Katy Trail Community Health Medical and Title X Policies

Origination Approval: Linda Messenger **Date:** 6/06

Revisions Approved By Board of Directors: November 19, 2020

Mary Nell Steinman
Board President

Chris Stewart
Chief Executive Officer

Chief Medical Officer

Medical Clinical and Title X Policy

Board Approved November 2020

Medical Clinical and Title X Policy & Procedure Table of Contents		
Policy Number	**Policy Name**	**Page Number**
8.01	Direct Admission to Bothwell Regional Health Center	
8.02	Direct Admission to Golden Valley Memorial Hospital	
8.03	Direct Admission to John Fitzgibbon Memorial Hospital	
8.04	Advanced Nurse Practitioner	
8.05	APN Nursing Students	
8.06	Nurse Practitioners Prescribing Controlled Substances	
8.07	Advanced Directives	
8.08	Continuity of Care	
8.09	Evidence Based Clinical Guidelines	
8.10	Diabetes Patient Care Guidelines	
8.11	Tobacco Use Clinical Guidelines	
8.12	Depression Treatment and Management Guidelines	
8.13	Hypertension Patient Care Guidelines	
8.14	Hyperlipidemia Patient Care Guidelines	
8.15	Audiometer	
8.16	OAE	
8.17	Ear Irrigation (Ear Lavage)	
8.18	EKG	
8.19	Spirometry	
8.20	Nebulization	
8.21	Pulse Oximetry Usage	
8.22	Suction Operation Instructions	
8.23	Acquiring Patient Temperatures	
8.24	Tympanogram	
8.25	Vision Screening Snellen Chart	
8.26	Standing Orders	
8.27	Administration of Depo-Provera	
8.28	Orders for Immunization Clinic and Guidelines	
8.29	Vaccine Refrigerator Alarm System	
8.30	Vaccine Management Plan/Emergency Response Plan	
8.31	Nursing Clinical Guidelines	
8.32	Patient Health Questionnaire (PHQ3 and PHQ9)	
8.33	Transfer Policy	
8.34	School Sports Physicals	
8.35	Emergency Contacts	
8.36	Allergy Injections	
8.37	Diagnosis and Management of Group A Streptococcal Pharyngitis	
8.38	Pediatric Blood Lead Screening	
8.39	Immunization, Administration of Immunization	
8.40	Compliance with Clinical Laboratory Improvement Amendment of 1988 (CLIA)	

8.41	Laboratory Management	
8.42	Exposure Control Plan	
8.43	Lab Orders	
8.44	Venipuncture/Capillary, Obtaining a Blood Specimen	
8.45	Provider Notification of Abnormal and Critical Lab Values	
8.46	Non-Alteration of Reference Laboratory	
8.47	DCA Vantage Analyzer-HbA1c	
8.48	Clinitek Status-Urine Controls and Testing	
8.49	Hemoglobin Controls and Testing	
8.50	OSOM Strep A Controls and Testing	
8.51	Urine HCG Controls and Testing	
8.52	Henry Schein One Step + Influenza A and B	
8.53	Microalbumin Controls and Testing	
8.54	Quidel Quick Vue RSV Controls and Testing	
8.55	Hemosure Fecal Occult Blood Testing	
8.56	Lead Screening	
8.57	PT/INR Testing	
8.58	Rapid Mono Testing	
8.59	CLIA Waived Urine Drug Screen	
8.60	OraQuick Advance Rapid HIV	
8.61	Pap Smear Monitoring	
8.62	Phenol-Safe Use and Disposal	
8.63	340 B Program (Special Pricing)	
8.64	Management of Donated Medications	
8.65	Sample Medication	
8.66	Patient Assistance Program (PAP)	
8.67	On-Site Medications	
8.68	Destruction of Medications	
8.69	In-House Formulary	
8.70	Out of House Formulary	
	Title X Policy	
8.71	Adolescent Services	
8.72	Title X Family Planning Client	
8.73	Communication with MFHC	
8.74	Community Participation, Education, and Project Promotion	
8.75	Family Planning Immunizations	
8.76	Female Client Visit	
8.77	Gynecological Services and Special Counseling	
8.78	Human Subjects Clearance	
8.79	Infertility Services	
8.80	Client Education/Informed Consent	
8.81	Male Client Visit	
8.82	Medical Director	

8.83	Medical Records	
8.84	Title X Pharmaceuticals	
8.85	Preconception Health Services	
8.86	Pregnancy Test and Counseling	
8.87	Title X Referral and Follow-up	
8.88	Required Components	
8.89	Title X Required Services	
8.90	Sexually Transmitted Illnesses	
8.91	Title X Data Reporting	
8.92	Title X Training	
8.93	Confidentiality	
8.94	Prohibition of Abortion	
8.95	Intimate Partner Violence and Human Trafficking	
8.96	Preconception Health Services	
8.97	Voluntary Participation	

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Direct Admission to Bothwell Regional Health Center **Policy Number:** 8.01

BOD Approval: 05/2010 **Effective Date**: 05/2010
Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

Katy Trail Physicians, Nurse Practitioners, or Physician Assistants may direct admit to the Bothwell Regional Health Center under certain circumstances as defined below.

II. GUIDELINES:

To be eligible for a direct admission by the Hospitalist Service:

1. Patient should be in the Primary Care Physician (PCP) office or should have been seen by the PCP in the last 12 hours. The diagnosis must be fairly certain, and the patient should not be critically ill or unstable. The patient should not have an immediate need for IV fluids, IV antibiotics, imaging, or high oxygen demand.

2. The direct admission must be physician to physician communication. Please call Bothwell Regional Health Center at **660-826-8833 to have the hospitalist on call paged**. As a general guideline, direct admissions should arrive before **4:00 pm** to assure optimal outcome for the patient and any necessary consults, radiology work ups, and send out lab to be performed.

3. Patient should meet the acuity of care in the hospital or meet the criteria for observation. For bed placement you will need to contact the House Supervisor at 660-619-4742; as well as admissions at 660-827-9400 If the Hospitalist is unclear, case management will be contacted either by the hospitalist or transferring the call from the PCP to a case manager. Once a determination is made, the case manager will advise the Hospitalist. The Hospitalist will notify the PCP within 30 minutes.

4. Discharge of patient: The Hospitalist will contact the PCP by phone to verbally hand off the patient. If the patient should require home health the Hospitalist will write the order for home health and sign the home health face to face encounter. The "Initial Plan of Care Orders" will need to be forwarded to the PCP for their signature.

5. Any questions or concerns please do not to hesitate to call or email the Hospitalist.

6. Bothwell Regional Health Center is contracting with the University of Missouri to provide hospitalist services. Patients who are cared for by the hospitalists will be billed separately for those services by the hospitalist practice. Bothwell will bill patients for their hospital stay, nursing care, supplies, procedures and/or diagnostic tests done.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Direct Admission to Golden Valley Memorial Hospital **Policy Number:** 8.02
BOD Approval: 07/2013 **Effective Date**: 07/2013
Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

Katy Trail Community Health Physicians, Nurse Practitioners, or Physician Assistants may direct admit to Golden Valley Memorial Hospital under certain circumstances as defined below.

II. GUIDELINES:

To be eligible for a direct admission by the Hospitalist Service:

1. Patient should be in the Primary Care Physician (PCP) office or should have seen by the PCP in the last 12 hours. The diagnosis must be fairly certain, and the patient should not be critically ill or unstable. If so, go to the Emergency Room for stabilization. The patient should not have an immediate need for IV fluids, IV antibiotics, imaging, or high oxygen demand.

2. The direct admission must be physician to physician communication. Please call Golden Valley Memorial Hospital at **-660-890-4569 to reach the House supervision or 660-890-7181 (this is direct line to ED)** and ask to speak to the Hospitalist on call. A provider to provider consult will be completed. If patient is acute (i.e. Chest Pain) send patient to Emergency Department for workup. As a general guideline, direct admissions should arrive before **4:00 pm** to assure optimal outcome for the patient and any necessary consults, radiology work ups, and send out lab to be performed.

3. The PCP or nurse will call the house supervisor and give report with following information:

    a. Patient name
    b. Patient DOB
    c. Demographics
    d. Name of PCP
    e. Medication list
    f. Preferred Pharmacy
    g. Primary diagnosis and secondary if available
    h. H&P if possible

4. Patient should meet the acuity of care in the hospital or meet the criteria for observation. If the Hospitalist is unclear, case management will be contacted either by the hospitalist or transferring the call from the PCP to a case manager. Once a determination is made, the case manager will advise the Hospitalist. The Hospitalist will notify the PCP within 30 minutes.

5. Discharge of patient: The Hospitalist will attempt to contact the PCP by phone to verbally hand off the patient. If the patient should require home health the Hospitalist will write the order for home health and sign the home health face-to-face encounter. The "Initial Plan of Care Orders" will need to be forwarded to the PCP for their signature.

6. Any questions or concerns please do not to hesitate to call or email the Hospitalist Medical Director or the Hospitalist Practice Coordinator at:

-Cheryl Hayes, Hospitalist Practice Coordinator:
Phone: 660-890-7376
Email: chayes@gvmh.org
Fax 660-890-7375

-Lynette Hayes, Assistant Administrator, Patient Care Services
Phone 660-890-7167
Email: lhayes@gvmh.org

7. Golden Valley Memorial Hospital is contracting with St. Luke's to provide hospitalist services. Patients who are cared for by the hospitalists will be billed separately for those services by the hospitalist practice. Golden Valley is contracting with MCare for Emergency Department physicians. Golden Valley will bill patients for their hospital stay, nursing care, supplies, procedures and/or diagnostic tests done.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Direct Admission to John Fitzgibbon Memorial Hospital **Policy Number:** 8.03

BOD Approval: 09/2015 **Effective Date**: 01/2016
Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

Katy Trail Physicians, Nurse Practitioners, or Physician Assistants may direct admit to the John Fitzgibbon Memorial Hospital under certain circumstances as defined below.

II. GUIDELINES:

To be eligible for a direct admission by the Hospitalist Service:

1. Patient should be in the Primary Care Physician (PCP) office or should have been seen by the PCP in the last 12 hours. The diagnosis must be fairly certain, and the patient should not be critically ill or unstable. The patient should not have an immediate need for IV fluids, IV antibiotics, imaging, or high oxygen demand.

2. The direct admission must be physician to physician communication. Please call John Fitzgibbon Memorial Hospital at **660-886-7431 to have the Clinical Care Coordinator (CCC) paged**. There will always be a CCC on duty and will know if the hospitalist is present and/or the hospitalist on call in order to make the connection. A brief discussion regarding the patient's condition will take place.

3. Patient should meet the acuity of care in the hospital or meet the criteria for observation. If the Hospitalist is unclear, case management will be contacted either by the hospitalist or transferring the call from the PCP to a case manager. Once a determination is made, the case manager will advise the Hospitalist. The Hospitalist will notify the PCP within 30 minutes.

4. Discharge of patient: Discharge summary will be faxed to PCP. If the patient should require home health the Hospitalist will write the order for home health and sign the home health face to face encounter. The "Initial Plan of Care Orders" will need to be forwarded to the PCP for their signature.

5. Any questions or concerns please do not to hesitate to call or email the Hospitalist.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Advanced Nurse Practitioners/Physician Assistants **Policy Number:** 8.04

BOD Approval: 06/2006 **Effective Date**: 06/2006
Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

Katy Trail Community Health (KTCH) has established a comprehensive model of primary care delivery which includes a complete group of services delivered by a multidisciplinary team of professional providers, including advanced practice nurses and physician assistants.

II. GUIDELINES:

1. APN's/PA's may be employed by KTCH.

2. Every APN/PA who delivers healthcare services at KTCH must maintain a Collaborative Practice Agreement. Chart review on the APN's/PA's cases will be conducted as outlined in the Collaborative Practice Agreement.

3. The APN /PA are responsible for maintaining all licensure requirements and must agree to follow all policies and procedures established by KTCH.

4. The APN /PA must orient with a collaborating physician for one calendar month prior to establishing their own schedule of patients. This requirement is in keeping with the Nurse Practice Act of the State of Missouri and NCCPA and the Missouri State Board of Healing Arts. The collaborating physician provider(s) will be responsible for documenting progress and releasing the APN /PA from orientation.

5. Upon completion of the orientation period, an APN/ PA may elect to shadow a physician provider one-half day every month, to enhance their practice knowledge on a topic of interest.

6. For employed APN's/PA's, KTCH provides malpractice coverage by virtue of its "deemed status" under the Federal Torts Claims Act.

7. Advanced Practice Nurses/Physician Assistants are expected to attend all relevant medical staff meetings, as outlined in the job description.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: APN Nursing Students
BOD Approval: 07/2010
Responsibility: Clinical Staff

Policy Number: 8.05
Effective Date: 06/2010
Distribution: All Departments

I. POLICY:

Katy Trail Community Health is committed to the training of Advanced Practice Nursing students and will make every effort to accommodate their clinical requirements.

II. GUIDELINES:

Advanced Practitioner Nursing Students (hereby referred to as "student") may be allowed to perform their APN clinical time at Katy Trail Community Health (KTCH). This will be approved through the Chief Operations Officer through consultation with the Chief Medical Officer. A contract with the student's university must be established in advance of the clinical rotation and must be approved by the Chief Executive Officer.

1. ANP must agree to serve as the preceptor (hereby referred to as "preceptor") for the student. The preceptor must have a minimum of one year experience in the area of training.

2. Student must complete HIPAA training and sign the KTCH Confidentiality Form prior to accessing the EHR.

3. Student will be set up in IMS with LPN rights. They will not be able to sign off on any charts. Prior to working, a new user form will be completed and sent to JMARK

4. Preceptor will have a face-to-face encounter with all patients being seen by the student and all billing functionality will be through the same process that currently exists for the preceptor. Patient will not leave KTCH without the preceptor seeing the patient with or after the student sees the patient.

5. When the student's required clinical hours are completed, preceptor will complete an evaluation on the student, as required by the University.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Nurse Practitioners Prescribing Controlled Substances
Policy Number: 8.06
BOD Approval: 01/2016
Effective Date: 09/16
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) is committed to permitting nurse practitioners to write for controlled substances as set forth by the Missouri Board of Nursing. These practitioners must first obtain a certificate of authority from their respective licensing board, and then can submit applications to the BNDD for a state controlled drug registration. Although these practitioners do not purchase, stock and dispense controlled substances, they have prescriptive authority in Schedules 2, 3, 4, and 5 and all laws pertaining to registrations, record keeping and prescribing apply. Schedule 2 is restricted to only hydrocodone products and a 5-day supply.

II. GUIDELINES:

A. Those nurse practitioners who have met the requirements of the State Board of Nursing, the BNDD and the DEA and have obtained their license to prescribe controlled substances in Schedule II-V are eligible to do the following:

1. The only schedule II drug allowed is Hydrocodone. It may only be written for a 5-day supply with no refills.
2. Schedule III drugs may only be written for a 5-day supply with no refills.
3. Schedule IV and V may be written for a month's supply with a maximum of 5 refills
4. A minimum of 20% of the charts where controlled substances are written need to be submitted to the collaborating physician for review.
5. Any and all patients receiving mental health drugs must be referred to a KTCH psychiatrist no less than every six months or we must have written documentation in the patient's chart that they have seen a psychiatrist during the last six months.

B. Nurse Practitioners will forward all charts where they have written controlled substances to their collaborating physicians for review. This will be separate from the normal preceptor review process that has already been established.

C. Attached is the list of controlled substances submitted to the BNDD as required by their application. These are only ones that can be written at Katy Trail Community Health Center.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Advance Directives
BOD Approval: 3/2018
Responsibility: All departments

Policy Number: 8.07
Effective Date: 7/2011
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will honor all valid directives of patients regarding their care and treatment. KTCH will follow the procedures as outlined in the **Patient Self-Determination Act of 1991.**

II. PROCEDURE(S):

1. As part of the initial assessment process for all new patients, a member of the patient's care team will ascertain whether the patient has an advanced directive. This will be documented in the medical records.
    a. If the patient has an advanced directive, a copy must be scanned into the medical record into document category – advanced directive.
    b. Once the document is scanned into this category, then it will link and alert the provider on the visit note for every visit
    c. If patient does not have an advance directive and desires information, KTCH will give the patient the written material available within the clinic.

2. Document in the medical records in the plan that information was given to the patient.

3. KTCH will provide for education for staff and the community on issues concerning advanced directives.

4. KTCH will not condition the provision of care or otherwise discriminate against an individual based on whether the individual has executed an advance directive.

Resources

a) The Missouri Advance Directive: Planning for Important Healthcare Decisions is available for any member of the care team to give to a patient.
b) This advance directive pamphlet is a product of Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO).

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Continuity of Care
BOD Approval: 06/11
Responsibility: Clinical Staff

Policy Number: 8.08
Effective Date: 07/11
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) is committed to independently or in conjunction with an external organization engage in the following activities that provide continuity of care for patients who receive care in inpatient or outpatient facilities or patients who are transitioning to other care.

II. GUIDELINES:

III.

1. KTCH identifies patients who receive care in external facilities. The Business Office Manager or his/her designee is responsible for pulling a listing daily from our Regional Health Center of all patients who received care in the emergency department(ED) or who were discharged from an inpatient stay and who identified KTCH provider as their Primary Care Physician(PCP).
2. Once a patient is identified as having received care at the ED or as an inpatient, medical records including discharge summaries are obtained electronically by Medical Records.
3. All patients receiving care in the ED and/or hospitalized are contacted via phone and/or written correspondence generated by the Triage Nurse within 72 hours. The goal would be to encourage patients to seek follow up care with their PCP at KTCH, or as indicated on the discharge summary.
4. KTCH systematically sends clinical information to facilities with patients as soon as possible when the PCP is making a referral to a specialty provider. Please refer to the policy/procedure titled **Referral Tracking (Policy # 2.27) .**
5. KTCH coordinates care with external disease management or case management organizations, as appropriate. External case managers are welcome to accompany patients to their visits and ask questions and/or express concerns they may have on behalf of the patient. Care managers may include but are not limited to care coordinators from behavioral health agencies, group homes, independent living centers, and commercial insurance carriers. KTCH will meet with community agencies as needed to facilitate the flow of information among external case managers and KTCH staff. KTCH will also participate in community agency coalitions so as to facilitate the cooperation of agency members to better serve our patients.
6. It is the responsibility of the Medical Record Specialist to receive and respond to all communications from external care managers. The document is electronically sent to the provider for their review and response.
7. KTCH also works with patients/families that are in need of ongoing disease

management or high risk case management. KTCH has an internal staff of nursing care teams whose job duties includes assisting patients to manage chronic diseases and or patients who are considered at risk patients.

8. Should a patient require referral to a specialist or consultant, the KTCH referral specialist will arrange the appointment upon request from a provider and send all corresponding referral letters, visit notes, and diagnostic studies needed to complete the referral. Should a patient require referral to a new primary care physician, the Business Office Manager or his/her designee will send all corresponding medical records with the appropriate release of information documentation.
    a. If a patient is moving out of our service area and requests assistance in finding a new primary care physician they will be referred to care coordinator for assistance.
    b. The care coordinator will assist the patient in locating a primary care provider and in scheduling the initial visit to establish care.
    c. If the patient chooses to request their medical records electronically, the medical records department will copy all records onto disk within three business days and contact patient when the disk is ready to be picked up.
9. When a hospital/emergency department request medical records to treat a patient at their facility (continuation of care), the practice will complete the following steps:
    a. Confirm that the patient in question is an established patient at KTCH, by verifying patient name and patient DOB.
    b. Obtain the caller's name, facility name, facility phone/fax number, and what records are needed to treat the patient (minimum necessity rule).
    c. Document request in the "Medical Records Tracking Log".
    d. Electronically fax records to the requesting facility.

.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Evidence Based Clinical Guidelines
Policy Number: 8.09
BOD Approval: 07/11
Effective Date: 07/11
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) is committed to systematically managing care for individual patients according to their conditions and needs. KTCH will maintain continuous relationships with patients by establishing evidence-based clinical guidelines and applying them to the identified needs of the individual patients over time and with the intensity needed by the patients

II. GUIDELINES:

1. Adoption of evidence-based guidelines.
    a) KTCH will identify the conditions that are clinically important in our practice. The conditions may be selected based on risk factors in the service area of our patient population and/or the most frequently seen diagnoses in our practice. The resulting conditions identified will be those conditions on which KTCH will concentrates its care management efforts.
    b) The medical staff led by the Chief Medical Officer will identify evidence based clinical guidelines for each of the conditions identified above. As defined by the Institute of Medicine, evidence-based guidelines are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances". The criteria for selection will include those guidelines that have been established based on evidence derived from research, industry standards, and our patient demographics.
    c) The medical staff led by the Chief Medical Officer will review the guidelines selected.
    d) Final approval will be obtained from the KTCH Board of Directors. The recommendations for clinical guidelines will be presented to the Board of Directors by the Chief Medical Officer or his/her designee.

2. Implementation of evidence-based guidelines
    a) Metrics will be developed for each of the conditions selected.
    b) Metrics will be utilized to determine the efficacy and efficiency of the guidelines upon patient care.
    c) Metrics will be filtered by provider to evaluate the performance of that provider.
    d) Metrics will be complied quarterly to give each provider feedback at set intervals.
    e) Metrics will be calculated through utilization of our data in our EHR.

3. Utilization
    a) Patient flow sheets will be developed for each condition and in accord with the practice guidelines.
    b) Patient packets consisting of education and self-management materials will be developed for different stages within the practice guidelines.
    c) Distribution of these materials will be recorded within the KTCH EHR system.

.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Diabetes Patient Care Guidelines
Policy Number: 8.10
BOD Approval: 07/11
Effective Date: 07/11
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) has selected the American Diabetes Association guidelines for treating our diabetic patients. The complete guidelines are available at http://professional.diabetes.org/CPR_search.aspx for the nurse-provider team in order to improve the quality of life for our diabetic patients while also preventing acute complications of diabetes as well as long-term complications that include cardiovascular disease, retinopathy, nephropathy, neuropathy, for our diabetic patients.

II. GUIDELINES:

THE DIABETIC PATIENT:
A patient is defined to have diabetes if a blood test result shows at any point a fasting glucose measured at >126mg/dl, or a 2 hour plasma glucose after a 75g oral glucose tolerance test (GTT) measured at >200mg/dl, or a Hemoglobin A1C measured at >6.5%.

RECOMMENDATIONS OF CARE:

The guidelines state routine monitoring of *blood sugar* can improve diet and assist in medication adjustment for ultimately improved glycemic control:

1.
Monthly **Hemoglobin A1C** (HgbA1C) will be tested on all uncontrolled diabetic patients
2. Quarterly **Hemoglobin A1C** (HgbA1C) will be tested on all controlled diabetic patients
3. Blood Sugar Logs will be completed by patient and brought to clinical visits for review with provider

The guidelines state controlled *cholesterol* decrease risk for cardiovascular disease:

1. **A lipid panel** will be obtained quarterly until goal reached and then annually. The goal is for the LDL to be <100mg/dl.
2. If not contraindicated, **Statins** are recommended if LDL is not at the desired goal of <100mg/dl. Caution in women of child bearing age.
3. **Statins** are also recommended if patient has cardiovascular disease or if over 40 years of age and has at least one cardiovascular disease risk factor.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

The guidelines state controlled *blood pressure* decrease risk for cardiovascular disease. The goal for patient's blood pressure is <140/90.

