

**NorthEast Ohio Neighborhood Health Services, Inc.**

**NEON**



# **Provider Manual**

**November 2012  
Update**

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## **SECTION A: Mission, Strategic Clinical Plan, Scope of Practice**

### **NEON MISSION & VALUES STATEMENT**

The mission of NEON is to lead the health care industry in providing quality, personalized and family-oriented comprehensive health care services to Northeast Ohio residents at reasonable costs, with professional, dedicated employees, while employing the most current health care practices that are responsive to community needs for prevention and treatment of disease.

To fulfill this mission NEON will continue to:

- Enhance the quality of life for all who seek NEON services.
- Provide services in a caring and kind environment.
- Deliver efficient and effective health care services.
- Maintain and expand geographic and financial accessibility.
- Emphasize prevention through individual patient and community-based health education.
- Identify, recruit and retain provider, administrative, ancillary and other support staff of the highest quality.
- Act in a financially responsible manner.
- Collaborate with community-based organizations.
- Meet and attempt to exceed the requirements of Joint Commission on Accreditation of Healthcare Organizations.
- Comply with Federal, State and other regulatory agencies' requirements.

### **OVERVIEW of NEON**

Organized in 1967, NEON consists of a network of community health centers serving Greater Cleveland. NEON is a not-for-profit entity and is governed by a Board of Trustees that includes consumers of services and other concerned citizens in the health, civic, and legal fields. The Board of Trustees of NEON delegates the overall responsibility of managing the health center operation to the Chief Executive Officer.

The first NEON location began at what was the Norwood Health Center, which merged in 1998 with the second service location, Hough Health Center that opened in 1974. The mid-1980s marked a period of substantial growth as three additional health centers were established: Superior Health Center; Collinwood Health Center; and Southeast Health Center. The East Cleveland Health Center opened in 1995. Collectively, the five health centers have greatly expanded the availability of primary health care services to residents in the Greater Cleveland area. The health centers offer accessible, comprehensive primary care services to the entire family, including Adult Medicine, Pediatrics, Ob/Gyn, Dental, Optometry, and Podiatry services. Ancillary services available to users within the network of health centers include CLIA-certified laboratory services, x-ray, and pharmacy services.

NEON services are available to users on a sliding fee schedule that is based on the Federal Poverty Guidelines that take into consideration a client's income and immediate family size. NEON accepts a number of payment arrangements for services including Medicare, Medicaid, and various commercial insurers.

NEON is committed to a service delivery model that emphasizes accessible personalized care. Each patient has access to a primary care provider, who coordinates all of his or her health care needs. In addition to clinical services, patients have access to social work, health education, family planning, and nutrition counseling. All of this is directed at providing a multi-disciplinary approach to improving health outcomes. As of this edition of the Provider Manual, NEON has been continuously accredited by the Joint Commission since 1975.

## **HISTORICAL PERSPECTIVE OF NEON**

Throughout its four decades of service history, NEON has built a tradition of meeting the health care needs of underserved populations in the Greater Cleveland area. Founded in 1967 as a program of the Office of Economic Opportunity, NEON began serving the community. The following milestones highlight NEON's tradition of growth and service to Northeast Ohio residents:

<b>Year</b>	<b>Milestone</b>
1967	Services begin at its first location, Norwood Health Center
1974	A new facility, the Hough Health Center, is built, targeting residents of Cleveland's Hough neighborhood
1985	The Superior Health Center opens
1986	Collinwood Health Center and Southeast Health Center open
1987	Begins providing managed care services to the Medicaid population
1988	Receives funding to establish the Comprehensive Perinatal Care Program providing supportive health education and social work services to pregnant women
1991	Becomes a sub-grantee of the Cleveland Department of Public Health's Infant Mortality Reduction Healthy Family/ Healthy Start Program
1992	Receives Special Infant Mortality Reduction Initiative (SIMRI) funding to expand NEON's perinatal services support
1994	Becomes a provider of screening services for the Breast & Reproductive Cancer Prevention and early Detection Project for women with the Cuyahoga County Board of Health Department
1994	Enters into an agreement with MetroHealth Medical Center to provide Child and Family Health Services (CHFS) to East Cleveland residents
1995	Becomes a partner with the local American Cancer society affiliate in their Breast Cancer Education Screening and Treatment Project
1995	East Cleveland Health Center, a new facility, is opened
1996	Adopts its new name as NorthEast Ohio Neighborhood Health Services, Inc.
1996	Expands its relationships with Medicaid-serving HMOs beyond its homegrown HMO (Total Health Care Plan) to include by 1998 all such HMOs serving Cuyahoga County. Also enters into its first Medicare managed care contract
1997	Collaborates with the AIDS Taskforce of Greater Cleveland to provide case management and outreach services to individuals who are living with HIV/AIDS in our communities
2000	Is recognized by the BPHC as having been accredited by the JCAHO for the longest continuous period of time among FQHCs in the nation
2001	Designated as a National Community Center of Excellence in Women's Health
2002	Begins offering school-based health services
2003	Installs and implements Laboratory Information System
2003	Expands Dental Program to include onsite services at all health centers
2003	Restores Behavioral Health Services
2006	Completes major multi-million dollar capital improvement project
2006	Restores Norwood Health Center as a site for primary health care services
2007	Observes its 40 <sup>th</sup> year of providing comprehensive primary health care services
2008-2009	Installs and implements a new Practice Management System and Electronic Health Record (Dental & Medical)
2011	Moves in new Payne Avenue Corporate Administrative Office

## STRATEGIC CLINICAL PLAN

### Health and Social Realities of Our Target Populations

Every five years in response to Bureau of Primary Health Care grant requirements (a major funding source), NEON's clinical directors craft specific health plan objectives. These objectives feed into NEON's overall strategic clinical plan for health care delivery, inclusive of goals, objectives, measurements, and targets. This strategic clinical plan is organized around life cycles, namely: perinatal life cycle; pediatric life cycle; adolescent life cycle; adult life cycle; and, geriatric life cycle.

On an ongoing basis, our strategic clinical plan serves as a beacon for our clinical services and centers on a variety of local and regional health and social realities experienced by our patient population. Our Clinical Quality Improvement Program (CQIP) is one dimension of this strategic plan. Specific clinical guidelines that are refreshed on an annual basis comprise the other dimension of this strategic plan. NEON feeds on a steady diet of quality measurements to help our providers shore up our healthcare mission. Progress toward and attainment of strategic clinical goals and objectives are spurred by a continuous quality improvement loop that incorporates provider feedback. The CQIP also includes monitoring and evaluation health information management, patient satisfaction, pharmacy and therapeutics, credentialing, and medical risk management.

Given the significant role NEON plays in serving poor residents of Greater Cleveland, especially African-Americans, the ultimate success of our strategic clinical plan exerts substantial influence on the health outcomes for the indigent community at large. Given this precondition, NEON must demonstrate a high degree of sensitivity and responsiveness to the health and socioeconomic quagmire engulfing our current and potential users.

Our current strategic clinical plan addresses the problems listed below.

**Problem/Need Statement:** In Cleveland and Cuyahoga County, maternal and infant health has shown steady improvement over the past decade in the services area, but there are still neighborhoods/populations with significantly higher risk factors and/or less significant reduction of risk factors.

**Problem/Need Statement:** It is generally accepted that preventive healthcare for children is associated with less health problems during their growth process. NEON's healthcare mission is directed at eradicating health disparities. A major component of the task is in providing pediatric users convenient access to competent, early, periodic, screening, diagnostic, and testing services. These services highlight immunization programs and growth and development assessments.

**Problem/Need Statement:** In Cleveland two-thirds of homes were built between 1940 and 1960. Older homes and even some homes built after 1960 contain heavily leaded paint. Risk factors for children in older homes and poorer neighborhoods are increased because of exposure to lead-based paint or lead dust in soil. The effects of lead ingestion child development are well-established and described. Dangerous levels of lead in children may affect a child's development: neurobehavioral, stature, or growth. Even though NEON cannot play a direct role in decreasing child exposure to lead, its efforts at early detection can play an indirect role by alerting parents and guardians of the need to change their living arrangements such that additional children are not exposed.

**Problem/Need Statement:** It is general knowledge that disparities in health status indicators and risk factors for diet-related disease are evident in many segments of the population based on gender, age, race and ethnicity, and income. For example, overweight and obesity are observed in all population groups, but obesity is particularly common among Hispanic, African American, Native American, and Pacific Islander women. Obesity in the target population served by NEON, which is largely African American, reflects what has been noted nationally. Childhood obesity appears to be at epidemic levels. If obesity is not thwarted, Type 2 Diabetes develops quite commonly.

**Problem/Need Statement:** Effective preventive dental care in pediatric users is associated with less dental health problems as adults. Good oral health is associated with improved nutritional status. Greater access to and use of preventive dental care contributes to national objectives pertaining to 'untreated dental decay', 'reducing incidence of caries in primary or permanent teeth' and 'increasing the proportion of children who have received dental sealants on their molar teeth'.

**Problem/Need Statement:** High-risk behavior in adolescents is linked to an increased incidence of sexually transmitted diseases, teen pregnancy, bodily injury, and death. In Northeast Ohio it has been reported that young African Americans (0 to 14 years) were more than two and-a-half times as likely to die accidentally as their White peers; the average annual accidental death rate among African Americans was 12.1 per 100,000 compared to 4.7 among Whites in this age group. NEON has a substantial African American population and therefore has an obligation to exert a positive influence in the community with respect to narrowing this health disparity.'

**Problem/Need Statement:** Effective preventive dental care in adults is associated with less oral health problems and improved nutrition. Additionally, effective preventive dental health care can contribute to objectives of 'increasing the proportion of adults who have never had a permanent tooth extracted because of dental caries or periodontal disease' and 'reducing the proportion of older adults who have had all their natural teeth extracted'.

**Problem/Need Statement:** At an average of 261 cancer deaths per 100,000, the overall cancer death rate in Cleveland was 17 percent higher than the regional rate and 31 percent higher than the national rate. Similar to other geographic areas, the cancer death rate for African Americans in Cleveland (284 per 100,000) was higher than the death rate for Whites (258 per 100,000).

**Problem/Need Statement:** Anxiety disorders have high rates of lifetime prevalence: panic disorder (3.5%), agoraphobia (5.3%), social phobia (13.3%), generalized anxiety disorder (5.1%). The severity and number of mental health risk factors in NEON's catchment area may be expected to exacerbate these rates for NEON's patient population. Efficacy studies have demonstrated that anxiety disorders respond to treatment. The lifetime prevalence rates for Major Depressive Disorder are very high: 20-25% for women and 9-12% for men. Depression impairs social functioning more than any other chronic disease except cardiac illness. Only 19% of people with depression who see their primary care provider receive appropriate, guideline-based care.

**Problem/Need Statement:** Increased morbidity and mortality is associated with unrecognized and unmanaged impairment in the ability of geriatric patients to be functionally proficient in performing activities of daily living.

**Problem/Need Statement:** Increased morbidity and mortality is associated with over and under medication of geriatric patients. Careful documentation of medication regimens in a central location of the medical record should have a favorable impact on patient care.

**Problem/Need Statement:** The toll of diabetes on African Americans is significant in and of itself and in comparison with non-Hispanic Whites. The prevalence of diabetes has been reported as 130 cases per 1000 African Americans compared to 78 cases per 1000 non-Hispanic Whites. Cuyahoga County has not been spared from this apparent epidemic. Given the fact that a preponderance of NEON's target population is African American, it has a great challenge to face on an on-going basis in battling this disease amongst its users. Proper management of this condition can lessen its morbidity and mortality.

**Problem/Need Statement:** Cuyahoga County is experiencing a high prevalence of asthma (as much as 70/1000). Unfortunately, the burden of asthma falls most heavily on those below the poverty line; and the reality is that NEON's services areas are particularly impacted by asthma. NEON recognizes its clinical role in helping to realize regional clinical objectives that include: reducing activity limitations among persons with asthma, reducing activity limitations among persons with asthma, reducing hospitalizations due to asthma, and ultimately decreasing the mortality associated with chronic obstructive pulmonary disease that is particularly a factor in several service areas served by NEON.

## SECTION B: CLINICAL SERVICES

NEON's 'Scope of Clinical Practice' entails those clinical services that are permitted on-site within our network of community health centers. The 'scope' is herein presented as a delineation of segments of clinical scope that are further segmented into types or categories of care. The scope of clinical services permitted at our network health centers are herein illustrated, denoting those centers that are currently positioned to accommodate providers who are privileged accordingly. Privileges that are granted to providers (physicians, dentists, optometrists, podiatrists, physician assistants, and advanced practice nurses) are derived from NEON's 'Scope of Clinical Practice.'

CLINICAL SCOPE SEGMENT	TYPE OR CATEGORY OF CARE	DESCRIPTION OF CLINICAL ACTIVITIES	FACILITIES INCLUDED IN SCOPE SEGMENT
<p><b>General Medicine</b></p>	<p>Not Applicable</p>	<p>A. History, Examination, and Treatment of common and simple medical conditions affecting patients over the age of 2 years old and typically managed on an outpatient basis. Examples of such conditions include: acute upper respiratory viral infectious conditions, acute ENT viral and bacterial infectious conditions (e.g., otitis externa, otitis media, and pharyngitis), mild to moderate asthma exacerbations, simple dermatological disorders (e.g., uncomplicated burns, contact dermatitis, simple I&amp;D, and atopic dermatitis) and common sexually transmitted diseases.</p> <p>B. Without regard to the age of the patient, the following conditions can be managed on an interim basis: treatment of minor skin lacerations in benign locations, suture removal, immunization, initiation of prenatal care (initial counseling, initial labs, prescribing of prenatal vitamins, and referral to obstetrical provider), and hormonal contraception.</p> <p>C. Without regard to the age of the patient, if the patient has a stable chronic medical condition as determined by a review of the medical record, and the principle physician is inaccessible, simple medication refills are permitted.</p>	<p>All Health Centers</p>

CLINICAL SCOPE SEGMENT	TYPE OR CATEGORY OF CARE	DESCRIPTION OF CLINICAL ACTIVITIES	FACILITIES INCLUDED IN SCOPE SEGMENT
<b>Pediatric Medicine</b>	Level One	History, Examination and Treatment of up to moderately complex medical conditions affecting patients aged 0 to 21 years of age, whereby the conditions are typically managed without subspecialty consultant collaboration and on an outpatient basis.	All Health Centers. School-based health center Job Corps Wellness Center
	Level Two	History, Examination and Treatment of complex medical conditions affecting patients aged 0 to 21 years of age, whereby the conditions are typically managed with subspecialty consultant collaboration and on an outpatient basis (e.g., oncology disorders, sickle cell disease, cystic fibrosis, and AIDS)	All Health Centers. School-based health center Job Corps Wellness Center
<b>Adult Medicine</b>	Level One	History, Examination and Treatment of simple to moderately complex medical conditions affecting patients aged 18 years and older, whereby the conditions are typically managed without specialty or subspecialty consultant collaboration on an outpatient basis.	All Health Centers. Job Corps Wellness Center
	Level Two	History, Examination and Treatment of complex medical conditions affecting patients aged 18 years and older, whereby the conditions are typically managed with specialty or subspecialty consultant collaboration (e.g., oncology disorders, sickle cell disease, severe coronary artery disease, severe and complicated hypertensive disorders, conditions requiring anticoagulation, and AIDS) on an outpatient basis.	All Health Centers. Job Corps Wellness Center



CLINICAL SCOPE SEGMENT	TYPE OR CATEGORY OF CARE	DESCRIPTION OF CLINICAL ACTIVITIES	FACILITIES INCLUDED IN SCOPE SEGMENT
<b>Obstetrics and Gynecology</b>	Level One	History, Examination, and Treatment of common gynecological conditions affecting females 12 years and older (e.g., prenatal care for non-high-risk women, sexually transmitted diseases, hormonal contraception, contraceptive subdermal implant insertion & removal and contraceptive IUD insertion & removal (if properly trained) whereby the conditions can be managed on an outpatient basis with or without the direct involvement of an Ob/Gyn physician.	Hough Center, Superior Center, East Cleveland Center, and Southeast Center.
	Level Two	History, Examination, and Treatment of moderately complex gynecological conditions affecting females 12 years and older, typically managed on an outpatient basis (e.g., chronic dysfunctional uterine bleeding, primary and secondary amenorrhea, post-menopausal bleeding, and cervical dysplasia).	Hough Center, Superior Center, East Cleveland Center, and Southeast Center.
	Level Three	History, Examination, and Treatment of complex gynecological conditions affecting females 12 years and older whereby the conditions (e.g., moderately high risk pregnancies, chronic pelvic pain, and endometriosis) are typically managed by an Ob/Gyn physician.	Hough Center, Superior Center, East Cleveland Center, and Southeast Center.
	Cervical & Vulvar Biopsy	Performance of cervical and Vulvar biopsy in ambulatory setting.	Hough Center, Superior Center, and Southeast Center.
	Colposcopy	Performance of colposcopy in ambulatory setting.	Hough Center, Superior Center, and Southeast Center.
	Cryosurgery	Performance of cryosurgery in ambulatory setting.	Hough Center, Superior Center, and Southeast Center.
	Ultrasonography	Limited Obstetrical ultrasound procedures for the purpose of evaluating gestational age, fetal heartbeat, placental location, and fetal position.  Limited non-obstetric gynecologic (transvaginal and transabdominal) procedures.	Hough Center

CLINICAL SCOPE SEGMENT	TYPE OR CATEGORY OF CARE	DESCRIPTION OF CLINICAL ACTIVITIES	FACILITIES INCLUDED IN SCOPE SEGMENT
<b>Podiatry</b>	Not Applicable	For patients of all ages: History, Examination, and Treatment of up to complex medical conditions of the foot and ankle, typically managed on an outpatient basis, which include the following: management of diabetic foot disorders; metatarsal, hallux, lesser toe, and follow-up fracture care; nail debridement; injections and aspirations of the foot and ankle; debridement of foot and ankle lesions; excision of benign lesion of less than 2 cm; biopsy of skin of foot and ankle; drainage of subungual hematoma; nail avulsions; nail matrixectomy; cryosurgery of minor lesions of foot and ankle.	Hough Center, Superior Center, Collinwood Center, Southeast Center.
<b>Optometry</b>	Level One	For patients of all ages: History, Examination, and Treatment of up to moderately complex visual disorders, typically managed on an outpatient basis, which include the following: sensorimotor examination; serial tonometry, visual field examination; prescribing and fitting of spectacles; prescribing and fitting of contact lenses.	Hough Center, Southeast Center.
	Level Two	For patients of all ages: History, Examination, and Treatment of mildly complex medical conditions of the eye and its structures, typically managed on an outpatient basis, which include: removal of foreign bodies of the external aspects of the eye; epilation by forceps; orthoptic training; medical treatment of mild open-angle glaucoma.  For patients of all ages: History, Examination, and Treatment of moderately complex medical conditions of the eye and its structures, typically managed on an outpatient basis, when co-managed by an off-site physician who has completed an accredited training program in ophthalmology.	Hough Center, Southeast Center.
<b>Nursing Facility Medicine</b>	Not Applicable	History, Examination and Treatment of simple to moderately complex medical conditions affecting patients aged 18 years and older, whereby the conditions are typically managed without specialty or subspecialty consultant collaboration on an outpatient basis. This type of care typically involves patients who do not require skilled nursing care.  History, Examination, Treatment, and Management of complex medical conditions affecting patients aged 18 years and older, whereby the patients require skilled nursing care with or without subspecialty consultantation.	Nursing Homes

<b>CLINICAL SCOPE SEGMENT</b>	<b>TYPE OR CATEGORY OF CARE</b>	<b>DESCRIPTION OF CLINICAL ACTIVITIES</b>	<b>FACILITIES INCLUDED IN SCOPE SEGMENT</b>
<b>Pathology</b>	CLIA-Waived	Laboratory services include the following, at a minimum: urine pregnancy testing; dipstick urinalysis; capillary glucose; capillary PT/INR, PPMP	All Health Centers
	CLIA-Certified	Laboratory services include PT/INR only	Hough Center
<b>Radiology</b>	Plain Films	Plain film radiology services include the following, at a minimum: chest studies; flat plate of abdomen; sinus films; skeletal studies.	Hough Center
	Mammography	Mammography services are available for the purposes of both screening and pathological investigation.	Hough Center
<b>General Dentistry</b>	Not Applicable	History, Examination and Treatment of oral health conditions. Includes initial oral examinations; emergency dental care that is limited to the diagnosis and treatment of an acute episode of pain, infection, swelling, hemorrhage or trauma; and, primary preventive dental health services, intraoral radiology, restorative dental services, basic endodontics services, routine extractions, space maintenance, removable prosthetic services, and fixed prosthetic services.	All Health Centers
<b>Oral Surgery</b>	Level One	History and examination. Routine or simple oral surgery procedures such as extractions, simple tori removal.	All Health Centers
	Level Two	History and examination and preoperative evaluation. Oral surgery procedures that are reserved for a specialist in Oral and Maxillofacial surgery because these procedures require the greatest degree of expertise and special skills acquired during said specialty training. These procedures are rendered on an outpatient basis and in accord with the local standards of care. Anesthesia for these procedures is limited to local anesthesia.	Hough Center

