursing Supervisor or the Therapy Supervisor as appropriate and the supervisor will follow up with the physician's office.

PEER REVIEW AUDIT TOOL

Date of Audit: _____

Patient Record #: _____ SOC Date: ____ / ____ / ____ Primary Clinician: _____

Active OR Discharge (circle one) Services: SN PT OT SLP MSW RD HHA PCA RT (circle) Payor Source _____

PHYSICIAN ORDERS		YES	NO	N/A	COMMENTS
1	Was the Start of Care (SOC) visit completed within 48 hours?				
	a) Was the Start of Care visit completed on the initial physician ordered SOC date?				
	b) If not, was the physician notified, and a verbal order for a new Start of Care date obtained?				
	c) Was the verbal order (containing supporting documentation) transcribed into a written order and sent to the physician for signature?				
2	At SOC, if there is a 1wk1 order for an ancillary service (therapy, MSW) evaluation, did the clinician complete the evaluation within 7 days?				
	a) If not, did the clinician contact the physician to notify the physician as to why the evaluation wasn't done within 7 days and obtain a new verbal 1wk1 order?				
	b) If a new verbal order for the 1wk1 evaluation was obtained, was it put into writing and sent to the physician for signature?				
3	If any verbal order was taken by a clinician, was it transcribed into a written order and sent to physician for signature?				
4	Is the patient taking a nutritional supplement?				
5	If yes, does 485 contain an order for a nutritional supplement?				
6	If no order on 485,				
	a) was the physician contacted regarding the supplement and verbal order obtained?				
	b) was the verbal order put into writing and sent to MD for signature?				
7	Does the patient use anti-embolism stockings?				
8	If yes, does the 485 contain:				
	a) an order for anti-embolism stockings				
	b) specific order regarding frequency of stocking application and removal				
9	If no order on 485,				
	a) was the physician contacted regarding the anti-embolism stockings and a verbal order obtained?				
	b) was the verbal order put into writing and sent to MD for signature?				
10	Does the patient use oxygen?				
11	If yes, does the 485 contain:				
	a) an order for oxygen;				
	b) method of delivery;				
	c) liters per minute				

PHYSICIAN ORDERS (cont.)		YES	NO	N/A	COMMENTS
12	If no order on the 485, a) was the physician contacted regarding the oxygen and a verbal order obtained?				
	b) was the verbal order put into writing and sent to MD for signature?				
13	If there is an order for patient to titrate their oxygen, does it contain specific parameters as to when oxygen should be titrated?				
14	Does patient use an insulin pump?				
15	If yes, does the 485 contain an order for:				
	a) the insulin pump;				
	b) person responsible for the pump settings;				
	c) type of insulin;				
	d) who is responsible for changing the insertion site?				
16	If no order on 485, a) was the physician contacted regarding the insulin pump and a verbal order obtained?				
	b) was the verbal order put into writing and sent to MD for signature?				
17	Does the patient/caregiver use a glucometer?				
18	If yes, does the 485 contain an order that indicates:				
	a) how often fingersticks are to be done; b) who is responsible to perform them				
19	If no order on 485, a) was the physician contacted regarding the glucometer and verbal order obtained?				
	b) was the verbal order put into writing and sent to MD for signature?				
20	If patient is a diabetic, does 485 contain an order regarding diabetic foot care and education?				
21	Does the patient have a wound?				
22	Does the 485 contain orders for wound care?				
23	If no order on 485, was the physician contacted regarding the wound and an interim order obtained?				
24	Does the wound care order state type and location of wound?				
25	If there are changes in the wound care, are there interim orders for the changes?				
26	If wounds were not measured every 7 days:				
	a) was the physician notified that same day? b) was an order written with reason why and date that measurements and photos will be done and sent to the physician for signature?				
27	Was frequency and duration of all disciplines on 485 followed?				
28	If not, was MD notified and a written order done?				