1. Blood pressure is to be monitored at every provider visit if blood pressure is controlled.
2. Blood pressure is to be monitored at every provider visits and nurse visits as recommended by provider if blood pressure is uncontrolled.
3. If not contraindicated, blood pressure medications are recommended if BP is not at the desired goal of
   < 140/90

The guidelines recommend yearly *eye exams* due to diabetic patients being at higher risk for retinopathy.

1. Each patient will be asked yearly if they have had their annual **eye exam including a retinopathy screening**. The date of the exam will be recorded in the electronic medical record (EMR). A representative of the patient's care team will ask the patient to sign a release of information for the purpose of obtaining the narrative report of the eye examination and screening.
2. If the patient has not had a screening within the past twelve (12) months, the provider will refer to an optometrist and/or ophthalmology.
3. Uninsured Referrals: KTCH will establish a budget annually to provide retinal eye exams for diabetic patients.

The guidelines recommend annual *dental exams* due to diabetic patients being at higher risk for dental disease.

1. Each patient will be asked yearly if they have had their **annual dental exam**. The date of the exam will be recorded in the electronic medical record (EMR). A representative of the patient's care team will ask the patient to sign a release of information for the purpose of obtaining the narrative report of the dental examination and screening.
2. If the patient has not had a screening within the past twelve (12) months, the provider will refer to a dentist.

The guidelines recommend *lifestyle management* including *smoking cessation* in order to decrease risk for cardiovascular disease and diabetes complications.

1. The provider should refer to the Katy Trail Community Health "Tobacco Use Clinical Guidelines" policy to assist patient with smoking cessation.

The guidelines recommend *lifestyle management* including *alcohol cessation* in order to decrease risk for cardiovascular disease and diabetes complications.

1. At each visit a member of the patient's care team should document consumption of alcohol in social history.

Pre-SBIRT should be administered at annually and updated as needed. If positive, the patient should be referred to a Behavior Health Consult (BHC).

The guidelines recommend *foot exams* to decrease risk of poor foot health associated with neuropathy in diabetes.

1. A member of the patient care team will complete a **monofilament foot exam** no less than annually.
2. Education on **self-examination** will be included as part of all foot exams
3. Should the provider diagnose a foot problem, they may complete a **referral** to an outside specialist for additional care and treatment.

The guidelines recommend screening for *nephropathy* yearly

1. **Micro albumin test** via urine will be obtained annually on all diabetic patients.
2. Routine **creatinine** screening as determined by provider for kidney function will be performed.
3. **ACE/ARB** recommended for over 40 years of age in patients if not contraindicated. Note this is a teratogen. Caution in women of child bearing age.

To decrease risk of *cardiovascular disease* guidelines recommend that all diabetic patients take ASA 81mg daily if not contraindicated

The provider will assess *psycho-social issues* affecting patient's self-management of their diabetes including:

1) **PHQ** to be completed to assess depression symptoms at least annually.
2) **Refer to care coordinators** as needed for patients needing assistance for non-medical issues that may be inhibiting optimal care e.g. transportation assistance, food assistance, housing assistance, etc.
3) Providers will utilize $4 **pharmacy plans**, PAPRx, or 340B prescription **programs** to help patients afford their diabetic medications.
4) **Handouts and education** should be distributed based on the patient's level of readiness.

***Vaccinations* should be encouraged and up to date. Refer to CDC guidelines:**

1. **Influenza** vaccine (annually)
2. **Pneumococcal** Vaccine (Before 65 years of age & after 65 years of age in lifetime)
3. **Tdap once, then a TD every 10 years or after 5 years if patient has received an injury.**

The guidelines recommend *diabetes education* to assist patient in managing their diabetes

1. The provider will make a **referral to a dietician and/or diabetes educator as well as Behavioral Health Consultant** for all patients with a new diagnosis of diabetes, needing assistance in controlling their diabetes, or at the request of a patient.
2. Patient should be assessed for their **readiness to change**.
    - Pre-Contemplation
    - Contemplation
    - Preparation
    - Action
    - Maintenance

3. A menu of **educational materials** will be distributed based on the patient's level of readiness.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Tobacco Use Clinical Guidelines
Policy Number: 8.11
BOD Approval: 07/11
Effective Date: 06/11
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) has selected the Surgeon Generals' recommendations for Treating Tobacco Use and Dependence as clinical guidelines for our practice. The overarching goal of the guidelines is that our providers strongly recommend the use of effective tobacco dependence counseling, including the 1-800-QUITNOW and medication treatments to their patients who use tobacco.

II. GUIDELINES:

TEN KEY GUIDELINE RECOMMENDATIONS

1. Tobacco dependence is a chronic disease that often requires repeated intervention and multiple attempts to quit. Effective treatments exist, however, that can significantly increase rates of long-term abstinence.

2. It is essential that our clinicians consistently identify and document tobacco use status and treat every tobacco user seen in our health care setting.

3. Tobacco dependence treatments are effective across a broad range of populations. Providers should encourage every patient willing to make a quit attempt to use the counseling treatments and medications recommended in this Guideline.

4. Brief tobacco dependence treatment is effective. Clinicians should offer every patient who uses tobacco at least the brief treatments shown to be effective in this Guideline.

5. Individual, group, and telephone counseling are effective, and their effectiveness increases with treatment intensity. Two components of counseling are especially effective, and clinicians should use these when counseling patients making a quit attempt:
    - Practical counseling (problem solving/skills training)
    - Social support delivered as part of treatment

6. Numerous effective medications are available for tobacco dependence, and providers should encourage their use by all patients attempting to quit smoking—except when medically contraindicated or with specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women,

smokeless tobacco users, light smokers, and adolescents).
Seven first-line medications (5nicotine and 2 non-nicotine) reliably increase long-term smoking abstinence rates:

Bupropion SR (Wellbutrin)
Nicotine gum
Nicotine inhaler
Nicotine lozenge
Nicotine nasal spray
Nicotine patch
Varenicline (Chantix)

Providers also should consider the use of certain combinations of medications identified as effective in this Guideline.

7. Counseling and medication are effective when used by themselves for treating tobacco product dependence. The combination of counseling and medication, however, is more effective than either alone. Thus, providers should encourage all individuals making a quit attempt to use both counseling and medication, except when medically indicated.

8. Referral to a behavioral health consultant should be made when a patient is in a pre-contemplation or contemplation stage of change.

9. Telephone Quitline counseling is effective with diverse populations and has broad reach. Therefore, providers should ensure patient access to Quitlines and promote Quitline use.

STEPS FOR ASSESSMENT AND INTERVENTION

Care teams should seize the office visit for universal assessment and intervention. Specifically, every patient who presents to KTCH should be asked if he/she uses tobacco. In order words,

ASK about Tobacco Use and document tobacco use status in our EHR for every patient at every visit.

Screening for current or past tobacco use will result in four possible responses:

(1) The patient uses tobacco products;
(2) The patient once used tobacco products but has since quit; and
(3) The patient never regularly used tobacco products.

ADVISE all tobacco users to quit in a clear, strong and personalized manner.
ASSESS the readiness to make a quit attempt at this time.
ASSIST the patient to use problem- solving methods and skills for cessation. Regardless of which of the 5 stages of readiness the patient is at, the following handouts are to be given to the patient:

STAGES	**HANDOUTS**
1.. Pre-contemplation- the patient has no intention of	1. Reasons to Quit

quitting smoking (not ready)	
2.. Contemplation- The patient acknowledges that they have a problem and begin to think seriously about quitting smoking (getting ready).	2. Rewards of Quitting
3.. Preparation- The patient is ready to make a plan to begin within a 1 month time period. The patient makes the intent to quit smoking public. (preparing) ☑ Notify provider that patient is preparing for action ☑ Warm handoff to Behavioral Health Consultant (BHC) **THAT DAY IF POSSIBLE**.	3. You Can Quit Smoking
1. Action-taking a definitive action to quit smoking(ready) ☑ Notify provider that patient is ready for action ☑ Warm handoff to Behavioral Health Consultant (BHC) **THAT DAY IF POSSIBLE**.	2. Which Quit Smoking Medication is Right for you?
3. Maintenance- maintaining their new behavior of non- smoking (maintaining)	Maintenance is Staying Smoke Free

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Depression Treatment and Management Guidelines
Policy Number: 8.12
BOD Approval: 3/2018
Effective Date: 7/2011
Responsibility: All departments
Distribution: All Departments

I. POLICY:

For patients at Katy Trail Community Health (KTCH), management of depression consists of interventions and activities that should be initiated and provided during all phases of treatment. A complete diagnosis of depression should address the following:

1. Improve the early recognition and treatment of depression in the primary care setting.
2. Improve patient's understanding of depression and its treatment.
3. Familiarize clinicians with appropriate treatment options, i.e. medications and psychotherapies.
4. Identify when referral is indicated. Additional information regarding the guidelines may be found at: http://psychiatryonline.org/guidelines.aspx

Zero Suicide is a program based on the foundational belief that suicide deaths by patients under the care of health and behavioral health providers is preventable.

- Katy Trail Community Health participates in the Zero Suicide Program.
- KTCH is dedicated to improving patient safety by collaborating with our community partners to help stop deaths by suicide in our communities.

4.• It is our mission at KTCH to pursue a reduction in suicide and improve the care for those who seek help.

II. GUIDLEINES:

Major Depression

The essential feature of a Major Depressive episode is a period of at least 2 weeks during which there is depressed mood or the loss of interest or pleasure in nearly all activities.

Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.

- Depressed mood

- Loss of interest or pleasure in nearly all activities
- Thoughts of death/suicidal
- Weight loss/gain
- Fatigue/loss of energy
- Insomnia/hypersomnia
- Psychomotor retardation/agitation
- Worthlessness/guilt
- Impaired concentration

A. Screening

A patient self-reported questionnaire is completed by the patient during each office visit.

Screening will be performed as follows:

1. **PHQ-3:** All new & existing patients at every visit age 12 years and older
2. **PHQ-9:** At age 18 years and older, if the patient answers "Yes" to either of the questions on the PHQ-2 questionnaire or if patient completed PHQ-9 at last visit
3. **PHQ**-9A: At age 12-17 years, if the patient answers "Yes" to either of the questions on the PHQ-2 questionnaire or if patient completed PHQ-9A at last visit

Crisis lines:

SEDALIA CRISIS # (Burrell)	**1-800-395-2132**
WARSAW CRISIS # (Pathways)	**1-800-833-3915**
VERSAILLES CRISIS # (Burrell)	**1-800-395-2132**
MARSHALL CRISIS # (Burrell) (if child may need to go to the Lexington office)	**1-800-395-2132**

B. Goals of Treatment

- Reduce if not remove all symptoms of the disease.
- Restore occupational and psychosocial functioning.
- Reduce the likelihood of relapse and recurrence.

C. Types and Evaluation of Treatment

- **Supportive care** - The treatment of all patients diagnosed with major depression should include patient education and exercise.
- **Psychotherapy** – Patients with mild to moderate clinical depression (usually Dysthymia or Depressive Disorder NOS) may be selected for psychotherapy alone if the patient prefers. If symptoms do not significantly improve within 2 to 3 months, then medication should be strongly considered.
- **Medication** – Patients with moderate to severe clinical depression (usually Major Depression) are appropriately selected for medication, whether formal psychotherapy is also used.
- **Medication and Psychotherapy** – This combination may hold a particular advantage for complicated, chronic depressions. It may also be advantageous for patients with only a partial response to either treatment alone.
- Ongoing clinical assessment.

D. Office Visit Frequency

- Frequent office visits with the prescribing physician during the first 4 -12 weeks of treatment are usually necessary to assess efficacy and side effects, as well as make any medication adjustments to optimize response.
- **A first follow-up visit is recommended within 1 to 4 weeks after the initial prescription.** At follow-up visits re-assess the diagnosis of depression and measure changes in symptom severity (depression scores) and patient function.
- **The patient should be seen at least 3 times in the critical 12 weeks acute treatment phase.**
- If treating a patient in conjunction with a behavioral health therapist conducting psychotherapy, then only one of these 3 follow-up visits need to be with the PCP.
- It is recommended to advise the patient to call the PCP between visits for any side effect problems.
- Continue to monitor for safety

E. Initial Medication Selection and Management

Psychiatrist or PCP may choose to administer GeneSight Psychotropic test to assist in prescribing the most genetically optimal medication.

- A selective serotonin reuptake inhibitor (SSRI) would usually be the first choice unless the patient has a history or risk of intolerable side effects, is taking other essential medications that put the patient at risk for significant drug interactions, or has a personal or family history of a positive response to another class of antidepressants. Some authorities recommend lower starting doses for women.
- Starting dosages may have to be reduced to lessen side effects and improve compliance. It is highly recommended in the elderly to reduce these starting dosages by half.

- For medication selection, this quick reference guide should be utilized https://www.continuingedcourses.net/active/courses/images/course015-quickreference2014.pdf

Note: Be aware of drug interactions and side effects. Refer to exhibit A Tables 3-7

F. Antidepressant Side Effects

Side effects account for as many as two-thirds of all pre-mature discontinuations of antidepressants. Most side effects are early onset and time limited and includes decreased appetite, nausea, diarrhea, agitation, anxiety, and headache. These side effects can be managed by temporary aids to tolerance. Persistent or late onset side effects, which may include apathy, fatigue, weight gain, and sexual dysfunction, may require additional medications or a switch in antidepressants.

Strategies for managing antidepressant side effects include:

- Allow the patient to verbalize his/her complaint about side effects.
- Wait and provide support. Some side effects will subside over 1 to 2 weeks.
- Lower the dose temporarily.
- Treat the side effects.
- Change to a different antidepressant.
- Discontinue medications and start psychological counseling.

G. Psychiatric Referral

Referral for psychiatric consultation, treatment, and/or psychotherapy can occur at any time at the PCP's discretion and/or the patient's choice. In all cases, the mental health provider should communicate and coordinate with the PCP, after obtaining the patient's permission.

It is strongly recommended that referral to the mental health provider is considered in any of the following circumstances:

- Significant evidence of danger to self or others
- Suspicion of Bipolar Disorder (note—strongly consider psychiatric referral to any member who describes periods of (1) too much energy, and (2) lack of need for sleep. Use of antidepressant medications with bipolar members may further destabilize the clinical picture.)
- Presence of psychotic symptoms
- Treatment-resistant depression
- Depression during pregnancy and postpartum
- Childhood depression

- Depression with comorbid psychiatric/substance use disorders
- Depression with eating disorders
- Depression with Dementia
- Depression with severe/chronic medical disorder

Exhibit A Tables 3-7

Table 3. Factors to Consider in Choosing an Antidepressant Medication
Patient preference
Nature of prior response to medication
Relative efficacy and effectiveness
Safety, tolerability, and anticipated side effects
Co-occurring psychiatric or general medical conditions
Potential drug interactions
Half-life
Cost

Table 4. Cytochrome P450 Enzyme Metabolism of Antidepressive Agents

	1A2	2B6	2C9	2C19	2D6	3A4
Amitriptyline	+	+	++	++	++	+
Bupropion Hydroxybupropion	+	++	+		+++	
Citalopram				++	+	++
Desipramine	+				++	
Desvenlafaxine						+
Duloxetine	++				++	
Escitalopram				++	+	+
Fluoxetine Norfluoxetine	+	+	++	+	+++++	+
Imipramine	++	+		++	++	++
Maprotiline	+				++	
Mirtazapine 8-Hydroxymirtazapine[b] Mirtazapine-*N*-oxide	++		+		++++	+++++
Nortriptyline	+			+	++	+

Paroxetine					++	
Protriptyline					++	
Selegiline	+	++		+	+	
Sertraline		++	+	++	+	+
Venlafaxine *O*-Norvenlafaxine			+	+	++++	+

Table 5. Cytochrome P450 Enzyme Inhibition by Antidepressive Agents

	1A2	2A6	2B6	2C8	2C9	2C19	2D6	2E1	3A4
Amitriptyline	+				+			+	
Bupropion							+++		
Citalopram	+		+			+	+		
Desipramine		++	++				++	+	++
Desvenlafaxine									+
Duloxetine							++		
Escitalopram							++		
Fluoxetine Norfluoxetine	+++		++++	++	++	++	+++++		++
Imipramine	+					+	+		+
Mirtazapine	+								+
Nortriptyline				++			+	+	++
Paroxetine	+		+++		+	+	+++		+
Selegiline	+	+			+	+	+	+	+
Sertraline Desmethylsertraline	+		+++	+	++	++	+++		+++
Venlafaxine			+				+		+

Table 6. Dosing of Medications Shown To Be Effective in Treating Major Depressive Disorder

Generic Name	Starting Dose (mg/day)	Usual Dose (mg/day)

For convenience, medications other than TCAs have been classified by their presumptive mechanism of action. However, the exact mechanism of action of several medications has yet to be determined or varies by dose. Lower starting doses are recommended for elderly patients and for patients with panic disorder, significant anxiety or hepatic disease, and co-occurring general medical conditions. For some of these medications (e.g., TCAs) the upper dosing limit reflects risk of toxicity or need for plasma level assessment, whereas for other medications (e.g., SSRIs), higher doses can be used safely but without evidence for overall superior efficacy. These medications are likely to be optimal medications in terms of safety, the patient's acceptance of side effects, and the quantity and quality of clinical trial data. Dose varies with diagnosis; see text for specific guidelines. Has been used at doses up to 400 mg/day, although doses above 50 mg/day may not provide additional benefit. This medication is not typically used for this indication. Selegiline selectively inhibits MAO B at low doses but inhibits both MAO A and MAO B at the higher doses that are typically required for antidepressant activity.

Table 6. Dosing of Medications Shown To Be Effective in Treating Major Depressive Disorder

Generic Name	Starting Dose (mg/day)	Usual Dose (mg/day)
Selective serotonin reuptake inhibitors		
Citalopram	20	20–60
Escitalopram	10	10–20
Fluoxetine	20	20–60
Paroxetine	20	20–60
Paroxetine, extended release	12.5	25–75
Sertraline	50	50–200
Dopamine norepinephrine reuptake inhibitor		
Bupropion, immediate release	150	300–450
Bupropion, sustained release	150	300–400
Bupropion, extended release	150	300–450
Serotonin norepinephrine reuptake inhibitors		
Venlafaxine, immediate release	37.5	75–375
Venlafaxine, extended release	37.5	75–375
Desvenlafaxine	50	50
Duloxetine	60	60–120
Serotonin modulators		
Nefazodone	50	150–300
Trazodone	150	150–600
Norepinephrine-serotonin modulator		
Mirtazapine	15	15–45
Tricyclics and tetracyclics		
Amitriptyline	25–50	100–300
Doxepin	25–50	100–300
Imipramine	25–50	100–300
Desipramine	25–50	100–300
Nortriptyline	25	50–200
Trimipramine	25–50	75–300
Protriptyline	10–20	20–60
Maprotiline	75	100–225

Table 6. Dosing of Medications Shown To Be Effective in Treating Major Depressive Disorder

Generic Name	Starting Dose (mg/day)	Usual Dose (mg/day)
Monoamine oxidase inhibitors (MAOIs)		
Irreversible, nonselective inhibitors		
Phenelzine	15	45–90
Tranylcypromine	10	30–60
Isocarboxazid	10–20	30–60
Irreversible, MAO B selective inhibitor		
Selegiline transdermal	6	6–12
Reversible MAO A selective inhibitor		
Moclobemide	150	300–600

Table 7. Potential Treatments for Side Effects of Antidepressant Medications

Side Effect	Antidepressant Associated With Effect	Treatment
Cardiovascular		
Arrhythmias	TCAs	Avoid in patients with cardiac instability or ischemia. Attend to interactions with anti-arrhythmics.
Hypertension	SNRIs, bupropion	Monitor blood pressure. Keep dose as low as possible. Add antihypertensive.
Hypertensive crisis	MAOIs	Seek emergency treatment. If hypertension is severe, intravenous antihypertensive agents (e.g., labetalol, sodium nitroprusside) may be required.
Increase in cholesterol	Mirtazapine	Add a statin.
Orthostatic hypotension	TCAs, trazodone, nefazodone, MAOIs	Add fludrocortisone. Add salt to diet.
Anticholinergic		
Constipation	TCAs	Encourage adequate hydration. Add bulk laxative.
Delirium	TCAs	Evaluate for other possible contributors to delirium.
Dry mouth	TCAs, SNRIs, bupropion	Suggest use of sugarless gum or candy.

Table 7. Potential Treatments for Side Effects of Antidepressant Medications

Side Effect	Antidepressant Associated With Effect	Treatment
Urinary hesitancy	TCAs	Add bethanechol.
Visual changes	TCAs	Add pilocarpine eye drops.
Neurologic		
Headaches	SSRIs, SNRIs, bupropion	Assess for other etiologies (e.g., caffeinism, bruxism, migraine, tension headache).
Myoclonus	TCAs, MAOIs	Add clonazepam.
Seizures	Bupropion, TCAs, amoxapine	Assess for other etiologies, and add anticonvulsant medication, if clinically indicated.
Sexual		
Arousal, erectile dysfunction	TCAs, SSRIs, SNRIs	Add sildenafil, tadalafil, buspirone, or bupropion.
Orgasm dysfunction	TCAs, SSRIs, venlafaxine, desvenlafaxine, MAOIs	Add sildenafil, tadalafil, buspirone, or bupropion.
Priapism	Trazodone	Obtain emergency urological evaluation.
Other		
Activation	SSRIs, SNRIs, bupropion	Administer in the morning.
Akathisia	SSRIs, SNRIs	Add a beta-blocker or benzodiazepine.
Bruxism	SSRIs	Obtain dental consultation, if clinically indicated
Diaphoresis	TCAs, some SSRIs, SNRIs	Add an $_1$-adrenergic antagonist (e.g., terazosin), central $_2$-adrenergic agonist (e.g., clonidine), or anticholinergic agent (e.g., benztropine).
Fall risk	TCAs, SSRIs	Monitor blood pressure for evidence of hypotension or orthostasis; assess for sedation, blurred vision, or confusion; modify environment to reduce risk.
Gastrointestinal (GI) bleeding	SSRIs	Identify whether concomitant medications may affect clotting.
Hepatotoxicity	Nefazodone	Provide education about and monitor for clinical evidence of hepatic dysfunction. Obtain hepatic function tests, if clinically indicated.