CLINICAL SCOPE SEGMENT	TYPE OR CATEGORY OF CARE	DESCRIPTION OF CLINICAL ACTIVITIES	FACILITIES INCLUDED IN SCOPE SEGMENT
<b>General Mental Health &amp; Substance Abuse</b>	Not Applicable	<p>A. History (e.g. Intake and Social History), Bio-Psycho-Social-Spiritual/Cultural Assessment using Clinical Interview, Observation, Limited Psychometric Testing, and use of Rapid Assessment Instruments (RAIs), and Treatment of common and simple mental health and substance abuse conditions affecting patients over the age of 2 years old and typically managed on an outpatient basis.</p> <p>B. Without regard to the age of the patient, the following conditions can be managed on an interim basis: treatment of an acute/brief psychotic episode, bi-polar disorder, acute crisis situations requiring immediate attention, e.g. suicide, hospitalization for danger to self or to others, gross intoxication, and child endangerment.</p>	All Health Centers
<b>Pediatric Mental Health</b>	Level One	History (e.g. Intake and Social History), Bio-Psycho-Social-Spiritual/Cultural Assessment using Clinical Interview, Observation, limited Psychometric Testing, and Rapid Assessment Instruments (RAIs), and treatment of minor to moderately complex emotional psychological conditions affecting patients 2 to 18 years old and typically managed on an outpatient basis whereby the conditions are typically managed with subspecialty consultant and collaboration (e.g., child developmental psychologist, child psychiatrist, psychotherapist with advanced training, experience and or fellowship in child and adolescent developmental disorders).	All Health Centers
	Level Two	History (e.g. Intake and Social History), Bio-Psycho-Social-Spiritual/Cultural Assessment using Clinical Interview, Observation, Psychometric Testing, and Rapid Assessment Instruments (RAIs), and Treatment of complex mental health and substance abuse conditions affecting patients over the age of 3 to 18 years old and typically managed on an outpatient basis whereby the conditions are typically managed without subspecialty consultant collaboration (e.g., child developmental psychologist, child psychiatrist, psychotherapist with advanced training, experience and or fellowship in child and adolescent developmental disorders).	All Health Centers

CLINICAL SCOPE SEGMENT	TYPE OR CATEGORY OF CARE	DESCRIPTION OF CLINICAL ACTIVITIES	FACILITIES INCLUDED IN SCOPE SEGMENT
<b>Adult Mental Health</b>	Level One	History (e.g. Intake and Social History), Bio-Psycho-Social-Spiritual/Cultural Assessment using Clinical Interview, Observation, Psychometric Testing, and Rapid Assessment Instruments (RAIs), and Treatment of common simple to moderate mental health and substance abuse conditions affecting patients $\geq 18$ years old and typically managed on an outpatient basis whereby the conditions are managed with subspecialty consultant collaboration and typically on an outpatient basis (e.g. psychologist psychiatrist, senior psychotherapist with advanced training, experience and or fellowship in adult disorders).	All Health Centers
	Level Two	History (e.g. Intake and Social History), Bio-Psycho-Social-Spiritual/Cultural Assessment using Clinical Interview, Observation, Psychometric Testing, and use of Rapid Assessment Instruments (RAIs), and treatment of moderate to complex mental health conditions affecting patients aged 18 years and older, whereby the conditions are managed without subspecialty consultant collaboration and typically on an outpatient.	All Health Centers
<b>Couples Psychotherapy</b>	Not Applicable	Performance of outpatient-based couple's psychotherapy on patients aged 18 years and older in a fashion consistent with the professional and community standards of marriage therapy.	All Health Centers
<b>Family Counseling &amp; Therapy</b>	Not Applicable	History, Assessment, and Treatment of outpatient family counseling with families consisting of all age levels and structures.	All Health Centers
<b>Group Therapy</b>	Not Applicable	<ol style="list-style-type: none"> <li>1. For patients of all ages: History, Assessment and Treatment for mild and moderate mental health and substance abuse conditions that are most effectively addressed through the use of group therapy and managed on an outpatient basis.</li> <li>2. The use of Group Therapy is indicated when psychological or substance abuse treatment on an individual basis would be ineffective or when several patients share a common disorder in which group treatment would be the efficient use of a therapist time. This includes but is not limited to support, therapeutic, limited and/or task centered (e.g. smoking cessation), and self-management groups.</li> </ol>	All Health Centers

CLINICAL SCOPE SEGMENT	TYPE OR CATEGORY OF CARE	DESCRIPTION OF CLINICAL ACTIVITIES	FACILITIES INCLUDED IN SCOPE SEGMENT
<b>Psycho-logical Assessment &amp; Psychometric Testing</b>	Level One	For patients of all ages: the History and Assessment of up to moderately complex psychological disorders.	All Health Centers
	Level Two	A. For patients of ages 3 through 13: the History and Assessment of complex childhood developmental and psychological disorders (e.g. Attention Deficit Disorder, Hyperactivity Disorder, Learning Disorders, Developmental Delays, Autism, reading and language disorders, conduct disorder-childhood onset, oppositional, defiant, or separation disorders).	All Health Centers
		B. For patients ages 14-20: the History and Assessment of complex adolescent developmental and psychological disorders, (e.g. Attention Deficit Disorder, Hyperactivity Disorder, Learning Disorders, Developmental Delays, Autism, reading and language disorders, conduct disorder-adolescent onset, oppositional, defiant, or separation disorders).  C. For patients 20-85: the History and Assessment of complex adult psychological disorders, (e.g. Personality Disorders, development disorders diagnosed in childhood or adolescence, ADHD-Adult onset, Obsessive-Compulsive Disorders, Posttraumatic Stress Disorder, Postpartum disorders, Mood Disorders and Anxiety Disorders).	All Health Centers

## **BEHAVIORAL HEALTH SERVICES**

These services are intended to generally be available by appointment. More importantly, the clinical model for this program will rely heavily on the ability of our Primary Care Providers to become integrated more fully into the provision of behavioral health services. Clinical psychiatrists, psychologists and clinical social workers shall provide the bulk of services, but will be reliant on the participation of and collaboration with physicians in terms of the therapeutic and clinical advancement of the patient.

## **CENTER OF EXCELLENCE IN WOMEN'S HEALTH SERVICES**

NEON has the distinction of being a Center of Excellence in Women's Health. With this distinction by the National Center on Women's Health came the obligation to focus some of our energy and creative juices on the needs of our female patient population, which is our largest gender constituency. The vision of this program specific to NEON is: "Women at each stage of their lives will be empowered with knowledge, tools and services to lead healthy lives without regard to their economic status."

Program components include the following:

- Comprehensive Women's Health Services;
- Collaborative Provider Network & Outreach;
- Community Health Education and Training;
- Health Internship Program;
- Community-based Research;
- Community Health Centers Shares Program;
- Mammogram Connection;
- Women's Health Consortium;
- CFHS Outreach Program.

## **DENTAL SERVICES**

Dental services are generally available by appointment. Our dental providers serve patients of all ages. General Dentistry and Oral Surgery services are offered onsite. A referral for these services should be written in the medical record progress note in order for the ancillary staff person to be alerted to the need for an appointment. However, only our dentists may refer a patient to the Oral Surgeon. Oral surgery services are provided at the Hough Health Center whereas General Dentistry is offered or will be offered at all health centers. Dental providers are also on call at night to provide consultation to patients with urgent dental problems.

Our dental providers depend on the clinical support of their medical colleagues when faced with clinical situations that might impact the delivery of dental services. In these instances, they from time to time need to consult with our physicians for medical advice. It is essential that our physicians comply with these requests. The responses should be documented in the medical record. This medical advice often falls within the following categories: blood pressure elevations; level of glucose control; and need for Antibiotic Prophylaxis (details are updated periodically in NEON's Clinical Guidelines for Adult Medicine and Pediatrics).

## **FAMILY PLANNING SERVICES**

Female users of childbearing age can access pregnancy testing at all health centers upon demand. Results of pregnancy tests should be relayed to the patient promptly and supplemented by an inquiry as to the patient's family planning methodology, counseling on family planning, and referral for prenatal care, if applicable.

## LABORATORY SERVICES

Through one or the other means, most lab tests that fall within the realm of primary care that would help the provider manage a patient's care can be obtained. Tests are ordered via online computer order entry via the electronic health record (EHR). The EHR allow for tracking of laboratory tests. Results of these tests are made available via the EHR system (or by hardcopy as a back-up) to the ordering provide.

With the EHR system, it is imperative that providers check their Provider Approval Queue (NextGen) on a daily basis to retrieve results of laboratory work and address applicable findings immediately in the electronic health record. It is the provider's responsibility to initiate follow-up of abnormal laboratory results. The provider is responsible for acknowledging in the health record that the abnormal test was noted, and initiating and documenting the appropriate action (depending upon the circumstances).

The EHR allow perpetual online access to this information for laboratory tests performed in-house. Results of tests performed at our primary reference laboratory (LabCorp) are perpetually available online at eResults after proper login by providers. This information is available both locally and remotely via virtual private network browsing capabilities.

Panic lab values require that laboratory personnel inform the ordering provider immediately. You may be contacted during routine office hours or afterhours if you are the covering physician for the respective clinical group to accept results of a panic lab report. You must determine whether this report requires immediate action or can wait until the next day. Panic lab values are values that fall substantially outside the normal ranges established by our Laboratory Supervisor/Director and the Medical Director.

A large number of our patients are uninsured. Therefore, for financial reasons, the sky is not the limit for what we can order on their behalf. Furthermore, tests that are performed by the reference lab are the financial responsibility of the patient (albeit, deeply discounted based on a sliding fee scale). The tests tabulated below were determined by consensus to be those most vital and cost effective in our practice, given our scope of practice. However, this list is subject to change. Refer to [www.neonproviders.com](http://www.neonproviders.com) (AFFAIRS – Lab Test Formularies section) for updates.

Test	LabCorp Code		LabCorp Code
ABO Grouping & Rho(D) Typing	006049	Carbamazepine (Tegretol)	007419
Aerobic Bacterial Culture	008649	Cervical biopsy pathology (Surgical Pathology)	883021
AFP TETRA	017319	Chlamydia (STD) DNA Probe	098012
AFP X-tra Profile	017335	Cholesterol	001065
Albumin	001081	Comprehensive Metabolic Panel	322000
Alpha Fetal Protein (AFP), Serum Tumor Marker	002253	Creatine Kinase, Total Serum	001362
Alkaline Phosphatase	001107	Creatinine	001370
ALT	001545	Creatinine Clearance	003004
Amylase	001396	CRP (C-Reactive Protein)	120766
ANA w/Reflex	164962	Digoxin	007385
Antibody Screen	006015	Dilantin (Phenytoin)	007401
ASO Titer	006031	Electrolyte Panel	303754
AST	001123	Ferritin, Serum	004598
B12 and Folate	000810	Folate	002014
Basic Metabolic Panel	322758	Folate(Folic Acid), Serum	002014
Beta HCG/Qualitative	004556	FSH and LH	028480
Beta HCG/Quantitative	004416	FSH, Serum	004309
Bilirubin, Direct	001222	Fungus (Mycology) Culture	001693
Bilirubin, Total	001099	GC (STD) DNA Probe	098004
BUN	001040	GGT	001958



Test	LabCorp Code		LabCorp Code
Glucose Gestation Diabetes Screen, Serum/Plasma	102277	Renal Panel	322777
Glucose, Serum/Plasma	082947	Rheumatoid Arthritis Factor	006502
Glucose Tolerance for Pregnant Patients (5 specimens, serum)	090373	RPR	006072
HDL	001925	RPR titre	006460
Hemoglobin A1c	001453	Rubella Antibodies IgG	006197
Hemoglobinopathy Profile	121679	Sed Rate	005215
Hemogram/differential	005009	Sickle Prep	121679
Hepatitis A Antibody, IgM	006734	Sodium	001198
Hepatitis B Core Antibody, IgM	016881	Stool Culture	008144
Hepatitis B Surface Antibody	006395	Strep Group B Cult/DNA Probe	188128
Hepatitis B Surface Antigen	006510	Testosterone	004226
Hepatitis C (HCV) Virus Antibody	140659	Theophylline	007336
Hepatitis Diagnostic Profile 1 (Anti-HBc, IgM, HGsAg, anti-HAV, IgM)	058560	Throat Culture	087081
HPV, Non-Ordered Reflex Test	507301	Thyroid Panel (FTI, T4, T3, T3Uptake)	000455
HSV (Herpes Simplex Virus) Culture with typing	008250	Thyroxine (T4)	001149
Infectious Mono	006189	Treponema Pallidum Antibodies (TP-PA)	082370
Inorganic Phosphorus	001024	Triglyceride	001172
Iron and TIBC	001321	TSH	004259
LDH	001115	Uric Acid	001057
Lead, Blood (PEDIATRIC PATIENTS ONLY)	717009	Urine Culture, Routine	008847
LH, Serum	004283	Valproic Acid (Depakote)	007260
Lipase, Serum	001404	Varicella Zoster V Ab, IgG	096206
Lipid Panel	303756	Vitamin B12 & Folate	000810
Lithium	007708		
Liver Panel/Hepatic Function	322755		
Magnesium	001537		
Microalbumin/Creat Ratio	140285		
MMR (Mumps, Measles, Rubella) Immunity	058495		
Ova & Parasite Exam	008623		
Pap Test, Liq-based	192005		
Pap Test, image guided, Reflex HPV on ASC-U	194074		
Physician read Pap	881411		
Phenobarbital, Serum	007823		
Platelet Count	005249		
Potassium	001180		
Prolactin	004465		
Protein Electrophoresis, Serum	001487		
Protein, Total, 24 Hour Urine	003277		
Protime (INR)	005199		
PSA (prostate specific antigen)	010322		
PTH, Intact (parathyroid hormone)	015610		

## **NUTRITION SERVICES**

Nutritional services, if available, are provided at all health centers by appointment only. These services are provided in the format of one-on-one consultation and group sessions. A referral for these services should be written in the medical record progress note in order for the ancillary staff person to be alerted to the need for an appointment. Services are generally accessible to adolescents and adults. Priority areas of clinical focus for our Nutritional Program are as follows:

- Obesity (Child and Adult);
- Hyperlipidemia;
- Diabetes;
- Hypertension.

## **OBSTETRICS & GYNECOLOGY SERVICES**

Obstetrics and gynecology services are available to all health center patients and generally by appointment. Our Ob/Gyn team is comprised of physicians specializing in Ob/Gyn and Certified Nurse Midwives. Services are provided at all health centers, except the Collinwood Health Center. Patients from that center are generally referred internally to the East Cleveland Health Center. A referral for these services should be written in the medical record progress note in order for the ancillary staff person to be alerted to the need for an appointment.

Our Ob/Gyn physicians and specially-trained certified nurse midwives perform colposcopy at the Hough, Superior, and Southeast health centers. Our physicians perform only minor surgery onsite at the health centers. Elective gynecological surgery that requires a hospital setting is referred out and not performed by NEON Ob/Gyn physicians.

NEON midwives collaborate with hospital-based physicians in the performance of obstetrical services that occur in the hospital setting and do not perform obstetrical deliveries in the hospital setting.

The bulk of NEON's onsite obstetrical services are performed by our certified nurse midwives. As such, there are certain limits to the types of obstetrical patients that can be managed by our midwives and collaborating physicians. The following types of obstetrical patients, considered high risk, must be referred to a tertiary hospital facility or obstetrical specialist for care:

1. Sickle Cell disease (SS or SC disease);
2. Seizure disorder, if has had a seizure within 3 months of the LMP or during current pregnancy;
3. Systemic Lupus Erythematosus;
4. Connective tissue disease and on steroid therapy;
5. Seropositive of HIV;
6. NYHA Class II cardiac disease or greater;
7. Multiple gestation;
8. Chronic hypertension;
9. Diabetes;
10. Asthma (persistent categories), if poorly controlled by NEON adult or pediatric medicine providers;
11. Invasive carcinoma;
12. Placenta previa;
13. Placenta accrete complicating their previous pregnancy;
14. Deep venous thrombosis or any type of hypercoagulation (clot forming) syndrome;
15. Active thyroid disease;
16. Pulmonary hypertension;
17. Active renal disease (serum creatinine greater than 1.5 mg/dl)
18. History of major abdominal surgery;
19. History of C-section, desiring repeat C-section, when 4<sup>th</sup> C-section or more;

20. Incompetent cervix;
21. Mental illness – Schizophrenia;
22. Rh antibody sensitization (Rh-negative antibody positive);
23. Severe Obesity with a BMI of **50** or greater (e.g., 300 lb woman with a height of 65 inches).

Working alongside our obstetrical providers is our staff of the Comprehensive Perinatal Care Program. This staff comprises caseworkers that work with individual perinatal patients in order to ensure adherence to standard pre/postnatal care. They provide education and hospital-based follow-up with our maternal patients to enhance the chance for healthy outcomes and appropriate postpartum care.

## OPTOMETRY SERVICES

Optometry services are available to all NEON patients by appointment. Optometry services are limited to the Hough Health Center and the Southeast Health Center. However, these services are accessible to all NEON patients. Services are generally accessible to patients of all ages. We have the capacity of performing visual fields assessments and slit lamp examinations. The bulk of our optometry services fall into the following categories:

- Corrective vision;
- Dilated Diabetic Eye exams;
- Management of Glaucoma;
- Minor medical conditions of the external eye and surrounding structure.

## PHARMACY PROGRAM AND MEDICATION MANAGEMENT SYSTEM (MMS)

NEON maintains a pharmacy program that deploys fully functional pharmacies that are distributed geographically throughout its network of health centers. The Pharmacy Program is under the direction of a Pharmacy Director, who collaborates with NEON's Medical & Dental Directors, all of whom comprise the Pharmacy & Therapeutics Committee. The scope of this program includes how and under what circumstances all medications are procured, stored, and dispensed by NEON staff members who are involved in NEON's Medication Management System (MMS). To ensure safe medication management, NEON's MMS involves the following eight components:

1. **Patient-Specific Information:** where vital patient information is readily accessible to those involved in the medication management system.
2. **Selection and Procurement:** where we have a process for collaborative development of a listing of medications that are available at all times and a process to obtain medications.
3. **Sample Medications:** where we have a process that allows willing prescribing providers to accept and maintain sample medications for the purpose of dispensing to NEON patients.
4. **Storage:** where we have a process for control of medications, be it in our pharmacies or in the dispensing of sample medications.
5. **Ordering and Transcribing:** where there is a method to our selection of medications and how that information is conveyed to another party in our patient care environment (internal and external).
6. **Preparing and Dispensing:** where we have a process for preparation and issuance of one or more doses of a prescribed drug by a pharmacist or other authorized staff person and distribution of a patient-specific medication.
7. **Administration:** where we have a process for safely giving prescribed and prepared dose of an identified drug to a patient.
8. **Monitoring:** where we have a clinical process in place for assessing the effects of medications prescribed and administered to our patients.

**Patient-Specific Information (MMS)**

A major cause of medication-related sentinel events and medication errors is a lack of adequate information. Licensed independent practitioners and health care staff who participate in NEON's medication management system need access to important information about each patient in order to do the following:

- Facilitate continuity of care, treatment and services
- Create an accurate medication history and a current list of medications
- Safely order, prepare, dispense, administer, and monitor medications, as appropriate.

In order to accomplish the above-noted objectives, any staff member involved in NEON's Medication Management System, **must have access** to the medical record in making decisions on medication management. When such access is precluded for one reason or another, a licensed independent practitioner must examine the patient and gather all necessary information in order to safely accomplish the above-noted objectives. **Minimum information on the patient that should be accessible or obtained includes the following:**

1. Age
2. Sex
3. Current medications
4. Diagnosis, co-morbidities, and concurrently occurring conditions
5. Relevant laboratory values
6. Allergies and past sensitivities
7. Weight and height, as appropriate
8. Pregnancy and lactation status, as appropriate
9. Any other pertinent clinical information needed for safe medication management.

**Selection and Procurement (MMS)**

NEON's Pharmacy & Therapeutics Committee articulates on a periodic basis a formulary that will be available to patients at NEON pharmacies. The NEON Pharmacy Formulary manual (located at [www.neonproviders.com](http://www.neonproviders.com) under 'AFFAIRS - Drug Formularies') represents this articulation. This formulary is updated periodically. This formulary also includes medications that are available through pharmaceutical company supplemental programs that are designated for low-income, uninsured, and underinsured patients.

If a non-formulary pharmaceutical item is urgently needed, the patient should be referred to an outside pharmacy. A formal request can be made to a NEON pharmacist that an item be supplied to a specific patient in need of a particular medication on a short-term basis. The request will be subject to the approval of the Medical Director. A formal request can also be made seeking the addition of a particular medication to the formulary for general use. Such a request should be forwarded in writing to the Pharmacy Director. The request will be subject to the approval of the Pharmacy & Therapeutics Committee.