PHYSICIAN ORDERS (cont.)		YES	NO	N/A	COMMENTS
29	Was there a reduction in SN, PT, OT SLP, MSW, RD, RT, MOW and HHA visit frequency or duration that differed from the current plan of care (485)?				
30	If yes, was an HHCCN completed for the reduction and signed by the patient? (Medicare PPS patients only)				
31	If there was more than one service reduced for different reasons, was a separate HHCCN done for each reduction? (Medicare PPS patients only)				
32	Was there a termination of service(s) by the physician or agency? (other than when goals are met)				
33	If yes, was an HHCCN completed for the termination and signed by the patient?				
CARE PLAN		YES	NO	N/A	COMMENTS
1	If patient takes a nutritional supplement, does the care plan contain information regarding the name and frequency the supplement is taken?				
2	If patient uses anti-embolism stockings, does the care plan list and address specific orders regarding frequency of stocking application and removal?				
3	If patient uses oxygen, are the oxygen orders including oxygen titration parameters, if applicable, and oxygen safety teaching listed and addressed in the care plan?				
4	If the patient uses an insulin pump: a) is it documented in the care plan?				
	b) does it match the orders on the 485?				
5	If the patient uses a glucometer, does the care plan list and address: -how often fingersticks are to be done;				
	-who is responsible to perform fingersticks?				
6	If patient is a diabetic, does care plan list and address foot care education?				
7	If patient has a wound, are the current wound care orders listed and addressed in the care plan?				
8	If patient has a wound, is a regular weekday listed in the care plan that wound measurements and photos are to be done?				
9	If patient has a wound, were wound measurements and pictures done and documented every 7 days?				
10	If wound measurements and pictures weren't done every 7 days on the specified day, is there appropriate and detailed documentation explaining why? ("measurements and or pictures not done" is not appropriate documentation)				
11	If patient has pain, is type and location of pain documented in the "Intervention" section of care plan?				
12	Is patient's response to pain management measures documented in the "Response" section of the care plan or in the clinical assessment?				
13	If the patient has a diagnosis of: COPD, CHF, Diabetes, wounds, catheter, or pneumonia, is zone tool use documented in the care plan?				
14	Are due dates in care plans updated (catheter changes, wound measurements/pictures, routine injections, HHA supervisions)?				

MEDICATION PROFILE		YES	NO	N/A	COMMENTS
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	Do medications listed on the referral match the initial medication profile?				
5	If not, was a medication reconciliation done with MD?				
6	Are all medication reconciliation changes indicated on the medication profile?				
7	If patient takes sliding scale insulin, are the sliding scale instructions listed on the medication profile?				
8	During the course of care, if new medications were ordered, or dosage of a medication was changed, were they:				
	a) verified with physician?				
	b) documented on the medication profile?				
9	If a medication has a finite end date, is that end date documented on medication profile? (i.e., antibiotics, blood thinners, steroids)				
10	If a verbal order was received for a medicated ointment, was it transcribed into a written order (containing the specific name of the medicated ointment), and sent to the physician for signature?				
11	If a medicated ointment was ordered, was it listed in the medication profile?				
12	Does the specific name of the medicated ointment listed on the physician order match the specific name of the medicated ointment listed in the medication profile?				
DOCUMENTATION REQUIREMENTS		YES	NO	N/A	COMMENTS
1	Have ankle measurements been documented in the "Cardiac" section of visit note, or in care plan, per agency standard?				
	a) If not, is reason documented?				
2	Have weights been documented in "Vital Signs" section of visit note, or in care plan, per agency standard?				
	a) If not, is reason documented?				
3	If vital signs were outside the agency parameters for any visit, is there documentation that MD was notified?				
4	If patient has a wound, is a thorough description of the wound including correct anatomic location, type of tissue visualized, undermining, tunneling, slough, drainage, documented in every visit note?				