Table 7. Potential Treatments for Side Effects of Antidepressant Medications

Side Effect	Antidepressant Associated With Effect	Treatment
Insomnia	SSRIs, SNRIs, bupropion	Use morning dosing. Add a sedative-hypnotic at bedtime. Add melatonin. Provide CBT or education in sleep hygiene.
Nausea, vomiting	SSRIs, SNRIs, bupropion	Administer after food or in divided doses.
Osteopenia	SSRIs	If clinically indicated, obtain bone density monitoring and add specific treatment to reduce bone loss (e.g., calcium and vitamin D supplements, bisphosphonates, selective estrogen receptor agents).
Sedation	TCAs, trazodone, nefazodone, mirtazapine	Use bedtime dosing. Add modafinil or methylphenidate.
Severe serotonin syndrome	MAOIs	Obtain emergency evaluation. Consider admission to a critical care unit.
Weight gain	SSRIs, mirtazapine, TCAs, MAOIs	Encourage exercise. Obtain input from dietician. If changing antidepressants, consider a secondary amine (if a TCA is required) or other antidepressant with fewer weight issues (e.g., bupropion). Initial approaches to treatment-emergent side effects include decreasing or discontinuing the medication and changing to another antidepressant with a different side effect profile. Treatments included here are additional measures.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Hypertension Patient Care Guidelines
BOD Approval: 07/2011
Responsibility: Clinical Staff

Policy Number: 8.13
Effective Date: 07/11
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) has selected the Eight Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC -7) for treating our hypertension patients.
The complete guidelines are available at: http://www.nhlbi.nih.gov/guidelines/hypertension/index.htm, for the nurse-provider team in order to improve the quality of life for our hypertension patients while also preventing acute complications of hypertension as well as long-term complications

II. GUIDELINES:

HA recommended blood pressure levels

Blood Pressure Category	Systolic mm Hg		Diastolic mm Hg
Normal	<120	and	<80
Elevated	120-129	and	<80
HTN Stage 1	130-139	or	80-89
HTN Stage 2	>140	or	>90
Hypertensive Crisis	>180	and/or	>120

DIAGNOSTIC WORKUP OF HYPERTENSION:

- Assess risk factors and comorbidities.
- Reveal identifiable causes of hypertension.
- Assess presence of target organ damage.
- Conduct history and physical examination.
- Obtain laboratory tests: urinalysis, blood glucose, hematocrit and lipid panel, serum potassium, creatinine, and calcium. Optional: urinary albumin/creatinine ratio.
- Obtain electrocardiogram**.**

ASSESS FOR MAJOR CARDIOVASCULAR DISEASE (CVD) RISK FACTORS:

- Hypertension
- Obesity (body mass index >30)
- Dyslipidemia
- Diabetes mellitus
- Cigarette smoking

- Physical inactivity
- Microalbuminuria, estimated glomerular filtration rate (GFR)<60 mL/min
- Age (>55 for men, >65 for women)
- Family history of premature CVD (men age <55, women age <65)

ASSESS FOR IDENTIFIABLE CAUSES OF HYPERTENSION FACTORS

- Sleep apnea
- Drug induced/related
- Chronic kidney disease
- Primary aldosteronism
- Renovascular disease
    - Cushing's syndrome or steroid therapy
    - Pheochromocytoma
    - Coarctation of aorta
    - Thyroid/parathyroid disease

TREATMENT

PRINCIPLES OF HYPERTENSION TREATMENT

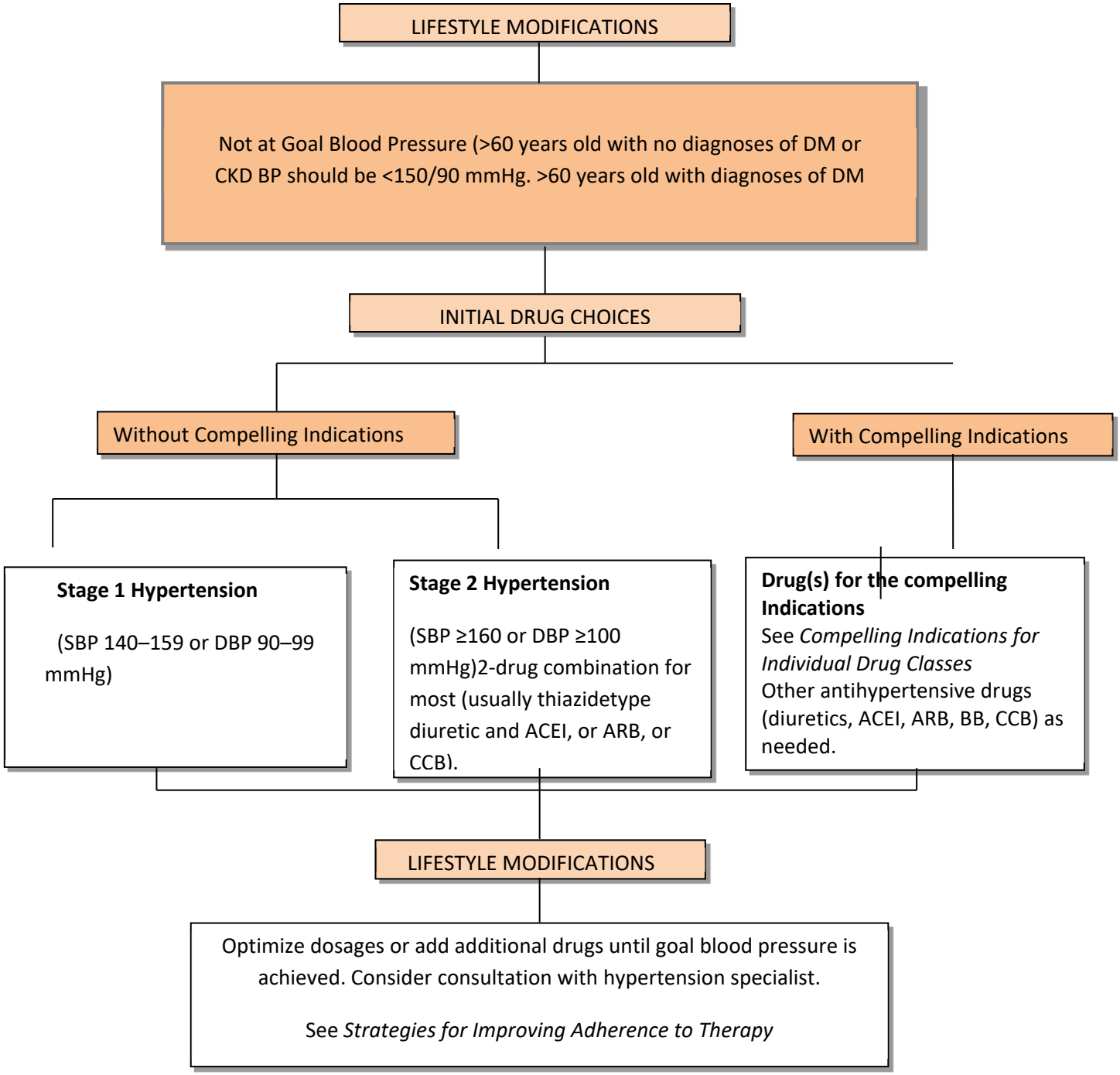
- Treat to BP <140/90 mmHg in all patients.
- Majority of patients will require two medications to reach goal.

Blood Pressure Measurement Techniques

METHOD	NOTES
In-office	Ensure patient has an empty bladder Patient should avoid caffeine, exercise and smoking for 30 minutes prior to reading Two readings, 5 minutes apart, sitting in chair quietly with feet on the floor and arm supported at heart level. Confirm elevated reading in contralateral (opposite) arm.
Ambulatory BP monitoring	Indicated for evaluation of "white coat hypertension." Absence of 10–20 percent BP decrease during sleep may indicate increased CVD risk.
Patient self-check	Provides information on response to therapy. May help improve adherence to therapy and is useful for evaluating "white coat hypertension."

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

ALGORITHM FOR TREATMENT OF HYPERTENSION



CAUSES OF RESISTANT HYPERTENSION

- Improper BP measurement
- Excess sodium intake
- Inadequate diuretic therapy
- Medication
    - Inadequate doses
    - Drug actions and interactions (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs), illicit drugs, sympathomimetics, oral contraceptives)
    - Over the counter (OTC) drugs and herbal supplements
- Excess alcohol intake
- Identifiable causes of hypertension

COMPELLING INDICATIONS FOR INDIVIDUAL DRUG CLASSES

COMPELLING INDICATION	**INITIAL THERAPY OPTIONS**
• Heart failure	THIAZ, ACEI, ARB, ALDO ANT
• Post myocardial infarction	BB, ACEI, ALDO ANT
• High CVD risk	THIAZ, ACEI, CCB
• Diabetes	THIAZ, ACEI, ARB, CCB
• Chronic kidney disease	ACEI, ARB
• Recurrent stroke prevention	THIAZ, ACEI
• African American	THIAZ, CCB avoid ACEI and BB

Compelling indications for Individual Drug Classes
Key: THIAZ = thiazide diuretic, ACEI= angiotensin converting enzyme inhibitor, ARB = angiotensin receptor
blocker, BB = beta blocker, CCB = calcium channel blocker, ALDO ANT = aldosterone antagonist

STRATEGIES FOR IMPROVING ADHERENCE TO THERAPY

• Clinician empathy increases patient trust, motivation, and adherence to therapy.
• Physicians should consider their patients' cultural beliefs and individual attitudes in formulating therapy.

PRINCIPLES OF LIFESTYLE MODIFICATION

• Encourage healthy lifestyles for all individuals.
• Prescribe lifestyle modifications for all patients with prehypertension and hypertension.
• Components of lifestyle modifications include weight reduction, DASH eating plan, dietary sodium reduction, aerobic physical activity, and moderation of alcohol consumption.

LIFESTYLE MODIFICATION RECOMMENDATIONS

Modification	Recommendation	Avg. SBP Reduction Range†
Weight reduction	Maintain normal body weight (body mass index 18.5–24.9 kg/m2).	5–20 mmHg/10 kg
DASH eating PLAN	Adopt a diet rich in fruits, vegetables, and lowfat dairy products with reduced content of saturated and total fat.	8–14 mmHg
Dietary sodium reduction	Reduce dietary sodium intake to < 2.4 g sodium (2400 mg) per day.	2–8 mmHg
Aerobic physical activity	Regular aerobic physical activity (e.g., brisk walking) at least 30 minutes per day, most days of the week.	4–9 mmHg
Moderation of alcohol consumption	Men: limit to <2 drinks* per day. Women and lighter weight persons: limit to <1 drink* per day.	2–4 mmHg

* 1 drink = 1/2 oz or 15 mL ethanol (e.g., 12 oz beer, 5 oz wine, 1.5 oz 80-proof whiskey).
† Effects are dose and time dependent.

FOLLOW UP
• Follow up should be at least once monthly until goal is achieved, then 3-6 month intervals.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Hyperlipidemia Patient Care Guidelines
BOD Approval: 07/2011
Responsibility: Clinical Staff

Policy Number: 8.14
Effective Date: 07/11
Distribution: All Departments

I. **POLICY:**

Katy Trail Community Health (KTCH) has selected the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel- ATP-III) for treating our hyperlipidemia patients.

II. **GUIDELINES:**

The complete guidelines are available from the American College of Cardiology and American Heart Association for the nurse-provider team in order to improve the quality of life for our hyperlipidemia patients while also preventing acute complications of hyperlipidemia as well as long-term complications

III. REFERENCES:

https://www.ahajournals.org/doi/pdf/10.1161/CIR.0000000000000677

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Audiometer
BOD Approval: 3/2018
Responsibility: Clinical Staff

Policy Number: 8.15
Effective Date: 5/2007
Distribution: All Departments

I. POLICY:

It is the policy of Katy Trail Community Health (KTCH) to provide diagnostic services including the use of an Audiometer. Audiometers are available at each KTCH site in the clinical areas, making them easily accessible to the provider/nursing staff when needed.

See Procedure 8.15 Audiometer for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Otoacoustic Emissions (OAE) Hearing Test
Policy Number: 8.16
BOD Approval: 01/2016
Effective Date: 05/2007
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

A provider may order an Otoacoustic Emissions (OAE) hearing test to aid in the assessment to detect deafness, hearing sensitivity and/or functional hearing loss in infants, children, and adults. Only physicians, NP's, PA's, RN's, LPN's and CMA/RMA's who have been trained will perform this procedure.

If the patient fails, the hearing test for either or both ears they will be referred to ENT/audiologist for further screening.

See Procedure 8.16 Otoacoustic Emissions (OAE) Hearing Test for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Ear Irrigation (Ear Lavage)
BOD Approval: 12/2017
Responsibility: Clinical Staff

Policy Number: 8.17
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Obstruction of external ear canals can result from multiple causes. Accumulated cerumen (ear wax) may become impacted and interfere with hearing. The tympanic membrane (TM) may have perforated, and the resulting drainage may occlude the canal. In children, the obstruction may be the result of foreign bodies such as vegetable matter, paper, crayons, or insects. Whether irrigation is appropriate or not depends upon the cause of the obstruction. Therefore, this procedure is to be performed only upon the order of the providers.

See Procedure 8.17 Ear Irrigation (Ear Lavage) for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: EKG
BOD Approval: 06/2006
Responsibility: Clinical Staff

Policy Number: 8.18
Effective Date: 06/2006
Distribution: All Departments

I. POLICY:

A provider may order a non-invasive EKG to aid in the assessment of a patient's cardiac status. Only physicians, NPs, PAs, RNs, LPNs and CMA/RMA's who have been trained will perform this procedure.

See Procedure 8.18 EKG for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Spirometry
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.19
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

A provider may order a spirometry to aid in the assessment of a patient's pulmonary functioning. Only physicians, NP's, PA's, RN's, LPN's and CMA/ RMA's who have been trained will perform this procedure.

See Procedure 8.19 Spirometry for further instructions.

II. GUIDELINES:

Essentially, a spirometer is a device that measures lung volumes, through the forced expiration of air in our lungs. Flow can also be assessed, by measuring the total volume of air that is expired in the first second of expiration.

The standard indices are:-

- Forced Expired Volume in one second (FEV1) – how much air can be exhaled in the first second of expiration
- Forced Vital Capacity (FVC) – the maximum volume of air that can be forcibly expired
- Ration of FEV1/FVC as % - the proportion of total volume of air that can be expired in the first second of expiration.

Like any test, spirometry results will only be of value if the expirations are performed satisfactorily and consistently. Three such readings are required and there should be at least two readings of FEV1 that are within 100mls or 5% of each other. Measurements must continue until no more air can be exhaled, which in the case of severe COPD, can take up to 15 seconds.

The degree of severity of COPD can be judged by comparing the patient's FEV1 reading with normal predicted values – the BTS Guidelines describes Mild, Moderate and Severe COPD according to the percentage of normal obtained.

In asthma, the reduction in FEV1 provides a measure of the severity of airflow obstruction, and parallels change in peak expiratory flow. In both COPD and Asthma, FVC is usually much less reduced, and can be normal. Hence a reduced FEV1 and a near normal FVC give a reduced FEV1/FVC ration – the hallmark of airflow obstruction if

below 70%.

Obstructive

Narrowed airways decrease the volume of air that can be forcibly exhaled in the first second (FEV1). Note that the FVC is only achieved after a long exhalation. The Fev1/FVC ratio is markedly reduced. Expiration is prolonged with a slow rise in the curve and the plateau is not reached for as long as 15 seconds (in emphysema).

Restrictive

Both FEV1 and FVC are reduced. As the airways are open and unblocked expiration is rapid and completed within 2-3 seconds. The FEV1/FVC ration is normal or increased. A high or normal proportion is exhaled in the first second, resulting in a rapid rise in the curve but with long volumes reduced compared with predicted levels.

Mixed

Expiration is prolonged with a slow rise to plateau levels. The vital capacity is likely to be significantly reduced compared with an obstructive defect. Mixed patterns, if less severe, can be difficult to differentiate from obstructive patterns.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Nebulization
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.20
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide medication through nebulization as deemed medically necessary and as ordered by the provider.

See Procedure 8.20 Nebulization for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Pulse Oximetry Usage
BOD Approval: 05/07
Responsibility: Clinical Staff

Policy Number: 8.21
Effective Date: 05/07
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will measure pulse oximetry at every provider visit to aid in monitoring oxygen levels of the blood.

See Procedure 8.21 Pulse Oximetry Usage for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Suction Operating Instructions
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.22
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide suctioning for the patients as deemed medically necessary and as ordered by the provider.

See Procedure 8.22 Suction Operating Instructions for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Acquiring Patient Temperature
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.23
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will obtain temperature measurements on all medical patients at every provider visit.

See Procedure 8.23 Acquiring Patient Temperature for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Tympanogram
BOD Approval: 05/07
Responsibility: Clinical Staff

Policy Number: 8.24
Effective Date: 05/07
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide a tympanogram for patients as deemed medically necessary and as ordered by the provider.

See Procedure 8.24 Tympanogram for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Vision Screening Snellen Chart
BOD Approval: 05/07
Responsibility: Clinical Staff

Policy Number: 8.25
Effective Date: 05/07
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide vision screenings for patients as deemed medically necessary and as ordered by the provider.

See Procedure 8.25 Vision Screening Snellen Chart for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Standing Orders
BOD Approval: 05/07
Responsibility: Clinical Staff

Policy Number: 8.26
Effective Date: 05/07
Distribution: All Departments

I. POLICY:

The *Standing Orders and Clinical Guidelines* will be a guideline for clinical staff.

II. GUIDELINES:

1. Standing Orders are reviewed at initial Orientation and Training and signed by employee and Chief Medical Officer.
2. On annual basis, Standing Orders will be reviewed and signed by each employee and the Chief Medical Officer

III REFERENCES:

P:\Staff\Standing Orders-Clinical Guidelines 2020.docx

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Administration of Depo-Provera
BOD Approval: 06/06
Responsibility: Clinical Staff

Policy Number: 8.27
Effective Date: 06/06
Distribution: All Departments

I. POLICY:

Katy Trail Community Health will provide Depo-Provera injections either IM or Sub Q as a contraceptive method**.**

See Procedure 8.27 Administration of Depo-Provera for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Orders for Immunization Clinic and Guidelines
Policy Number: 8.28
BOD Approval: 01/2016
Effective Date: 05/2007
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

CMA/RMA/LPN/RNs working in conjunction with Katy Trail Community Health (KTCH) will administer vaccines to protect against communicable, contagious, dangerous or infectious diseases herein designated or recommended by the Missouri Department of Health and Senior Services, to those persons presenting themselves for such immunizations, in accordance with the guidelines set forth by the Immunization Practices Advisory Committee (ACIP) and directives accompanying the vaccine.

II. GUIDELINES:

All KTCH LPN's, RMA's, CMA's, or RN's who provide immunization services should review the *Emergency Medical Management and Medical Management of Vaccines* prior to administering any vaccine. Vaccines are to be administered in accordance with directions accompanying each manufacturer, Center for Disease Control (CDC) and Missouri Department of Health and Senior Services' Immunizations Schedule. Each nurse must be fully aware of the KTCH plan for obtaining medical care in the case of emergency.

Immunizations will not be given to any patient presenting with moderate or severe febrile illness or possible allergic reaction to any vaccine component.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Vaccine Refrigerator Alarm System
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.29
Effective Date: 07/2010
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will store and monitor all vaccines as recommended by the manufacturer and/or Vaccine for Children (VFC).

II. GUIDELINES:

Vaccine refrigerator and freezer have an alarm system installed which is linked to the security company in all clinical facilities that house VFC. This system will be set for accurate temperatures in accordance with the VFC guidelines-temperatures are listed on the refrigerator/freezer log sheet located on side of the refrigerator or on the counter next to the refrigerator. E-mail alerts for out of range temperatures are sent to the site manager or designee within five (5) minutes. Within one hour when the temperature is out of range, the security company will alert the site manager or designee.

When the staff is notified:

1. The Security Company will notify the site manager or designee VFC site contact.
2. The site manager, or CNO or VFC site contact will check the temperature of the refrigerator /freezer, ensure the doors are securely closed, adjust the thermostat if necessary and monitor for 1 hour.
3. Record on the refrigerator log and document a note describing the corrective action in the VFC book.
4. Vaccines both from the freezer and refrigerator need to be transported to Benton County Health Department in Warsaw, Pettis County Health Center (PCHC) in Sedalia only if generator fails, and Good Shepard Nursing Home in Morgan County by using coolers with ice packs (towels packed between vaccines and ice packs) as quickly as possible. There is an Emergency Response Plan that is to be followed per VFC program. This emergency response plan is located at each clinic in the coolers and posted on the refrigerator for easy access during a power outage. See the Vaccine Management Plan policy for further details on how to transport the vaccines.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Vaccine Management Plan/Emergency Response Plan **Policy Number:** 8.30
BOD Approval: 01/2018 **Effective Date**: 07/2011
Responsibility: Clinical Staff **Distribution:** All Departments

I. POLICY:

Katy Trail will follow vaccine storage, handling, ordering, and shipping plans outlined by the Vaccine for Children (VFC) Program, CDC Vaccine and Handling Plan, and CDC How to protect your Vaccine Supply.

II. GUIDELINES:

Facility Name: KATY TRAIL COMMUNITY HEALTH
VFC Pin Number: Sedalia-159100/ Warsaw-015100/ Versailles- 14110

I. Designation of primary vaccine coordinator and at least one back-up staff

II. Vaccine Storage and Handling

*Vaccine storage and handling plans follow the "**Vaccine Management Guidelines**" as found in the **Vaccine for Children (VFC) Program Manual.***

Procedures for receiving, storing, and handling of vaccine(s) include:

1. Upon receipt of vaccine, immediately examine all vaccine shipments for damage, or opening prior to receipt, contacting VFC Program within 2 hours of delivery if abnormalities are noted.
2. Immediately open the shipping box and count vaccines received, comparing the numbers against shipping invoice and order form, check the temperature strip of the vaccine to see that they are not out of range, again contacting the VFC Program within 2 hours of delivery if abnormalities are noted.
3. All staff will only open one box of vaccine(s) at a time.
4. All staff will not "dump" vaccine into other containers (even if they are the same vaccine).
5. All staff will check and use vaccine within time frames specified by manufacturer labeling and recommendations prior to administration.
6. All staff will ensure that vaccines are not "pre-drawn" from their vials.
7. Immediately store vaccine(s) in the appropriate refrigeration storage units, checking expiration dates and placing the order received in the proper stock rotation to assure usage of the shortest expiration dated vaccine(s) are used first, and add vaccine received to the Vaccine Accountability Form.
8. All staff will ensure that vaccines are kept away from sides and back of the refrigerator.
9. Place bottles of water in crisper drawers, refrigerator, and parameter around the refrigerator.
10. Ensure that vaccines are not stored in the door of the refrigerator.