**Medications acquired directly by a NEON practitioner from sources other than NEON's Pharmacy Program which includes the Sample Medications program described above and our network pharmacies may not be dispensed to patients.**

**Sample Medications (MMS)**

Various regulatory agencies (Joint Commission and Ohio Department of Health) have expressed specific guidelines on the use and handling of sample medications. It is important to emphasize that when an Ohio licensed prescribing provider accepts and dispenses sample medications, he/she must act in accordance with rules and regulations established by the DEA and the Ohio Board of Pharmacy. In essence, the prescribing provider becomes a pharmacist and must act accordingly in order to avoid licensure and medico legal repercussions. Only licensed prescribing providers may dispense non-OTC samples at NEON.

**PROVIDERS ARE PROHIBITED FROM ACCEPTING SAMPLES ON SITE THAT ARE CONTROLLED SUBSTANCES AND DISPENSING THEM DIRECTLY TO NEON PATIENTS.**

If a NEON prescribing provider would like to participate in the Pharmacy Program by handling and dispensing samples, the provider must adhere to the following requirements:

1. Sample Medication Inventory:
  - a. An intake inventory of all sample medications (non-OTC) must be maintained.

2. A Personalized Log Book must be maintained that allows for documenting the following:
  - a. Name and medical record number of patient who received sample medication.
  - b. Name of medication;
  - c. Lot number;
  - d. Date dispensed;
  - e. Date of expiration;
3. When dispensing sample medications, the original packaging must be utilized.
4. Instructions for use must be applied to the package.
5. The patient's name must also be applied to the package.
6. Expired medications must be forwarded to the Pharmacy Department for proper disposal.

If a prescribing provider is found out of compliance with the requirements described above and those related to storage described below, the provider risks DEA and NEON sanctions. At a minimum, the provider will lose the right to participate in the Pharmacy Program as a dispenser.

### **Storage (MMS)**

Whether it is clinical unit stock medications, sample medications, or pharmacy inventory medications, all medications must be stored in areas of the facility that can be secured under lock and key in order to deter non-authorized use. Manufacturer instructions must be followed in relationship to manufacturer requirements for proper storage, i.e. temperature, climate, and light exposure restrictions.

Whether it is clinical unit stock medications, samples medications, or pharmacy inventory medication, all medications must be retained in their original containers prior to administering or dispensing these medications to NEON patients.

Whether it is clinical unit stock medications or samples medications, all expired medications must be returned to the Pharmacy Department for proper disposal.

Additional requirements relating to storage are noted below:

1. Medications in stock bottles must clearly display the name of the medication, the lot number, and expiration date.
2. The date that the stock bottle was opened should be indicated on the bottle along with the initials of the provider who broke the seal.
3. Controlled substances must be handled according to federal and state regulations.
4. NEON pharmacies have the sole responsibility and authority to order and lawfully store controlled substances and are responsible for their lawful distribution.
5. If controlled substances are found missing and no record is available of the use of the missing substance, a written report must be made by the pharmacy stating the name and strength of the missing controlled substance, the quantity missing and the date and time the loss was noted.

### **Ordering and Transcribing (MMS)**

Only providers that are legally-authorized and certified to write a prescription order may do so. **PROVIDERS WHO ARE ENROLLED IN SURESCRIPTS E-SCRIBING SYSTEM ARE REQUIRED TO TRANSMIT ELIGIBLE PRESCRIPTIONS ELECTRONICALLY, UNLESS THE SURESCRIPTS SYSTEM IS DISABLED OR ACCESS TO THE SURESCRIPTS SYSTEM IMPEDED.** If the SureScripts system is disabled or inaccessible and NextGen EHR is operable then the prescription must be generated via the Medication Module of NextGen EHR and printed for a hard-copy to be given to the patient.

If NextGen EHR is disabled then the prescription must be handwritten, whenever appropriate. In writing a prescription order, the prescribing provider is responsible for completing the prescription in its entirety. NEON pharmacies reserve the right to reject any prescription that is **incomplete or illegible**. Each prescription blank is designed for only one medication request. The prescription order must include the **INDICATION/REASON** for the medication, described clearly on the prescription blank. This allows the staff pharmacist (or outside pharmacist) to perform a final check on appropriate indications for the medication. If the pharmacist feels that there is a mismatch between the stated indication and the medication, the prescribing provider will be contacted immediately for clarification. If the provider cannot be contacted, the patient will be referred back to the clinical unit for reassessment and pharmaceutical confirmation. If the indication/reason for the medication is missing from the prescription order, it will be rejected by NEON pharmacies.

Handwritten prescriptions for **controlled substances** must contain the provider's **DEA number** and the number of pills requested must be represented alpha and numerically on the prescription form. The prescription must be placed on tamper proof prescription paper. The clinical rationale for prescribing the controlled substance must be clearly documented in the health record.

Providers are required to treat NEON-specific **tamper proof prescription paper** in the following manner:

1. Prescription paper must be secured at all times to prevent theft of prescription forms. (Unfortunately, patients have been known to steal the forms and commit crimes of forgery.)
2. NEON pharmacies have the responsibility of storing this paper until handed off individually to prescribing providers upon their signing a pharmacy log that represents this hand-off.

Prescribing providers are **prohibited** from using the abbreviations listed in the table shown below under the "Prohibited Abbreviation" column. In regards to the individual or sets of prohibited abbreviations, clinical staff should abide by the instructions listed in the "Accepted Term" column corresponding to each one. This prohibition includes documentation in the health record on the patient, referrals, and prescriptions.

<b><i>Prohibited Abbreviations</i></b>	<b><i>Accepted Term</i></b>
BT (for bedtime)	Write "hs"
CC ( cubic centimeters)	Write "ml"
HS (for half strength)	Write "half strength"
U (for unit)	Write "unit"
IU (for international unit)	Write "international unit"
Q.D. or Q.O.D.	Write "daily" and "every other day"
Trailing zero (X.0 mg), Lack of leading zero (.X mg)	Never write a zero by itself after a decimal point (X mg), & always use a zero before a decimal point (0.X mg)
T.I.W. (for 3 times weekly)	Write "3 times weekly"
Qn (for nightly)	Write "Nightly"
MS (for morphine), MSO <sub>4</sub> (for morphine), MgSO <sub>4</sub> (for mag sulfate)	Write "morphine sulfate" or "magnesium sulfate"

### **Preparing and Dispensing (MMS)**

Once it is determined that a patient needs to be prescribed medication, it should then be determined how soon the patient needs the medication. When the prescription is given the patient, the patient should be directed to a pharmacy in-house or out-of-house where the patient can procure the medication within the required clinical time-frame. If the in-house pharmacy cannot fill a prescription for a medication prescribed by a NEON provider and the medication is on the current NEON formulary, the provider should be contacted, immediately, by the pharmacist to determine the clinical time-frame. If the provider indicates that the patient needs the medication on the date it was prescribed, the patient should be referred to an outside pharmacy that has the medication. Otherwise, the patient and provider should be informed as to the date of availability at the NEON pharmacy to have the prescription filled. **NEON pharmacies are expected to dispense medications to patients within 2 hours of receipt of a prescription order written by a NEON prescribing provider.**

**ONLY LICENSED NURSES AND CERTIFIED MEDICAL ASSISTANTS MAY PREPARE FOR AND ADMINISTER INJECTIONS ORDERED BY PRESCRIBING PROVIDERS.**

### **Administration (MMS)**

NEON pharmacies follow various processes for safely preparing and dispensing prescribed doses of medication to identified patients. When errors occur, they are required to investigate the root cause and develop and implement a process improvement. Similarly, medical and dental staff who prepare and administer medication directly to patients are required to follow safe practices in doing so.

For these areas of NEON's MMS practice, it is essential that respective patients are doubly identified and a check for allergies and other contraindications are performed prior to administration.

### **Monitoring (MMS)**

NEON providers are responsible for assessing the effects of medications once they are prescribed and taken by their patients. At a minimum, the medical record must display serial notation of effects (beneficial or otherwise) of prescribed medication for chronic medical problems.

## **PODIATRY SERVICES**

Podiatry services are available at most of our health centers generally by appointment only. A referral for these services should be written in the medical record progress note in order for the ancillary staff person to be alerted to the need for an appointment. No formal referral form is required as would be the case if the patient were referred to an external specialist.

## **PRIMARY CARE SERVICES**

Primary care providers like pediatricians, internists, family medicine physicians, nurse practitioners, and physician assistants provide our primary care services. These services are available by appointment and on a same-day basis. Primary care providers (PCPs) play an integral part in coordinating health care for our patients across space and the continuum of time. PCPs are particularly depended on for their reliable accessibility to patients, provision of preventive health services, controlling chronic medical conditions, making referrals to specialists, communicating with specialists, involvement in coordinating hospital care, and integrating overall health care provided to the patient; in route to minimizing inappropriate and duplicate services. The overall structure of our primary care services will be modeled after the principles of the Patient Centered Medical Home as defined by the likes of NCQA and other accrediting organizations.

## **RADIOLOGY SERVICES**

Hough Health Center, Superior Health Center, Collinwood Health Center, and Southeast Health Center are equipped and staffed for performing plain film x-ray procedures. Radiology studies are available, promptly, for the interpretation by the ordering provider. An official interpretation by a radiologist is generally performed within one business day on all x-ray studies performed at NEON health centers.

The following guidance should be adhered to in ordering in-house radiology studies:

- NEON RADIOLOGY REQUISITION form can be generated from NextGen after successfully ordering the procedure in NextGen and is utilized for any in-house study. The name of the ordering provider's name will be indicated on the requisition form to enable the radiologist to easily identify the ordering provider. The provider should identify the part of the body to be x-rayed and those views most appropriate (if known).
- When applicable, the provider should include a brief description of pertinent clinical findings or the reason the study is requested in order to assist the radiologist in interpreting the study. Additionally, the provider should describe their preliminary interpretation of the radiology study, if possible.
- The Radiology Department will screen orders for duplicated "routine" studies to determine whether the patient has been recently x-rayed for the same indication. This is to help protect patients from excessive exposure to radiation. The ordering provider will have the second to the last word in this; the Medical Director, the final word.
- If the patient is known or suspected to be pregnant, this should be made known to the radiology technician by clearly noting this in the requisition order. Obviously, pregnant women should not be x-rayed unless the need is critically important (as in a suspected fracture). The radiology technician will also ask the patient about pregnancy status.
- Films cannot be checked out of the Radiology Department until they have been officially read.
- After the official reading, the radiology report will be forwarded to the ordering provider electronically, primarily, and hard-copy as back-up. Adventitious findings that appear to not have been anticipated by the ordering provider will be reported to the ordering provider as soon as possible.
- Radiology reports must be signed-off by a provider prior to official inclusion in health record. This is generally accomplished via the Provider Approval Queue in the electronic health record system. This procedure ensures that abnormal x-ray studies are reported to the ordering provider.
- Federal law requires that patients receive a written report of findings of mammography (performed only at Hough Health Center). The Radiology Department sends a form letter to the patient.

### **Ordering specialized radiological studies:**

To order contrast and other specialized radiological studies at area radiological facilities or hospitals, a formal specialty referral must be executed in NextGen, specifying the procedure desired, and the reason it is needed and a referral order must be forwarded to a Referral Coordinator. The ordering provider is responsible for making certain that all vital information required on the patient specific to the requested procedure is performed and noted on the referral form; otherwise, the referral process will be delayed.

## ULTRASOUND SERVICES

Level One ultrasounds apply only to obstetrical patients and are offered at limited locations in network. An ultrasound technician performs these services. These services are available generally by appointment. Same day examinations can be arranged, when the schedule permits, by contacting the Ultrasound Technician directly. Level One ultrasounds are ordered via the electronic health record and the order is forwarded electronically to the attention of the ultrasound technician. The ultrasound technician will provide appropriate instructions to the patient in preparation for the procedure.

Level One ultrasounds are intended for the following utilities:

- *During the First Trimester* – confirming pregnancy and verifying location of pregnancy (uterine or ectopic); detecting multi-fetal gestations; determining the position of the uterus, cervix, and area of the placenta location.
- *Second & Third Trimester* – confirming gestational age; locating the placenta when there is vaginal bleeding and a placenta previa is suspected; determining fetal presentation & determining amniotic fluid volume; evaluating amniotic fluid index (depth of fluid in all four quadrants surrounding the maternal umbilicus); monitoring & documenting fetal movements.



## SECTION C: CLINICAL ADMINISTRATION

### ABUSE, PHYSICAL & MENTAL (CHILD AND CERTAIN ADULTS)

Providers have certain administrative/legal obligations relative to certain types of domestic violence in the form of suspected child and adult abuse. Although 'child' in this context is defined in a traditional sense, 'adult' in this context **is defined any person sixty years of age or older within this state who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents him from providing for his own care or protection, and who resides in an independent living arrangement.** Mandated obligations in regards to 'child' and 'adult' abuse are specified in Ohio Revised Code 2151 & 5101 (ORC).

#### Pertaining to Child Abuse (ORC 2151.031)

##### Pertinent Definitions

An "abused child" includes any child who:

- a. Is the victim of "sexual activity" as defined under Chapter 2907 of the Revised Code, where such activity would constitute an offense under that chapter, except that the court need not find that any person has been convicted of the offense in order to find that the child is an abused child;
- b. Is endangered as defined in section 2919.22 of the Revised Code, except that the court need not find that any person has been convicted under that section in order to find that the child is an abused child;
- c. Exhibits evidence of any physical or mental injury or death, inflicted other than by accidental means, or an injury or death, which is at variance with the history given of it. Except as provided in division (d) of below, a child exhibiting evidence of corporal punishment or other physical disciplinary measure by a parent, guardian, custodian, person having custody or control, or person in loco parentis of a child is not an abused child under this division if the measure is not prohibited under section 2919.22 of the Revised Code.
- d. Because of the acts of his parents, guardian, or custodian, suffers physical or mental injury that harms or threatens to harm the child's health or welfare.
- e. Is subjected to out-of-home care child abuse.

**No person** described in the paragraph below who is acting in an official or professional capacity and knows or suspects that a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired child under twenty-one years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, **shall fail to immediately report that knowledge or suspicion to the public children services agency or a municipal or county peace officer in the county in which the child resides or in which the abuse or neglect is occurring or has occurred.**

Relative to NEON, the paragraph above applies to any person who is a physician; dentist; podiatrist; midlevel provider (i.e., Physician Assistant or Advanced Practice Nurse); registered nurse; licensed practical nurse; visiting nurse; other health care professional; licensed psychologist; person engaged in social work or the practice of professional counseling.

A provider is not required to make a report concerning any communication the attorney or medical provider receives from a client or patient in an attorney-client or physician-patient relationship, if the attorney or physician could not testify with respect to that communication in a civil or criminal proceeding, except that the client or patient is deemed to have waived any testimonial privilege under division (A) or (B) of section 2317.02 of the Revised Code with respect to that communication and the attorney or physician shall make a report pursuant to ORC with respect to that communication, if all of the following apply:

1. The client or patient, at the time of the communication, is either a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired person under twenty-one years of age.
2. The provider knows or suspects, as a result of the communication or any observations made during that communication, that the client or patient has suffered or faces a threat of suffering any physical

or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the client or patient.

3. The provider-patient relationship does not arise out of the client's or patient's attempt to have an abortion without the notification of her parents, guardian, or custodian in accordance with section 2151.85 of the Revised Code.

### **Mandatory Reporting**

Anyone, who knows or suspects that a child under eighteen years of age or a mentally retarded, developmentally disabled, or physically impaired person under twenty-one years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or other condition of a nature that reasonably indicates abuse or neglect of the child, should report or cause reports to be made of that knowledge or suspicion to the public children services agency or to a municipal or county peace officer. In addition, this information must be reported to the Medical Director who is a member of NEON's Risk Management Team (a structural component of NEON's Risk Management Program).

Any report made pursuant to this section shall be made forthwith either by telephone or in person and shall be followed by a written report, if requested by the receiving agency or officer. The written report shall contain:

1. The names and addresses of the child and the child's parents or the person or persons having custody of the child, if known;
2. The child's age and the nature and extent of the child's known or suspected injuries, abuse, or neglect or of the known or suspected threat of injury, abuse, or neglect, including any evidence of previous injuries, abuse, or neglect;
3. Any other information that might be helpful in establishing the cause of the known or suspected injury, abuse, or neglect or of the known or suspected threat of injury, abuse, or neglect.

Any person, who is required to report known or suspected child abuse or child neglect, may obtain color photographs of areas of trauma visible on a child and, if medically indicated, perform radiological examinations of the child.

No township, municipal, or county peace officer shall remove a child about whom a report is made pursuant to this section from the child's parents, stepparents, or guardian or any other persons having custody of the child without consultation with the public children services agency, unless, in the judgment of the officer, and, if the report was made by physician, the physician indicates that immediate removal is considered essential to protect the child from further abuse or neglect.

Generally, the public children services agency shall investigate, within twenty-four hours, each report of known or suspected child abuse or child neglect and of a known or suspected threat of child abuse or child neglect that is referred to it under this section to determine the circumstances surrounding the injuries, abuse, or neglect or the threat of injury, abuse, or neglect, the cause of the injuries, abuse, neglect, or threat, and the person or persons responsible.

### **696-KIDS (Cuyahoga County Children Services hotline)**

As a medical provider and child advocate, the provider who is evaluating a case of suspected child abuse should report suspected abuse to **696-KIDS** first. If there is an immediate danger to the child in returning to the home, the Children and Family Services' social worker will usually advise the family to stay at the health facility while the social worker (and possibly the police) comes to the clinic.

If it is felt that the family will not wait and the child is in danger, the provider should call a NEON social worker to assist and call 911 immediately.

Children's and Family Services will call the police in non-emergent situations. All suspected pediatric abuse cases should be referred to MetroHealth's or RBC's Child Abuse Clinic. Call the respective ER to be routed to the appropriate individual(s). Document your findings and the 696-KIDS reference number in NextGen EHR. **In addition, this information must be reported to the Medical Director.**

### **Immunity**

- Anyone participating in good faith in the making of mandatory reports shall be immune from any civil or criminal liability for injury, death, or loss to person or property that otherwise might be incurred or imposed as a result of the making of the reports or the participation in the judicial proceeding.

**Physician-patient privilege**

- Generally, the physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report submitted pursuant to this section.
- The information provided in a report made pursuant to this section and the name of the person who made the report shall not be released for use, and shall not be used, as evidence in any civil action or proceeding brought against the person who made the report. In a criminal proceeding, the report is admissible in evidence in accordance with the Rules of Evidence and is subject to discovery in accordance with the Rules of Criminal Procedure.

**Pertaining to Adult Abuse (ORC 5101)****Pertinent Definitions**

- "Abuse" means the infliction upon an adult by himself or others of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish.
- "Adult" means any person sixty years of age or older within this state who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents him from providing for his own care or protection, and who resides in an independent living arrangement. An "independent living arrangement" is a domicile of a person's own choosing, including, but not limited to, a private home, apartment, trailer, or rooming house. Except as otherwise provided in this division, it "independent living arrangement" includes a community alternative home licensed pursuant to section 3724.03 of the Revised Code but does not include other institutions or facilities licensed by the state, or facilities in which a person resides as a result of voluntary, civil, or criminal commitment. "Independent living arrangement" does include adult care facilities licensed pursuant to Chapter 3722. of the Revised Code.
- "Caretaker" means the person assuming the responsibility for the care of an adult on a voluntary basis, by contract, through receipt of payment for care, as a result of a family relationship, or by order of a court of competent jurisdiction.
- "Emergency" means that the adult is living in conditions, which present a substantial risk of immediate and irreparable physical harm or death to himself or any other person.
- "Emergency services" means protective services furnished to an adult in an emergency.
- "Exploitation" means the unlawful or improper act of a caretaker using an adult or his resources for monetary or personal benefit, profit, or gain.
- "In need of protective services" means an adult known or suspected to be suffering from abuse, neglect, or exploitation to an extent that either life is endangered or physical harm, mental anguish, or mental illness results or is likely to result.
- "Incapacitated person" means a person who is impaired for any reason to the extent that he lacks sufficient understanding or capacity to make and carry out reasonable decisions concerning his person or resources, with or without the assistance of a caretaker. Refusal to consent to the provision of services shall not be the sole determinative that the person is incapacitated. "Reasonable decisions" are decisions made in daily living, which facilitate the provision of food, shelter, clothing, and health care necessary for life support.
- "Mental illness" means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life.
- "Neglect" means the failure of an adult to provide for himself the goods or services necessary to avoid physical harm, mental anguish, or mental illness or the failure of a caretaker to provide such goods or services.
- "Physical harm" means bodily pain, injury, impairment, or disease suffered by an adult.
- "Protective services" means services provided by the county department of human services or its designated agency to an adult who has been determined by evaluation to require such services for the prevention, correction, or discontinuance of an act of as well as conditions resulting from abuse, neglect, or exploitation. Protective services may include, but are not limited to, case work services, medical care, mental health services, legal services, fiscal management, home health care, homemaker services,

housing-related services, guardianship services, and placement services as well as the provision of such commodities as food, clothing, and shelter.