DOCUMENTATION REQUIREMENTS (cont.)		YES	NO	N/A	COMMENTS
5	IF PT ONLY CASE:				
	a) did PT inquire about surgical wound at each visit and document?				
	b) did PT observe surgical wound at least once a week and document?				
	c) if PT noted incision abnormalities or s/s of infection, did they notify MD?				
	d) If MD ordered SN visit to eval incision, did PT obtain physician order?				
	e) Did PT conference with PT supervisor regarding SN visit request, and document conference with PT supervisor?				
	f) did PT supervisor discuss MD order for nursing visit with CHHA nursing supervisor and document in patient record?				
6	If the clinician noted, or the patient reported a change in the patient's condition, was the physician notified the same day?				
7	If the clinician noted or the patient reported non-compliance with medication:				
	a) was it reported to the physician the same day?				
	b) was an order written regarding the medication non-compliance and sent to the physician for signature?				
8	If the patient reported a medication change,				
	a) was the physician contacted to confirm the medication change on the same day?				
	b) was the order transcribed into writing and sent to the physician for signature?				
9	If the clinician attempted to contact the physician regarding a change in the patient's condition or a medication change and did not receive a response:				
	a) did the clinician continue to try to contact the physician until a response was obtained?				
	b) If not, did the clinician report to a supervisor or covering clinician to follow-up?				
10	Is the patient a diabetic?				
	a) if the patient reported a fingerstick result outside of agency or physician ordered parameters, was the physician notified the same day?				
11	If there were changes in the patient's condition, is there documentation of coordination between disciplines?				
12	Is there documentation regarding influenza and pneumonia vaccination status under Patient History in the SOC OASIS, and any recertification and ROC OASIS?				
13	If patient has poor pain control, is there documentation indicating communication with the physician?				
14	If MD prescribed new pain management orders, is there documentation indicating follow-up and teaching with patient?				
15	If there were medication discrepancies, is there documentation of communication with the physician regarding medication discrepancies and reconciliation?				
16	If medications had to be reconciled, is there follow-up documentation that patient/caregivers, and therapist, if applicable, were made aware of changes?				

DOCUMENTATION REQUIREMENTS (cont.)		YES	NO	N/A	COMMENTS
17	Is there documentation of medication teaching at SOC, ROC, Recertification, and/or following medication reconciliation, including desired effects, adverse effects, and possible interactions?				
18	If new medication(s) are ordered during the course of care, is medication teaching documented?				
19	Is there a patient signature sheet for every nursing and therapy visit?				
	a) Does "time in" on the signature sheet match the "time in" on clinical note?				
20	If at any point during the episode, Medicare PPS would no longer cover services, and patient wished to continue under another insurance or self-pay, was an ABN completed and signed by patient?				
21	Was the patient notified and ABN issued in advance of the date that payer changed?				
22	If at any point during the episode, the patient services were reduced from frequencies listed on the 485, or terminated, was an HHCCN completed and signed by patient? (Medicare PPS only)				
23	Was the patient notified and the HHCCN issued in advance before services were reduced or terminated?				
24	If services were terminated and HHCCN was not issued in advance, is there documentation substantiating why? (i.e., staff threatened by someone in home, drug trafficking in the home)				
AIDE CARE PLAN AND NOTES		YES	NO	N/A	COMMENTS
1	Does the patient have HHA service?				
2	Do the activities documented on the aide notes match the activities listed on the aide care plan?				
	a) If not, is there documentation in the chart that the nurse discussed with aide to only complete tasks that are authorized on the aide care plan?				
3	If the patient is taking an anti-coagulant, are bleeding precautions listed on the aide care plan?				
4	If the patient has an order for anti-embolism stockings, is application and removal of the stockings listed on the aide care plan?				
5	Is there documentation on the aide notes that the notes were reviewed and initialed by the case manager?				
MISCELLANEOUS		YES	NO	N/A	COMMENTS
1	Are planned services and frequencies documented on the Welcome Letter that is completed and signed at SOC?				