11. Line the freezer sides and floor with ice packs.
12. Regularly check all storage units to ensure adequate air circulation is occurring around vaccine and that vaccine has not been placed in closed bins (such as the plastic closed containers supplied by drug manufacturer representatives).
13. Write the expiration date in black marker on top of the vaccine box.
14. Tape boxes of vaccine note already secured by the manufacturer to avoid opening more than one box of vaccine(s) at a time and to help facilitate your monthly vaccine inventory count.
15. Take appropriate steps to ensure refrigerators and freezers are not unplugged accidentally, the "Do Not Unplug" sticker is visible, and the use of plug guards or other means to secure plugs are in place.
16. Ensure that refrigeration units are plugged directly into outlets and not into power strips or extension cords).
17. Identify and label the circuit breakers for the vaccine refrigerators and freezers using the "Do Not Turn Off" stickers or similar labeling.
18. Ensure that all staff are familiar with the ***Vaccine Loss and Replacement Protocol*** and that vaccine allowed to expire, or is wasted due to negligence, may require replacement (***see Vaccine Loss and Replacement Protocol***). http://health.mo.gov/living/wellness/immunizations/pdf/VFCManual.pdf
19. Ensure that all staff is proficient in their ability to properly pack vaccine for transfer or emergency shipping.
20. Ensure that all staff is proficient in their ability to read thermometers, know correct temperature ranges, and can properly record temperatures on correct (Fahrenheit or Celsius) temperature log sheets.
21. Ensure that temperatures are taken twice per day AM/PM when clinic is open and logged on appropriate (Fahrenheit or Celsius) temperature log.
22. Clinic Site Manager or designee will review temperature log and sign-off on the log weekly indicating all temperatures were within range or that proper corrective action was taken. Signed temperature logs that contain out of range temperatures that were marked "Yes" temperature was within range is considered negligence.
23. If at any time there is a break in the cold chain the VFC program is to be immediately notified and provided with: the temperature of the storage unit upon discovery, period of time excursion occurred, have all manufacturers been notified; if so – provide name of individual you spoke to along with discussion confirmation number.
24. Ensure that all required VFC monthly reports are submitted to the VFC program on time and that the most current form is used.
25. Maintain a simple training log documenting staff training date.

III. Vaccine ordering

Vaccine ordering plans follow the "**Vaccine Management Guidelines**" as found in the **Vaccine for Children (VFC) Program Manual.**
http://health.mo.gov/living/wellness/immunizations/pdf/VFCManual.pdf

IV. Vaccine Transportation:

Vaccine shipping plans follow the "**Vaccine Management Guidelines**" as found in the **Vaccine for Children (VFC) Program Manual**.

This policy/ procedure shall be periodically reviewed and updated consistent with the requirements and standards established by the Board of Directors and by Health Center management, Federal and State law and regulations, and applicable accrediting and review organizations.

Procedures for vaccine transport include:

a. When transporting vaccine, place vaccine in Styrofoam transport container, along with all packing supplies and copy of transfer form, as directed below:
b. **Freezer Vaccines**: MMR (not diluents), MMRV, and Varicella (VAR). In container marked "Freezer Vaccines" place vaccine(s) along with thermometer and pack container with enough gel packs to maintain temperature. If temperature exceeds 5°F (-15°C) contact the vaccine manufacturer for assistance. Log time and temperature on transfer form before transport and immediately upon arrival at destination. Vaccines will be transported within the vehicle and not in the trunk of a vehicle or in the back of a pick-up truck.
c. **Refrigerator Vaccine**: To pack for transport, place ice packs or refrigerated gel packs in the bottom of container, lay a barrier bubble wrap, crumpled paper, etc.) on top of the ice or gel packs. Close lid. Log time and temperature on transfer form before transport and immediately upon arrival at destination. The vaccine(s) will be transported within the vehicle and not in the in the trunk of a vehicle or in the back of a pick-up truck.
d. Contact the VFC Program at 800-219-3224 prior to transfer. Fill-out Vaccine Transfer sheet found (state location) and take with the vaccine to the new location. Upon arrival open the containers, record the temperatures, inventory the stock (with the receiving person) and see that the receiving person places vaccines in the proper refrigeration units which are maintained at the proper temperature ranges. If vaccine has been placed in a closed ziplock bag for transfer the vaccine must be removed from the bag prior to being placed in storage unit to allow for proper air circulation. After transfer is complete, fax a copy of the Vaccine Transfer sheet to the VFC Program at (573-526-5220), and deduct the transferred vaccine from the Vaccine Accountability sheet.

V. Inventory control (e.g. stock rotation)

Inventory control plans follow the follow the "**Vaccine Management Guidelines**" as found in the **Vaccine for Children (VFC) Program Manual**.

Procedures for inventory control include:

1. Vaccines will be accounted for by utilizing the Vaccine Accountability Form monthly.
2. Check expiration dates monthly; put the expiration date on the box so it is easily visible yet not obscuring vital vaccine information on the box; rotates vaccine as needed to ensure that the shortest expiration dated vaccine is used first.
3. Ensure that vaccine does not expire; if expiration date is within 90 days, contact VFC Program for transfer assistance.

VI. Vaccine wastage

Vaccine wastage plans follow the "***Vaccine Management Guidelines***" as found in the ***Vaccine for Children (VFC) Program Manual***.

Procedures for vaccine wastage include:

1. In the event that vaccine is wasted, the information regarding the reason for the wastage will be listed on the Vaccine Wastage Form.
2. Collect and record the wastage information accounting for the vaccine wasted on the Vaccine Accountability form submitted to the VFC Program monthly.
3. Contact VFC Program at 800-219-3224 to obtain shipping label to return out-dated, unopened vials of vaccine for excise tax credit to McKesson per the VFC return policy.

EMERGENCY RESPONSE PLAN

Your Emergency Response Plan will include actions to be taken in the event of refrigerator or freezer malfunction, power failure, natural disasters or other emergencies that might compromise appropriate vaccine storage condition.

Generator:
Sedalia: The generator has an Automatic Transfer Switch that will power on the generator in loss of electricity. It is run by natural gas through the gas line.
Warsaw: The generator has an Automatic Transfer Switch that will power on the generator in loss of electricity. It is run by gasoline supplied by Zollicker Gas in Warsaw, MO. Phone: 660-438-5331

Vaccine Transportation:
Person(s) transport vaccine(s) may be any of the primary or back-up vaccine coordinators.

Vaccine(s) will be transported in Styrofoam transport container(s) using:

- Ice/Gel packs to use will be located in freezers in the vaccine storage units
- Bubble wrap or other barrier stored inside the Styrofoam transport containers

CALL: Before transporting vaccine(s) call the back-up location site to ensure that their generator is working, and they are aware you will be transporting vaccine to them. Once you arrive at the back up location assure that they are aware of how to properly store and maintain the vaccine while it is in their possession.
CHECK: That vaccine containers are properly labeled with facility name and your contact information.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: Nursing Clinical Guidelines
BOD Approval: 07/11
Responsibility: Clinical Staff

Policy Number: 8.31
Effective Date: 07/11
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) is committed to systematically managing care for individual patients according to their conditions and needs by hiring qualified personnel for the care teams

II. GUIDELINES:

1. Nursing clinical staff shall execute standing orders as established by the Chief Medical Officer. Standing orders have been pre-approved and can be executed depending upon staff licensure, training or level of expertise. (See attached)
    a. All nursing clinical staff shall review the current standing orders on an annual basis and sign-off stating they have read the current orders and understand how to execute the orders. Copies of their sign-off will be kept in their personnel file.
    b. If a nursing clinical staff member feels they do not have the skills to execute any approved standing order, they should notify their supervisor immediately for additional training.
    c. Any additional training necessary for the staff to perform their duties should be documented in the employee's personnel file.

2. Nursing clinical staff shall provide education to patients, families, and other individuals providing care and/or services to the patient. The education shall consist of but not limited to:
    a. The nurse will use the teach-back method to include demonstrating a procedure or educating on the topic and have the individual being trained return demonstration or express verbal knowledge on how they would teach on the topic.
    b. giving injections
    c. possible side-effects from medications and/or tests performed
    d. diet counseling
    e. smoking cessation
    f. obtaining specimens for testing
    g. medication refill protocol
    h. provide handout on immunizations that have been given
    i. provide handout material via IMS or other methods available
    j. nutritional counseling including diabetic information
    k. provide Internet site information for additional resources. These sites should be consistent with the evidence-based guidelines used at KTCH
    l. provide self-management information and/or handouts

m. provide disease specific information as requested
n. provide information on local support groups

3. Nursing clinical staff shall coordinate care with external disease management or case management organizations, as appropriate. With the appropriate releases of information, external case managers are welcome to accompany patients to their visits and ask questions and/or express concerns they may have on behalf of the patient. Paperwork needed by external care coordinators such as medications listings will also be provided with the appropriate releases. Care managers may include but are not limited to care coordinators from behavioral health agencies, group homes, independent living centers, and commercial insurance carriers. KTCH will meet with community agencies as needed to facilitate the flow of information among external case managers and KTCH staff. KTCH will also participate in community agency coalitions so as to facilitate the cooperation of agency members to better serve our patients.

Refer to clinical policy "Standing Orders" for the standing orders

KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: Patient Health Questionnaire (PHQ-3 and PHQ-9)
Policy Number: 8.32
BOD Approval: 06/13
Effective Date: 08/12
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will complete the 3 question Patient Health Questionnaire (PHQ) on all medical patients, 11 years and older, to screen for depression at every visit. A third question has been added to the standardized PHQ-3 to identify patients at risk for suicide (The PHQ-2 will hereafter be called the PHQ-3)

II. GUIDELINES:

1. When the patient is escorted to the exam room, the LPN/MA will give a PHQ-3 (see attachment A) to the patient to complete during the work up. The patient will independently complete the questionnaire unless the patient requests assistance from the LPN/MA.
2. The LPN/MA will wait in the exam room for the patient to complete the PHQ-3 and determine if a PHQ-9 needs to be completed or if immediate referral to a BHC is required. Immediate referral to a BHC is only required if a patient answers yes to the third question.
3. If the responses to any two of the questions on the PHQ-3 questionnaire are "Yes", then a PHQ-9 is to be completed by the patient (See Attachment B). The results of both the PHQ-2 & 9 will be documented in the patient's chart under MMSE/PHQ on the left-hand side of the visit note screen by the LPN/MA. The LPN/MA may document the results in the EMR immediately or after the provider visit. If not documented in the EMR immediately, the paper copy will be left in the room for the provider and the provider will be alerted that the PHQ-9 was completed.
4. All PHQ questionnaires are to be shredded after entering results into the patient's chart.
5. Providers must acknowledge their review of the PHQ within their visit note under HPI.

.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: Transfer Policy
BOD Approval: 06/13
Responsibility: Clinical Staff

Policy Number: 8.33
Effective Date: 12/11
Distribution: All Departments

I. POLICY:

For patients being transferred to another facility, KTCH employees will provide the correct information to other medical organizations for continuity of care. All the appropriate paperwork will be filled out and prepared for the admitting physician/facility, whether it is inpatient admittance or emergency care

II. GUIDELINES:

When transferring a patient to an outside care provider/hospital for admittance or emergency care, complete the KTCH transfer form (Appendix A) completely. Next, print off the KTCH patient's face sheet, visit note from that day's office visit, and recent labs/diagnostics, if applicable.

The direct admission must be physician to physician communication. Please call Bothwell Regional Health Center at 660-826-8833 to have the hospitalist on call paged. As a general guideline, direct admissions should arrive before 4:00 pm to assure optimal outcome for the patient and any necessary consults, radiology work ups, and send out lab to be performed. Patient should meet the acuity of care in the hospital or meet the criteria for observation. For bed placement you will need to contact the House Supervisor at 660-619-4742; as well as admissions at 660-827-9400 If the Hospitalist is unclear, case management will be contacted either by the hospitalist or transferring the call from the PCP to a case manager. Once a determination is made, the case manager will advise the Hospitalist. The Hospitalist will notify the PCP within 30 minutes and the ambulance can be notified to transfer the patient.

Direct admittance to a different hospital requires all the necessary paperwork stated above and the admitting provider in agreement before the transfer is made.

According to the COBRA/EMTALA guidelines:

"Once a patient's emergency medical condition has been stabilized, the patient may be transferred to receive a higher level of care at another hospital. A patient with an incompletely stabilized emergency medical condition may still be transferred without violating EMTALA rules under any one of the following circumstances:

- The patient, while understanding the risks and benefits of transfer, provides a written request for transfer despite being informed of the hospital's EMTALA obligations to

provide treatment.

- The treating physician certifies that the benefits of transfer outweigh the risks.
- The on-call physician fails or refuses to appear within a reasonable period of time and without the services of the on-call physician the benefit of transfer outweighs the risk."

1. To be eligible for a direct admission by the Hospitalist Service:
   Patient should be in the Primary Care Physician (PCP) office or should have seen by the PCP in the last 12 hours. The diagnosis must be fairly certain, and the patient should not be critically ill or unstable. If so, go to the Emergency Room for stabilization. The patient should not have an immediate need for IV fluids, IV antibiotics, imaging, or high oxygen demand.

2. The direct admission must be physician to physician communication. Please call the admitting hospital and ask to speak to the Hospitalist on call. A provider to provider consult will be completed. If patient is acute (i.e. Chest Pain) send patient to Emergency Department for workup. As a general guideline, direct admissions should arrive before **4:00 pm** to assure optimal outcome for the patient and any necessary consults, radiology work ups, and send out lab to be performed.
3. The PCP or nurse will call the house supervisor and give report with following information:
   - Patient name
   - Patient DOB
   - Demographics
   - Name of PCP
   - Medication list
   - Preferred Pharmacy
   - Primary diagnosis and secondary if available
   - H&P if possible

4. Patient should meet the acuity of care in the hospital or meet the criteria for observation. If the Hospitalist is unclear, case management will be contacted either by the hospitalist or transferring the call from the PCP to a case manager. Once a determination is made, the case

manager will advise the Hospitalist. The Hospitalist will notify the PCP within 30 minutes.

.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: School Sports Physicals
BOD Approval: 06/13
Responsibility: Clinical Staff

Policy Number: 8.34
Effective Date: 06/12
Distribution: All Departments

I. POLICY:

KTCH is committed to providing sports physicals to school age children within our service area. Sports physicals may be provided on site at the school or at any of the three clinical facilities

II. GUIDELINES:

On-site sports physicals:

1. KTCH will be notified of the need to provide on-site sports physicals by a representative of the requesting school district. The Outreach and Enrollment Coordinator will be the key contact person for the school representative. All calls requesting on-site sports physicals should be directed to the Clinical Data Coordinator Business Office Manager.
2. KTCH will attempt to honor all requests submitted by schools but cannot guarantee that requests submitted less than one month in advance will be scheduled.
3. KTCH will attempt to schedule during the date and time preferred by the school. If that date and time will not work for KTCH provider schedules, KTCH will offer the school no less than two alternate dates and times that we would be able to provide.
4. Once a date and time has been agreed upon, the KTCH provider group will be immediately notified via email of the opportunity to staff an on-site sports physical event. KTCH expects that all providers will volunteer to staff on-site sports physical events.
5. Once a date and time has been agreed upon, the KTCH clinical managers will be immediately notified via email of the need to staff an on-site sports physical event. Nursing staff that volunteer to staff these events will be paid time and half if they are non-exempt, if applicable.
6. The CDC Business Office Manager will confirm that sufficient staffing has been arranged and notify the school of such.
7. The CDC Business Office Manager will confirm that the school has sufficient space to adequately perform sports physicals on-site. The CDC Business Office Manager will also verify whether the school has a scale where all students can be weighted and height measured.
8. The CDC Business Office Manager will send the school representative a packet of information that all parents/ guardians will need to complete prior to the actual event. This packet of information will include patient demographic page, health history form, and a minor consent for treatment. These forms are attached to this policy for reference. It will be the responsibility of the school representative to assure that all of these forms are completed and ready for KTCH staff review on the day of the event.
9. KTCH may charge for on-site sports physicals. The decision as to whether to charge for the event and the amount to charge for the event will be decided by the KTCH CEO and CFO.

10. If there is a per-student charge for the event, all monies must be collected at the time of the event. KTCH will not bill for on-site sports physicals. The school representative will assure that all students have exact change or a check made out for the exact amount as KTCH will not bring any cash to make change.
11. The CDC Business Office Manager will request that provider schedules be blocked if needed. The COO will approve any schedule change and it will be distributed via the schedule change process.
12. It is the responsibility of the nursing staff to collect supplies needed for the on-site event. Supplies may include, but are not limited to eye charts, privacy screens, and stethoscopes.
13. It is also the responsibility of the nursing staff to set up the space for the event once they arrive at the school.
14. Nursing staff will complete their section of the sports physical and assure that the history is complete and signed. It is the responsibility of the school representative to assure that the signature is representative or a parent/ guardian of the student. Finally, the nursing staff will collect payment prior to alerting the physician that that student is ready for his/her physical.
15. The nursing staff will be provided a money bag to keep all payments. The money bag will be given to KTCH finance personnel the next day or as soon as possible after the event.
16. The nursing staff will compile all documentation per student and will give to the CDC Business Office Manager the next day or as soon as possible after the event. If the school representative wants a copy of any of the documentation, they will need to make a copy at the time of the event and as KTCH must retain the original documentation. If the school chooses not to make a copy at the time of the event, the CDC Business Office Manager will make copies upon request and send to the school representative.
17. Students receiving sports physicals will not be registered in the KTCH EMR as they will not become patients of KTCH. Should a student already be an established patient of KTCH, the sports physical will be scanned into the student's medical record. The original documents will be maintained by the Medical Records Dept.
18. A follow up call will be made by the CDC Business Office Manager to the school representative after the event to evaluate the outcome of the event and make notes on any areas that may need improvement.

Sports physicals provided in-house:

1. A sports physical may be scheduled in-house with any provider at any location. As is KTCH policy it is recommended that a sports physical be scheduled with a student's PCP if that student is an established patient.
2. KTCH will complete the sports physical documentation as required by all school districts within the state of Missouri. This document will be scanned into the patient's medical record. The original document will be given to the patient. A visit note will also need to be complete by the provider, as this is a billable service.
3. Sports physicals may be scheduled throughout a work day and maybe placed in a wave slot or a same day slot on the schedule.
4. Sports physicals require payment in advance of the appointment. The charge for a sports physical will be set by the CFO on an annual basis.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: Emergency Contacts
BOD Approval: 01/16
Responsibility: Clinical Staff

Policy Number: 8.35
Effective Date: 01/14
Distribution: All Departments

I. POLICY:

Each clinical facility will maintain a list of emergency contact numbers.

II. GUIDELINES:

1. Emergency Numbers:

Sedalia

****** Dial 9 and then the number**

- Fire 660-826-8044
- Police 660-826-8100
- Ambulance 660-826-7400
- County Fire/Sheriff 660-827-0052
- Emergency Management Agency 660-827-5515
- Missouri State Highway Patrol 660-530-5515
- Poison Control 800-222-1222

Marshall

****** Dial 9 and then the number**

- Fire 660-886-3312
- Police 660-886-7411
- Ambulance 660-886-3317
- County Fire/Sheriff 660-886-5511
- Emergency Management Agency 660-886-3312/ 660-831-1911
- Missouri State Highway Patrol 660-530-5515
- Poison Control 800-222-1222

Versailles

****** Dial 9 and then the number**

- Fire 573-378-4634
- Police 573-378-4634
- Ambulance 573-378-5350
- County Fire/Sheriff 573-378-4681

- Missouri State Highway Patrol 573-751-1000
- Poison Control 800-222-1222

Warsaw

****** Dial 9 and then the number**

- Fire 660-438-9732
- Police 660-438-9555
- Ambulance 660-438-2993
- County Fire/Sheriff 660-438-9555 or 660-438-6135
- Emergency Management Agency 660-438-8412 or 660-423-4090
- Missouri State Management Patrol 800-525-5555
  Poison Control 800-222-1222

.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: Allergy Shot Administration Policy
BOD Approval: 01/16
Responsibility: Clinical Staff
Policy Number: 8.36
Effective Date: 09/13
Distribution: All Departments

I. POLICY:

Patients requesting administration of immunotherapy extracts will complete a consent and request form titled "*Request and Consent for Administration of Allergy Immunotherapy*". Referring allergists will provide:

1. Allergan Extract for injection
2. Detailed protocols for dosing and dose adjustments including schedules for: escalation and maintenance dosing, the use of new vials, during seasonal exposures, if the constituents of the allergen immunotherapy extract have changed, missed dose and when reactions occur.

The referring allergist is responsible for the management of the individual immunotherapy and modification of dosing schedules. Katy Trail Community Health (KTCH) will periodically send updated treatment history back to the referring allergist if required by the referring allergist.

II. GUIDELINES:

1. Allergy immunotherapy will not be administered unless a KTCH provider is present and readily available in the office.
2. The patient will not see a KTCH provider as part of routine immunotherapy injection visits.
3. Administration of immunotherapy will be performed by nursing personnel.
4. Nursing personnel will document the immunotherapy injection as a nursing visit. The documentation will include the following information:
    a. Current health status (document recent illnesses); Include statement attesting to whether patient's asthma is stable or not.
    b. Temperature
    c. Record if any reaction occurred with most previous injection (local swelling, local itching, wheezing, hives, delayed reaction, systemic, large local, etc.)
    d. Current medications and allergies
    e. Missed or late dose
    f. Protocol reference for next dose
    g. Injection information including extract, concentration, volume, location of injection
    h. Documentation that patient was observed for 20 minutes or if patient left early
    i. Inspection and description of injection site after 20 minutes or before patient left.
    j. Reaction, if any
    k. Post injection treatment to include ice, topical steroid, oral antihistamines, resuscitation, etc.

5. The *"Request and Consent for Allergy Immunotherapy"* form must be completed by the patient prior to the first injection and must be scanned into the patient's medical record.
6. Protocols for dosing and dose adjustment must be provided by the referring Allergist.
7. KTCH will provide the service of storing allergen extracts for patients between injections as described below. KTCH is not liable for the compromise and the integrity of the medication due to handling before KTCH receives the medication or for loss or compromise of integrity due to power outage, storage equipment failure, or catastrophic event:
    a. The extract is to be stored in containers clearly indicating the patient's name and labeled to identify the contents of the vial.
    b. The extract is to be stored, refrigerated and kept between 3ºC and 6ºC (37.4ºF and 42.8ºF).
    c. If the extract is exposed to heat or frozen, KTCH will contact the referring Allergist for instructions and document the contact and instructions in a phone consult note.
8. Injections are given subcutaneously using a 1 mL syringe with a 26 or 27 gauge needle. Injections should be given in the posterior portion of the middle third of the upper arm at the junction of the deltoid and triceps muscles. The syringe should be aspirated to check for blood return in the syringe before injecting. If blood is present, the solution should not be injected and the syringe removed and discarded in an approved container.
9. Dose changes are indicated and ordered by the ordering Allergist/Physician:
    a. During escalation and maintenance dosing
    b. Use of new vials
    c. During seasonal exposures
    d. If the constituents of the allergen immunotherapy extract have changed
    e. Missed doses
    f. If reaction has occurred
    -Any questions or clarifications should be made to the referring Allergist.
10. Contraindications include:
    a. Injections should be postponed if the patient is ill, febrile, has symptomatic asthma, or has sunburn or irritation at the injection site.
    b. Injections should not be given to patients taking beta-blocker medication.
    c. Caution advised- appropriately revised dosage schedules must be obtained from the referring Allergist in order to continue injections during pregnancy.
11. Treatment of **local reactions** should be done as ordered by the allergist as indicated on the dosing/treatment sheet that came with the allergen vials which include:
    a. Usually no treatment is required for local reactions except applicable of ice pack and adjustment of future doses
12. Acute management of **systemic reactions**:
    a. If a systemic reaction is suspected, assess airway, breathing, and circulation.
    b. A physician should be summoned urgently.
    c. The nursing personnel can ONLY administer a dose of epinephrine intramuscularly into the deltoid near the injection site as ordered by the physician..
    d. 911 may be called and the patient may be transferred to the emergency room.
    e. Place tourniquet, lightly above allergen injection site.

f. Staff should stay with the patient and monitor vital signs every 2-5 minutes.
g. Place patient in supine position with feel elevated.
h. Given oxygen (6-8 L/minutes) via mask
i. Consider diphenhydramine 50 mg PO x1 >30 kg or 1mg/ kg PO x1 for <30 kg for itching and urticarial only.
j. Consider albuterol via nebulizer if patient develops bronchospasm.