Relative to NEON, any physician, podiatrist, dentist, psychologist, midlevel provider (i.e., Physician Assistant or Advanced Practice Nurse), licensed nurse, employee of an ambulatory health facility, employee of a nursing home, residential care facility, or home for the aging, senior service provider, or any person engaged in social work or counseling having reasonable cause to believe that an adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation shall immediately report such belief to the county department of human services. **In addition, this information must be reported to the Medical Director who is a member of NEON's Risk Management Team (a structural component of NEON's Risk Management Program).**

The reports made under this section shall be made orally or in writing except that oral reports shall be followed by a written report if the department requests a written report. Written reports shall include:

1. The name, address, and approximate age of the adult who is the subject of the report;
2. The name and address of the individual responsible for the adult's care, if any individual is, and if he is known;
3. The nature and extent of the alleged abuse, neglect, or exploitation of the adult;
4. The basis of the reporter's belief that the adult has been abused, neglected, or exploited.

### Immunity

- Any person with reasonable cause to believe that an adult is suffering abuse, neglect, or exploitation who makes a report pursuant to this section or who testifies in any administrative or judicial proceeding arising from such a report, or any employee of the state or any of its subdivisions who is discharging responsibilities under section 5101.62 of the Revised Code shall be immune from civil or criminal liability on account of such investigation, report, or testimony, except liability for perjury, unless the person has acted in bad faith or with malicious purpose.

### ABUSE, SEXUAL

Providers have certain administrative/legal obligations relative to the reporting of the possibility of sexual abuse. Mandated obligations in regards to sexual abuse are specified in Ohio Revised Code (ORC). Generally, we herein refer to: ORC 2151.421(A)(1) & (B), ORC 2907.02, ORC 2907.03, and ORC 2907.04.

**Who must report:** Licensed psychologists, marriage and family therapists, persons engaged in social work, persons engaged in professional counseling, health professionals, and school professionals.

#### How much should you know before you report?

- Use reasonable judgment, common sense, and professional experience.
- Don't need to have "hard evidence."
- Up to agency to investigate, not our NEON staff.
- Don't act out of hostility.
- If in doubt, report.

#### If you must report, the following is true:

- You get absolute immunity from civil and criminal liability.
- You don't even have to show you acted in "good faith."
- Doesn't mean someone can't sue, but they will lose.

#### What happens if you fail to report?

- If you must report and don't, you may be criminally liable.
- If you must report and don't, you may be civilly liable.

#### How do you report?

- By telephone or in person or in writing;
- To public children services agency where child resides;
- If you must report, you may take photographs, x-rays of victim.

#### Who is the victim?

- A person under 18 years of age; or

- A mentally impaired, developmentally disabled or physically disabled person under 21 years of age.

**Definitions of Sexual Activity:**

1. "Sexual conduct" means vaginal intercourse between a male and female, and intercourse, fellatio and cunnilingus between persons regardless of sex; and without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus or other object into the vaginal or anal cavity of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse. ***Please note that confirmed pregnancy infers "sexual conduct".***
2. "Sexual contact" means any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person.

**Sexual Conduct Crimes Matrix**

<b>RAPE</b>		
<b>ACTIVITY</b>	<b>OFFENDER</b>	<b>VICTIM</b>
Non-compelled "sexual conduct"	Any person can be offender	Must report if victim is under 13
Compelled "sexual conduct" including use of force, threat of force, drugs, alcohol, etc. or if victim has been duped, is mentally impaired, etc.	Any person can be the offender	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.
<b>SEXUAL BATTERY (NON-SPOUSE)</b>		
<b>ACTIVITY</b>	<b>OFFENDER</b>	<b>VICTIM</b>
Non-compelled "sexual conduct"	Parent, stepparent, guardian, custodian, loco parentis	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.
Non-compelled "sexual conduct"	Teacher, administrator, coach or other person in authority at elementary or secondary school or institution of higher learning	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.
Non-compelled "sexual conduct"	Victim's athletic or other type of coach, scout leader, or someone with temporary disciplinary control of victim	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.
Non-compelled "sexual conduct"	Person who is in supervisory or disciplinary control of victim in hospital or other institution or is employee in detention facility	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.
Compelled "sexual conduct" includes knowing coercion, knowledge of impaired victim, knowledge that victim doesn't know what is happening; being a health professional and duping the victim into believing "sexual conduct" is therapy	Any person except spouse of victim	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.
<b>UNLAWFUL SEXUAL CONDUCT WITH MINOR (NON-SPOUSE)</b>		
<b>ACTIVITY</b>	<b>OFFENDER</b>	<b>VICTIM</b>
Non-compelled "sexual conduct"	18 or over who knows the age of victim or is reckless in that regard	Must report if victim is over 13 and under 16
<b>GROSS SEXUAL IMPOSITION (NON-SPOUSE)</b>		
<b>ACTIVITY</b>	<b>OFFENDER</b>	<b>VICTIM</b>
Non-compelled "sexual conduct"	Any person whether knows the age of victim or not	Must report if victim under 13
Compelled "sexual conduct" including use of force, threat of force	Any person	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.

Matrix continued on next page...

SEXUAL IMPOSITION (NON-SPOUSE)		
ACTIVITY	OFFENDER	VICTIM
Non-compelled "sexual conduct"	At least 18 and 4 years older than victim whether or not knows the age of the victim	Must report if victim is over 13 and under 16
Compelled "sexual conduct"	Any person who knows or is reckless and the contact is offensive to victim or victim submits unknowingly or victim is impaired	Must report if victim is under 18 or under 21 if victim is physically or mentally disabled.

### ABUSIVE PATIENTS AND TERMINATION OF SERVICES TO ABUSIVE PATIENTS

Termination of the **Abusive Patient** from NEON's practice in certain unusual circumstances is warranted. However, these instances have proven over time to be rare occurrence but they generally involve **patient abuse of staff or of other patients**.

The NEON Administration (i.e., Operations Director, Medical Director, or Dental Director) should be made immediately aware of potential abusive patients. Administration is obligated to investigate the situation and make the determination whether termination is warranted. If termination is warranted, Administration shall handle the deliberation on and execution of the patient termination process, to include the following steps, at a minimum:

1. Sending a certified letter explaining the rationale for the termination;
2. Enclose a 'Release of Information' form that can be signed by the terminated patient and offer to forward medical records to another provider designated by the individual.
3. Establish in letter a firm date that the termination will become effective (e.g., 30 days hence);
4. Establish in letter the scope of termination as including all NEON health centers and providers or specific providers;
5. Establish in letter that NEON will provide urgent care until the effective date of the termination;
6. Emphasize in letter that patient should continue to receive care from another provider;
7. Provide in letter a listing of providers in the community that are available to serve the needs of the terminated patient if said listing is not evident in the telephone directory.
8. If terminated from all health centers, inform all NEON health centers, in writing, of the action. Because of the rarity of patient termination, all receptionists, appointment clerks, and office managers should be made aware of the individual's identity and effective termination date. If the patient is successful in securing care at another health center, the termination action is nullified and must be reinitiated.

### ADVANCE DIRECTIVES

Patients have the right to formulate and execute Advance Directives; both the Living Will and the Durable Power of Attorney for Health Care. **NEON providers have an obligation to inform patients of this right and honor any such advance directives if our providers are directly involved in dispensing applicable care.** Providers are responsible for indication in health record whether or not advance directives are in place.

Illustrated below is what should be explained to patients with regards to their rights in this regard:

## Your Rights as a NEON Patient

All adults in hospitals, skilled nursing facilities, and health care settings have certain rights. For example, you have a right to confidentiality of your personal and medical records and to know what treatment you will receive.

You also have another right. You have the right to prepare a document called "**advance directives**." In one type of advance directive, you state in advance what kind of treatment you want or do not want if you ever become mentally or physically unable to choose or communicate your wishes. In a second type, you authorize another person to make those decisions for you if you become incapacitated. Federal law requires community health centers (such as NEON), hospitals, skilled nursing facilities, hospices, home health agencies and health maintenance organizations (HMOs) serving persons covered by either Medicare or Medicaid to give you information about advance directives and explain your legal choices in making decisions about medical care.

The law is intended to increase your control over medical treatment decisions. Be mindful, however, that state laws governing advance directives do differ. The health care provider is required to give to you information about the laws with respect to advance directives for the state in which the provider is located. If you reside in another state, you may wish to gather information about your state laws from another source such as the office of the state attorney general.

### What is an Advance Directive?

Generally, an advance directive is a written document you prepare stating how you want medical decisions made if you lose the ability to make decisions for yourself. The two most commonly prepared advance directives are:

- a "**Living Will**"; and
- a "**Durable Power of Attorney for Health Care**."

The value of an advance directive is that it allows you to state your choices for health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. In short, an advance directive ensures your right to accept or refuse medical care. You can say "yes" to treatment you want, or "no" to treatment you don't want.

### Living Will

A living will generally states the kind of medical care you want (or do not want) if you become unable to make your own decision. It is called a living will because it takes effect while you are still living. Most states have their own living will forms, each somewhat different. It may also be possible to complete and sign a preprinted living will form available in your own community, draw up your own form, or simply write a statement of your preferences for treatment. You may also wish to speak to an attorney or your physician to be certain you have completed the living will in a way that your wishes will be understood and followed.

### Durable Power of Attorney for Health Care

In many states, a durable power of attorney for health care is a signed, dated, and witnessed paper naming another person, such as a husband, wife, daughter, son, or close friend, as your authorized spokesperson to make medical decisions for you if you should become unable to make them for yourself. You can also include instructions about any treatment you want to avoid. Some states have specific laws allowing a health care power of attorney, and provide printed forms.

### Which is Better: a Living Will or a Durable Power of Attorney for Health Care?

In some states, laws may make it better to have one or the other. It may also be possible to have both, or to combine them in a single document that describes treatment choices in a variety of situations (ask your doctor about these) and names someone (patient advocate) to make decisions for you, should you be unable to make decisions for yourself.

The law on honoring an advance directive from one state to another is unclear. However, because an advance directive specifies your wishes regarding medical care, it may be honored wherever you are, if you make it known that you have an advance directive. But if you spend a great deal of time in a state other than your home state, you may wish to consider having your advance directive meet the laws of both states, as much as possible.

**Advance Directives are not Required and may be Canceled at any Time**

You do not have to prepare an advance directive if you do not want one. If you do prepare one, you have the right to change or cancel it at any time. Any change or cancellation should be written, signed, and dated in accordance with state law, and copies should be given to your doctor, or to others to whom you may have given copies of the original. In addition, some states allow you to change an advance directive by oral statement.

If you wish to cancel an advance directive while you are in the hospital, you should notify your doctor, your family, and others who may need to know. Even without a change in writing, your wishes stated in person directly to your doctor generally carry more weight than a living will or durable power of attorney, as long as you can decide for yourself and can communicate your wishes. But be sure to state your wishes clearly and be sure that they are understood.

Make sure that someone, such as your lawyer or a family member, knows that you have an advance directive and knows where it is located. You might also consider the following:

- If you have a durable power of attorney, give a copy or the original to your agent or proxy.
- Ask your physician to make your advance directive part of your permanent medical record.
- Keep a copy of your advance directive in a safe place where it can be found easily, if it is needed.
- Keep a small card in your purse or wallet stating that you have an advance directive, where it is located and who your agent or proxy is, if you have named one.

**Who Should Prepare an Advance Directive?**

You may want to consider preparing an advance directive if:

- You want your physician or other health care provider to know the kind of medical care you want or don't want if you become incapacitated.
- You want to relieve your family and friends of the responsibility, for making decisions regarding life-prolonging actions.

**Finally, NEON physicians and our other licensed practitioners are required to honor your “advance directives” if something was to happen to you while under their direct care.**

**Additional Information**

If you need help in preparing an advance directive, or if you would like more information, you may want to contact a lawyer, a nearby hospital, hospice or long-term care facility, or your state attorney general's office. You may also request a form from NEON's Health Information Services Department (Medical Record).

**APPOINTMENT SYSTEM ISSUES**

NEON users are extended the opportunity to make appointments to see health center providers. We continually strive to identify ways to improve our appointment system and strategies. Maximum efficiency and minimum waiting time is the goal for patients. Appointments are centralized.

Patients are given a specific appointment for up to three months ahead. A mailed reminder may precede the visit. For appointments longer than three months, patients may be sent a reminder to call for an appointment.

The schedule is booked in such a fashion to account for respective patient show rates of individual providers.

The following factors are particularly important for the provider to take under consideration:

1. When a patient is seen, always indicate when you want to see him/her again.
2. At a minimum, indicate in the health record the approximate interval prior to the next requested patient encounter (i.e., two weeks, six months, prn, etc). As part of patient discharge planning,



clinical ancillary staff will coordinate with the appointment clerk the scheduling of the desired appointment or establish the appointment themselves.

3. If the next visit is three months or more distant, a specific appointment won't be made. Instead, the patient is advised by clinical ancillary staff to call the health center to reserve an appointment up to 30 days before the desired date.
4. If it is desirable that a patient return on a certain day within a period of less than 30 days, the specific date should be indicated in the health record in the Plan section. The discharging clinical ancillary staff person (i.e., nurse, medical/dental assistant) will communicate this request to the staff person handling appointments (i.e., appointment clerk or office manager) or establish the appointment themselves.
5. With respect to appointments for physical examinations, unless the patient asks for an appointment for a routine physical examination, a regular follow-up appointment will be made.
6. The key to assuring that the patient has an appointment for a routine physical examination is for the patient to ask for one.

### **Late Arrivals for Appointments**

There is no official policy that dictates that a NEON patient appearing late for his/her appointment should be denied the opportunity to see the appointed provider. Therefore, it should be the **exception** rather than the rule that this late-arriving patient is not served. The nature of our target patient population is such that they **are not** always in control over their means of transportation to a given health center. Therefore, we should be respectful and understanding of their limitations. Foremost, they should not be penalized for their late arrival if it is for reasonable cause.

If it is determined that extenuating circumstances exist whereby the late-arriving patient cannot be seen, the following steps **must** be taken:

1. The clinical circumstances of the patient should be evaluated by an applicable clinical staff person (medical or dental) making certain that the patient's acute needs (like medication refills) have been addressed to tide them over until his/her return.
2. A clinical staff person should assist the patient in making alternate arrangements (e.g., being seen at a later time, a later date, or at another facility).

### **Missed Critical Follow-up**

An extremely important component of our Risk Management Program is our responsiveness to "missed critical follow-up." It is essential that the provider with whom the follow-up is intended act on all missed opportunities for patients who require critical follow-up. This activity is accomplished by making certain that for all patients with critical test (lab and radiology) results who absolutely require follow-up that the provider assigns to him/herself a task (or To Do) in the respective provider's Workflow (NextGen Inbox) with a reminder to check on a near future date whether the patient has been seen for the important clinical matter (e.g., abnormal Pap, positive stool heme, anemia in a male, etc.). If in executing the task, the provider finds that the patient has not appeared for critical follow-up during the recommended period, the provider should document in the electronic health record via a 'chart update' other efforts at contacting the patient (e.g., telephone call documentation and/or sending another abnormal lab letter, certified or otherwise). The task self-assignment should have a DUE DATE in the electronic health record that is consistent with the nature of the clinical problem. The chart update must in essence demonstrate an "action plan" and, at a minimum, the degree of urgency to which the patient should be re-evaluated based upon the patient's clinical circumstances.

#### **'Missed Critical Follow-up' Action Plans:**

1. If the patient has a severe problem that needs follow-up, all reasonable actions should be exhausted before terminating one's efforts at achieving patient adherence, including writing a letter to the patient and telephoning the patient.
2. It is important to document what actions are taken so it is apparent to any internal or external reviewer of the medical record that all reasonable efforts have been exhausted in hopes of achieving patient adherence.

## EMERGENCY RESPONSE

Emergency response requires carefully thought-out protocols, accessible equipment, and regular practice. Practice sessions are arranged periodically. All medical providers and medical ancillary staff **are required** to maintain CPR (BLS) certification, at a minimum. Additionally, all nursing staff is given the opportunity to become certified in performing CPR. This training is arranged through NEON Clinical Services and administered by certified instructors.

Laminated Medical Emergency "Code Blue" and Hazardous Emergency procedures are posted in various places around each center.

### Code Blue Procedure:

1. Any employee who sees any person in the center who may be having a cardiac or pulmonary arrest or another medical emergency should immediately go to the person's aid and notify the respective NEON Health Center Operator, stating that there is a "Code Blue" emergency, giving the specific location of the emergency relative to the respective Health Center.
2. The NEON Health Center Operator shall announce a "Code Blue" along with the specific location of the emergency in the health center (e.g., "*Code Blue, Pediatric Department, Waiting Area!*"). This announcement should be made repeatedly until a health center staff person, responding to the emergency, indicates to the operator that appropriate staff has reported to the site of the Code Blue and that the announcements should be discontinued.
3. Security personnel shall proceed to the announced location to direct non-essential persons away from the emergency area.
4. The nursing staff shall transport the emergency cart/suitcase, oxygen and supplies to the announced location.
5. All licensed independent medical practitioners shall report to the announced location. At least one licensed independent medical practitioner (e.g., physician, advanced practiced nurse, physician assistant) will immediately elect to take charge of the medical emergency due to his or her degree of competency in handling the emergency and, thereafter, dismiss all individuals who have responded to the emergency that are viewed as non-essential to managing said emergency.
6. The first qualified CPR-trained person at the location should initiate cardiopulmonary resuscitation as soon as it has been ascertained that the victim's breathing and/or heartbeat have ceased.
7. Further clinical actions shall be carried out as per the orders of the.
8. If patient is registered at NEON, an entry should be made in the electronic health record describing the incident.
9. IN THE EVENT OF THE UNAVAILABILITY OF A LICENSED INDEPENDENT MEDICAL PRACTITIONER, health center staff responding to the Code Blue should call EMS (911) and notify the respective NEON Health Center Operator that this call has been made.
10. If EMS (911) is summoned, the NEON Health Center Operator should be notified that the call was made and Security should be directed to be on the lookout for EMS to assist them, upon arrival, in getting to the location in the health center where the event is taking place.

## Hazard Emergencies

### Hazardous Spills:

According to OSHA, the basic guidelines for managing hazardous spills include the following:

1. Contain the spill;
2. Leave the area;
3. Emergency eye wash, if applicable;
4. Access material safety data sheet (MSDS);
5. Notify the supervisor as soon as possible.

**Fires:**

The person discovering the fire does the following:

1. Sounds the alarm;
2. Attempts to confine the fire by shutting access doors to the area of the fire;
3. Notifies the respective NEON Facility Operator to give the fire location and brief description of fire involvement;
4. Exits the building, using stairs -- **not elevators**.

The NEON Facility Operator does the following:

1. Calls the Fire Department;
2. Attempts to notify the Center Director, if available;
3. Exits the building.

The Fire Captain or the Lead Person does the following:

1. Insures that all patients, visitors and personnel are evacuated from the immediate area, directing patients and non-center personnel to the nearest exit away from the fire;
2. Checks all rooms including bathrooms to make certain that all patients have been removed from the area;
3. Closes doors in the area and exits the building;
4. Assembles staff and patients in the parking lot away from the building and takes a head count (separate for non-center personnel and employees);
5. Reports the non-center personnel count and the employee count to the Center Director or responsible person if different.

**ENCOUNTER & BILLING-RELATED FORMS**

In order to expedite NEON's billing process, providers are required to complete Evaluation & Management Coding. For every encounter, there are procedures (CPT codes) and diagnoses (ICD codes). NEON is reliant on its provider staff to address CPT and ICD coding in a diligent and conscientious fashion. NEON providers have access to a variety of specialty-related electronic billing templates covering multiple facets of our clinical operation.

Unless extenuating circumstances dictate otherwise as approved by Administration, the provider is expected to ensure that the billing information is complete and submitted on the same day a service or no later than seven (7) days after the completion of the delivery of services to a Patient treated in a hospital facility (inpatient and outpatient) or an extended care facility.

**HEALTH INFORMATION RECORDS**

The Health Information Management Services (HIMS) (also referred to as Medical Records Department or Medical Records) will assist providers with requests for information from insurance companies, attorneys, and patients themselves. Providers may refer requests to the HIMS department at their health center. HIS staff will retrieve the chart and prepare the paperwork for the provider's completion and signature.

**Standards for of Health Records**

There are written standards for the confidentiality of Health Records. Some of the most relevant points are:

- **Accessibility to Records**. Only authorized personnel for whom the need has been established shall have access to health records. All personnel must at all times exercise extreme caution directed at preventing disclosure of health information to unauthorized persons in the health centers. Health records should never be left in an area that is unattended and vulnerable to inspection by non-authorized personnel nor should electronic record be left visible to non-authorized personnel.
- **Availability of Records**. Health records shall be available to administrative staff and providers for appropriate services and business purposes as the need arises. This includes Patient Financial

Services personnel for billing purposes and other administrative staff, for evaluation, special problems and education purposes.