DISCHARGE		YES	NO	N/A	COMMENTS
1	Was patient transferred to an acute care hospital and discharged from agency?				
2	If yes, was a discharge summary order completed and sent to the physician for signature that included the following:				
	a) Reason for discharge				
	b) Date of discharge				
3	Is there documentation that the physician was contacted and notified of discharge?				
4	Was the patient discharged from the agency for reasons other than acute care hospitalization? (i.e., goals met, no further skilled need, no longer homebound, patient refused further services)				
5	If yes, was a discharge summary order completed and sent to the physician for signature that included the following:				
	a) A summary of patient care provided?				
	b) A summary of patient teaching provided?				
	c) A summary of patient teach back?				
	d) Patient's status at discharge?				
	e) Were goals met/partially met?				
	f) Primary caregiver, if any?				
	g) Community supports, if any?				
	h) Information on physician follow-up plan after discharge?				
6	Is there documentation in the record that the physician was contacted to discuss discharge?				
7	Was a Notice of Non-Coverage given to the patient 48 hours in advance of discharge?				
8	If the patient no longer qualified for home care services based on insurance or no skilled need, was the patient offered a sliding fee?				

Saratoga County Public Health Nursing Service
COMPLIANCE RECORD AUDIT TOOL

Patient Initials: _____ ID# _____ Date of Audit: _____

DOCUMENTATION REQUIREMENTS		YES	NO	N/A	Comments
PHYSICIAN ORDERS					
1	Was the Start of Care visit completed within 48 hours of receiving the referral?				
	1a) If not, was the Start of Care visit completed on the initial physician ordered Start of Care date?				
	1b) If not, was the physician notified, and a verbal order for a new Start of Care date obtained?				
	1c) Was the verbal order (containing supporting documentation) transcribed into a written order and sent to the physician for signature?				
2	At SOC, if there is a 1wk1 order for an ancillary service (therapy, MSW) evaluation, did the clinician complete the evaluation within 7 days?				
	2a) If not, did the clinician contact the physician to notify the physician as to why the evaluation wasn't done within 7 days and obtain a new verbal 1wk1 order?				
	2b) If a new verbal order for the 1wk1 evaluation was obtained, was it put into writing and sent to the physician for signature?				
3	If any verbal order was taken by a clinician, was it transcribed into a written order and sent to physician for signature?				
4	If an insulin pump is ordered, does an order indicate the type of insulin placed in the insulin pump as well as who is responsible for the pump settings?				
5	If PRN oxygen is ordered and a patient may titrate the oxygen, does the order include parameters to instruct a patient as to when oxygen should be titrated?				
6	If anti-embolism stockings are ordered, does the POC include an order for anti-embolism stockings?				
	6a) Does the MD order include specific instructions for application/removal of stockings?				
7	If the patient is taking a dietary/nutritional supplements:				
	7a) Was the physician notified?				
	7b) Is there an order on the 485 or interim order for the supplement?				
8	Was the MD notified if vital signs were outside of agency or physician ordered parameters?				
9	Was the frequency and duration of visits stated in the POC followed?				
	9a) If no, was the MD notified of change in frequency and/or duration in POC and a Resumption of Care date if indicated?				
	9b) Was an order written and sent to MD for signature?				
MEDICATIONS					
1	Do the medications listed on the referral match the initial medication profile?				
	1a) If no, was it documented that a medication reconciliation was completed with MD?				

Saratoga County Public Health Nursing Service
COMPLIANCE RECORD AUDIT TOOL

	DOCUMENTATION REQUIREMENTS	YES	NO	N/A	Comments
	MEDICATIONS (continued)				
2	Does the Medication Profile include any known allergies a patient may have or indicate no known allergies?				
3	If there were medication changes, does the Medication Profile reflect changes?				
4	If an inhalation medication is ordered, does the order include the number of times of day the medication can be taken or the time interval between doses?				
5	If a verbal order was received for a medicated ointment, was it transcribed into a written order (containing the specific name of the medicated ointment) and sent to the physician for signature?				
6	If a medicated ointment was ordered, was it listed in the medication profile?				
7	Does the specific name of the medicated ointment listed on the physician order match the specific name of the medicated ointment listed in the medication profile?				
WOUND CARE					
1	Does the patient have a wound?				
	1a) If yes, have the "Standards for Wound Assessment" been followed?				
2	Were wound measurements and photos done every 7 days?				
	2a) If not, was the physician notified that same day?				
	2b) Was an order written with reason why and date that measurements and photos will be done, and sent to the physician for signature?				
3	Is the patient seen by a wound healing center?				
	3a) If yes, does the SCPHNS clinical record indicate coordination and documentation of current wound status per "Standards for Wound Assessment"?				
AIDE CARE PLAN AND NOTES					
1	Does the patient have HHA service?				
2	Do the activities documented on the aide notes match the activities listed on the aide care plan?				
	2a) If not, is there documentation in the chart that the nurse discussed with aide to only complete tasks that are authorized on the aide care plan?				
3	If the patient is taking an anti-coagulant, are bleeding precautions listed on the aide care plan?				
4	If the patient has an order for anti-embolism stockings, is application and removal of the stockings listed on the aide care plan?				
5	Is there documentation on the aide notes that the notes were reviewed and initialed by the case manager?				