Consider liquid Benadryl 12.5 mg/5 mL or Benadryl tablets 25 mg

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X

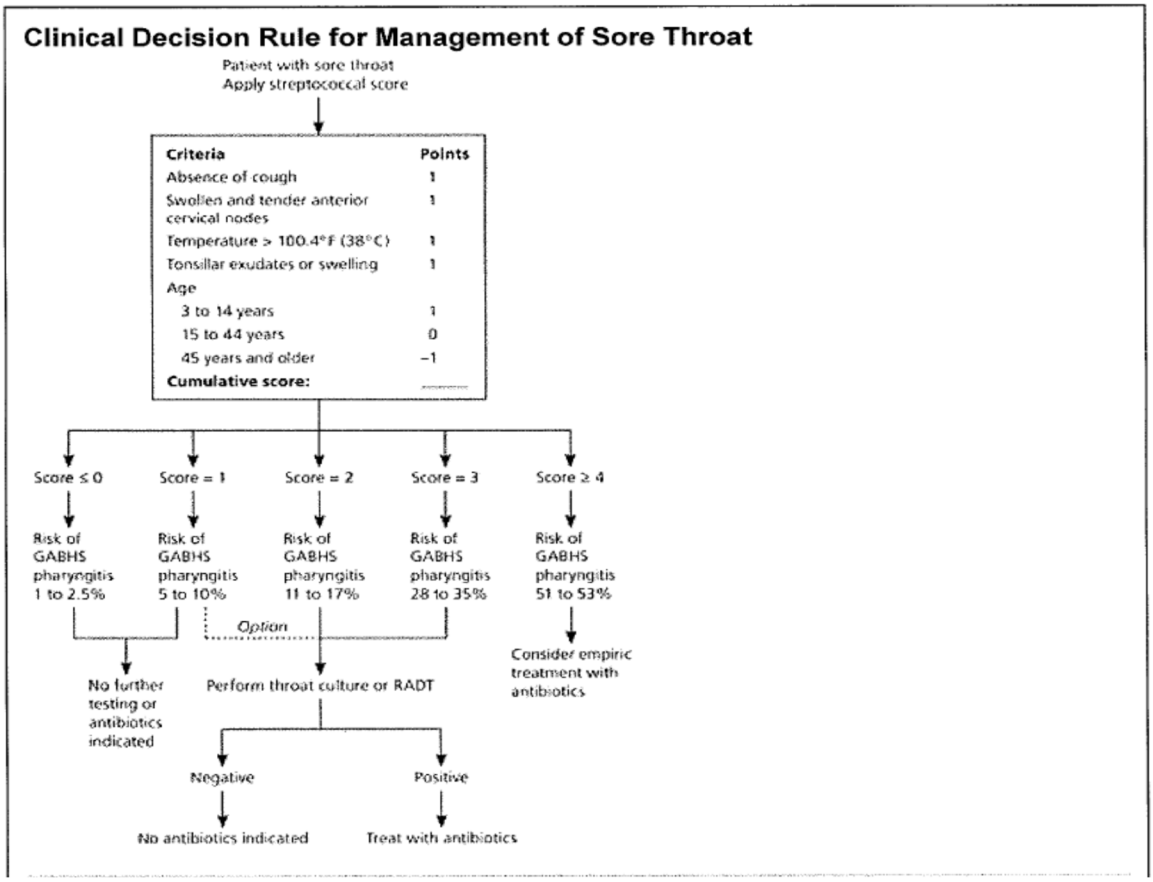
Policy Title: Diagnosis and Management of Group A Streptococcal Pharyngitis
Policy Number: 8.37
BOD Approval: 01/16
Effective Date: 09/13
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) has selected the American Academy of Family Physicians best practice for diagnosis and treatment of Group A Streptococcal Pharyngitis.

PROCEDURE(S):
Guidelines are available on-line at the below sites:
http://www.aafp.org/afp/2009/0301/p383.html

Diagnosis and Treatment of Streptococcal Pharyngitis



KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: Pediatric Blood Lead Screening
BOD Approval: 02/16
Responsibility: Clinical Staff

Policy Number: 8.38
Effective Date: 03/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) has selected the Missouri Department of Health and Senior Services recommendations for Blood Lead Testing in Missouri. The Center for Disease Control (CDC) and the Association of Pediatrics ; along with the Centers for Medicare and Medicaid Services (CMS)/Missouri Department of Social Services, Division of Medical Services and Department of health and Senior Services have state requirements for the blood lead testing of children.

II. GUIDELINES:

http://www.aoec.org/pehsu/documents/medical-mgmnt-childhood-lead-exposure-June-2013.pdf
http://health.mo.gov/living/environment/lead/pdf/StatewideMap.pdf
http://health.mo.gov/living/environment/lead/guidelines.php

- Children should be tested between 6 months and 3 years of age because children at this age spend a lot of time on the floor and often put things in their mouths. The hand to mouth behavior is one of the most common pathways for lead poisoning to occur. Testing is highly recommended for this age group if the child lives in or regularly visits a house that was built prior to 1978.
- All siblings of a child who has an elevated lead level should be tested.
- All children receiving Medicaid benefits are required to be blood tested for lead at 12 and 24 months of age.
- Newborns of women who had suspected or elevated blood lead levels during pregnancy should be tested.
- Children and pregnant women who reside in a pre-1978 home, which is undergoing renovation, may require more frequent blood lead testing during the renovation process and after renovations are completed.
- If you are unsure if your child should be tested, consult your child's physician.

Universal (High Risk) Area Requirements:

- Any child under the age of 6 years will be blood lead tested annually if he/she lives in a universal (high risk) testing area.
- Day care facilities are required to record a "proof of lead testing" signed by the Health Care Provider performing the test within thirty (30) days of the child's enrollment. If the parent/guardian does not provide it or a written statement stating why they do not want the child tested, the Day care facility is to offer the parent assistance in scheduling a test.

Targeted (Non-High Risk) Area Requirements:

- Any child under the age of 6 years will be tested annually if he/she lives in a non-high risk testing area, but visits for more than 10 hours per week a universal (high risk) testing area.
- Each child will be screened annually by the child's physician using the **HCY Lead Risk Assessment Guide** to determine whether the child is at risk for lead poisoning.
- If a positive answer is given, the child is considered at risk for lead poisoning and is recommended to have a blood lead test.

Key Recommendations:

- **All children receiving Medicaid benefits are required to be blood tested for lead at 12 and 24 months of age**
- **Any child under the age of 6 years will be blood lead tested ANNUALLY if he/she lives in a universal (high risk) testing area.**
- **Any child under the age of 6 years will be blood lead tested ANNUALLY if he/she lives in a non-high risk testing area BUT visits for more than 10 hours a week a universal high risk testing area.**
- **The choice sample collection method (venous or capillary) should be determined by the provider.**
    - **If the capillary results are 10ug/dl or greater the result should be confirmed with a venous blood draw.**
- **All lead testing will be documented in the patient chart and in the lead screening log. The log will be faxed to the county health department or the state weekly.**
- **Any lead screening result greater than 5 must be reported to the county immediately.**

.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical

Policy Title: Immunization, Administration of Immunizations
Policy Number: 8.39
BOD Approval: 05/07
Effective Date: 05/07
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will administer all vaccines as ordered by the provider and/or per standing orders.

II. GUIDELINES:

Assess current immunizations by reviewing patient immunization record on file or from the patient. Clinical staff may Access Show Me Vax for a more complete immunization record.

2. Assessment for contraindications may be obtained at the following websites:
   a. http://www.cdc.gov/vaccines/recs/acip
   b. http://www.aap.org
   c. http:// www.aafp.org
3. Obtain signed consent from adult patient, or legal parent or guardian on Consent for Immunization form (in EMR).
4. Give current vaccine information handout statement sheet (VIS) to patient or parent/guardian prior to receiving the vaccine.

1. Obtain supplies as needed:
   - 3cc syringe with 23g 1" or 25g 5/8" needle
   - Appropriate vaccine
   - Alcohol wipes, cotton balls, and Band-Aids
   - Gloves

6. Administer vaccine Intramuscular (IM) or Subcutaneous (SC) according to manufacturer's recommendation:
   a. Don gloves
   b. Cleanse top of vial with alcohol and let air dry.
   c. Remove cap from needle and pull back plunger to draw up 0.55 cc of air. Insert the needle into stopper of vial and inject air into vial.
   d. Pull back plunger on syringe to withdraw correct amount of medication into the syringe.
   e. Withdraw needle and recap.
   f. Purge air from syringe.
   g. Ask a nursing staff member to verify order and vaccine that was drawn
   h. Explain the procedure to the parent/guardian or patient.
   i. Identify injection sites according to the age and vaccine (see attached charts).

j. Immobilize the extremity.
k. Identify landmarks to locate injection site.
l. Prepare site by cleansing with alcohol wipe, then dry with a cotton ball.
m. Insert needle following guidelines for IM or SubQ injections.
n. Withdraw needle and apply pressure with cotton ball.
o. Dispose of syringe in a sharps container.
p. Apply band-aid to site of injection
q Remove gloves and place in trash.
r. Complete documentation in EMR under Immunizations, Immunization consent form, patient immunization record, and Show Me Vax.

.

KATY TRAIL COMMUNITY HEALTH
Laboratory

Policy Title: Compliance with Clinical Laboratory Improvement Amendment of 1988 (CLIA)
Policy Number: 8.40
BOD Approval: 05/07
Effective Date: 05/07
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

It is the policy of Katy Trail Community Health (KTCH) to ensure that all laboratory services that are provided onsite are in strict adherence with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) requirements. Additionally, KTCH will ensure that all laboratory services provided off site are performed in compliance with CLIA. The staff physician will serve as director of the lab.

Katy Trail Community Health (KTCH) laboratories complies with all applicable laws and regulations, such as the Clinical Laboratory Improvement Amendments (CLIA), by developing, implementing and monitoring appropriate policies, procedures and processes. Our goal is to deliver accurate, high-quality, and timely results so that diagnostic and treatment decisions can be made as quickly as possible for patient care. A staff physician will serve as director of the lab.

II. APPROVALS:

Lab Director

III. GUIDELINES:

1. KTCH has properly made application to and been approved to provide the following CLIA waived approved lab tests. KTCH will ensure that the CLIA review is done annually or as required by CLIA and that a CLIA certificate for the appropriate testing category, including waived testing, is issued, and is current before CLIA laboratory testing is performed.
2. KTCH will maintain a board-approved laboratory policy and procedure manual for reference by providers and staff. Policies and procedures are established to ensure that the laboratory function is in compliance with OSHAs safety and infection control requirements.
3. KTCH will staff the laboratory with technicians/nurses who receive training and complete a competency at least every two years.
4. Panic values for various tests that are conducted in the laboratory will be provided, and protocols to handle such occurrences will be established.

5. All laboratory equipment will be calibrated, tested, and monitored as required by manufactures to ensure quality control, and there will be timely follow up on any abnormal or problem results.

6. Patients without insurance or financial resources will receive medically necessary diagnostic laboratory tests. If KTCH procures outside laboratory testing, ie LabCorp, there will be a written contract with that outside laboratory which states that that laboratory properly licensed and meets all Federal, State, and local laws and regulations, including CLIA.

7. This policy and procedure shall be reviewed periodically and updated according to requirements and standards established by the Board of Directors and management of KTCH, Federal and State laws and regulations, and applicable accrediting and review organizations.

8. CLIA waved tests offered at KTCH are:

- HbA1C
- Automated and/or Visual Urine Testing
- Urine Micro Albumin Testing
- Hemoglobin
- Rapid Strep A Testing
- Urine HCG Testing
- Influenza Testing
- RSV Testing
- Fecal Occult Blood Testing
- Lead screening
- PT/INR
- Cholesterol Testing (glucose/lipid screening) for Wise Woman Program/Children ages 11-17
- Rapid Mono Test
- Rapid HIV
- Urine Drug Screen

Assess current immunizations by reviewing patient immunization record on file or from the patient. Clinical staff may Access Show Me Vax for a more complete immunization record.

2. Assessment for contraindications may be obtained at the following websites:
   a. http://www.cdc.gov/vaccines/recs/acip
   b. http://www.aap.org
   c. http:// www.aafp.org
3. Obtain signed consent from adult patient, or legal parent or guardian on Consent for Immunization form (in EMR).
4. Give current vaccine information handout statement sheet (VIS) to patient or parent/guardian prior to receiving the vaccine.

1. Obtain supplies as needed:
   - 3cc syringe with 23g 1" or 25g 5/8" needle
   - Appropriate vaccine
   - Alcohol wipes, cotton balls, and Band-Aids
   - Gloves

6. Administer vaccine Intramuscular (IM) or Subcutaneous (SC) according to manufacturer's recommendation:
   a. Don gloves
   ab. Cleanse top of vial with alcohol and let air dry.
   cb. Remove cap from needle and pull back plunger to draw up 0.55 cc of air. Insert the needle into stopper of vial and inject air into vial.
   cd. Pull back plunger on syringe to withdraw correct amount of medication into the syringe.
   de. Withdraw needle and recap.
   f. Purge air from syringe.
   g. Ask a nursing staff member to verify order and vaccine that was drawn
   h. Explain the procedure to the parent/guardian or patient.
   i. Identify injection sites according to the age and vaccine (see attached charts).
   hj. Immobilize the extremity.
   ik. Identify landmarks to locate injection site.
   lj. Prepare site by cleansing with alcohol wipe, then dry with a cotton ball.
   km. Insert needle following guidelines for IM or SubQ injections.
   nl. Withdraw needle and apply pressure with cotton ball.
   mo. Dispose of syringe in a sharps container.
   pn. Apply band-aid to site of injection
   q Remove gloves and place in trash.
   ro. Complete documentation in EMR under Immunizations, Immunization consent form, patient immunization record, and Show Me Vax.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policies

Procedure Title: Laboratory Management **Policy Number: 8.41**
BOD Approval: **Effective Date**: 06/06
Responsibility: All departments **Distribution:** All Departments

---

I. POLICY:

The Chief Medical Officer, or his/her designee, will be responsible for internal laboratory management and will provide oversight for CLIA waived tests performed in the Katy Trail Community Health labs.

II. GUIDELINES:

1. Laboratory safety shall be discussed with all employees upon hire and no less than annually
2. Areas within the Labs have been designated as **CLEAN** and **DIRTY**. Caution must be taken to avoid cross contamination from dirty instruments, specimens, etc.
3. Eye wash station(s) exist in lab areas.
4. Combustible items will be stored away from chemicals.
5. All laboratory testing equipment will be calibrated per manufacturer's specifications, instruments and equipment will be maintained and cleaned on a regular basis. Quality control testing will be performed within the Lab on all CLIA waived lab equipment daily or as recommended by the manufacturer. The assigned nurse, QI Director or their designee will follow-up on laboratory issues such as maintaining equipment properly and quality control testing, including proper cleaning of equipment according to manufacturer instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Exposure Control Plan- General Safety Policies
Policy Number: 8.42
BOD Approval: 01/2016
Effective Date: 07/2011
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will follow guidelines and policies set forth by OSHA regulations. The following general safety policies will be followed

II. APPROVALS:

Lab Director

III. GUIDELINES:

a. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are strictly prohibited in treatment areas, sterilization areas, laboratory areas and waste storage areas.
b. Food, drink and cosmetics shall **NOT** be kept in refrigerators, freezers, shelves, and cabinets or on countertops or benches where medications, blood or other potentially infectious materials are stored or handled.
c. Medications/vaccines and lab specimens should **NOT** be stored in the same refrigerator/freezer.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Exposure Control Plan- General Safety Policies
Policy Number: 8.43
BOD Approval: 01/2016
Effective Date: 2009
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

All lab orders will be documented in the EMR.

II. APPROVALS:

Lab Director

III. GUIDELINES:

Providers will order the desired laboratory tests within the EMR laboratory module. The nurse/ phlebotomist shall arrange for and/or collect the appropriate specimen and label it appropriately. The nurse/phlebotomist can prevent unnecessary costs by using the correct procedure for obtaining and processing specimens. When there are questions about laboratory tests, the nurse/ phlebotomist should consult the laboratory's collection manual or call the laboratory. On occasion, an outside physician who we have referred the patient to may order a lab. A Katy Trail Community Health (KTCH) provider must approve and co-sign this order prior to the labs ~~t~~being performed.

1. Nurse/phlebotomist receives order from physician/provider within the EMR module, or an order generated within the EMR for outside lab services.

1. If labs are being performed outside of the clinic, the patient will be given an order, and instructed where and when to proceed, and given any specific instructions needed.
2. When the results are received, the KTCH clinical staff shall follow appropriate notification procedures for normal or abnormal lab results.
3. If a lab order is received from an outside facility the patient's Primary Care Provider (PCP) must approve and sign off on the lab order prior to the lab being drawn. A KTCH PCP, however, may opt not to approve and sign off on a lab order. The decision is at the discretion of the PCP.

4. When the lab results are received, the KTCH clinical staff shall follow appropriate notification procedures for normal or abnormal lab results. The KTCH clinical staff will also fax a copy of the lab results to the original ordering physician.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Venipuncture/ Capillary, Obtaining a Blood Specimen **Policy Number:** 8.44

BOD Approval: 01/2016 **Effective Date**: 06/2006
Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

The phlebotomist, nurses, medical assistants, or providers will perform venipuncture to obtain blood specimens for laboratory testing purposes, carefully maintaining universal precautions as described in the Blood Borne Pathogen Exposure Plan.

II. APPROVALS:

Lab Director

III. GUIDELINES:

1. Obtain order for lab test requiring a blood specimen.
2. Verify name and date of birth of patient and compare with lab requisition and label.
3. **All specimens must have two patient identifiers (full name and date of birth or chart number) and the specimen must be labeled in the presence of the patient.**
4. Gather equipment and supplies, including:
    - Disposable gloves
    - Alcohol
    - Sterile gauze
    - tourniquet
    - Band-Aid or adhesive tape
    - Appropriate blood tubes
    - Lab requisition (completed by nurse)
    - Lab specimen identification labels
    - Plastic transport bag for specimen

Vacutainer/vacuum tube method:

- Vacutainer/vacuum tube with needle holder
- Sterile double ended needles or butterfly needle
    1) Explain procedure to patient.
    2) Wash hands and don gloves

3) Attach double-ended needle to vacuum tubes (long end of needle is used to puncture vein, short end fits into blood tubes).
4) Have proper blood specimen tube resting inside of vacuum tube, but do not puncture rubber stopper.
5) Palpate site to locate the vein
6) Instruct patient to make a fist or tightly grasp a rolled object with their hand.
7) Cleanse venipuncture site with alcohol pad or swab moving in circular motion from site for approximately 2 inches.
8) Do not palpate site after cleaning.
9) Apply tourniquet above the venipuncture site.
10) Remove needle cover and inform patient that "stick" lasting only a few seconds will be felt.
11) Place thumb or forefinger of non-dominant hand 2.5 cm above or below site and pull skin taut. Stretch skin down until vein is stabilized.
12) Hold vacuum tube at a 15 to 30-degree angle from arm with the needle bevel up.
13) Insert needle into vein.
14) Grasp vacuum tube securely and advance specimen tube into needle of holder (do not advance needle in vein). Be sure to fill the lavender top tube last. If you are using a butterfly to obtain a PT/INR or PTT (light blue top tube), be sure to prime the butterfly tubing first using a plain red top tube.
15) Note flow of blood into tube (should be fairly rapid).
16) After specimen tube is filled, grasp vacuum tube firmly and remove tube. Insert additional specimen tube as needed.
17) After last tube is filled, release tourniquet.
18) Apply gauze pad over puncture site without applying pressure, and quickly but carefully withdraw needle from vein. **Pressure over needle can cause discomfort. Careful removal of needle minimizes discomfort and vein trauma.**
19) Apply pressure to venipuncture site to prevent bleeding/bruising.
20) Apply Band-Aid or tape with gauze pad over venipuncture site after checking to see if it's still bleeding.
21) For blood tubes containing additives, gently rotate back and forth 8 to 10 times. For blood obtained for blood cultures, gently mix each bottle after each inoculation.
22) Check tube for any sign of external contamination with blood. Decontaminate with 70% alcohol if necessary.
23) Remove and discard gloves.
24) Securely attach properly completed identification label to each tube and affix proper label to each tube and affix proper requisition; while in the presence of the patient
25) Spin blood specimen when using tiger top, red top, or when required.

Syringe method:

- Sterile needles (suggested needle size: 20 to 21 gauge for adults, 23 to 25 for children, 23 to 25 gauge butterfly for older adults)
- Sterile syringe for appropriate size.

13. .

1) Explain procedure to patient.
2) Wash hands and don gloves.
3) Have syringe with appropriate needle securely attached.
4) Palpate the site to locate the vein
5) Cleanse venipuncture site with alcohol swab moving in a circular motion from site for approximately two inches. Do not palpate site.
6) Apply tourniquet above venipuncture site.
7) Instruct patient to make a fist or tightly grasp a rolled object with their hand
8) Remove needle cover and inform patient that "stick" lasting only a few seconds will be felt.
9) Place thumb or forefinger of nondominant hand 2.5 cm above or below the site and pull skin tight. Stretch skin down until vein is stabilized.
10) Hold syringe and needle at a 15 to 30-degree angle from patient's arm with the needle bevel up.
11) Insert needle into the vein.
12) Hold syringe securely and pull back gently on the plunger.
13) Look for blood return.
14) Obtain desired amount of blood, keeping needle stabilized. After specimen is obtained, release tourniquet.
15) Apply gauze pad over puncture site without applying pressure and quickly but carefully withdraw needle from vein and apply pressure following the removal of the needle.
16) Apply pressure to venipuncture site to prevent bleeding/bruising.
17) Apply band aid or tape with a gauze pad over venipuncture site.
18) Connect transfer device to the specimen filled syringe and attach vacutainer to the other end of transfer device. If transfer device available carefully insert needle of specimen filled syringe into blood tube withdraw blood. **Do Not Push or Force Plunger of Syringe into Blood Tube.**
19) For blood tubes containing additives, gently rotate back and forth 8 to 10 times. For blood obtained for blood cultures, gently mix each bottle after inoculation.
20) Check tubes for any signs of external contamination with blood. Decontaminate with 70% alcohol if necessary.
21) Remove and discard gloves.
22) Securely attach proper completed identification label to each tube and affix proper label to each tube in the presence of the patient and affix proper requisition.
23) Spin blood specimen when required.