- **Release of Information**. HIMS staff is responsible for the release of all health information. Therefore, send all requests for information from the health record to the HIMS.
- **Removal of Records**. The Health Information Management Services Director must **approve** and the Medical/Dental Director or designee must **authorize** the removal of health records from the premises to non-agency sites.
- **Requests for Information**. The patient must be completely aware of any request for information from lawyers and insurance companies. The patient must sign a consent form specifying the name of the requesting agency and the type of information needed and dated within a ninety-day period.
- **Security**. The Health Information Management Services Department controls access to all records in its custody. Paper charts should not be retained in provider areas and other (unsecured) locations at the close of business daily. Paper charts must not be locked in cabinets in provider or nursing areas.
- **Special Consents for Release of Information**. Special consent forms are used for release of information of drug and alcohol records, and HIV-related information. Do not give any information over the phone to anyone asking about patients who have these conditions. Persons convicted of violating this law may receive heavy fines and/or jail sentences.

### HIPAA Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 incorporated provisions that mandated the adoption of Federal privacy protections for individually identifiable health information. The Privacy Rule does the following:

- Gives patients more control over their health information.
- Set boundaries on the use and release of health records.
- Establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- Holds violators accountable, with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
- Strikes a balance when public responsibility supports disclosure of some forms of data – for example, to protect public health.
- Enables patients to find out how their information may be used, and about certain disclosures of their information that have been made.
- It generally limits release of information to the minimum reasonably needed for the purpose of the disclosure.
- It generally gives patients the right to examine and obtain a copy of their own health records and request corrections.

The following practices are **permissible** under the Privacy Rule, if reasonable precautions are taken to minimize the chance of incidental disclosures to others who may be nearby:

- Health care staff may orally coordinate services at nursing stations.
- Nurses or other health care professionals may discuss a patient's condition over the phone with the patient, a provider, or a family member.
- A health care professional may discuss lab test results with a patient or other provider, or a family member.
- A health care professional may discuss lab test results with a patient or other provider in a joint treatment area.
- A physician may discuss patients' conditions or treatment regimen in the patient's semi-private room.
- Health care professionals may discuss a patient's condition during training rounds in an academic or training institution.
- A pharmacist may discuss a prescription with a patient over the pharmacy counter or with a physician or the patient over the phone.

- In these circumstances, reasonable precautions could include using lowered voices or talking apart from others when sharing protected health information. However, in an emergency situation, in a loud emergency room, or where a patient is hearing impaired, such precautions may not be practicable.
- Physician offices may use patient sign-in sheets or call out patient names in waiting rooms, so long as the information disclosed is appropriately limited.

### **Recordation**

- EVERY non-casual clinical encounter with a patient requires corresponding entry in the health record. Fraudulent billing practices are often postulated from billing instances for health care that is not documented in the health record. Our health records are subject to audits that compare reimbursements by various entities to health record entries in order to test for accuracy and appropriateness of billing.
- Providers should summarize all applicable information from hospitals, etc. to include diagnoses, procedures, etc., in the health record and the electronic listing of Chronic Problems, at a minimum.

### **Progress/Visit Note Essentials**

The progress note should include:

1. Date of entry;
2. Type of visit (Appointment, Walk in, Same Day, etc.);
3. Chief complaint or purpose of visit;
4. Objective findings;
5. Diagnosis or medical impression;
6. Studies ordered such as laboratory or x-ray;
7. Therapies administered (medications should be placed on the med flow sheet);
8. Disposition, recommendations and instructions to patients;
9. Treating provider's name and profession (DDS, CNM, MD, DO, etc.);
10. Patient exit instructions to the patient (generally completed by ancillary staff).

## **IMPAIRED LICENSED PRACTITIONER MANAGEMENT PROTOCOL**

### **Purpose:**

- To promote the health and well-being of its medical staff, while at the same time striving to assure that their patients receive quality care. In connection with those goals, NEON recognizes that alcohol abuse, drug/chemical abuse, physical or mental illnesses and/or medical conditions and personal problems may adversely affect their ability to deliver quality care at appropriate standards. In its efforts to achieve the above-stated ideals, NEON has established these procedures for the purpose of detecting, intervening upon, promoting rehabilitation for and monitoring licensed independent practitioners (LIP) who have been determined to be impaired for one of the above-specified reasons.

### **Responsibility:**

- When a LIP is suspected of impairment, a confidential process will occur that will validate whether or not the practitioner is impaired. If it is determined that a practitioner is impaired, such individuals will be referred to the respective Clinical Director for evaluation and referral for treatment. Recommendations of the applicable Clinical Director will be taken into consideration when the Board of Trustees considers a privileging decision that might negatively impact the LIP. All efforts will be made to enable the LIP to return to safe practice.

**Procedure:**

1. Self-referral: Any LIP may seek care for substance abuse or mental illness from a qualified mental health provider covered under their individual health care plan, (Kaiser HMO or Kaiser Added Choice). In cases of self-referral the treating provider will not advise the Medical Director of Dental Director of the LIP's impairment unless the LIP authorizes the release of this information.
2. Any co-worker of any LIP having information regarding a potentially impaired individual may report this information to the applicable Clinical Director. Sufficient cause for concern and subsequent reporting will include, but will not be limited to:
  - evidence of misuse of prescribed or non-prescribed drugs
  - evidence of use of alcoholic drugs while on duty
  - evidence of impaired performance while on duty
  - failure to meet duties and responsibilities that other licensed practitioners regularly fulfill
  - repeated absences that are inadequately explained
  - repeated tardiness for scheduled responsibilities
  - bizarre or disruptive behavior
  - any performance which is overtly negligent
  - physical or verbal abuse toward any colleague, staff member or patient any other factual circumstance reasonably suggesting the presence of substance abuse or mental illness
3. All such information will be held in confidence and will not be discussed among other members of the LIP's clinical department unless the applicable Clinical Director determines that certain individuals have a legitimate need to know in order to insure appropriate treatment for the LIP and/or provide safe patient care.
4. All allegations of substance abuse or mental illness significant enough to cause impairment will be considered by the applicable Clinical Director and investigated appropriately.
5. If the investigation reveals that a substance abuse problem exists or that significant mental illness exists or is likely to exist, immediate steps will be taken to remove the impaired LIP from patient care responsibilities. In this case, an intervention will be performed immediately under the direction of the applicable Clinical Director or another qualified mental health care provider. As part of this process a request will be made that the LIP will voluntarily submit to an evaluation and follow the recommendations for treatment made by the treatment facility, the applicable Clinical Director or the mental health care provider.
6. If the impaired LIP follows the course of action recommended during intervention, the individual will be placed on a medical leave of absence with no other disciplinary action. This leave of absence to obtain medical evaluation or treatment will be governed by the policies regarding medical leave.
7. Following successful treatment, all previously impaired LIPs must receive a release from the treating provider prior to returning to work. However, the final decision to allow the formerly impaired LIP to return to work following treatment will be made by the applicable Clinical Director.

**INFECTION CONTROL**

NEON focuses on patient safety and employee safety by executing an Infection Control Program. The Infection Control Program is administered and coordinated by our Safety Quality Committee. This program is supplemented by our Employee Infection Control Manual, which is located at [www.neonproviders.com](http://www.neonproviders.com) (*AFFAIRS - NEON Manuals*). Medical providers play a very important role in the first line of assistance for employees and patients who are faced with biohazard injuries on-site at the health center. The Employee Infection Control Manual describes the provider's role in great detail in regards to **SURVEILLANCE, PREVENTION, CONTROL & REPORTING OF INFECTION** within our network of health centers. Also captured in this manual are the roles of other employees such as nursing staff in this regard.

## INFORMED DECISION MAKING BY PATIENTS

1. It is NEON's policy that patients who need to make important health care decisions be provided with adequate, pertinent information to allow a rational decision to be made.
2. The information should be made available in the patient's primary language, in writing, and explained in an understandable way, orally.
3. The patient should be allowed time to consider the information presented, and, except in urgent situations, should be encouraged to discuss the matter with close relatives or intimate friends.
4. The patient's primary health care provider should make a recommendation to the patient about the decision if in his/her opinion the patient is likely to benefit from one course or another. However, the patient has the right to make the final decision.
5. The health care provider also has the responsibility to explain the likely harmful effects, if such are clearly possible, if the patient refuses recommended treatments or procedures. When possible, the patient should sign a statement in the progress notes that he/she understands the likely consequences of refusing recommended treatments.
6. Where minors are concerned, or those who have legal guardians, a similar informed decision procedure should be followed for parents or legal guardians. Where thought appropriate by parents, guardians, and/or health care provider, the patients should be presented decision-making materials consistent with their level of understanding.

For designated procedures (Class B and Class C), written patient consent is required prior to the procedure and it must be placed in the patient's health record. Such consent must cover the following concerns:

1. The nature of the proposed care, treatment, services, medications, interventions, or procedures;
2. Potential benefits, risks, or side effects, including potential problems that might occur during recuperation;
3. The likelihood of achieving goals;
4. Reasonable alternatives;
5. The relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and service;
6. When indicated, any limitation on the confidentiality of information learned from or about the patient.

Class A procedures do not require consent beyond verbal acknowledgement and consent. The basis for determining whether a procedure performed in a NEON facility requires written (or recorded) patient consent starts with determining whether the procedure is Class B or Class C. The classes are described below. Class C procedures require that specific privileges be granted to the provider performing the procedure by the respective Clinical Director. **All procedures require Universal Protocol execution (TIME OUT verification of Person, Place, Procedure, & Pharmaceutical).** However, documentation that Universal Protocol was performed is required for all Class B and Class C procedures.

**Class A Procedure:** (e.g., vaccine injections)

1. Optimal (wide) margin of safety if performed correctly;
2. Does not require specialized training to perform;
3. If done incompletely, is not associated with a delay in diagnosis or treatment of a life-threatening condition.

**Class B Procedure:** (e.g., joint injections and tooth extractions)

1. Less-than-optimal margin of safety even if performed correctly;
2. Does not require specialized training to perform;
3. If done incompletely, is not associated with a delay in diagnosis or treatment of a life-threatening condition.

**Class C Procedure:** (e.g., colposcopy and oral surgical procedures)

Less-than-optimal margin of safety even if performed correctly and at least one of the following:

- Requires specialized training to perform
- If done incompletely, is associated with a delay in diagnosis or treatment of a life-threatening condition

**Current listing of Class B and Class C procedures are tabulated below:**

<b>Discipline</b>	<b>Description</b>	<b>Class</b>
<b>Dental</b>	Crown and Bridges	B
	Endodontics	B
	Oral Surgery (Minor)	B
	Periodontics	B
	Prosthodontics	B
	Implants	C
	Maxillofacial Surgery and Prosthetics	C
	Open Reduction of Dislocation and Management of other TMJ Dysfunctions	C
	Oral Surgery (Major)	C
	Orthodontics	C
	Periodontics (Osseous Procedures)	C
	Treatment of Fractures	C
<b>Medical</b>	Arthrocentesis Procedures	B
	Intrauterine Device Insertion	C
	Hormonal Birth Control Implant Insertion or Removal	C
	Podiatric Nail or Soft Tissue Excisions or Cryosurgery	C
	Cervical, Vulvar, or Endometrial Biopsy	C
	Colposcopy	C
	Gynecological Cryosurgery	C
	Loop Electrosurgical Excision Procedure	C

**MALPRACTICE LIABILITY COVERAGE FOR NEON PROVIDERS**

Since July 1997, the Bureau of Primary Health Care (BPHC), in accordance with Section 224 of the Public Health Service (PHS) Act, 42 U.S.C. 233 (h) as amended by the Federally Supported Health Centers Assistance Act of 1995 (Pub.L. 104-73), deems NEON to be an employee of the Federal Government for the purposes of Section 224. Section 224(a) provides liability protection under the Federal Tort Claims Act (FTCA) for damages for personal injury, including death, resulting from the performance of medical, surgical, dental, and related functions and is exclusive of any other civil action or proceeding.

This "FTCA coverage" is applicable to deemed entities and their officers, governing board members, employees, and contractors who are physicians or other licensed or certified health care practitioners working full-time (minimum 32.5 hours per week) or part-time providing family practice, general internal medicine, general pediatrics, or obstetrics/gynecological services. In addition FTCA coverage is comparable to an "occurrence" policy without a monetary cap. Therefore, any coverage limits that may be mandated by other organizations are met. For example, a \$1.0 million each claim/\$3.0 million aggregate occurrence is met since FTCA would, as appropriate, provide for the payment to a plaintiff any damages awarded as a result of a judgment or settlement approved by the Attorney General (Federal), or any sums in excess of this amount.



**MALPRACTICE RISK REDUCTION** (General guidance on minimizing NEON's professional liability risk.)

In order for NEON to minimize its professional liability risk, providers and ancillary staff must be united in efforts to be vigilant at all times in ensuring congruence with a multitude of preventive measures as highlighted below.

- A. Implementation of written clinical protocols defining management of common health conditions:
  1. NEON clinical staff establishes or revises written protocols on an annual basis to ensure broad consistency in the management of common health conditions that are frequented by our patients.
  2. NEON espouses to generally accepted standards of care as practiced in the region and supported by local institutions of learning or espoused by federal agencies.
- B. Implementation of written protocols defining preventive health care:
  1. NEON clinical staff establishes or revises written protocols on an annual basis to ensure broad consistency in the provision of preventive health care for patients of all ages.
  2. Adult preventive health guidelines are incorporated in specially designed flow charts that are prominently displayed in the medical record.
  3. Pediatric preventive health guidelines are incorporated in the specially designed HealthChek forms that cover ages 0 through 20 years that are used as a guide for examination and ultimate documentation in the electronic health record barring the availability of a specific template.
  4. Failure to provide timely preventive health care that falls within the standard of care can be a basis for malpractice action if an individual suffers a medical consequence that could have been averted.
- C. Information relating to practitioner-specific patient encounters:
  1. Patient volume of individual practitioners should be monitored to expose potential needs for increasing practitioner capacity.
  2. The number of patients (especially managed care patients) assigned to individual practitioners should be monitored to expose potential needs to limit further patient assignments.
- D. Details on and analysis of patient appointments:
  1. Periodic determinations should be made as to how long it takes patients to schedule appointments.
  2. NEON must accommodate "same-day" or "walk-in" patients whenever humanly possible.
  3. Patient waiting times must be kept to a minimum. The rule is that patients should be advised of their wait status at no greater than 20-minute intervals.
  4. The volume and frequency of missed appointments should be assessed.
- E. Handling and documentation of patient phone calls:
  1. Important communications with patients should be documented in the health record.
  2. Written protocols in handling patient phone calls by non-medical staff should be followed in order to minimize inappropriate or untimely responses to patient symptoms.
  3. After-hours calls are forwarded to a service staffed by licensed nurses, who follow written protocols on how to advise patients.
  4. Our after-hours nurse advice line keeps abreast of staff coverage arrangements in order to coordinate communications amongst practitioners and between practitioners and patients.
  5. When a patient calls the health center after-hours and is given a recorded selection of options, it is advisable that the first recorded advisement should instruct the patient to seek emergency care immediately, if an emergency condition has developed.
- F. Preparation and handling of invasive office procedures:
  1. NEON must ensure that appropriately certified or qualified individuals administer invasive office procedures.
  2. Informed consent should be obtained prior to performing invasive procedures (i.e., gynecological procedures and oral surgery).

3. If sedation is used, NEON must ensure that individuals are qualified to do so. Furthermore, intra-operative clinical monitoring protocols should be followed during the administration of the sedative medication, where applicable (i.e., IV conscious sedation in the setting of our oral surgery program).
- G. Preparation and handling of medical emergencies:
1. It is not recommended that the practice maintain any medication (cardiac or otherwise, except for, possibly, Narcan), intubation equipment (tracheal or esophageal), ECG monitor/defibrillator, or other advance life support equipment unless practitioners are thoroughly familiar with their indications and use and appropriately certified.
  2. Emergency items should include the following:
    - Oxygen tank (allowing up to 15 liters/minute);
    - Suction equipment (including several catheters, some of which should be able to handle large particulate matter);
    - Ambu-bags (with appropriate face masks);
    - Several sizes of oral-pharyngeal airways;
    - Non-sterile gloves.
  3. BLS (Basic Life Support) certification of medical staff, at a minimum, is highly advisable.
  4. A written emergency policy and procedure is established at each health center. In general, the office emergency procedure should be oriented toward protecting and stabilizing the patient until EMS can arrive.
  5. If EMS is summoned to the health center, the procedure should also include designating a staff person to be responsible for flagging down and greeting the EMS crew in order to direct them to the stricken patient.
- H. Patient education:
1. Topics of educational materials given should be documented in the medical record.
  2. All commercial educational material should be reviewed thoroughly before deciding whether it is appropriate for patient use.
  3. Earlier material that was dispensed to patients and documented in the medical record should be archived when it is retired from circulation. In so archiving, the practitioner should indicate the expiration date of the educational material.
- I. Practice information:
1. Practice brochures should be available to patients that note the following, at a minimum:
    - Description of Health Center and office hours;
    - Practitioner information;
    - Telephone access procedures;
    - After-hours and emergency care provisions;
    - Billing practices and payment expectations.
- J. Patient tracking:
1. Missed critical follow-up must be documented in the health record.
  2. Practitioners must be interactive with missed critical follow-up situations by indicating in the health record the degree of urgency, if any, of follow-up.
  3. Patients must be advised either in writing or by phone call (or both) to reschedule an appointment based upon the recommendations of the provider in relationship to critical clinical issues. These activities must be documented in the health record.
  4. Lack of action related to missed critical follow-up on the part of the practitioner can make for a difficult defense in a malpractice case, if a delay in treatment or diagnostic follow-up ultimately leads to an adverse clinical outcome.
  5. To minimize missed follow-up, patients should be reminded of their appointments close to the appointed date.
  6. Appointments should be made for all NEON patients discharged from hospitals by NEON providers.

K. Health record documentation issues:

1. Allergy notation is critical.
2. Patient refusals of advised diagnostics and treatment modalities must be documented in the health record. However, one refusal is not enough. Continuous efforts to persuade patients and subsequent refusals must be documented clearly in the health record.
3. Patient refusals of preventive health care must be documented in the health record. Again, one refusal is not enough. Continuous efforts should be documented.
4. All prescriptions, refills, and dispensed meds (i.e., samples) must be documented in the health record.

L. Dealing with non-adherent (non-compliant) patients:

1. One of the greatest professional liability exposures faced by practitioners is the non-compliant patient.
2. The practitioner should discern, as best as possible, the reason for the non-adherence. Some common reasons for non-adherence are the following:
  - Cognitive limitations. In this case, the patient, because of some cognitive impairment, either does not understand the practitioner's instructions, or is unable to follow through on the instructions as given. (This is common with older people having trouble following medication regimens.)
  - The Fear Factor. Many patients fail to follow through on care, particularly some testing, because of fear of either pain or bad news.
  - Economic Factors. Some patients fail to follow the instructions because of the inability to pay for the needed care.
  - Intentional Non-Adherence. This group of patients does not fall into any of the categories noted above, however, for whatever reasons they choose to ignore the practitioner's recommendations. This group of non-compliant patients also tends to be very manipulative.
3. In each instance of non-adherence, the practitioner should endeavor to solve the non-adherence problems through any means at NEON's disposal or available in the community.
4. In the case of economic difficulties, all appropriate care should be recommended to the patient. However, based upon the economic reality faced by the patient, the practitioner may be able to suggest to the patient that, while all of the care is needed, certain aspects of the care should take priority.
5. In the case of the intentionally non-compliant patient, a four-step approach is recommended: counsel, then cajole, then warn, then terminate. All termination recommendations should be referred to the Medical or Dental Director, where applicable.
6. By far the most important step that can be taken to minimize professional liability exposure flowing from non-compliant patients (other than good communication and relationships with the patient) is adequate documentation.

P. Specialty consultation and hospitalizations:

1. When patients are referred for specialty consultations, return appointments should be scheduled to ensure their adherence with the consultation.
2. Consultative reports over the phone must be documented in the health record.
3. All returned consultative reports must be acknowledged by the referring provider and signed ('Accepted' in the Provider Approval Queue) before official filing in the health record.
4. The health should illustrate a summarizing statement, at a minimum, of the consultative report to demonstrate integration of the information with the practitioner's rendering of the patient's medical experience. This can be achieved by updated the Chronic Problem list and the Medical Module, at a minimum, if new potentially chronic health conditions and medications resulting from the external consultation.