Saratoga County Public Health Nursing Service
COMPLIANCE RECORD AUDIT TOOL

	DOCUMENTATION REQUIREMENTS	YES	NO	N/A	Comments
DOCUMENTATION					
1	If the clinician noted, or the patient reported a change in the patient's condition, was the physician notified the same day?				
2	If the clinician noted or the patient reported non-compliance with medication, was it reported to the physician the same day?				
	2a) Was an order written regarding the medication non-compliance and sent to the physician for signature?				
3	If the patient reported a medication change, was the physician contacted to confirm the medication change on the same day?				
	3a) Was the order transcribed into writing and sent to the physician for signature?				
4	If the clinician attempted to contact the physician regarding a change in the patient's condition or a medication change and did not receive a response, did the clinician continue to try to contact the physician until a response was obtained?				
5	If not, did the clinician report to a supervisor or covering clinician to follow-up?				
6	Is the patient a diabetic?				
	6a) If the patient reported a fingerstick result outside of agency or physician ordered parameters, was the physician notified the same day?				
7	If there were changes in the patient's condition is there documentation of coordination between disciplines?				
8	Is there documentation regarding influenza and pneumonia vaccination status under patient history in the SOC OASIS, and any Recertification, and ROC OASIS?				
MISCELLANEOUS					
1	Are planned services and frequencies documented on the Welcome Letter that is completed and signed at SOC?				

Follow-up action required: _____

Signature / Title of Reviewer

Corrections Completed/Date

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR PROTECTED HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

Saratoga County Public Health Nursing Service is committed to maintaining the confidentiality of your Protected Health Information (PHI). In providing your care, we will create records regarding your treatment and the services we provide to you. We are required by law to maintain the confidentiality of your Protected Health Information.

This notice will provide you with information on how we may use and disclose your Protected Health Information.

This notice applies to all records maintained by this agency containing your Protected Health Information. We reserve the right to revise or amend this privacy notice. Any changes will be effective for Protected Health Information we maintain about you at that time. Our agency will post a copy of our revised notice in our office and you may request a copy by calling our office at (518) 584-7460.

If you have questions regarding this notice, you may contact the HIPAA Compliance Office at (518) 584-7460 during normal business hours.

WAYS WE MAY BE USING AND DISCLOSING YOUR PROTECTED HEALTH INFORMATION

The following are ways in which we may use and disclose your Protected Health Information:

TREATMENT: Our agency may use your PHI to provide treatment to you. We may allow or disclose information to agency nurses access to your medical record to provide ordered care. In addition, we may disclose information to others who may assist in your care such as therapist and home health aides and home health aide agencies.

PAYMENT: Our agency may use and disclose PHI for billing and payment for services and supplies you may receive. Examples of such use and disclosure may include: contacting your health insurance provider to verify coverage and to obtain payment. We may also release information to you or other third party individuals to obtain payment.

HEALTH CARE OPERATIONS: Our agency may use and disclose your PHI to conduct business. For example we may use and disclose your information to evaluate the quality of care you received or monitor our compliance with state and federal regulations.

APPOINTMENT REMINDERS: Our agency may use and disclose your PHI to contact you to remind you of visits and/or appointments.

BUSINESS ASSOCIATES: Our agency may use or disclose information to a person or entity we contract with to perform some of our functions for us and who need access to the information to perform those functions. For example: a billing service, attorney, and auditor.

HEALTH RELATED BENEFITS: Our agency may use or disclose your PHI to facilitate your discharge.