CAPILLARY SPECIMEN COLLECTION METHOD:

PRINCIPLE:

This is an alternate method for obtaining a blood sample from an adult or child over 1year of age, when only a small volume is needed and/or venipuncture is not possible. Fingers of an infant less than 1 year of age may not contain enough tissue to prevent contact with the bone and is not suitable for use.

SPECIMEN:

PATIENT PREPARATION:

1. The non-dominant hand is preferred, with the hand positioned below the heart.
2. The third and fourth fingers on the plantar side are the sites of choice for finger puncture.
3. The tip and sides of the finger contain only half tissue mass of the central area the possibility of bone injury is increased in these areas.

EQUIPMENT AND MATERIALS:

- Specimen collection tubes and/or micro-containers and/or test strips, etc.
  (will vary depending on ordered tests)
- 2 x 2 sterile gauze pads/ cotton ball
- clean gloves
- 70 % isopropyl alcohol preps
- sharps container
- Automatic lancet device
- band aid

TEST PROCEDURE:

1. Identify self to patient and/or guardian and explain procedure. ID patient in accordance with the positive ID policy using the name and DOB
2. Confirm patient identity by asking for full name and date of birth.
3. Confirm test order and specimen requirements before beginning procedure.
4. Assemble necessary materials.

5. Instruct patient to let arm hang in a downward position for at least 30 seconds.
6. Wash hands and put on clean gloves.
7. Choose either the middle or 3rd finger of non-dominant hand and cleanse the fingertip with 70% alcohol prep. Allow to air dry.
8. Using a sterile automatic lancet device, puncture skin just off center of the finger pad. The puncture should be made across the ridges of the fingerprint to enhance droplet formation.
9. Wipe away first drop of blood with sterile gauze for each test except PT/INR. 10. Gently massage the patient's finger to force the blood toward the tip. Then, gently apply pressure to the sides of the finger. (Avoid excessive pressure.)
11. Apply drops of blood into or onto the appropriate containers as required by ordered tests. Tubes containing anticoagulant should be capped and then gently inverted and/or tapped to mix properly. Do NOT shake violently.
12. When collection is finished, have patient hold sterile gauze onto puncture site until bleeding stops.
13. Label each container with the patient's name and DOB, in the presence of the patient.
14. Check the condition of the patient. Bandage finger if necessary
15. Place specimen in biohazard specimen bag.
16. Dispose of contaminated materials in appropriate containers. Lancets must be placed in a sharps container.
17. Remove gloves and wash hands.
18. Perform the rest of the test that required the capillary blood.

LIMITATIONS OF PROCEDURE:

1. Blood Cultures must NOT be collected by finger stick or heel stick.
2. Specimens MUST be discarded and re-collected if: improperly labeled, unlabeled, Hemolyzed, clotted (in anticoagulant) AND/OR exceeds time requirements
3. Order of draw for the vaccu-containers: light blue, red/tiger top, lavender (last so as to contaminate tiger top with potassium)

Blood Cultures:

- Gloves
- Povidone-iodine (Betadine)
- Two 20-ml syringes
- Sterile needles or butterfly needles.
- Anaerobic and aerobic culture bottles

- (LabCorp provides a kit for drawing up pediatric and adult cultures with these supplies) **DO NOT USE ALCOHOL WHILE DRAWING BLOOD CULTURE. IT ALTERS THE RESULTS.**

1. Follow steps 1 through 17 under syringe method.
2. Wash hands and don gloves.
3. Explain procedure to patient.
4. Have syringe with appropriate needle securely attached.
5. Obtain desired amount of blood keeping needle stabilized. **If using blood culture container, put blood culture bottle into device and push in until needle punctures rubber stopper and blood is pulled into tube by vacuum; keep blood culture container in device until it is ¾ full. Remove blood culture container and replace with new culture container if additional specimens are needed.**
6. After specimen is obtained, release tourniquet.
7. Apply gauze pad over puncture site without applying pressure and quickly but carefully withdraw needle from vein and apply pressure following removal of needle.

Documentation in patient visit notes:

1. Record initials of who collected specimen and document location of lab draw if drawn by LPN/MA or provider. If the phlebotomist from Labcorp draws, documentation in the chart is not required.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Provider Notification of Abnormal and Critical Lab Values **Policy Number:** 8.45

BOD Approval: 01/2016 **Effective Date**: 06/2006
Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

Katy Trail Community Health (KTCH) will communicate the results of tests considered abnormal or critical to patient care to the provider in a timely and reliable manner

II. APPROVALS:

Lab Director

2/26/16

III. GUIDELINES:

DOCUMENTATION OF LABS/DIAGNOSTICS:

1. All documentation must be done in the EMR
2. Results will be received either through an interface or scanned directly into the EMR and linked to the lab/diagnostic order.
3. The results are automatically sent to the ordering provider's task box as "Received" with the current date.
4. The provider will review the results and notate within the lab/diagnostic document in the "checked note" box regarding what actions should be completed.
5. The provider and/or designee will notate the actions taken including the means of communication and the date that the action was completed, followed by their initials in the "note" box of the lab/diagnostic document, and will forward to care team.
6. Care Team member will review lab/diagnostic order and only mark as "Reviewed" once all actions are completed.

ABNORMAL RESULTS:

KTCH's EMR flags abnormal test results by turning Quick Launch button red and placing as asterisk next to the abnormal result. KTCH clinical staff will report all abnormal lab results within 72 business hours/3 business days to the patient.

Patient will be notified via contact phone number(s) in the patient record. If no contact is made, two letters will be mailed to the patient, one normal postage and the second will be sent certified

with a returned receipt requested. All attempts and follow up will be documented in the EMR by the primary care provider and/or a member of their care team.

CRITICAL RESULTS:

Clinical lab (from laboratory) staff will report all Life Threatening (Panic) Limits

(Panic Critical Limits) to the provider ordering the test, or his/her designee within 15 minutes of receiving notification of such values. Providers will write orders for specific parameters, if they want to be notified of other lab results. If no provider is in building, call KTCH on-call provider/physician.

Patient will be notified via contact phone number(s) in the patient record. If no contact is made, the provider will attempt emergency contact, or any other contact listed in the patient record. If still no contact is made, the provider will contact the patient's primary pharmacy for additional contact information. If still no contact is made, the provider may determine that a police check is necessary or the KTCH community health worker may be sent to the patient's home. All attempts and follow up will be documented in the EMR by the primary care provider and/or a member of their care team.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Non-Alteration of Reference Laboratory Reports **Policy Number:** 8.46

BOD Approval: 01/2016 **Effective Date**: 06/2006

Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

Non-alteration of results received from outside testing laboratories

II. APPROVALS:

Lab Director

III. GUIDELINES:

Outside laboratory testing is contracted through Laboratory Corporation of America (LabCorp). A LabCorp employee is stationed on-site at KTCH Sedalia Clinic for phlebotomy and specimen processing.

PURPOSE:

The purpose of this procedure is to ensure that reports that are received from LabCorp, or any other outside reference laboratory, will not be altered by KTCH personnel in any manner. This includes correction of the spelling of the patient's name or birthdate.

REQUIREMENTS:

Alteration of reference laboratory result reports results in invalidation of the testing. If there are corrections that need to be made in a reference laboratory report, the request is to be made to the laboratory for a corrected report which contains the correct information.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: DCA Vantage Analyzer- HbA1C
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.47
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Clinical staff will check HbA1C levels on all patients known to have diabetes and all other patients suspected to have diabetes at least twice per year as ordered by the provider and/or per standing orders.

II. APPROVALS:

Lab Director

III. GUIDELINES:

Procedures for Receiving Kit:

Upon receipt of the kit, check the temperature indicator located on the front of the carton. If the indicator has turned red, do use the reagent cartridges. Note time and date received and for assistance in obtaining a replacement kit, refer to instructions given on the carton.

Storage: Store reagent cartridges refrigerated at 36-46°F. Capillary holders may be stored refrigerated or at room temperature.

Use Life: Reagent cartridges can be kept for up to three months at room temperature any time before the expiration date. Record on the carton, the date it was placed at room temperature.

After opening the foil pouch, the reagent cartridge must be used within (1) hour.

IMPORTANT: after the glass capillary is filled with the blood sample, analysis must begin within 5 minutes.

PROCEDURE FOR PERFOMING TESTING:

Quality Controls:

It is recommended that the quality control specimens be tested with each new lot of reagents, new shipment of reagents, and monthly for reagents that have been stored for more than 30 days. QC

testing is recommended to ensure reagent storage integrity, train and confirm performance acceptability for new users, and when patients' clinical conditions or symptoms do not match.

Both of the DCA 2000 A1C, Normal and Abnormal controls are lyophilized and must be reconstituted prior to use.

The control solutions are only good for 90 days after reconstitution.

The box should be labeled as to when the controls were opened and when they expire with initials of person opening the control solution.

The following directions for reconstitution should be followed: **[Replace directions below if using a different control product.]**

1. Remove the control bottle from the refrigerator just prior to reconstitution. Write the "opened" expiration date (3 months from date of reconstitution) on the control vial.
2. Gently tap the bottom of the control bottle on the counter to collect as much material as possible on the bottom of the bottle.
3. Carefully remove the cap from the control bottle.
4. Holding the Reconstitution Fluid dropper bottle vertically, add six (6) drops of fluid to the control bottle.
   Note: Discard the first drop to ensure constant volume of the drops thereafter.
5. Carefully replace the cap, not the eyedropper, and swirl the control bottle several times. Let the control stand at room temperature for 15 minutes.
6. After 15 minutes, coat all surfaces by rotating and inverting the bottle. Continue mixing until the solution is homogenous and all lyophilized material is reconstituted.
7. Remove and discard the cap. Replace the cap with an Eyedropper Cap Assembly. Use reconstituted controls within 30 minutes or refrigerate to store for later use.
8. Scan the new Calibration Card (DO NOT THROW THE CARD AWAY-until all cartridges are used) found in the box of new A1C cartridges.
9. Perform the Hemoglobin A1C as normal with both normal and abnormal solutions.
10. Be sure to record controls in the Control Log book located in the Laboratory when finished.

Patient Testing:

1. Identify patient using two patient identifiers (patient's name and date of birth or patient name and chart number)
2. Gather equipment:
   - Gloves
   - Alcohol wipes
   - Cotton balls
   - Lancets

- Capillary Holder
- DCA cartridge
- Write patient's name and date of birth or chart number on the cartridge

3. Explain procedure to patient.
4. Wash hands.
5. Don gloves.
6. Wipe patient's fingertip with alcohol pad. Let air dry.
7. Gently manipulate finger to determine if good blood supply is available.
8. Take cover off lancet. Place lancet against side of finger and pressing gently on the activating button. The lancet punctures skin immediately. Discard lancet in sharps container.
9. Gently massage the base of the finger, stroking toward the puncture site. **DO NOT** squeeze or apply pressure to site. **Rationale:** Massaging increased blood flow to fingertips.
10. Wait a few seconds to allow blood to collect at puncture site.
11. Wipe away first drop of blood to collect at puncture site. Use the second drop of blood.
12. Touch tip of capillary into small drop of blood until capillary is filled.
13. Wipe sides of capillary tube with tissue.
14. Insert capillary holder into cartridge (flat side towards cartridge) until holder snaps.
15. Scan cartridge through bar code reader.
    - Hold cartridge so that bar code faces right.
    - Insert cartridge into compartment until a click is heard.
    - Slowly and firmly, pull to remove pull tab.
    - Close door.
    - Put in patient identifying information- Patient's initials and chart number in the DCA machine when prompted.
16. After test is completed, record results from display.
17. Remove cartridge.
    - Hold button down with right hand.
    - With left hand, *gently* push pull tab on cartridge to right to unlock.
    - Pull upward; discard cartridge in sharps container to prevent injury and possible contamination to others.
18. Remove gloves and dispose in the proper receptacle.
19. Document all orders and results in EMR system.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Clinitek Status + Urine Controls and Testing
Policy Number: 8.48
BOD Approval: 01/2016
Effective Date: 06/2006
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

It is the policy of KTCH to perform a urinalysis on patients to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes. Clinical staff shall perform a urine test per provider order and/or standing orders.

II. APPROVALS:

Lab Director

III. GUIDELINES:

QUALITY CONTROL TESTING (QC): Quality control must be completed every morning, whenever a new bottle of strips has been opened, and when uncertain if an open bottle of strips has been tested or not.

Gather equipment:

- **Gloves**
- **Urine Controls (remove from refrigerator and bring to room temperature)**
- **Test Strips**
- **Urine Clinitek machine**

Performing controls using the Clinitek Status Urine Machine

1. Gloves must be worn when testing urine samples.
2. Bring urine controls to room temperature and verify expiration date. Discard outdated urine controls.
3. Confirm expiration date on Reagent strip bottle. Discard outdated strips. The bottle has been control checked if the label contains date and initials of the person who checked the container (NOTE: Unopened bottles of strips must be checked for quality control, see below).
4. Testing can only be started from the READY FOR TEST screen.

5. Remove strip from bottle and recap bottle immediately.
6. From screen, choose Strip test by touching this icon on the screen
7. Enter Operator's name
8. Enter Control Normal
9. Choose Start
10. Drop one drop of the urine solution onto each colored pads on the strip.
    - **You only have 10 seconds to prepare the strip.**
    - Blot by touching the edge of the strip to paper towel to remove excess urine.
11. Place the Reagent strip in middle trough of test strip table, with the test pads facing up. Slide strip to end of trough. Do not push or pull table. It is automatically pulled into the analyzer. The analyzer automatically identifies the strip. Results are obtained in one minute. If any of the results are not within range as set by the manufacturer, a corrective action must be documented. Patient testing cannot be done if the results are not within range.
12. Dispose of the used strip into the trash. Then clean the trough (tray) with an alcohol pad after each use. Remove gloves and dispose in trash.
13. Document the results in the Quality Control log book.

(Repeat steps 1-13 for the abnormal control.)

Performing Quality Controls Visually when the Clinitek Status Urine machine is out of order.

1. QC is performed whenever a new bottle of strips is opened and/or if it is uncertain whether or not an open bottle has been tested. DO NOT use outdated (expired) strips or control solution. Reaction of the Reagent Strips should be confirmed by testing known positive and negative liquid controls (control solution stored in the refrigerator). Urine controls must be brought to room temperature prior to use.
2. Obtain two Reagent Strips from the same bottle and lay pad side up on paper towels.
3. Using negative control solution, drop one drop of control solution onto each pad of one Reagent Strip. Blot excess. Compare to color chart on bottle at the time limits noted on the bottle as to when to read. Using positive control solution, place one drop of solution on second Reagent Strip.
4. Blot excess. Compare to color chart on bottle at the time limits noted on the bottle as to when to read.
5. Compare to color chart on strip bottle. Document results in the Quality Control log book
6. *Discard strip bottle if either quality control is not comparable to chart on bottle.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Performing Patient Testing:

1. Record two identifiers (chart number, date of birth or full name) on sterile urine container to be used for collection. This must be labeled in the presence of the patient.
2. Gloves must be worn when testing urine samples.
3. Collect urine specimen, If testing cannot be done within one hour after voiding, refrigerate specimen immediately and let it return to room temperature prior to testing.
4. Confirm expiration date on Reagent strip bottle. Discard outdated strips. The bottle has been control checked if the label contains date and initials of the person who checked the container (NOTE: Unopened bottles of strips must be checked for quality control, see below).
5. Testing can only be started from the READY FOR TEST screen.
6. Remove strip from bottle and recap bottle immediately.
7. From screen, choose Strip test by touching this icon on the screen
8. Enter Operator's name
9. Enter the Patient first name
10. Enter the patient ID
11. Choose Start
12. Dip strip into the urine specimen. **You only have 10 seconds to prepare the strip.** Drag strip edges against side of container as you remove it.
13. Blot by touching the edge of the strip to paper towel to remove excess urine.
14. Place the Reagent strip in middle trough of test strip table, with the test pads facing up. Slide strip to end of trough. Do not push or pull table. It is automatically pulled into the analyzer, with the reagent strip; the analyzer automatically identifies the strip. Results are obtained in one minute.
15. Dispose of the used strip into the trash. Then clean the trough (tray) with an alcohol pad after each use. Remove gloves and dispose in trash.
16. Record results in patient's EMR. And place the printed patient test strip results in the patient test log.

TO PERFORM URINE TESTING MANUALLY:

1. Dip the test strip completely for no more than one second in fresh, well-mixed, and <u>un-centrifuged</u> urine.
2. Draw the edge of the strip along the rim of the specimen container to remove excess urine.
3. Turn the strip on its side and tap once on a piece of paper towels to remove any remaining urine and to prevent the mixing of chemicals. Excessive urine on the test strip may give incorrect results.
4. Compare the test results carefully with the color chart on the label <u>after</u> the appropriate time period. **Proper reading time of 60 to 120 seconds is critical for accurate results.**

NOTE: While comparing, keep the strip in horizontal position to avoid possible interaction of chemicals between reagent pads when excessive urine is present. Consult manufacturer's directions if you have any questions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Hemoglobin Controls and Testing
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.49
Effective Date: 06/2006
Distribution: All Departments

I. POLICY:

It is the policy of KTCH to perform a hemoglobin test on patients to obtain a quantitative diagnostic determination of hemoglobin in blood using a specially designed photometer.

Clinical staff shall perform a Hemoglobin test per provider order and/or standing orders.

See Procedure 8.49 Hemoglobin Controls and Testing for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: OSOM Strep A Controls and Testing
Policy Number: 8.50
BOD Approval: 05/07
Effective Date: 05/07
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Clinical staff shall perform an OSOM Strep A test per provider order and/or standing orders to aid in the diagnosis of a strep infection.

See Procedure 8.50 OSOM Strep A Controls and Testing for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Urine HCG Controls and Testing
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.51
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Clinical staff shall perform a HCG urine test per provider order and/or standing orders to aid in the early detection of pregnancy.

See Procedure 8.51 Urine HCG Controls and Testing for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Henry Schein One Step+ Influenza A and B
Policy Number: 8.52
BOD Approval: 01/2016
Effective Date: 05/2007
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Clinical staff shall perform an influenza A and B test per provider order and/or standing orders to aid in the diagnosis of influenza infection.

See Procedure 8.52 Henry Schein One Step + Influenza A and B for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Microalbumin Controls and Testing
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.53
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Clinical staff shall perform a Microalbumin test per provider order and/or standing orders. Microalbuminuria has been reported to be an early predictor of the development of glomerular damage in the absence of overt nephropathy. Patients with diabetes and hypertension are the primary risk groups.

See Procedure 8.53 Microalbumin Controls and Testing for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Quidel QuickVue RSV Controls and Testing
Policy Number: 8.54
BOD Approval: 01/2016
Effective Date: 05/2007
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Clinical staff shall perform an RSV nasopharyngeal swab test per provider order and/or standing orders.
The RSV test is intended for use as an aid in the diagnosis of acute respiratory syncytial viral infections on children under the age of 5 or at provider's discretion.

See Procedure 8.54 Quidel QuickVue RSV Controls and Testing for further instructions.

II. GUIDELINES:

Quality Controls:

The RSV kit has built in procedural control features. A two color result format provides a simple interpretation for positive and negative results. The appearance of to a blue procedural Control Line provides several forms of positive control by demonstrating sufficient flow has occurred and the functional integrity of the test strip was maintained. **If the blue procedural Control Line does not develop within 15 minutes, the result is considered invalid.**

A built in negative control is provided by the clearing of red background color verifying the test has been performed correctly. Within 15 minutes, the result area should be white to light pink and allow the clear interpretation of the test result. **If the background color remains and interferes with interpretation of the test result, the result is considered invalid.** Should this occur, review the procedure and repeat the test with a new test strip.

External controls should also be used to demonstrate that the reagents and assay procedure perform properly. It is recommended that positive and negative controls be run once for each untrained operator, once for each new shipment of kits or each new lot number.

Additional Control swabs may be obtained separately by contacting the Quidel's Customer Support Services at 800-874-1517 (toll free) or at 858-552-1100.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Hemosure Fecal Occult Blood Testing
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.55
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Clinical staff shall perform fecal occult blood test on patients, who are reporting blood in their stool, patients over the age of 50 years who have not had a colonoscopy within the last 10 years or has not had a fecal occult blood test within the last 12 months per the provider's orders or standing orders.

The immunological fecal occult blood test is a rapid, immunochemical device for the qualitative determination of fecal occult blood by laboratories or physician's office. It is useful in determining gastrointestinal (GI) bleeding in a number of GI disorders, e.g. diverticulitis, colitis, polyps, and colorectal cancer.

See Procedure 8.55 Hemosure Fecal Occult Blood Testing

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Lead Screening
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.56
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Clinical staff shall perform a lead test per provider order and/or standing orders. Per Katy Trail Community Health standing orders: Annual lead screening questionnaire will be completed for ages 6 months through 6 years. If there is a positive response, then a blood lead test must be completed.

See Procedure 8.56 Lead Screening for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: PT/INR Testing
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.57
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Clinical staff shall perform a PT/INR test per provider order and/or as follow up recommended by provider.

See Procedure 8.57 PT/INR Testing for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Rapid Mono Test
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.58
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

Clinical Staff will perform the rapid Mono test per provider order and/or Standing Orders as an aid in the diagnosis of infectious mononucleosis.

Controls will be performed with each new box or new untrained operator.

See Procedure 8.58 Rapid Mono Testing for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: CLIA Waived Urine Drug Screen
BOD Approval: 6/2013
Responsibility: Clinical Staff

Policy Number: 8.59
Effective Date: 11/2012
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide instant drug testing services using a CLIA Waived Urine Drug Screen test when it ordered by the provider. KTCH personnel shall use the following procedures to ensure appropriate specimen collection, of the collected urine specimen for foreign substance testing.

See Procedure 8.59 CLIA Waived Urine Dug Screen for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: OraQuick Advance Rapid HIV- ½ Antibody Test
Policy Number: 8.60
BOD Approval: 01/2016
Effective Date: 05/2007
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Clinical Staff shall perform a OraQuick Advance Rapid HIV- ½ Antibody test per provider order.

See Procedure 8.60 OraQuick Advance Rapid HIV- ½ Antibody Test for further instructions.

II. GUIDELINES:

Quality Control:

Built-in Control Features

The OraQuick ADVANCE ® Rapid HIV-1/2 Antibody Test has a built-in procedural control that demonstrates assay validity. A reddish-purple line in the Control ("C") area of the Result Window indicates that a specimen was added and that the fluid migrated appropriately through the Test Device. The Control line will appear on all valid tests, whether the sample is reactive or nonreactive.