5. **DETAILS OF COMMUNICATIONS FROM HOSPITAL-BASED PHYSICIANS CONCERNING HOSPITALIZED NEON PATIENTS (AND THEIR SUBSEQUENT DISCHARGES) SHOULD BE DOCUMENTED, IMMEDIATELY, IN THE HEALTH RECORD. THIS MUST TAKE PLACE EVEN IF THE NEON PROVIDER IS NOT THE PRIMARY CARE PROVIDER ASSOCIATED WITH THE PATIENT'S CARE. THIS OFF-SITE COMMUNICATION CAN BE CAPTURED IN THE FORM OF A CHART UPDATE AND A TASK CAN BE CREATED AND SENT TO THE ATTENTION OF THE PROVIDER AT THE MEDICAL HOME IN THE NEON NETWORK OF HEALTH CENTERS. COMMUNICATING DIRECTLY WITH THE PRIMARY CARE PROVIDER AND HAVING THAT PROVIDER AGREE TO DOCUMENT SAID COMMUNICATION IN THE MEDICAL RECORD CAN ALSO ACHIEVE THIS OBJECTIVE.**
  6. All written hospital discharge summary reports (scanned into electronic health record) must be acknowledged by the principal NEON provider and signed ('Accepted' in the Provider Approval Queue) before official filing in the health record.
  7. The progress note should illustrate a summarizing statement regarding the hospitalization to demonstrate integration with the practitioner's rendering of the patient's medical experience.
  8. New chronic medical conditions and chronic medications resulting from the hospitalization should be listed in the Chronic Problem List and the Medication Module of the electronic health record.
- Q. Billing issues:
1. Patient billing procedures must be tolerant.
  2. Providers should be involved in decisions to turn patient bills over to collections. If for instance the patient has a condition that mandates continuous treatment, the patient should not be dissuaded from adherence to clinical needs that are potentially impacted payment problems.
- S. Third-party payer denial of services:
1. In the setting where a provider makes a referral or advises a certain procedure for a patient covered by a third-party payer, the provider is obligated to assist patients with the appeals process in appealing adverse decisions made by the third-party payer.
  2. **If the provider feels strongly that a referral or procedure is indicated despite the HMO's denial, the patient should be advised, in no uncertain fashion, to persist in seeking the care. This advisement should be documented clearly in the medical record.**
  3. Provider adherence with HMO denial decisions without protest is tantamount to concurrence with said decisions. Therefore, in the event that a malpractice action proposes that significant harm came to the patient resulting from the HMO denial decision, the concurring (non-protesting) NEON provider could be implicated as well.
- T. Infection control:
1. An Infection Control Manual is applicable to all Category 1 and Category 2 employees. The manual is available at [www.neonproviders.com](http://www.neonproviders.com) (AFFAIRS – NEON Manual section). Use of gloves, hand washing, and disposal of "sharps" is described.
  2. Position descriptions describe applicable exposure categories.
  3. Employees are offered initial and annual OSHA training.
  4. Employees are offered Hepatitis B vaccination.
  5. Where applicable, autoclave testing is performed at appropriate intervals.
- U. Facility issues:
1. Controlled substances must be securely stored;
  2. Expiration dates must be checked on medications and samples;
  3. Dispensing logs for sample medications must be maintained in case of drug recalls;
  4. In dispensing sample medications, the physician must place the instructions on the container (box or bottle) housing the medication;
  5. Prescription pads must be securely stored and patients should not have easy access to them;
  6. Patients and non-medical staff should not have access to hypodermic needles;
  7. Equipment maintenance logs should be kept up-to-date.

## Miscellaneous Legal Issues

### Witnessed Examinations:

- All pelvic examinations must be done with another female in the room to serve as a witness that the examination was done in a professional manner. While this is essential when the examiner is male, it is wise to do it even if the examination is by a female. It is advisable that the female assisting should indicate in writing (including signature or initials) in the pelvic exam section of the progress note that the exam was witnessed. This allows a credible defense later should a patient accuse us of nonprofessional conduct.

### Responding to Subpoenas:

- Every individual employee of the center is subject to be subpoenaed by the courts as a routine of performing his/her regular duties with respect to health care delivery. There are two kinds of subpoenas, that which compels the attendance of a witness, and the subpoena "duces tecum", that in which the witness is required to produce certain records in his custody or possession.
- If and when you are served with a subpoena, you are required to honor it. Willful disregard of a subpoena is "contempt of court", and a punishable offense. If you receive a subpoena "duces tecum" concerning the medical record of a NEON patient, do not attempt to honor it yourself. The Chief Medical Records Supervisor of the Health Information Management Services Department is responsible for releasing this type of information and will respond to all verifiably legal requests for release of medical information from NEON.

### Responding to Requests for Testimony:

With increasing frequency, physicians and other employees of NEON deemed eligible for medical malpractice coverage under the Federal Torts and Claims Act (FTCA) are being requested to provide testimony in litigation in which they are not currently a party. This happens primarily in the following two situations:

- The health center and/or the physician being subpoenaed were named as defendants in a medical malpractice lawsuit. However, the claim against the physician is dismissed but continues against other defendants, such as a local hospital and non-health center physicians.
- Neither the health center nor the physician being subpoenaed has been made a defendant in the medical malpractice suit to date. However, the physician likely will be asked to testify about health care that he or she provided to the injured plaintiff, who may then decide to include the physician and health center as new defendants.

In either situation, the health center and subpoenaed employee should have legal representation, and the Federal Government may have a strong interest in participating in that representation. Therefore, if you are asked to testify and the above situations apply you must notify the Medical Director or the Assistant to the CEO immediately. NEON must obtain approval from the federal government for giving testimony. This approval process allows them to determine whether legal representation is required, in which case they would provide through an assigned intermediary.

## MANAGED HEALTH CARE RELATIONSHIPS

HMO requirements tend to vary substantially from plan to plan. Therefore, the provider manual for the respective plans should be referenced in addressing HMO requirements. Nevertheless, the leitmotif for NEON providers is that our HMO obligations are ultimately a group responsibility. Any concerns over clinical demands that are made by contracted HMOs should be directed to the Medical Director who will take up the matter with the respective HMO on behalf of both the provider and the group (NEON).

## MIDLEVEL PROVIDER RELATIONSHIPS

Midlevel providers play a vital role in the delivery of health care services at NEON. However, it is extremely important that we maintain a proper environment that sustains appropriate and mandated clinical relationship amongst physicians and midlevel providers and between midlevel providers and our patients. As such, certain regulations apply to how our midlevel providers are to be utilized and integrated into our provision of medical services. These regulations are expressed in the form of Ohio Revised Code.

We employ the basic types of midlevel providers, namely: Physician Assistants, Advanced Practice Nurses, and Certified Nurse Midwives. Physicians Assistants are dependent on physicians for supervision and ultimate execution of clinical services. However, Advanced Practice Nurses and Certified Nurse Midwives are considered Independent Licensed Practitioners, with certain restrictions, but must have physicians available to collaborate with when certain clinical conditions are met.

### Physician Assistants

The authorized scope of practice of a physician assistant depends upon a Utilization Plan that has been approved by the State Medical Board for the Supervising Physician under whose supervision the Physician Assistant is practicing. The supervision agreement that must be filed by all supervising physicians prior to initiating supervision of a physician assistant requires the physician and the physician assistant to agree that they will practice in accordance with the conditions specified in the Utilization Plan. Practicing in a manner inconsistent with the standard or supplemental plan is both grounds for discipline and a criminal offense. Failure of a supervising physician to maintain the required supervision is also grounds for discipline and a criminal offense.

To be eligible for approval by the state medical board under section 4730.17 of the Revised Code, a physician supervisory plan must meet the requirements of any applicable rules adopted by the Board and shall specify all of the following:

- The responsibilities to be fulfilled by the physician supervising a physician assistant under the plan;
- The responsibilities to be fulfilled by a physician assistant when performing services under the plan;
- Circumstances under which a physician assistant is required to refer a patient to the supervising physician;
- Procedures to be followed by a physician assistant when writing medical orders, including prescriptions written in the exercise of the physician-delegated prescriptive authority granted to the physician assistant;
- Any special services that the physician may delegate to a physician assistant.

Pursuant to a standard utilization plan as approved by the Board and pertinent to NEON's Scope of Practice, a supervising physician may authorize a physician assistant to perform the following functions (not an all-inclusive listing), under "off-site supervision, on-site supervision, or direct supervision" as defined in Chapter 4730 of the Ohio Revised Code:

- Obtaining comprehensive patient histories;
- Performing physical examinations, including audiometry screening, routine visual screening, and pelvic, rectal, and genital-urinary examinations, when indicated;
- Ordering, performing, or ordering and performing routine diagnostic procedures, as indicated;
- Identifying normal and abnormal findings on histories, physical examinations, and commonly performed diagnostic studies;
- Assessing patients and developing and implementing treatment plans for patients;
- Monitoring the effectiveness of therapeutic interventions;
- Exercising physician-delegated limited prescriptive authority pursuant to a certificate to prescribe issued by the Medical Board;
- Carrying out or relaying the supervising physician's orders for the administration of medication, to the extent permitted by law;
- Providing patient education;
- Instituting and changing orders on patient charts;

- Performing wound care management, suturing minor lacerations and removing the sutures, and incision and drainage of uncomplicated superficial abscesses;
- Removing superficial foreign bodies;
- Performing biopsies of superficial lesions;
- Making appropriate referrals as directed by the supervising physician;
- Fitting or inserting family planning devices, including intrauterine devices, diaphragms, and cervical caps;
- Performing arthrocentesis of the knee;
- Performing knee joint injections;
- Any other services permitted by the policies of the health care facility, except that the facility may not authorize a physician assistant to perform a service that is prohibited by the Medical Board.

Health record entries by physician assistants do not require supervising physician sign-off or oversight.

### **Advanced Practice Nurses (Nurse Practitioners and Midwives)**

The relationship that is maintained between advance practice nurses (APNs) and physicians and APNs and patients is specified in a Standard Care Arrangement, a supplemental document. This Standard Care Arrangement (SCA) is a written formal guide for the Advanced Practice Nurse who has been appropriately credentialed and has privileges to serve NEON as an APN in the capacity of Nurse Practitioner or Nurse Midwife. This SCA is pursuant to Ohio Administrative Code Section 4723.431. Otherwise, the

To execute this SCA, the signatures of the Medical Director, the NEON APN, and all applicable NEON collaborating physicians are affixed to the 'Standard Care Arrangement Signature Page'. This SCA must be executed prior to engaging in the practice as an APN for NEON. A new SCA must be executed when engaging in practice with a different collaborating physician. This SCA is reviewed and revised, if necessary, on an annual basis.

The APN must practice in collaboration with at least one physician who has NEON privileges in the respective and pertinent medical discipline relative to the type of patient served. Each collaborating physician must satisfy NEON's credentialing policies and procedures at all times, without restriction in their privileges.

NEON APNs in general have limited prescriptive authority pursuant to a certificate to prescribe issued by the Nursing Board. The selection of medications is specified in a State Formulary specific to APNs. The terms of this prescriptive authority are also specified in the SCA.

Health record entries by advanced practice nurses do not require collaborating physician sign-off or oversight.

### **MOONLIGHTING**

In considering performing outside (non-NEON-related) clinical activities such as moonlighting, the provider is advised that he/she will be able to perform such outside services and activities as long as these activities do not interfere with the rendering of quality care and maintaining satisfactory attendance and availability at NEON. In the event it is determined by NEON Administration that outside clinical services or activities do indeed appear to interfere with either the provider's performance or attendance and availability relative to contractual services, the provider will be advised in writing, urging him/her to cease such outside activities. In this instance, the provider's prompt compliance will assure the maintenance of the employment arrangement with NEON.

With respect to outside clinical services and activities, the moonlighting provider is adjured to adhere to the following guidelines:

- He/she may not perform these outside activities during a time-period in which NEON is compensating him/her for clinical care.
- He/she may work, without restriction, during a time-period in which he/she is on approved Leave of the health center.

- He/she may not perform these outside activities during periods in which he/she is presumed ill and benefitting from NEON's EIB leave benefit.
- Outside employment must not interfere with performing hospital call duty for NEON.
- He/she must find and secure his/her own medical liability insurance to cover outside clinical activities.
- Any compensation earned during time-periods other than when NEON is compensating him/her for clinical or administrative services or EIB leave is his/hers to keep.

## NIGHT & WEEKEND TELEPHONY COVERAGE

- **Pager (or Cellular Phone, when applicable) Access**
  1. NEON medical providers are required to maintain some form off-site communication access, which can be achieved by carrying a NEON-issued pager or by allowing access to their cellular phone.
  2. Providers are obligated to notify Clinical Services as to their preference of accessibility. Their access numbers and preferences will be posted with all pertinent parties at NEON and at hospitals in order to make certain that provider can be contacted when needed.
  3. On-call providers must keep their pagers operable (or personal cellular phones, if applicable) for as long as they are on call or notify NEON's answering service where they can be promptly reached when the pager (or cellular phone, when applicable) is nonfunctional or intentionally turned-off.
  4. Unless on approved leave, all on-call providers are obligated to respond to their pages within 20 minutes of the pager alert during the applicable times and days.

## ON-CALL, AFTER-HOURS

### Continuity Call

Generally, NEON providers are responsible for providing '**continuity call**' coverage on a rotational basis; from 5:30 PM to 8:29 AM on weekdays, and all day and night on the weekends. With this type of coverage, telephony access to our providers is critical. The Continuity Call Provider is expected to serve the respective clinical discipline by default when the primary provider is not available or responsive during routine office hours. This provider is responsible for relaying pertinent clinical information about a patient to the respective primary care provider (or delegate) during the next routine business day. This information may concern patient admissions, discharges, or emergency room visits. The Continuity Call Provider is also expected to be able to access the NextGen electronic health record system during the after-hours and convey pertinent information to external health care entities and input information into the system in order to ensure continuity of care and of information. This access is achieved by either VPN (virtual private network), designated LogMeIn, or Citrix access.

### General After-hours Call Duties

Provider input that is offered by the Continuity Call Provider is as follows:

1. **A pharmacist** may need clarification about a prescription that was written that day by a particular prescribing provider.
2. **A reference laboratory** may need to alert a provider of a panic lab value.
3. **A NEON radiology technician** may need to alert the ordering provider of a grossly abnormal chest x-ray. For example, if the x-ray is classical for pneumonia, the ordering provider may have already considered this diagnosis and might have already started treatment for presumptive community acquired pneumonia.
4. **A hospital ER physician** may need to contact the provider about a patient seen by him/her that same day or in fact referred to the ER by that provider. The referring NEON provider might have talked to another ER physician on the referral, but due to a change in shift (usually around 6:00 PM), another ER



physician is now on board and it took several hours for the patient to either get to the ER or get checked into the ER treatment area.

5. **A Nurse Triage Service** staff person may need assistance on deciding how to address a medical need for a patient.

### **Direct Hospital-based Care**

If a NEON provider is providing hospital-based care, he/she is responsible for the follow-up of all results until there is adequate communication with the outpatient NEON provider delivering principal care to the patient. All ancillary studies or specialty consultations ordered for a hospitalized patient by a particular NEON provider are the responsibility of said provider until that time in which care is formally transferred to another provider. This formal transfer must include explicit communication on all pending ancillary studies and consultations and the particular clinical circumstances of the patient. Patients, who have been discharged before transferring hospital on-call responsibility, remain the responsibility of the original hospital provider until the patient's principal NEON provider is adequately informed of the patient's clinical circumstances. When a person is discharged, the ordering provider is responsible for the results of all ordered lab until that responsibility is formally transferred to another provider (preferably the patient's designated NEON provider). Finally, it is the responsibility of the discharging provider to make certain that a discharge summary is delivered to NEON so that it can be scanned into the EHR and directed to the attention of the appropriate medical provider via the Provider Approval Queue.

### **Non-direct Hospital-based Care**

If a NEON provider is made aware that a patient has been hospitalized, he/she is responsible for making certain that the health record reflects the outcome of this care. The Problem List and Medication List must be updated with relevant new information that could impact the care of the patient. If the informed NEON provider is not the primary care provider for the patient, the provider is obligated to make the primary care provider aware of the patient's hospitalization and make certain that any documentation related to said care is delivered to the HIMS Department for immediate scanning into the EHR and to the attention of the primary care provider via the Provider Approval Queue. The informed NEON provider who is not the primary care provider should create an INBOX ToDo task and assign it to the primary care provider (supplemented by an email) with an appropriate DUE DATE. If it is evident that the ToDo task has not been responded to, the informed NEON provider should contact the primary care provider directly or refer the matter to the Medical Director by email to expedite the **secondary notification** process.

## **PATIENT FEES & PAYMENT ARRANGEMENTS**

Providers should not involve themselves with the financial arrangements between patients and NEON. However, since these matters are of real importance to our patients and to the survival of the health centers, some general understanding of patient fees and payment arrangements is necessary. Providers should be acutely aware that patients have varying degrees of payment responsibilities in regards to services provided or initiated at NEON facilities. Patients without insurance are often responsible for minimum fees associated with visits that are inclusive of a limited set of laboratory services and radiology services.

Most patients are provided care through fee-for-service arrangements, either with the patient or with an insurance carrier such as Medicare, Medicaid, or private insurance. Financial arrangements with patients vary by financial classes. Partial Pay and Full Pay patients are charged according to their ability to pay. This is driven by a sliding fee schedule based on the current federal government poverty guideline, which is published yearly. To the extent that patients qualify for and benefit from various degrees of discounts as a result of this fee schedule is the extent to which our federal grant monies subsidize their care.

Due to NEON's status as a federally qualified health center (FQHC), the way it is reimbursed by Medicare and Medicaid is derived from a formula that takes into consideration NEON's overall costs related to serving patients insured by Medicare. However, this formula only looks at the prior year's experience.

## **PATIENT PRIVACY**

All patients have the right to privacy in various respects as noted below:

### *Auditory Privacy*

- Patients should not be asked to divulge sensitive financial or personal information when anyone but the patient and the staff member (who has a legitimate need for this information) can hear.
- Patients should not be asked to state their complaint or medical problem publicly when it could be heard by anyone but the staff member who has a legitimate need to know.
- No staff member should mention diagnostic or financial or other potentially embarrassing information about a patient when a third, unauthorized person could overhear.

### *Visual Privacy*

- No patient should be asked to disrobe in surroundings where there is the possibility of exposure to the view of any individual (staff member or not) who does not have a legitimate need and reason to be there.
- While disrobed, patients should be provided with garments and/or sheets that will minimize exposure to the extent necessary for the legitimate examination of the patient.

In general, all patients will be treated with dignity and consideration and their individual rights to aural and visual privacy maintained.

## **PATIENT RIGHTS & RESPONSIBILITIES**

Providers and ancillary health staff are responsible for educating patients on their rights and responsibilities. Providers and ancillary health staff are also obligated to respect these rights and responsibilities. Our patients should be instructed on the following rights and responsibilities:

- Receive services regardless of race, color, culture, language, Vietnam veteran status, sexual preference, and income.
- Be treated with respect, consideration, dignity, and be provided quality services, appropriate healthcare, and timely delivery of healthcare.
- Participate in all decisions involving their healthcare unless this is not medically advisable.
- Strict confidentiality of health records and health information as required by law and decency.
- Auditory and visual privacy during all healthcare interviews, examinations, and treatments.
- Voice complaints about our services.
- Refusal of medical or surgical treatment or therapy.
- Be informed that a student doctor is seeing them, if this applies, under the guidance of a doctor; and, they have the right to refuse to be seen or examined by a student.
- Refuse participation in experimental research.
- Advance Directives, unless conditions are stated under which the doctor should not honor such directives.

## **PEER REVIEW PROGRAM**

Medical peer review is a necessary component of NEON's overall quality improvement efforts. It is a process by which designated physicians investigate the medical care rendered by colleagues in a prescribed manner in order to determine whether accepted standards or guidelines of care have been met. If it is determined from said review that the provider has departed from accepted standards or guidelines, it may be recommended that the provider receive remedial attention by the Medical Director. Ultimately, if it is determined that remedial action is not fruitful in altering the practice of the provider, limiting or termination of privileges may be the final action as so determined by the Chief Executive Officer in collaboration with the Medical Director, in accordance with policy set forth by NEON's Governance.

The Chairman of the Board of Trustees appoints the members and the Chair of the Quality Committee of the Board. The Quality Committee functions within the by-laws of the organization. The Quality Committee of the Board shall consist of at least three members. At least one of these members shall be a healthcare professional. This Committee constitutes the Professional Review Body for NEON.

The Chief Executive Officer, Clinical Directors, Corporate Compliance Officer, the Director of Human Resources, and legal counsel serve as ex-officio members of the Quality Committee. The primary functions of the Quality Committee are to review the quality of care rendered by practitioners and quality of practitioners' (employed or contracted by NEON) credentials. This Committee is charged with the responsibility of reviewing the Quality Improvement Program for NEON, reviewing credentials of practitioners, and making privileging recommendations to the Board. The efforts of the Professional Review Body are supplemented by the review work of select professionals who are trained to perform structured implicit quality reviews to support this program.

It is intended that the Quality Committee meet periodically to perform routine reviews, propose specific policy changes, and make recommendations for action to the Board of Trustees. The Chair may call the Quality Committee into an emergency session when deemed necessary. With the input of the Quality Committee, the Board of Trustees has the ultimate authority to summarily suspend or terminate a practitioner's clinical privileges, once the practitioner is afforded what is carefully construed as 'due process'. The Quality Committee has the responsibility of recommending to the Board of Trustees whatever other adverse actions that are warranted, particularly the extent of any suspension or the timing of a proposed termination. However, prior to such recommendations being made to the Board, the practitioner shall be notified in writing of his/her right to a hearing before the Quality Committee.