RELEASE OF INFORMATION TO FAMILY/FRIENDS: Our agency may use or disclose your PHI to a friend or family member that is assisting in your care or helping you pay for your health care.

USES AND DISCLOSURES OF PHI WITHOUT AN AUTHORIZATION: Our agency may use or disclose your PHI as required by law and by government agencies, such as to respond to a court order or subpoena and for public health information.

USES AND DISCLOSURES OF PHI WITH AN AUTHORIZATION: In addition, our agency will obtain a signed authorization for any uses or disclosures not for treatment, health care operations, and payment and will use the information as stated in the authorization. All such requests will be looked at on a case-by-case basis to limit the release of information to the minimum amount necessary. You have the right to cancel an authorization at any time, except to the extent that this agency or another company or individual has already relied on the information.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI): You have the following rights regarding the PHI that our agency maintains about you. You may contact the agency's HIPAA Compliance Coordinator at (518) 584-7460 to obtain the appropriate form needed to exercise any of these rights.

CONFIDENTIAL COMMUNICATIONS: You have the right to request our agency to communicate with you about your PHI in a particular manner or at a certain location. You must make such a request in writing to the agency HIPAA Compliance Coordinator. We will respond to you in writing within 30 days of receiving your written request.

REQUESTING RESTRICTIONS: You have the right to request a restriction on the uses and disclosure of your PHI. We are not required to agree with your request. You may make your request in writing to the agency's HIPAA Compliance Coordinator.

RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION (PHI): You have the right to inspect and obtain copies of your PHI in your medical record. Medical records are the property of this agency. You must make your request in writing to the agency's HIPAA Compliance Coordinator. You may inspect your record within 48 business hours of receipt of your request. Our agency may charge a fee for the cost of copying and postage. You will be informed of the amount prior to the copying. Our agency may deny your request. We will inform you in writing of the reason for the request denial.

RIGHT TO AMEND YOUR PROTECTED HEALTH INFORMATION (PHI): You have the right to ask us to amend your health PHI if you believe it is incorrect or incomplete. You must specify who made the entry, date of entry, reason for change and what it should read. You may request a "Request for Amendment of Medical Record" form from the agency HIPAA Compliance Coordinator. We will respond to you within 60 days of receipt of your written request. If we approve your request we will make the change to your PHI and inform you of the change in writing. Our agency may deny your request if your PHI is accurate and complete; not created by our agency; not part of the PHI kept by us; or not allowed to be disclosed. You will receive written notification of the reason for the denial and will become part of your agency record.

RIGHT TO ACCOUNTING OF DISCLOSURES: You have the right to request a list of situations in which our agency has given out your PHI. The list may not include: disclosures we made so that you could receive treatment; disclosures made to receive payment for the care we provided to you; disclosures made in order to operate our business; disclosures made to you or people you choose; disclosures to law enforcement or authorized governmental agencies; disclosures made prior to April 14, 2003; or disclosures made in accordance with your authorization. You must submit a written request to the agency HIPAA Compliance Coordinator. We will respond within 60 days of receipt of your written request. Your request must state a time period that may not be longer than 6 years and not include dates prior to April 14, 2003. The list will include: date of the disclosure to person/agency disclosed to; description of information; and reason for disclosure. The first list you request within a 12-month period will be free. If you request another list within the same 12-month period, you may be charged a fee. You will be informed in advance of the fee and you will be given a chance to cancel or change your request.

RIGHT TO A COPY OF OUR NOTICE OF PRIVACY PRACTICES: You have a right to a copy of our Notice of Privacy Practices at any time. You may request a copy from the agency's HIPAA Compliance Coordinator at (518) 584-7460.

RIGHT TO FILE A COMPLAINT: If you believe your privacy rights have been violated, you may file a written complaint to the agency's HIPAA Compliance Coordinator at:

**Saratoga County Public Health Nursing Service
31 Woodlawn Avenue, Suite 1, Saratoga Springs, NY 12866-2198**

You may also file a complaint with the Office of Civil Rights, US Department of Health and Human Services. You will not be penalized for filing a complaint.