External Quality Control

OraQuick ADVANCE ® Rapid HIV-1/2 Antibody Test Kit Controls are available separately for use only with the OraQuick ADVANCE ® Rapid HIV-1/2 Antibody Test. The Kit Controls are specifically formulated and manufactured to ensure performance of the Test and are used to verify your ability to properly perform the test and interpret the results. The HIV-1 and HIV-2 Positive Controls will produce a reactive test result and have been manufactured to produce a very faint Test ("T") line. The Negative Control will produce a nonreactive test result. Use of kit control reagents manufactured by any other source may not produce the required results, and therefore, will not meet the requirements for an adequate quality assurance program for the OraQuick ADVANCE ® Rapid HIV-1/2 Antibody Test.

Run the Kit Controls under the following circumstances:

- **Each new operator prior to performing testing on patient specimens,**
- **When opening a new test kit lot,**
- **Whenever a new shipment of test kits is received,**
- **If the temperature of the test kit storage area falls outside of 2º- 27ºC (36º- 80ºF),**
- **If the temperature of the testing area falls outside of 15º- 37ºC (59º- 99ºF), and**
- **At periodic intervals as dictated by the user facility.**

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Pap Smear Monitoring
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.61
Effective Date: 6/2006
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) has selected *The American College of Obstetricians and Gynecologists* guidelines for our practice. The complete guidelines are available at http://www.acog.org for the nurse-provider team in order to improve the quality of life for our female patients.

See Procedure 8.61 Pap Smear Monitoring for further instructions.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Safe Use and Disposal of Phenol
Policy Number: 8.62
BOD Approval:
Effective Date:
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

It is the policy of Katy Trail Community Health Center (KTCH) to provide education for safe use and disposal to all staff that will be handling the chemical Phenol. Staff will also receive specific training and understand the hazardous properties, potential routes of exposure and symptoms of exposure. Staff will also be trained on how to handle an accidental spill.

II. GUIDELINES:

STORE BELOW EYE LEVEL but not on the floor

Hazardous Properties: Phenol is corrosive, toxic and can cause irritation. Initially it can cause numbness or slight tingling. If absorbed through the skin, it can cause muscle weakness, tremors, loss of coordination, shock, sudden collapse, coma, convulsions, organ damage and death. It may cause eye injury (including blindness) if it contacts the eyes and is extremely toxic (fatal) by ingestion.

Inhalation exposure is less likely- if inhaled phenol can cause upper respiratory irritation, lung damage and CNS (central nervous system) impairment.

Keep container closed as much as possible, use in the smallest quantities and lowest concentrations as practicable for the procedure being performed. Store container in a cool well-ventilated area. Keep container tightly closed until ready for use.

Equipment necessary for use of Phenol:

- Proper Laboratory Attire- pants or dresses below the knees, sleeved shirts, closed-toed shoes
- Lab coat-if high splash potential exists, wear a rubber or neoprene apron
- Eye/Face protection:
  - At a minimum safety glasses with side shields or goggles. Prescription glasses do not provide adequate protection
- Hand Protection
  - Gloves must be worn during all tasks
  - Wash hand thoroughly with soap and water before and immediately upon removal of gloves
- Eye Wash Station in immediate area
- Watch with second hand to monitor the length of time the phenol is in contact with patient during procedure (no longer than 60 seconds)

Spill and Accident Procedures:

- The availability, location and contents of chemical spill clean-up kits must be confirmed prior to handling or beginning ANY work with phenol
- Spill volumes less than approximately 25mL can be cleaned by personnel by using the Green-Z spill kits and placing in the biohazard waste containers
  - **STEPS FOR USING THE GREEN-Z SPILL KIT**
    - Wear appropriate protective clothing.
    - Sprinkle Green-Z powder to surround the spill and then evenly distribute over it.
    - Allow sufficient time for solidification to occur.
    - Remove solidified material with a scoop and scraper (or a similar tool) and place in and appropriate container.
    - Clean and disinfect contaminated areas after use and wash thoroughly
- Do not attempt to clean the spill if you feel unsure of ability to complete safely
- Personnel cleaning spill must, at minimum wear the same PPE required for handling/use
- In the event of skin contact, immediately remove the contaminated clothing and wash affected areas with soap and copious amounts of water
- In case of contact with eyes, immediately flush eyes with copious amounts of water for at least 15 minutes and obtain medical attention
- In the event of ingestion, obtain immediate medical attention. Do not induce vomiting unless directed to do so by medical personnel
- Call Poison Control 800-222-1222

Disposal of Phenol:

- **Dispose of in accordance with all applicable local, state, county and federal laws**
  - For accidental spills the solidified substance should be place into the biohazard container marked Hazardous Chemicals in the biohazard room.
  - Expired phenol will then be disposed of in Rx Destroyer by management team.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: 340 B Program (Special Pricing)
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.63
Effective Date: 5/2007
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) participates in the Federal 340 B Program. The intent of the 340 B Program is to permit covered entities "to stretch scarce Federal Resources as far as possible, reaching more eligible patients and providing more comprehensive services."

II. GUIDELINES:

a. Any medication or supply ordered for KTCH will utilize the 340 B Drug Pricing program when applicable.
b. Pricing will be compared throughout the year to ensure that best prices are being captured.
c. Any 340 B medication that is ordered and delivered to the specific address is to remain at that address and cannot be transferred to another facility.
d. 340 B drugs are to be provided only to individuals who are "patients" of the entity and receive care at that time.

III. REFERENCES:

Health Resources and Services Administration. (2015). Federal Register: The Daily Journal of the United /States Government. 340 B Drug Pricing Program Omnibus Guidance. Retrieved from https://www.federalregister.gov/documents/2015/08/28/2015-21246/340b-drug-pricing-program-omnibus-guidance

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Management of Donated Medications
Policy Number: 8.64
BOD Approval: 01/2016
Effective Date: 5/2007
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Our donated medication policy follows federal law and does not allow us to accept donated medications unless they are through the Repository Drug Program and are from Pharmacies, Hospitals, or Nursing Homes through the proper chain of command.

II. GUIDELINES:

Katy Trail Community Health (KTCH) cannot accept medications from any individual.

Any medications accepted will be through the drug repository program (information below) and follow all applicable state and federal laws.

Prescription Drug Repository

The Prescription Drug Repository was created by the Missouri Legislature to provide access to unused prescription drugs for persons who have economic need.

Medications that have been donated by individual patients may be provided by healthcare facilities such as nursing homes or hospitals to pharmacies, hospitals or non-profit clinics that agree to dispense the medications to eligible recipients.

For safety reasons, donated medications must have been under the control of a healthcare facility or healthcare professional and cannot have been in the possession of the individual owner. The owner of the medications is the patient for whom the medications were prescribed and dispensed, regardless of the method of payment.

The program went into effect on January 1, 2005.

For more information, go to http://www.dhss.mo.gov/DrugRepository/index.html

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Sample Medications
BOD Approval: 6/06
Responsibility: Clinical Staff

Policy Number: 8.65
Effective Date: 6/06
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will dedicate the resources necessary to obtain as many free sample medications as possible, to maintain an orderly inventory of these samples, and allow providers, or their designee, to efficiently dispense these medications to needy patients. For the purpose of this policy, sample medications include, prescription medications and over the counter medications.

PURPOSE: To store and dispense drugs in accordance with State, Federal and Local distribution laws and regulations.

II. PURPOSE:

To store and dispense drugs in accordance with State, Federal and Local distribution laws and regulations.

III. DEFINITIONS:

Drug: Any chemical compound, remedy or non-infectious biological substance, the action of which is not solely mechanical, which may be administered to patients by any route as an aid for the diagnosis, treatment or prevention of disease or other abnormal condition, for the relief of pain and suffering, or to control or improve any physiological or pathological condition.

Drug Administration: the action in which, a single dose of prescribed drug is given to the patient.

Drug Dispensing: the interpretation of an order for a drug, the proper selection, measuring, packaging, labeling, and issuance of the drug

IV. GUIDELINES:

STORAGE AND HANDLING

1. All drugs will be well organized and stored in specifically designated cupboards, cabinets, closets, or drawers.

2. Drugs will be stored under appropriate conditions of temperature, humidity, and light so that the identity, strength, quality, and purity of the drug product is not affected. Room temperature drugs should not be stored above 86º F (30ºC).

3. Prescriptions, samples, over-the counter drugs will be securely stored in a lockable space (cabinet or room) within the office/clinic.

4. Keys/ proxy patches to locked storage area will be available only to staff authorized by the providers to have access.

5. Drugs for external use in liquid, tablet, capsule, or powder form shall be stored separately from medications for internal use.

6. Drugs and immunobiologicals requiring refrigeration will be kept in refrigerators that shall be maintained between 35ºF (2º C) and 46ºF (8ºC). Vaccines will not be stored in the door of the refrigerator or freezer.

7. Drugs and immunobiologicals requiring freezing, will be kept in freezers that shall be maintained at 5ºF (-15ºC) or lower.

8. Temperatures will be recorded twice daily. If out of range, a corrective action must be documented.

9. Drugs must be kept separate from food, lab specimens, and other items that may potentially cause contamination.

10. Test reagents, germicides, disinfectants, and other household substances shall be stored separately from drugs.

PROCESS:

1. Sample Medications will be maintained by Clinic Site Manager, or designated backup, who will issue requested samples to providers or authorized nursing staff who distribute the medications to the patient.

2. Drug Company representatives will give samples to the Clinic Site Manager or designated backup.

3. Clinic Site Manager, or designated backup, will maintain a log that can be accessed by provider and nursing staff to determine availability of sample medications in stock.

4. Clinic Site Manager, or designated backup, will stock and maintain samples in an orderly manner to allow for ease of retrieval.

5. Clinic Site Manager, or designated backup, will maintain contact with medication reps to maximize samples received and attempt to obtain more samples if quantity is low.

6. Clinic Site Manager, or designated backup, will record the inventory according to lot number and medication.

In accordance with Missouri State regulations 20CSR2150-5.020

7. The provider must be in the clinic when authorized staff is dispensing sample medications.

8. All drugs dispensed by the provider shall bear a label permanently affixed to the exterior of the drug container/package which will contain the following information:

    - The date
    - The patient's name
    - Complete directions for usage Physician's name and address; and
    - The exact name and strength of the drug dispensed, and in case of a generic drug the name of the manufacturer or repackager of the drug.

9. Providers and/or Clinical Staff will be responsible for completing the sign in/out medication log. Any staff member, including providers, who accesses samples, MUST document them in the sample log and EMR.

When a sample is given to a patient there needs to be documentation on *that* visit note under "Prescription" module. (Document medication name, SIG, DAYS, QTY, Rx By: Sample, and in the Note section- you put the Lot # and Expiration Date. This documentation is done *additionally* to the sample medication log in the closet.

DISPOSAL OF OUTDATED DRUGS

Refer to Policy 8.68 for Destruction of Medications

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Patient Assistance Program
BOD Approval: 5/07
Responsibility: Clinical Staff

Policy Number: 8.66
Effective Date: 5/07
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will guide our patients through the process of determining their eligibility for the Patient Assistance Program (PAPRx) and subsequently obtaining free pharmaceuticals through PAPRx.

II. GUIDELINES:

1. All medication requests through PAPRx must be initiated and approved by the provider. The PAPRx patient advocate will receive an order from the provider through the electronic health record (EHR).

2. Once the order is received the patient information is entered into the PAPRx computer program. This includes all demographics from the patient face sheet, including income information.

3. Applications are printed from the PAPRx computer program. This allows KTCH to track utilization and patient compliance.

4.All companies require proof of income from the patient. Each company decides what type of proof of income they need. Some of this income information is in the patient's EHR, such as sliding fee scale information.

5.The medications will be delivered by U.S. Mail or a transport company of the vendor's choice to the designated KTCH site, except for Rx Outreach and Astra Zeneca, which mail the medication directly to the patient. The patient contacts their care team and notifies them when the prescription is received and to start the reorder process for the next shipment.

6.When the medications are received, the invoice will be checked to verify who it is for, and that the medication received is what was ordered. Some companies will mail the medication directly to the patient's address. A KTCH staff person will call the patient when medication is received at KTCH for the patient to come and pick up. A PapRx note will be entered that the medication was received at the clinic along with lot and expiration date of the medication and the patient was notified. The medication is then placed in a bag and a green sticker is then placed on the bag along with the date the patient was notified.

7. If the patient cannot be reached by phone, a letter will be sent from the EHR notifying the patient that their medication has arrived and noted in the PapRx note that the patient was not reached.The medication is then placed in a bad and a red sticker is ten placed on the bag along with the date that you attempted to contact the patient and a letter is sent to the patient notifying them that we have their medication and have been unable to contact them.

8. The patient or designee is the only one who can pick up their medication. For a designee to pick up the medication there must be a signed note from the patient in the patient's chart or presented at the time of pickup. The signature must be verified by the signature in the patient's chart. The patient is required to sign the medication log or the packing slip indicating that they received their medication. The only exception to this is if the patient has a signed note stating another person can pick up their medications within the EHR on a signed sheet of paper. Once the patient or the designated contact has arrived to pick up the medication, they are put on the schedule for a PapRx visit and a nurse will enter the medication was picked up and by whom into the EHR. A reminder will be attached to the note and sent to the PAPRx patient advocate.

Discontinuation, dosage change, transition of care to another PCP outside of KTCH or non-compliance may result in the medication not being picked up.

If the medication has not been picked up in 2-3 weeks, the patient will be contacted again. If the medication has not been picked up within 90 days the medication will be placed in the sample room at the clinical facility where it was delivered for general patient use and logged into the sample medication log. A nurse note is placed in the patient's chart stating that they did not pick up the medication. The patient remains eligible for the PAPRx program.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: On Site Medications
BOD Approval: 6/06
Responsibility: Clinical Staff

Policy Number: 8.67
Effective Date: 6/06
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will maintain sample medications, PAP medications, injectables, and medications to be administered to the patient on site. The Medications Storeroom, locked nursing cabinet, and locked file cabinet in the PAPRx area shall be used for this purpose.

1. Direct Relief International may provide free over the counter and prescription medication with a short expiration date. These medications may be ordered with approval from the Chief Medical Officer
2. Sample Medications, may be provided by Pharmaceutical Companies to be given by providers or their designated representative to KTCH patients.
3. PAP Medications may be received from Pharmaceutical Companies for specific individuals who have qualified under the Companies' various Patient Assistance Programs (PAP).

Access to medications storeroom/cabinet shall be limited to authorized personnel only. Storing medication is prohibited in locations other than the following authorized locations:

- Locked cabinets in lab
- Locked clinical supply storage
- Locked and limited access medication room/cabinet

Unauthorized use and/or storage of medications will invoke the disciplinary process.

II. GUIDELINES:

Medications Storeroom/Cabinet Management:

1. The Clinic Site Manager, or designated backup, will maintain KTCH Medication Room/cabinet**,** and access to the Medications Room/cabinet will be restricted.
2. The Clinical Staff, or designated backup, will maintain the medication database to track inventory, create and track the forms required by the pharmaceutical companies for the PAPRx program, and track status of patient PAPRx orders.
3. PAPRx Medications and Sample Medications must be physically segregated and cannot be co-mingled. Medications must be restricted from access by non-clinical staff and the general public. Doors must be closed and locked at all times.
4. All medications must be logged in and out by the clinical staff, to maintain an accurate inventory and to identify recalled lot numbers.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Stock Medications/In-House Formulary

1. Katy Trail Community Health (KTCH) will maintain in house only those drugs and vaccinations as approved by the Chief Medical Officer (CMO). The CMO will review this listing no less than annually and revise as needed to meet the needs of our patients.

2. Stock Medications will be maintained by the *Clinic Site Manager*, or designee per the in-house formulary.
3.. Clinic Site Manager, or designee, will stock and maintain Stock Medications in a segregated locked location in an orderly manner to allow for ease of retrieval.
4. Clinic Site Manager, or designee, will maintain the Stock Medication inventory as determined by the Chief Medical Officer.

Process to request Additional Medications

1. Only providers on staff at Katy Trail Community Health may request additions to the medication formulary
2. Providers are to use the Formulary Addition Request Form P:\Staff\Policy Hyperlinks\Formulary Addition Request Form.pdf
3. The information requested in the form must be completed and submitted to the Chief Medical Officer (CMO) by the 1st of the Month. Use additional paper if necessary to adequately complete the information requested.
4. The form does require the signature of the requesting individual(s)
5. The CMO will meet with the Chief Nursing Officer (CNO) to discuss and review all medication being considered. After review the CMO will take the request to the next provider meeting for discussion.
6. Once a decision is made regarding the request – the CNO will send to the appropriate departments for processing: CFO, Billing (to obtain a CPT code) and IT (EHR).
7. Once a decision is made an official email will be sent out to the requesting provider, CMO, CNO, and the appropriate site manager with the decision – approved or unapproved.
8. A timeline will be created by nursing site managers to determine education of new medication (if needed), ordering of medication and supplies, etc.…
9. The site manager(s) will then order the medication and will respond to all in the email that the medication was ordered and the estimated date of arrival.

10. Once all necessary education has been completed and the medication and supplies have arrived the site manager will send out an email to all providers and nursing staff that the medication is available and where it will be located.

Authorized personnel are those persons that have been given specific permission to be in the medication room. These employees have been designated by the Chief Medical Officer.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Destruction of Medications
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.68
Effective Date: 5/2007
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will inventory all medications no less than monthly to identify expired medications

II. GUIDELINES:

Medications will be destroyed according to the following instructions:

1. All expired medication will be disposed of on or before the expiration date by Clinic Site Manager and/or their designee and recorded in the Sample Medication Log.
2. Refer to OSHA Policies for proper disposal procedures.

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: In-House Formulary
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.69
Effective Date: 5/2007
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will maintain in house only those drugs and vaccinations as approved by the Chief Medical Officer (CMO). The CMO will review this listing no less than annually and revise as needed to meet the needs of our patients.

II. GUIDELINES:

An active formulary will be maintained and posted in an area accessible by all clinical staff at all times.
Pdrive>Staff>policy hyperlinks>formulary list

KATY TRAIL COMMUNITY HEALTH
Medical Clinical and Title X Policy

Policy Title: Out of House Formulary
BOD Approval: 01/2016
Responsibility: Clinical Staff

Policy Number: 8.70
Effective Date: 05/2007
Distribution: All Departments

I. POLICY:

A drug formulary is a list of medications that exists to allow health care providers to offer the most effective drug therapy possible with limited resources in today's environment of increase in drug prices. Having a formulary allows Katy Trail Community Health (KTCH) to offer the safest, most effective and least costly health care possible.

II. GUIDELINES:

A. KTCH uses the following criteria in the evaluation of product selection for its drug formulary:
   1. The drug product must demonstrate unequivocal safety for medical use
   2. The drug product must be efficacious and be medically necessary for the treatment, maintenance, or prophylaxis of the medical condition
   3. The drug product must demonstrate a therapeutic outcome
   4. The drug product must be accepted for use by the medical community
   5. The drug product must have an equitable cost ratio for the treatment of the medical condition

B. KTCH is committed to prescribing from the "4 dollar" list(s) assuming that all criteria listed above are met. A copy of the most recent "4 dollar" list(s) are attached for reference.

C. When available, FDA approves generic drugs are to be used in all situations, provided all criteria listed above are met.

D. KTCH providers will refer to 340B contracted pharmacies to assist patients to obtain drugs at the most cost-effective pricing.

E. Experimental drug products will not be prescribed by KTCH providers.

F. Consideration should be given to the patient's insurance specific drug formulary, if applicable.

G. This formulary will be reviewed annually at a provider meeting. The provider group will serve the function of the clinical committee which establishes the formulary.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Adolescent Family Planning Services
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.71
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

When providing Title X-funded care, Katy Trail Community Health (KTCH) will follow Title X laws and regulations. Providers will also follow applicable state and federal laws to the extent possible. If a state law conflicts with a Title X regulation, the Title X regulation preempts the state law if the state law would limit access or eligibility to the services provided through Title X.

II. GUIDELINES:

Federal Title X law and regulations establish special consent rules for services funded through Title X. Title X-funded services will be made available to all adolescents, regardless of age. Minors of any age will consent to services on their own behalf when those services are funded in full or in part by Title X monies and Title X service provision cannot be conditioned on parent consent or notification.

Title X regulations prohibit parental consent or notification when providing family planning services to minors. KTCH will encourage adolescents to involve a trusted adult in their reproductive decision-making; this discussion will be documented.

Missouri statutes concerning minors and health care can be found at:
http://www.moga.mo.gov/statutes/c400-499/4310000061.htm

Adolescent clients who require skilled counseling and age-appropriate information will have appointments available to them for counseling and clinical services same day as needed.

Adolescents seeking contraceptive services will be informed about all methods of contraception. Abstinence, as well as contraceptive and safer sex practice options to reduce risks for STI/HIV and pregnancy, will be discussed with all adolescents. AS the contraceptive needs of adolescents frequently change, counseling should prepare them to use a variety of methods effectively.

Adolescents will be assured that the counseling sessions are confidential and, if follow-up is necessary, every attempt will be made to assure the privacy of the individual. However, counselors will encourage family participation in the decision of minors to seek family planning services and provide counseling to minors on resisting attempts to coerce minors into engaging in sexual activities. KTCH will not require written consent of parents or

guardians for the provision of services to minors. Nor can the project notify parents or guardians before, or after a minor has requested and received Title X family planning services.

Title X regulations prohibit clinics from releasing information unless the clinic has written authorization for the release, the release is necessary to provide services to the client, or state or federal law requires the releases. Missouri law creates exemptions for mandated child abuse reporting and reporting certain communicable diseases (see *Sexually Transmitted Disease Services* policy). Records of a minor's confidential services will not be disclosed to parents without obtaining the minor's documented consent.

Notwithstanding any other provision of law, no provider under Title X, including KTCH, of the Public Health Service Act shall be exempt from any state law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest. Refer to the KTCH "child abuse" clinical policy which demonstrates compliance.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Title X Family Planning Client
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.72
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

The goal of family planning services is to offer health services to male and female clients who want to avoid unintended pregnancies or achieve attended pregnancies.

II. GUIDELINES:

Definition of a Family Planning Client Encounter

A family planning client encounter is a documented face-to-face encounter between an individual and a family planning provider that takes place at KTCH. The purpose of a family planning encounter – whether clinical or non-clinical – is to provide family planning and related preventive health services to male and female clients who want to avoid unintended pregnancies or achieve intended pregnancies.

STD Client Encounter

A client receiving only STD services is considered a family planning client if the following services are provided and documented in the medical record:

- STD history and sexual health assessment
- Lab service
- Contraceptive counseling
- STD counseling
- Treatment for chlamydia, gonorrhea, and/or vaginal infections will be provided as indicated

Pregnancy Test Client

A client requesting only pregnancy diagnosis is considered a family planning client if the following services are provided and documented in the medical record:

- Pregnancy history
- Pregnancy test
- Face-to-face counseling regarding pregnancy prevention/preconceptual counseling if pregnancy is desired

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Communication with MFHC
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.73
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

KTCH is contractually required to inform MFHC of substantial changes in scope of practice/operating plans as soon as possible. This communication will be in writing and submitted on KTCH's letterhead. In many cases, (e.g. addition or deletion of a subcontractor), MFHC will approve the request before KTCH can proceed.