It is intended that licensed practitioners directly employed by NEON shall undergo some form of formal professional review on an annual basis, at a minimum. The program sketched herein does not relate to Advanced Practice Nurses as they are reviewed within the context of their individual Standard Care Arrangements that include regular peer review.

Licensed practitioners shall be subjected to annual professional review activities as part of NEON's Professional Review Program. The professional review shall consist of a two-tier review process (Level One Reviews & Level Two Reviews) in which Professional Reviewers (also known as peer reviewers), selected by the Medical Director, shall perform first tier review activities in support of the program. Level One & Two Reviews will be based on a process referred to as a 'structured implicit review'.

Licensed practitioners (i.e., specializing in podiatry, optometry, and dermatology), who are minimally represented at NEON with two or fewer practitioners of like kind, will only be subjected to modified Level Two reviews by the Medical Director. These practitioners will be obligated to collaborate with the Medical Director in the development and/or modification of clinical guidelines specific to their practice that address the top ten (10) most frequent diagnoses that are relevant to the practitioner's specialty area in his/her clinical practice at NEON. Once developed, these guidelines shall be reviewed and modified, when appropriate, in collaboration with the minimally represented practitioner on an annual basis to ensure that the guidelines remain current and applicable to his/her clinical practice at NEON. This review will take place with the index practitioner present, to allow the practitioner to demonstrate how his/her practice, as illustrated in the randomly selected health records, reflects adherence to the agreed upon clinical guidelines.

Professional Reviewers are selected based on their historic demonstration of high quality health care and are practitioners in good clinical standing at NEON. These reviewers shall also be subjected to annual professional reviews. Reviewers will maintain their qualification to perform these quality reviews as long as they are devoid of quality findings on their own clinical work as illustrated by charts audited on patients cared for by them. Reviewers will only be subjected to modified Level Two reviews by the Medical Director. As with 'minimally represented' practitioners, these reviews will take place with the index Reviewer present, in order to allow the practitioner to demonstrate how his/her practice as illustrated in the randomly selected health records reflects adherence to clinical guidelines espoused by NEON.

Significant deficiencies noted in the annual review and confirmed by the Medical Director will prompt a second tier review. This two-tier review process shall also apply to interim reviews that are prompted by routine reviews.

## POLICY BULLETINS

From time to time, NEON policy bulletins are developed and distributed to applicable employees, generally posted on NEON's Intranet for future reference. An assortment of critical clinical policies and corporate compliance policies are also maintain at [www.neonproviders.com](http://www.neonproviders.com) ('AFFAIRS - Compliance' section).

## PRESCRIBING CONTROLLED AND OHIO-MONITORED MEDICATIONS

The purpose of this section pursuant to an established NEON Policy is to described our unified frontal attack on the part of NEON against the incidence of drug abuse or misuse among NEON patients who are prescribed Controlled (schedules II-V) or Ohio-monitored (Carisoprodol and Tramadol products) by NEON medical providers. This section should not be misconstrued to infer that NEON medical providers are encouraged to refrain from prescribing such medications.

### General Prescribing Clinical Standards

With the prescribing of Controlled and Ohio-monitored medications in the treatment of the patient, the NEON provider has the following obligations:

1. As a general rule, potentially habit forming medications should not be used if a non-habit forming medications will suffice. If habit forming medications are indicated, they shall be used in adequate dose and duration to relieve symptoms but discontinued as soon as possible. The following standards must be abided by:
  - a. NEON medical providers should not prescribe Controlled or Ohio-monitored medications to patients with a history of chemical dependency.
  - b. NEON medical providers should not prescribe Controlled or Ohio-monitored medications chronically (internally defined as more than 90 days) for patients with chronic pain (i.e., arthritis, headaches, back pain, etc.) nor for behavioral health disorders without the benefit of documented consultative advice of a specialist (i.e., rheumatologist, pain specialist, or psychologist) on an ongoing basis.
  - c. NEON medical providers should not prescribe Controlled or Ohio-monitored medications without taking into account the potential for abuse, the possibility of dependence, the possibility of drug use for non-therapeutic purposes or to distribute to others, and the possibility of an illicit market for the drug.
  - d. NEON medical providers should maintain accurate medical records that reflect examination, evaluation, and treatment plan for the condition judged to require therapy with Controlled or Ohio-monitored medications. Patient health records should accurately reflect the prescription quantity and dosing of Controlled or Ohio-monitored medications. Patient records must also clearly indicate an appropriate diagnosis and purpose for which the medication is utilized and additional information supporting the diagnosis (e.g., consultant reports).
  - e. Clinical documentation should be structured in such a manner that the following elements are documented on a consistent basis:
    - i. Degree of analgesia utilizing a pain scale
    - ii. Impact on activities of daily living
    - iii. Adverse events
    - iv. Aberrant drug-related behavior
2. NEON medical providers have a responsibility to address the medication needs of patients assigned to or cared for by absent colleagues and should observe the following:
  - a. NEON providers are permitted to refill prescriptions for Controlled or Ohio-monitored medication utilized in managing the disorders of NEON patients cared for by an absent NEON colleague, if the covering NEON medical provider agrees with the historic evaluation and the indications that are illustrated in the health record. Additionally, the patient must have been adherent with treatment recommendations and generally compliant with appointments with the absent colleague

- b. NEON providers are permitted to refill prescriptions for Controlled or Ohio-monitored medication utilized in managing the disorders of NEON patients cared for by an absent NEON colleague, if the covering NEON medical provider agrees with the historic evaluation and the indications that are illustrated in the health record. Additionally, the patient must have been adherent with treatment recommendations and generally compliant with appointments with the absent colleague
- c. If what the covering provider prescribes represents a dramatic change from the previous medication regimen, the patient should be advised to return to see his/her regular NEON medical provider as soon as possible

### Ohio Automated Rx Reporting System

**All NEON Adult, Pediatric, and Family Medicine providers with prescriptive authority are required to be registered with the Ohio Automated Rx Reporting System (OARRS) as a 'Prescriber Master'.**

Prior to prescribing controlled or Ohio-monitored drugs to any NEON medical user for non-acute conditions, on behalf of the user OARRS must be reviewed to determine whether the patient is being prescribed the same or similar drugs from other medical providers in Ohio. If abuse can be concluded from scrutiny of OARRS, the NEON provider is precluded from prescribing any Controlled or Ohio-monitored medication to said patient.

If a patient has been prescribed Controlled or Ohio-monitored medications recently by another medical provider and based on when the drugs were prescribed and the validity of indications for the drugs and prescription drug abuse is not apparent, then in order for a NEON medical provider to take on the care of that patient with respect to prescribing Controlled or Ohio-monitored medications, a formal referral/letter should be generated by the previous prescribing provider basically indicating that he/she has deferred similar treatment to the NEON medical provider.

Ohio Administrative Code (OAC) Rule 4731-11-11 (Standards and Procedures for Accessing OARRS **EFFECTIVE DATE 11/30/2011**) specifies the circumstances whereby prescribers are required to access OARRS. An OARRS Prescription History Report can assist in assuring that a patient is getting the appropriate drug therapy, is taking their medication as prescribed, and may alert prescribers to signs of possible misuse or diversion of controlled substances. The system serves a secondary purpose to enhance the monitoring of the misuse and diversion of controlled substances. **A physician prescribing or personally furnishing reported drugs to treat a patient on a protracted basis shall, at a minimum, document receipt and assessment of an OARRS report in the following circumstances:**

**(1) Once the physician has reason to believe that the treatment will be required on a protracted basis; and (2) At least once annually, thereafter.**

### NEON Drug Abuse Registry

A NEON Drug Abuse Registry is maintained by the Medical Director. When a NEON patient who has been prescribed Controlled or Ohio-monitored medications violates his/her drug contract (described below) with NEON, the patient's NAME & BIRTHDAY **must be reported** to the Medical Director (by email) immediately. That name and birthday will be added to an alphabetically sorted list that will be circulated to all medical providers as often as new reports are received by the Medical Director and no less than on a monthly basis. Along with performing the OARRS scrutiny described above, the most recent NEON Drug Abuse Registry listing must be checked to make certain that the respective patient is not on the list prior to prescribing a Controlled or Ohio-monitored medication to the patient. If the patient's name is on the registry, the NEON medical provider is prohibited from prescribing this category of medication.

### Standard Drug Contract

The patient for whom it is likely that an extended course of Controlled or Ohio-monitored medications will be indicated based on the findings of said provider must execute a NEON Controlled Substance Agreement (drug contract). The standard drug contract is located in Document Library of NextGen. The medical provider named on the drug contract must ensure that the patient is fully aware of all of the details and ramifications of the drug contract at the point of obtaining consensual agreement.

## **Drug Monitoring**

Monitoring and surveillance activities such as the use of urine drug screening and pill-counting may be considered in the management of NEON patients but is not mandated by this policy. However, if the patient refuses such monitoring and surveillance, he/she should be denied prescriptions for Controlled or Ohio-monitored medications.

## **Co-Management for Patients on Controlled Analgesic Medications**

All patients that are judged to require controlled analgesic medication to manage chronic pain disorders or must also receive periodic assessments by a pain specialist **and** a behavioral health specialist. This periodicity should be at least on an annual basis. If the patient does not consent to or cooperate with this co-management, the NEON medical provider is precluded from prescribing the medication.

## **Co-Management for Patients on Sedative Medications**

All patients that are judged to require controlled anxiolytic or sedative-hypnotic medication to manage chronic anxiety-related disorders or sleep disorders must also receive periodic assessment by a behavioral health specialist or a sleep specialist. This periodicity should be at least on an annual basis. If the patient does not consent to or cooperate with this co-management, the NEON medical provider is precluded from prescribing the medication.

## **No Multi-fill Prescriptions**

Patients should **not** be provided multi-fill prescriptions for Controlled or Ohio-monitored drugs.

## **Compliance**

Non-compliance on the part of NEON medical providers with the procedure herein described shall be grounds for discipline and/or loss of privileges.

## **QUALITY IMPROVEMENT PROGRAM (CLINICAL CARE)**

NEON's Quality Improvement Committee, chaired by the Medical Director, is composed of a diverse group of employees. NEON's Clinical Quality Improvement Program, devised by a subset of this group, attempts to measure and monitor a wide-range of issues focusing on the clinical care of our patient population as well as their perception of this care. The end result of these monitoring activities is to promote improvement in performance. NEON's Clinical Quality Improvement Program must be flexible enough to incorporate new components in order to continually reflect the reigning needs of the organization. Nonetheless, it is intended that the program respond at a minimum to clinical objectives espoused by the Bureau of Primary Health Care (one of our principal funding agencies) and reflective of NEON's strategic clinical plan.

## REFERRALS FOR SPECIALTY SERVICES

A limited number of specialty services (i.e., Ob/Gyn, podiatry, screening flexible sigmoidoscopy, ultrasound, dermatology, optometry, and oral surgery) are available onsite at NEON. All other specialty needs must be arranged with outside specialists. Oftentimes, the patient's health insurance coverage is the determinant of whom the patient can be referred to. If the patient is not insured and cannot afford out-of-pocket expenses, the specialty clinics of the MetroHealth (County hospital system) or Huron Hospital of the Cleveland Clinic Health System should be strong considerations. Patient preferences should also enter into the decision as to where they should or can be referred. Guidelines for arranging referrals are noted below. A Referral Coordinator is identified to serve each NEON Health Center location. The Referral Coordinator assists in arranging the appointment with the outside provider on behalf of the NEON provider.

A written referral should be generated for all specialty referrals directed at off-site specialty providers. A Referral Form is available for provider use in the Document Library template of NextGen in the preferred format. The referral document and attendant processes should reflect the following essential components:

1. The patient should be properly identified (Name, Insurance ID# if applicable, and DOB).
2. The specialist/consultant should be properly identified (Name, specialty, and address).
3. The date of referral should be noted.
4. A diagnosis (preliminary, presumptive or otherwise) should be indicated.
5. The referral should clearly indicate the procedure requested.
6. The referral should clearly indicate the reason for the referral, featuring pertinent history and/or physical exam details.
7. A listing of the patient's current medication list should be included with any referral. A listing of current medications can be generated from the NextGen Document Library template.
8. Information on pertinent laboratory and radiology reports should be included when applicable.
9. The referral should indicate the depth to which the specialist is asked to participate in the care of the patient (i.e., diagnosis and recommendation only, diagnosis and treatment, limited to comprehensive initial evaluation, and follow-up services ranging from limited to extensive).
10. Where applicable to health insuring corporations, the NEON provider should adhere to the respective entity's referral procedural specifications relative to the entity's utilization management and oversight program.

## RESEARCH AND TEACHING

NEON has occasionally been engaged in research projects; but only at the periphery. However, these projects are cognitive investigative in nature rather than instrumental or pharmaceutical. NEON's Board of Trustees must approve all clinical research projects if they have a chance of impacting a patient's privacy of health information. In any event, our patients have the right to refuse participation in research projects regardless of the scope of the research.

NEON providers are afforded the opportunity to teach students (e.g., trainees, medical students, medical residents, etc.). However, all teaching activities must be coordinated through the respective clinical director. All students must be registered with the Associate Director of Health Services.

**All patients must be advised of their right to not be seen or examined by a student of any sort or training background.** Furthermore, it must be announced to the patient that he/she is being attended to by a student and that such services are being supervised specifically by one of our staff clinicians who must be identified by name for the patient's future reference in regards to said care.

## STAFF PRIVILEGES & SANCTIONS OF PROVIDERS

### Staff Privileges:

After the initial credentialing and awarding of privileges, homologated by NEON's Governance, every two years, medical providers undergo a re-credentialing process. The following steps will be taken:

1. Verification is performed of the validity of the clinical license or certification to perform the respective clinical services.
2. A query of the National Practitioner Data Bank, which will include Medicaid and Medicare sanctions, is performed on the provider by NEON clinical administrative staff.
3. Verification is performed of specialty board certification, if the candidate attests to new certification or re-certification since the previous review by NEON.
4. A review of studies performed by NEON that pertains to the following:
  - Consumer complaints that have been lodged against the provider, over the previous period of privileges, that have been dealt with and disposed of by Administration and properly filed with the Human Resources Department in the provider's credentialing file;
  - Results of quality of clinical care reviews;
  - Consumer satisfaction surveys;
  - Review and evaluation by Administration of the provider's degree of general reliability and availability to his/her patient panel during the previous period of privileges.
5. A peer reference is obtained as to the current competency of the provider.
6. The provider's hospital privileges, if applicable, are confirmed.
7. The provider's accumulation of continuing professional education is reviewed as to whether it meets the minimum standard established by the respective state licensing or certifying board for the two years prior and up to the most recent re-licensure or re-certification.
8. The provider submits a request for privileges based on the applicable delineation of privileges that are derived from NEON's Scope of Medical Practice.
9. The provider's credentialing materials are reviewed.
10. The Medical Director approves or denies specific delineated privileges for the provider based on the review.
11. If the provider appears to be yet qualified, the respective Clinical Director petitions to NEON's Governance for the renewing of privileges for the provider for a period not to exceed two years.

#### **Sanctions of Providers:**

1. Providers who are found in violation of policies or procedures of NEON may be placed on probation, have their privileges suspended, have their privileges reduced/modified, or have their privileges terminated.
2. A provider may be placed on disciplinary probation when the situation is serious enough to warrant such action. Probation must be approved by the Chief Executive Officer and may last up to 90 days.
3. Rule violations are categorized as either minor or major. The lists of minor or major rule violations should be viewed as guidelines, which can be modified, at NEON's sole discretion, as circumstances and good judgment warrant. A violation, which is classified as major, is considered the equivalent of two minor violations. Therefore, any combination of major and minor violations equaling or exceeding four minor violations will be sufficient justification for dismissal.
4. Privileges may be suspended if a provider is in significant violation of NEON requirements, but may be able to reasonably eliminate the violation and therefore resume privileges.
5. If it is determined by various means that the scope of privileges awarded to a given provider are too broad or inappropriate, privileges will be reduced or modified.
6. Termination of privileges with NEON may occur if it is determined that it is in the best interest of NEON and its patients.
7. Providers who have been sanctioned may appeal to the Medical Director within 15 days of receipt of a sanction notification letter.
8. There is a formal grievance policy in the Personnel Policies and Procedures, which would be an avenue for appealing any sanction that the employee feels is unwarranted.
9. It is mandated that NEON report to the State Licensing Board and the National Practitioner Data Bank providers who are found to have had serious quality deficiencies resulting in suspension or termination.



## TIMELINESS GUIDELINES & EXPECTATIONS FOR THE DELIVERY OF HEALTH CARE

Patients presenting to a NEON health center shall be triaged or treated in a timely manner that reflects and is congruent with their clinical presentations. Patients seeking appointments at NEON should be provided appointments consistent with the guidelines herein stated below. Patients presenting to a health center on a non-appointed basis should be served in a timely manner based on criteria noted herein below and, above all, be given a reasonable expectation of the time frame in which they will be seen or be informed of other reasonable options for care.

### Emergency Care Timeliness

'Emergency Care' means services that are needed immediately because of an injury, for the relief of acute pain, amelioration of illness, or for the protection of public health, and for which a delay in services could be reasonably expected to result in death or the risk of permanent damage to the patient's health or in the case of a pregnant woman, the health of the woman or her unborn child. These conditions shall be referred to 'Emergency Medical Problems'. Office Managers are expected to notify a member of the medical team when they suspect that a patient, presenting to the health center, is in need of immediate medical attention.

A member of the medical team (e.g., nurse, medical assistant, or physician) is expected to immediately initiate care for a patient presenting to a health center with what appears to be an Emergency Medical Problem. The **Code Blue Procedure** should be utilized if a staff member is the least bit suspicious of a medical emergency. A patient experiencing what appears to be an Emergency Medical Problem should be referred to the nearest emergency facility for treatment, preferably to an affiliated hospital.

Examples of Emergency Medical Problems are listed below:

- Unconsciousness;
- Severe breathing difficulty;
- Symptoms of a heart attack;
- Severe bleeding;
- Convulsions or seizures;
- Report of Ingestion of poisons.

## Urgent Care Timeliness

'Urgent Care' means services that are provided for conditions due to illness or injury, which are not life threatening but require prompt attention and/or treatment to prevent complication to or deterioration of a patient's condition. These conditions are referred to as Urgent Medical Problems. Office Managers are expected to notify a member of the medical team when they suspect that a patient, presenting to the health center, is in need of prompt medical attention.

Within at least sixty (60) minutes of presentation, a member of the medical team (e.g., nurse, medical assistant, or physician) is expected to initiate care for the patient presenting to a health center with what appears to be an Urgent Medical Problem. The care rendered should be for the purpose of either treating or triaging the patient to an appropriate provider (e.g., Adult Medicine, Pediatrics, Ob/Gyn, or Dental, etc.) or another health care facility (e.g., hospital emergency department) for prompt medical attention.

Examples of Urgent Medical Problems are listed below:

- Corneal abrasions by report with moderate to severe eye pain; severe conjunctivitis or Red Eye;
- Severe toothache; moderate to severe sore throat; moderate to severe sinus infections; moderate to severe earaches;
- Moderate to severe headaches;
- Moderate to severely symptomatic person with signs of respiratory tract infection.
- Moderate exacerbation of asthma; Mild exacerbation of asthma, but out of medication;
- Moderate to severe chest pain presumed to be non-cardiac in nature in an otherwise healthy young person who is not demonstrating shortness of breath;
- Moderate to severe nausea, vomiting or diarrhea in patients;
- Moderate to severe urinary tract symptoms or moderate to severe low abdominal pain;
- Moderate to severe large joint sprains; moderate trauma to extremities with moderate to severe pain;
- Rashes that appears to be contagious (i.e., measles or chickenpox).

## Timeliness of Scheduling and Expectations for Delivery of Non-Emergency & Non-Urgent Care

- Patients making **Requests for Non-Urgent Care** should be scheduled appointments within thirty (30) days of their request. 'Routine Care' means services that are provided for patients that are not classified as Emergency Care or Urgent Care. Such care includes follow-up for acute or chronic conditions and physical examination.
- Patients who **May be Pregnant** (or suspect that they are) should be given an opportunity to schedule an initial consultation for testing and confirmation of pregnancy within three (3) routine business days of her request or can be instructed to come to health center as a walk-in patient for pregnancy testing on-demand.
- Patients who are **Pregnant** should be given an opportunity to schedule an initial consultation with an obstetrical provider within fourteen (14) days of their request.

## Timeliness of Initiation of Care for Appointed Patients upon Presentation

For patients with Routine Care needs, with an Appointment, singularly booked (or appear on the appointment screen in the first position of a multi-booked slot), and arriving at least twenty (20) minutes before their appointed time, every effort should be made to ensure that the appointed encounter with the designated health care provider is initiated no later than thirty (30) minutes after the appointed time.

For patients with Routine Care needs, with an Appointment, double booked (or appear on the appointment screen in the second position of a multi-booked slot), and arriving at least twenty (20) before their appointed time, every effort should be made to ensure that the health care encounter with the designated health care provider is initiated no later than forty-five (45) minutes after the appointed time.

For patients with Routine Care needs, with an Appointment, triple booked (or appear on the appointment screen in the third position of a multi-booked slot), and arriving at least twenty (20) minutes before their appointed time, every effort should be made to ensure that the health care encounter with the designated health care provider is initiated no later than sixty (60) minutes after the appointed time.

### Expectations for the Delivery of Walk-In/Same-day Care

For patients presenting for care on a non-appointed basis (so called 'walk-in'), it should be determined whether they are appearing for Non-urgent Care, Urgent Care, Emergency Care, or Pregnancy Testing. If the patient has what appears to be an Urgent Medical Problem or an Emergency Medical Problem, the patient should be triaged and/or treated as specified above.

If the 'walk-in'/same-day patient is requesting a **Pregnancy Test**, such testing should be performed and reported to patient within 30 minutes of the collection of urine specimen. Such testing should be accompanied by a healthcare encounter with a medical provider (primary care or obstetrical) in order to initiate prenatal counseling or to explore family planning options.

If the patient is presenting for what appears to be non-urgent care (perhaps to make-up for a missed appointment) and it has been determined that the health center has the medical capacity to serve the patient, the patient should be given a specific time-frame in which he/she will be seen on that day. If the health center does not have the medical capacity to serve the 'walk-in' patient with a non-urgent need, then the patient should be given specific guidance as to **when, where, and by whom** they can be seen.

A substantial number of center visits are 'walk-in' or 'same-day appointment' care opportunities. Many of these visits are for acute illness and are essential to facilitating ready patient access to care rather than encouraging them to seek care elsewhere (e.g., including emergency rooms). Managed care contractual obligations often specify certain expectations relative to patient access to care for urgent healthcare needs. NEON providers must make every effort to assist in fulfilling these expectations, both of the patient and of the respective insurance companies. Furthermore, the patients themselves often have specific needs and circumstances that require immediate attention.

Providers must endeavor to be empathetic to patients who find it necessary to present to the health center without an appointment seeking same-day attention to their perceived need for health care. It is often these episodes of care and NEON's response to patients' acute needs that influence whether or not the patient and other family members will utilize our facilities for health care delivery in the future. Therefore, the 'walk-in' episode could serve as an entry into continuing care, depending on how the patient views he/she has been treated (i.e., with caring, respect and dignity).

All walk-in/same-day appointment patients should receive consideration for preventive care when time allows. Thus a person not seen in the previous year should have a BP check; a woman who needs a pelvic exam and who is due for a Pap should have it, if time and the patient permits. All walk-in patients should be offered an opportunity and strongly encouraged to obtain a complete preventive health care evaluation by appointment.

It is the policy of NEON to treat our patients, who present for care without an appointment, with dignity and attentiveness to their needs. If the 'walk-in' patient is presenting for non-urgent care and it has been determined that the health center has the medical capacity to serve the patient, the patient should be given a specific time-frame or same-day appointment in which he/she will be seen. If the health center does not have the medical capacity to serve the 'walk-in' patient with a routine care need, then the patient should be informed as soon as possible.

If the patient is denied care at a health center for any reason, the patient should be dismissed from the health center with a clear understanding of the following:

- When the patient can return for care with the reasonable expectation of being seen in a timely fashion;
- Which medical provider will attend to the needs of the patient;
- Whether or not the patient should or can report to another health care facility (i.e., another NEON network health center, our after-hours health service, or a non-NEON facility).

## **TIME OUT PROCEDURE FOR INVASIVE ORAL MEDICINE PROCEDURES**

Herein below are guidelines to ensure that the correct surgical procedures are performed on the correct patient at the correct site whereby the dental staff observes a "time-out" procedure that minimizes the possibility of wrong procedure, wrong patient or wrong site surgery.

**Policy:** A "time –out" briefing must be conducted prior to dental procedures that are considered invasive in nature. This specifically includes tooth extractions, other oral surgery procedures and endodontic procedures.

**Procedure:** When an invasive procedure is planned, the following actions must take place:

1. The Oral Surgery Consent form is properly completed, including patient name, date of birth, tooth number, treatment/procedure recommended and appropriate signatures
2. The dentist with the patient should review a dental radiograph or diagram of the mouth showing the tooth (teeth) to be extracted or treated.
3. Both the dentist and the dental assistant verbally confirm/verify the planned extractions/procedures including tooth numbers, location/site of procedure to ensure consistency with the consent form and patient's expectations.
4. A "time- out" briefing is conducted just prior to starting the procedure. This must include the dentist and his dental assistant.

Following the procedure, the dentist must document the "time out" in the health record with both his initials and the dental assistant's initials.

In cases where the procedure results in unexpected finding that result in a change in the procedure or original site, the following must occur:

1. The change in procedure or site must be within the parameters of the signed consent form and verified.
2. All personnel involved in the procedure must stop to perform and additional "time out", noting the change in procedure and/or site.

The time out is performed whenever the dentist leaves the operatory if interrupted.

If at any point in the process, a discrepancy is discovered in the verification process, the dentist and dental assistant stops the procedure until the discrepancy is reconciled.

Any episode of wrong patient or wrong procedure is immediately reported to the Dental Director.

## **TRACKING PROCEDURES: HOSPITALIZATIONS, LAB, RADIOLOGY, AND SPECIALTY REFERRALS**

### **Tracking Direct Care Hospital-based:**

1. If a NEON provider is providing hospital-based care, he/she is responsible for the follow-up of all results until there is adequate communication with the outpatient NEON provider delivering principal care to the patient.
2. All ancillary studies or specialty consultations ordered for a hospitalized patient by a particular NEON provider are the responsibility of said provider until that time in which care is formally transferred to another provider.
3. This formal transfer must include explicit communication on all pending ancillary studies and consultations and the particular clinical circumstances of the patient.
4. Patients, who have been discharged before transferring hospital on-call responsibility, remain the responsibility of the original hospital provider until the patient's principal NEON provider is adequately informed of the patient's clinical circumstances.
5. When a person is discharged, the ordering provider is responsible for the results of all ordered lab until that responsibility is formally transferred to another provider (preferably the patient's designated NEON provider).

6. Finally, it is the responsibility of the discharging provider to make certain that a discharge summary is delivered to NEON so that it can be scanned into the EHR and directed to the attention of the appropriate medical provider via the Provider Approval Queue.

#### **Tracking Non-Direct Hospital-based Care:**

1. If a NEON provider is made aware that a patient has been hospitalized, he/she is responsible for making certain that the health record reflects the outcome of this care.
2. The Problem List and Medication List must be updated with relevant new information that could impact the care of the patient.
3. If the informed NEON provider is not the primary care provider for the patient, the provider is obligated to make the primary care provider aware of the patient's hospitalization and make certain that any documentation related to said care is delivered to the HIMS Department for immediate scanning into the EHR and to the attention of the primary care provider via the Provider Approval Queue.
4. The informed NEON provider who is not the primary care provider should create an INBOX ToDo task and assign it to the primary care provider (supplemented by an email) with an appropriate DUE DATE.
5. If it is evident that the ToDo task has not been responded to, the informed NEON provider should contact the primary care provider directly or refer the matter to the Medical Director by email to expedite the **secondary notification** process.

#### **Tracking Laboratory Test Reports:**

1. Provider is responsible for generating a Lab Test Order from within the NextGen EMR system using the appropriate template, which is sent automatically to the Laboratory Department.
2. For critical test orders, Ordering Provider is responsible for creating within the NextGen EMR system a ToDo Task self-assignment with a designated time-frame to serve as an individual tickler for the index patient and serve as a reminder as to whether the test result has been returned within the designated time-frame.
3. Laboratory Department staff is responsible for collecting the appropriate specimen and sending the lab order electronically to Reference Laboratory (e.g., LabCorp).
4. Upon NEON's electronic receipt by the NextGen EMR of the laboratory test report, the report is forwarded to the Ordering Provider.
5. Reference Laboratory and/or Laboratory Department staff are responsible for alerting Ordering Provider (or covering provider) directly of test results in the pre-determined and agreed upon CRITICAL/PANIC VALUE range.
6. Ordering Provider is responsible for reviewing the lab test report in his/her respective Provider Approval Queue (PAQ) in the NextGen EMR system within 7 business days.
7. Upon review of the lab test report in PAQ, Ordering Provider is responsible for electronically 'ACCEPTING' the report in PAQ and integrating the information into the NextGen EMR system.
8. When applicable, Ordering Provider is responsible for creating a New Folder and updating the health record utilizing the Chart Update visit type
9. Ordering Provider is responsible for creating Patient Letters within the NextGen EMR system and generating ToDo Task self-assignments within the NextGen EMR system with a designated time-frame to serve as an individual tickler for the index patient and serve as a reminder as to whether the index Patient has returned within the designated time-frame.

**Tracking Radiology Reports:**

1. For radiology examinations performed at NEON, Provider is responsible for generating a Radiology Order from within the NextGen EMR system making certain that all essential information is available (e.g., who, why, where, and supporting clinical information), which is automatically sent to the Radiology Department.
2. For radiology examinations performed outside NEON (e.g. MRI, CT), Ordering Provider is responsible for generating a standard Specialty Referral (see Specialty Referral Tracking procedure).
3. Radiology Department performs the appropriate radiology order and forwards the images to the external contracted radiologist.
4. Radiology Department keeps a log of all radiology image studies sent to the external radiologist in order to ensure that consultative reports are returned for each set of images.
5. Upon receipt by NEON of the radiology report, the report is forwarded to Health Information Management Services (HIMS) **ASAP** for scanning (ICS) into the NextGen EMR who, upon scanning, forwards the document to the attention of Ordering Provider.
6. Radiology Department staff is responsible for alerting Ordering Provider directly if the report reveals a critical finding (e.g., unsuspected pulmonary infiltrate or mass, bone fracture).
7. Ordering Provider is responsible for reviewing the radiology report in his/her respective Provider Approval Queue (PAQ) in the NextGen EMR system within 7 business days.
8. Upon review of the radiology report in PAQ, Ordering Provider is responsible for electronically 'ACCEPTING' the consultative report in PAQ and integrating the information into the NextGen EMR system.
9. When applicable, Ordering Provider is responsible for creating a New Folder and updating the health record utilizing the Chart Update visit type; updates include new diagnosis and change in medication regimen, at a minimum.
10. Ordering Provider is responsible for creating Patient Letters within the NextGen EMR system and generating ToDo Task self-assignments within the NextGen EMR system with a designated time-frame to serve as an individual tickler for the index patient and serve as a reminder as to whether the index patient has returned within the designated time-frame.

**Tracking Specialty Referral Reports:**

1. Provider is responsible for generating a specialty referral letter from within the NextGen EMR system making certain that all essential information is available (e.g., who, why, where, and supporting clinical information).
2. Provider is responsible for generating a Referral Order and generating a ToDo Task from within the NextGen EMR system and sending the task electronically to Referral Coordinator Group.
3. Referral Coordinator Group is responsible for arranging the referral appointment for the patient and placing this information in the NextGen EMR in association with the applicable Referral Order.
4. Upon receipt by NEON of the referral consultative report, the report is forwarded to Health Information Management Services (HIMS) **ASAP** for scanning (ICS) into the NextGen EMR who, upon scanning, forwards the document to the attention of Ordering Provider.
5. Ordering Provider is responsible for reviewing the consultative report in his/her respective Provider Approval Queue (PAQ) in the NextGen EMR system within 7 business days.
6. Upon review of the consultative report in PAQ, Ordering Provider is responsible for electronically 'ACCEPTING' the consultative report in PAQ and integrating the information into the NextGen EMR system.

7. When applicable, Ordering Provider is responsible for creating a New Folder and updating the health record utilizing the Chart Update visit type; updates include new diagnosis and change in medication regimen, at a minimum.
8. Ordering Provider is responsible for creating Patient Letters within the NextGen EMR system and generating ToDo Task self-assignments within the NextGen EMR system with a designated time-frame to serve as an individual tickler for the index patient and serve as a reminder as to whether the index patient has returned within the designated time-frame.

### **TREATMENT OF MINORS (Accompanied & Unaccompanied)**

Minors (below the age of eighteen years) who present with an adult attesting to be the patient's parent or guardian can be registered for evaluation and treatment. If there is any doubt as to the validity of the attestation of guardianship, the matter should be resolved before the patient is presented to a provider for evaluation and treatment. In documenting the care provided to the minor, the progress note should include notation as to the identity of the adult attesting to be the patient's parent or guardian.

Minors (below the age of eighteen years), unaccompanied by a parent or guardian should not be registered for evaluation and treatment unless one of the following *exemptions* exists:

1. The minor has written verifiable consent from a parent or legal guardian.
2. Parental consent is not needed in the event of a medical emergency where treatment appears to be immediately necessary to preserve the health and well-being of a minor.
3. The minor may consent to and be provided contraceptives, unless the person lacks sufficient maturity to understand the results of treatment. The United States Supreme Court has held that the federal constitutional right of privacy in matters relating to the use of contraception protects minors as well as adults. Source: Title X Family Planning Program
4. Upon the certificate of one or more reputable practicing physicians, the court may summarily provide for emergency medical and surgical treatment that appears to be immediately necessary to preserve the health and well being of any child. Source: ORC 2151.33
5. A minor may consent to the diagnosis or treatment of any venereal disease. Please note that according to Ohio law, the provider may inform parents of the treatment of HIV, but not for the treatment of other STDs. Source: ORC 3709.241 and ORC 3709.242(B).
6. A minor may consent to being given an HIV test for the diagnosis of AIDS or an AIDS-related condition. The consent is not subject to disaffirmance because of minority. Source: ORC 3701.242(B)
7. A minor may consent to the diagnosis or treatment of any condition that it is reasonable to believe is caused by substance abuse. According to Ohio law, the provider is not allowed to inform the minor's parents of such treatment that is consented by the minor, absent the parent. Source: ORC 3719.012
8. A minor may consent to outpatient behavioral health services provided that the minor is at least 14 years of age. Treatment without parental consent must be limited to six sessions or thirty days (excluding the use of medication). The provider may not inform the parent, without the minor's consent, unless the behavioral health professional determines that there is a compelling need for disclosure based on substantial probability of harm to the minor or to other persons, and the minor is notified of the intent to inform the minor's parent or guardian. Source: ORC 5122.04
9. On a case-by-case basis, the physician may make a determination that the minor has the capacity to give consent under the Mature Minor Doctrine, if the physician or nurse is unable to contact the parent or legal guardian for the purpose of obtaining verbal consent. This decision should only be made if the physician feels that a delay in treatment may be detrimental to the minor's health. The physician should employ the same criteria used to determine the ability of an adult to consent whose decisional capacity is in question. Once a finding has been made that the minor possesses the capacity to consent, the minor must give informed consent exactly as an adult would. However, the physician without judicial guidance should not determine minors younger than fifteen (15) mature. Source: *Lacey v. Laird*, 166 Ohio St. 12, 1399 N.E. 2d 25 91956
10. If a minor is emancipated. A minor is emancipated if he or she is no longer under the protection and control of his or her parents or guardian, informally or formally by judicial decree. Minors who are married, in the armed services or living away from the parents' home and self-supporting are usually

considered emancipated. Unmarried minor mothers who live with their parents are sometimes considered emancipated because they are able to make medical care and treatment decision on behalf of their children. However, a minor mother should be able to demonstrate the capacity of a “mature minor” before treatment is provided without parental consent. Source: ORC 2919.121

**Procedure relating to the provision of health services to an unaccompanied minor:**

1. When an unaccompanied minor presents to the health center seeking health services and can demonstrate proof that he or she is emancipated, they are permitted to execute a standard ‘Consent/Release Form’ on their own behalf and such consent shall remain in force for subsequent encounters at the health center.
2. When a minor presents to the health center seeking health care services unaccompanied by a parent or guardian, the Office Manager should refer the minor to the medical staff for medical triage, in the procedural manner dictated by the Center Director.
3. Medical staff (principally nursing staff), in performing medical triage, should perform the following tasks:
  - (a) Determine whether the minor fulfills any of the *exemptions* noted in this policy that allow for rendering health care services in the absence of parent or guardian consent.
  - (b) If the minor fulfills any of the *exemptions* noted in this policy, the minor should be registered and rendered medical care that is specific to the minor’s exemption circumstances.
  - (c) If the minor is being seen because he or she fulfills the Mature Minor Doctrine, the minor should sign an “Unaccompanied Minor Temporary Consent/Release Form” form prior to initial treatment for the particular medical condition in question. The ‘Unaccompanied Minor Temporary Consent/Release’ should be viewed as only specific to the medical condition in question and not blanket consent for future treatments.
  - (d) If the minor is to be treated in accordance to the *exemptions* related to Title X Family Planning Program or Emancipation, parental or guardian notification subsequent to evaluation and treatment by the medical provider is prohibited. With all other exemptions, the obligation to inform the parent or legal guardian of the minor’s diagnosis and treatment remains. This can be accomplished by providing the minor a brief written medical statement that is intended for delivery to the minor’s parent or legal guardian.
  - (e) If the minor does not fulfill any of the *exemptions* noted in this policy, the minor should be informed in as dignified and caring a manner as possible that the health center cannot legally render the service. The circumstances of the minor’s presentation and the reason for denial of services should be documented in the medical record. Additionally, an attempt should be made to contact the minor’s parents or guardians regarding the minor’s presentation to the health center.

**Documentation issues:**

1. A description of the medical triage assessment should be documented in the minor’s medical record.
2. A brief description of the nature of parental or guardian notification, if applicable, should be documented in the medical record.

**Billing issues related to services provided to an unaccompanied minor in accordance with this policy bulletin:**

1. If parental or guardian notification took place and they consented to financial responsibility for treatment of the *exemption*, they are financially responsible for the services rendered by NEON, unless the minor is enrolled in a health-insuring corporation that covers the cost of outpatient care; in which case, the health-insuring corporation is financially responsible.
2. If consent (verbal or written) is not obtainable from a parent or guardian and the minor is not enrolled in a health insuring corporation the minor should be classified under Financial Class ‘06’ (or comparable or other applicable code(s)).
3. If the minor is emancipated, he or she should be financially classified and billed in the same manner utilized for adult patients who are financially responsible for their own health care.



## TRIAGE PROTOCOL FOR MEDICAL CARE

### Routine Office Hours Telephone Triage

Nurse telephone triage coverage by an RN is provided during routine office hours. Access to this coverage is made possible by call being forwarded to the RN by either an Operator or Centralized Appointment Center staff. This RN works in close proximity and collaboration with the Centralized Appointment Center staff. When an RN staff person needs input from our providers, they will contact the appropriate provider or the provider covering the respective clinical service. Documentation of triage activity is input into the EHR system utilizing the Telephone Call Template. If the patient requires an appointment, the RN ensures that this is done by directing the patient to the Centralized Appointment Center staff.

### Afterhours Telephone Triage

Nurse telephone triage coverage by RNs (PhoneMed) is provided during the after-hours seven days a week. Access to this coverage is made possible by calls being automatically forwarded to this contracted service during the afterhours. When PhoneMed staff needs input from our providers, they will contact the respective on-call provider covering the respective clinical service. PhoneMed relays triage documentation to the health center on the first available business day. Triage documentation is scanned into the EHR system by the HIMS Department or appropriately trained delegate and made available to the appropriate provider by means of the Provider Approval Queue.

### Onsite Medical Triage

#### Procedure:

1. When a patient presents for care who feels he/she needs to be seen **urgently** and the patient cannot be given immediate access to a medical provider by means of a same-day appointment Front Desk personnel alerts the medical unit of the need to perform a medical triage of the patient; Front Desk personnel directs the patient to the medical triage area (designated for the particular health center);
2. Front Desk can ask for an immediate triage if she feels the patient is in acute distress or the staff person can announce a Code Blue if he/she feels the patient is in immediate danger or distress;
3. Through a previously established and agreed upon internal means of communication that can be unique/peculiar to the specific health center, the medical reception of the patient into the medical unit should be actively anticipated by the responding medical staff (e.g., nurse, medical assistant, or medical provider);
4. A nursing staff representative collects information related to the patient's signs and symptoms and places that information on the designated NEON Triage form;
5. The nursing staff (LPNs and MA's) presents the triage form and a brief medical case summary to the appropriate medical provider
6. The appropriate medical provider makes a triage determination (e.g., must see today somehow, can be seen on another day, or should be referred to an ER) and signs the form, which is ultimately scanned into the electronic record **if the patient is not seen at the health center on the day of initial presentation**. Prior to the triage determination, the provider is encouraged to make a quick face-to-face assessment if time permits.
7. It should also be advised that LPNs and medical assistants are not allowed to make medical triage determinations on the information they collect. Only RNs and medical providers can make a medical triage determination.
8. If the decision is to see the patient on the same day, the front desk should be alerted to register the patient for care. **If the patient is seen, the triage form can be discarded.**