II. GUIDELINES:

Subcontractors are encouraged to communicate with their funding agency before contacting MFHC.

KTCH's Agency Advisory Committee (DAC) is a standing committee of MFHC. DAC meetings are typically held four times a year. KTCH is required to send a representative to all meetings.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Community Participation, Education, & Project Promotion
Policy Number: 8.74
BOD Approval: 11/14
Effective Date: 1/16
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) shall establish and maintain a Family Planning Information & Education Advisory Committee (I & E Committee) by participating in the Adolescent Health Coalition in Pettis County. This committee shall be broadly representative of the community and knowledgeable about family planning service needs. The committee will approves all educational materials for program-wide distribution

II. GUIDELINES:

Information & Education /Community Committee-

1. The Committee shall meet at least once per year.

2. KTCH shall provide orientation to Title X for all committee members before they assume committee responsibilities.

3. The committee shall be established as follows:
    a. The committee shall consist of 5-9 members.

    b. The committee shall include individuals broadly representative (in terms of demographic factors such as race, color, national origin, socioeconomic status, disability, sex, gender identity and expression, age, sexuality, etc.) of population of community for which the materials are intended.

    c. Members shall be knowledgeable about community needs for family planning services.

4. In reviewing materials the committee **must**:

    a. Consider the educational and cultural backgrounds of the individuals to whom the materials are addressed;

    b. Consider the standards of the population or community to be served with respect to such materials;

    c. Review the content of the material to assure that the information is factually correct and consistent with Title X requirements;

d. Determine whether the material is suitable for the population or community for which it is to be made available; and

e. Establish a written record of its determinations through meeting minutes or other communication for review by MFHC.

f. Include a Title X and grant number citation on any informational and education materials developed by KTCH.

g. A copy of ANY PROJECT funded by the Title X program, or with the grant number listed, will be submitted to MFHC, immediately upon completion.

5. The committee will delegate responsibility for the review of the factual, technical, and clinical accuracy to appropriate project staff. However, final approval of the committee material rests with the committee.

Community Education-

1. KTCH establish and implement planned activities to facilitate community awareness of and access to family planning services. KTCH will provide for community education programs.

2. Community education will serve to enhance community understanding of the objectives of the project, make known the availability of services to potential clients, and encourage continued participation by persons to whom family planning may be beneficial.

3. Promotion activities will be reviewed annually and be responsive to the changing needs of the community.

4. Documentation of community education will be provided to MFHC on a quarterly basis.

Publications & Copyrights-

Unless otherwise stipulated, publications resulting from activities conducted under the Title X grant need not be submitted for prior approval. Publications developed under Title X will not contain information that is contrary to program requirements or accepted clinical practice and will be scientifically accurate.

Federal grant support will be acknowledged in any publication developed using Title X dollars. Recommended language: *"The Family Planning Program is funded in part by the U.S. Department of Health and Human Services (DHHS) through the Missouri Family Health Council, Inc., under Grant Number (insert current number). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of DHHS."*

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Restrictions on motion picture film production are outlined in the Public Health Service Grants Policy Statement. Any such copyrighted materials shall be subject to a royalty-free, non-exclusive, and irrevocable right of the government to reproduce, publish, or otherwise use such materials for federal purposes and authorize others to do so.

MFHC reserves the right to distribute any materials created by KTCH.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Family Planning Immunizations
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.75
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH).is committed to the prevention of HPV and Hep B through immunizations and education.

II. GUIDELINES:

Human Papillomavirus (HPV)-

KTCH will provide female clients aged 11-26 years either human papillomavirus (HPV) 2 or HPV4 vaccine for the prevention of HPV and cervical cancer if not previously vaccinated. Series can be started in persons as young as age 9 years

Male clients aged 11-21 years will be offered HPV4 vaccine, if not vaccinated previously.

Hepatitis B-

Routine hepatitis B vaccination will be offered to all unvaccinated children and adolescents aged <19 years and all adults who are unvaccinated and do not have documented history of hepatitis B infections.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Female Client Visit
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.76
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will follow the below procedures for female family planning visits.

II. GUIDELINES:

Chief Complaint- Obtain and record the purpose of the visit, chief complaint, and/or additional health concerns prompting the desire for health care.

History- A complete medical/ social/ family/ OBGYN history will be obtained on all female clients. Pertinent history will be updated at subsequent clinical visits. The comprehensive medical history will address at least the following areas:

- Significant illnesses; hospitalizations; surgery; blood transfusion or exposure to blood products; and chronic or acute medical conditions;
- Allergies;
- Current use of prescription and over-the-counter medications;
- Extent of use of tobacco, alcohol, and other drugs;
- Immunization and Rubella status;
- Review of systems;
- Pertinent history of immediate family members; and
- Partner history
    - Injectable drug use;
    - Multiple partners;
    - Risk history for STIs and HIV; and
    - Bisexuality.

Histories of reproductive function in female clients will include at least the following:

- Contraceptive use past and current (including adverse effects);
- Menstrual history;
- Sexual history;
- Obstetrical history;
- Gynecological conditions;
- Sexually transmitted diseases, including HBV;
- HIV; and
- Pap Testing history

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Physical Assessment (Review of Symptoms (ROS and/or Examination)- A complete physical examination will be completed on all new and established patients of KTCH and will be consistent with national standards for care (e.g., ACOG, ACS, SCCP, USPSTF), as appropriate.

KTCH will provide and encourage patients to use health maintenance screening(s), as indicated. KTCH will provide and stress the importance of the following to all patients:

- Blood pressure evaluation;
- Breast exam, if appropriate;
- Pap smear according to USPSTF recommendations; and
- STI and HIV screening, as indicated.

Family Planning Education and Counseling- The following patient education and counseling will be provided to all family planning patients-

1. An overview of all contraceptive methods.
2. Guidance to facilitate choice of method.
3. Assess ability to comply with chosen method.
4. Instructions concerning effectiveness, proper use, indications/precautions, risks, benefits, possible minor side effects and potential life threatening complications of their chosen method will be provided.
5. Initiate method of choice.
6. Discuss future plans for pregnancy, desired family size, spacing of children.
7. Provide interim contraception for sexually active clients if the physical exam cannot be accomplished because of scheduling problems.
8. Consistent and correct use of condoms for all at-risk for STD/HIV.
9. Instruct on clinic procedures and recommended screening test and exam.
10. Instruction following initiation of contraceptives to include visit for blood pressure and weight.
11. Recommend daily folic acid (0.4mg) or multivitamin for all women of childbearing potential.

If Problems Are Discovered- Appropriate referrals will be made for patient conditions that are beyond the scope of KTCH.

Laboratory Testing- Specific laboratory tests are required for the provision of specific methods of contraception. Laboratory tests can also be important indicators of client health status and useful for diagnostic purposes. Pregnancy testing will be provided onsite. The following laboratory procedures will be provided to clients if required in the provision of a contraceptive method, and *may* be provided for the maintenance of health status and/or diagnostic purposes, either onsite or by referral:

- Gonorrhea and Chlamydia test;
- Diabetes testing;
- Hepatitis B testing;
- Syphilis serology (VDRL, RPR); and
- HIV testing.

Notification of Abnormal Lab Results- A procedure which addresses client confidentiality has been established to allow for client notification and adequate follow-up of abnormal laboratory results.

Other Laboratory Services or Procedures- Other procedures and lab tests may be indicated for some clients and may be provided onsite or by referral.

Revisits- Revisit schedules will be based on client need for:

1. Education
2. Counseling
3. Clinical care beyond that provided at previous visit

First time users of hormonal methods, IUDs, and diaphragms should be scheduled for early revisit.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Gynecological Services and Special Counseling **Policy Number:** 8.77
BOD Approval: 11/14 **Effective Date**: 1/16
Responsibility: Clinical Staff **Distribution:** All Departments

---

I. POLICY:

Katy Trail Community Health (KTCH) will provide gynecological services and special counseling as detailed below in "procedures".

II. GUIDELINES:

Gynecologic Services

KTCH will provide for the diagnosis and treatment of minor gynecologic problems so as to avoid fragmentation or lack of health care for family planning clients with these conditions. Problems urinary tract infection may be amenable to on-the-spot diagnosis and treatment. More complex procedures, such as colposcopy, will be referred.

If a medical chart has documentation of a family planning encounter within the grant year, other gynecological services may be funded under Title X to promote continuity of care.

Special Counseling

Clients may be offered appropriate counseling and referral as indicated regarding future planned pregnancies, management of a current pregnancy, and other individual concerns (e.g., substance use and abuse, sexual abuse, domestic violence, genetic issues, nutrition, sexual concerns, etc.) as indicated.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Human Subjects Clearance
Policy Number: 8.78
BOD Approval: 11/14
Effective Date: 1/16
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Clinical or sociological research on Title X clients as subjects will adhere to the legal requirements governing human subject research at 45 CFR Part 46, as applicable.

II. GUIDELINES:

MFHC will advise the federal regional office in writing of research projects involving Title X clients or resources.

Katy Trail Community Health (KTCH) shall forward a copy of such research request to MFHC, which in turn shall forward to regional office details regarding the Protection of Human Subjects and its requirements will be included in such request.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Infertility Services
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.79
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will make basic infertility services available to women and men desiring such services.

II. GUIDELINES:

Infertility services are categorized as follows:

- Basic (Level I) infertility care - includes initial infertility interview, education, physical examination, counseling, and appropriate referral.
- Intermediate (Level II) infertility care - includes such testing as semen analysis, assessment of ovulatory function, and post-coital testing.
- Advanced (Level III) infertility care - more sophisticated and complex than Level I and Level II services.

KTCH will provide basic infertility services as a minimum. Intermediate and advanced infertility services will be referred to a specialist.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Client Education/Informed Consent
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.80
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide services on a voluntary basis. Written informed consent is obtained prior to services. The consent forms will be written in a language understood by the client or translated and witnessed by an interpreter. KTCH is committed to providing counseling and education to its family planning patients as detailed below

II. GUIDELINES:

Documentation of counseling will be included in client record. Clinical staff will be sufficiently knowledgeable to provide accurate information regarding the benefits and risk, safety, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the various contraceptive methods. Clinical staff should be objective, nonjudgmental, culturally aware, and sensitive to individual differences of patients. Clinical staff should be knowledgeable about other services offered by the clinic.

Education services offered allow patients to make informed decisions and take positive healthy actions. When appropriate, this includes:

- Information needed to make informed decisions about family planning, including reproductive life plan;
- Reduce risk of transmission of sexually transmitted diseases and Human Immunodeficiency Virus (HIV); and
- Health promotion/disease prevention information (i.e., nutrition, exercise, smoking cessation, alcohol/drug use, domestic violence, and sexual abuse).

Method counseling is provided, when indicated, and includes:

- results of physical exam and lab studies, if appropriate
- effective use of contraceptive methods, benefits, and efficacy of the methods
- possible side effects/complications
- how to discontinue the method selected and information regarding back-up method used
- planned return schedule
- emergency 24-hour telephone number
- location where emergency services can be obtained
- appropriate referral for additional services, if needed

KATY TRAIL COMMUNITY HEALTH
Title X Policies

KTCH will offer STD/HIV and HIV prevention education according to national recognized standards. At a minimum, this includes:

- Education about HIV infection and AIDS
- Information on risks, infection prevention, and referral services
- Discussion of personal risk and risk reduction steps

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Male Client Visit
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.81
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will follow the below procedures for Male family planning visits.

II. GUIDELINES:

Chief Complaint- Obtain and record the purpose of the visit, chief complaint, and/or additional health concerns prompting the desire for health care.

History-A complete medical/ social/ family history will be obtained on all male clients. Pertinent history will be updated at subsequent clinical visits. The comprehensive medical history will address at least the following areas:

- Significant illnesses; hospitalizations; surgery; blood transfusion or exposure to blood products; and chronic or acute medical conditions;
- Allergies;
- Current use of prescription and over-the-counter medications;
- Extent of use of tobacco, alcohol, and other drugs;
- Immunization;
- Review of systems;
- Pertinent history of immediate family members; and
- Partner history
  - Injectable drug use;
  - Multiple partners;
  - Risk history for STIs and HIV; and
  - Bisexuality.

Histories of reproductive function in male clients will include at least the following:

- Sexual history;
- Sexually transmitted diseases (including HBV);
- HIV; and
- Urological conditions.

Physical Assessment (Review of Symptoms (ROS and/or Examination)- Family planning clinics *may* be an important source of reproductive health care for male clients. Contraceptive services to male clients *should* encompass the following minimum requirements:

- A brief description of contraceptive methods, including sterilization;
- Instructions for the use of condoms;
- Information on where to obtain additional supplies;
- Information on HIV;
- Information on STDs and how to obtain services;
- At minimum, include the provision of education and condoms.

Physical examination *should* be made available to male clients, including height and weight. Clinics *should* stress the importance of the following to male clients:

- Genital examination including inspecting skin and hair, palpating inguinal nodes, scrotal contents and penis, and inspecting perianal region, as indicated;
- Blood pressure evaluation; and
- STI and HIV screening, as indicated.

Male sexual partners of female clients treated for STDs *should* be strongly encouraged to seek treatment and counseling, either onsite or by referral. The provision of treatment to eligible male sexual partners of female clients who are treated for sexually transmitted diseases minimally *should* include: male medical history, HIV/STD screening history, and treatment. Education and counseling *should* include:

- Mode of transmission;
- Prevention;
- Importance of compliance with treatment regimen; and
- Necessity to notify any exposed sex partners.

Family Planning Education and Counseling- The following patient education and counseling will be provided to all family planning patients-

1. Discuss future plans for pregnancy, desired family size, spacing of children.
2. Consistent and correct use of condoms for all at-risk for STD/HIV.
3. Instruct on clinic procedures and recommended screening test and exam.

If Problems Are Discovered-Appropriate referrals will be made for client conditions that are beyond the scope of family planning clinic services.

Laboratory Testing- Laboratory tests can also be important indicators of client health status and useful for diagnostic purposes. The following laboratory procedures *may* be provided for the maintenance of health status and/or diagnostic purposes, either onsite or by referral:

- Gonorrhea and Chlamydia test;
- Diabetes testing;
- Hepatitis B testing;
- Syphilis serology (VDRL, RPR); and
- HIV testing.

Notification of Abnormal Lab Results- A procedure which addresses client confidentiality will be established to allow for client notification and adequate follow-up of abnormal laboratory results.

Other Laboratory Services or Procedures- Other procedures and lab tests *may* be indicated for some clients and *may* be provided onsite or by referral.

Revisits- Revisit schedules will be based on client need for:

1. Education
2. Counseling
3. Clinical care beyond that provided at previous visit

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Medical Director
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.82
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will have a Medical Director who oversees the clinical care component of the Title X program. KTCH's Medical Director will be a licensed and qualified physician with specialized training or experience in family planning

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Medical Records
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.83
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will establish a medical record for every client who obtains clinical services. These records will be maintained in accordance with accepted medical standards and state laws with regard to record retention.

II. GUIDELINES:

Records will be:

- Complete, legible, and accurate, including documentation of telephone encounters of a clinical nature;
- Signed by the clinician and other appropriately trained health professionals making entries, including name, title and date;
- Readily accessible;
- Systematically organized to facilitate prompt retrieval and compilation of information;
- Confidential; and
- Safeguarded against loss or use by unauthorized persons

Content of the Client Record

The client's medical record will contain sufficient information to identify the client, indicate where and how the client can be contacted, justify the clinical impression or diagnosis, and warrant the treatment and end results. The required content of the medical record includes but is not limited to:

- Personal data;
- Medical/social/family/OBGYN history, physical exam, laboratory test orders, results, and follow-up;
- Treatment and special instructions;
- Scheduled revisits;
- Informed consents;
- Refusal of services; and
- Allergies and untoward reactions to drug(s) recorded in a prominent and specific location.

The record will also contain reports of clinical findings, diagnostic, and therapeutic orders, and documentation of continuing care, referral, and follow-up. The record will allow for entries by care

coordination, case management, and behavioral health staff, as appropriate. The electronic medical record will contain an up to date problem list within the record.

Confidentiality and Release of Records

See the KTCH privacy policies.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Title X Pharmaceuticals
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.84
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will be operated in accordance with federal and state laws relating to security and record keeping for drugs and devices. The inventory, supply, and provision of pharmaceuticals will be conducted in accordance with state pharmacy laws and professional practice regulations.

II. GUIDELINES:

These federal and state laws include, but are not limited to the following:

- All drugs given by a physician shall bear a label permanently affixed to the exterior of the drug container which sets forth the following information:
    - Date;
    - Client's name;
    - Complete directions for usage;
    - Physician's name and address; and
    - Exact name and strength of the drug given and, in the case of a generic drug, the name of the manufacturer or repackager of the drug

- Whenever providing pharmaceuticals, appropriate records shall be maintained. These records will be adequate to show the name of the client, the name and strength of the drug given, the quantity, the dose, etc. KTCH will not give controlled substances.

- KTCH will have systems in place to assure that medications are secure from theft, and that inventory is monitored.

Each clinical facility maintains an adequate supply and variety of drugs and devices to effectively manage the contraceptive needs of its clients. KTCH will also ensure access to other drugs or devices that are necessary for the provision of other medical services included within the scope of the Title X project.

KTCH will maintain a current written list, or formulary, of all drugs maintained onsite, and which is updated and signed as revisions are made. The formulary shall contain manufacturer's name, dosage, route or form of drug kept in stock, and a dated signature from the medical director. KTCH will not prescribe any contraceptive that is not included in the contraceptive formulary. The prescribing of medications off the formulary can create a variation in the quality of services to those clients without

financial means, insurance, Medicaid, or other ability to get the supplies elsewhere. Patients may be given a prescription for medications on the formulary to take to a third party private pharmacy as long as there is no barrier to the client receiving pharmacy services.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Contraceptive Services
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.85
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will offer contraceptive services to patients who wish to delay or prevent pregnancy. Contraceptive services will include a wide range of FDA-approved contraceptive methods; a brief assessment to identify the contraceptive methods that are safe for the patient; contraceptive counseling to help a patient choose a method of contraception and use it correctly and consistently; and provision of one or more selected contraceptive method(s) on site or by referral, if necessary (42 CFR 59.5 (b)(8).

II. GUIDELINES:

Patients will receive information and be educated regarding the benefits and risks, safety, effectiveness, potential side effects, complications, discontinuation issues and danger signs of the various contraceptive methods. Additionally detailed education on these items will be given regarding the contraceptive method chosen. This education and information give to the patient will be documented in the EHR outlining additional discussions and validating the patient's understanding.

Providers will also inform patients about the availability of emergency contraceptive pills and may provide patients an advance supply of emergency contraceptive pills onsite or by prescription, if requested, at provider discretion.

Contraceptive counseling is defined as a process that enables patients to make and follow through on decisions about their contraceptive use. Education is an integral component of the contraceptive counseling process that helps patients to make informed decisions and obtain the information they need to use contraceptive methods correctly. The following steps:

1. Establish and maintain rapport with the patient.
2. Obtain clinical and social information from the patient.
3. Work with the patient interactively to select the most effective and appropriate contraceptive method.
4. Conduct a physical assessment related to contraceptive use.
5. Provide the contraceptive method along with instructions about correct and consistent use, help the patient develop a plan for using the selected method and for follow-up, and confirm patient understanding.

Providers will use a patient-centered, interactive counseling and shared decision-making approach to presenting contraceptive methods.

Standard Procedure:
Informed Consent

Informed consent will be obtained prior to receiving services. Patients must sign this general consent for services and a copy must be saved in their medical record.

Data Collection & Documentation in the EHR

Subjective Data-

Female patient should include:

- Reason for visit or chief complaint
- Reproductive life plan
- Menstrual history (last menstrual period)
- Gynecologic history
- Obstetrical history
- Contraceptive use
- Allergies
- Medications
- Recent intercourse (vaginal, oral or anal)
- Reproductive history
- Infectious or chronic health condition (present)
- Other characteristics and exposures (e.g., age, postpartum, breastfeeding) that might affect the patient's medical eligibility criteria (US MEC) for contraceptive methods.
- Social history/risk behaviors (i.e. tobacco use)
- Sexual history and risk assessment
- Intimate partner violence and sexual violence
- Mental health

Male patient should include:

- Reproductive life plan
- Use of condoms
- Allergies (i.e., condoms)
- Medications
- Recent intercourse (vaginal, oral or anal)
- Partner history (use of contraception, pregnant, has children, had a miscarriage or termination)
- Infectious or chronic health condition (present)
- Contraceptive experiences and preferences
- Sexual history and risk assessment
- Intimate partner violence and sexual violence
- Interest in sterilization, if age appropriate (> 21 per federal law requirement)

Objective Data-

1. Physical Exam & Laboratory
    a. Female patients, the below will be collected:
        i. BP, every visit
        ii. Vitals (Height, Weight, BMI)
        iii. Bimanual exam and cervical inspection (Prior to IUD insertion, fitting diaphragm or cervical cap).
        iv. Pap screening and clinical breast exam, if indicated

v. Chlamydia testing annually for all females < 25 years, sexually active women >25 years with risk factors (infected partner, partner with other concurrent partners, symptoms, history of STI or multiple partners in the last year).
vi. CT and GC testing for patients requesting IUD insertion, if indicated.

2. Referral for Zika screening, if indicated,
3. Assessment at start of contraceptive method and/or if no desire for pregnancy within 12 months for injectable.

Plan-

1. Contraceptives will be prescribed based on provider recommendation but no more than a 12 month period.
    a. For patients desiring a contraceptive method or brand not included on the agency's formulary, a prescription can be issued at the patient's request.
2. A back up method of contraceptive will be prescribed, as indicated
3. Authorized emergency contraception will be documented within the plan
4. Follow up scheduling will be identified at the provider's discretion
5. Return for age appropriate periodic assessment(s) will be indicated

Patient Education

All education topics and the patient's understanding of this education must be thoroughly documented.

1. Patients **must** understand the following:
    a. Method effectiveness
    b. Correct and consistent use of the method
    c. Benefits and risks
    d. Potential side effects
    e. Protection from STDs, including HIV
    f. Starting the method
    g. Warning signs
    h. Availability of emergency contraception (provide onsite or by prescription)
    i. Follow-up visit (to obtain selected method)
    j. Emergency 24 hour telephone number
    k. Location emergency services can be obtained

2. Quality contraceptive counseling includes the following:
    a. Establish and maintain rapport.
    b. Assess the patient's need and personalize the discussion.
    c. Work with the patient to establish a plan.
    d. Provide information in a manner that can be understood by the patient (using a patient-centered, shared decision-making, interactive counseling approach to counseling).
    e. Confirm the patient's understanding:
    • The teach-back method may be used to confirm the patient's understanding by asking the patient to repeat back messages about effectiveness, risks, benefits, appropriate method use, protection from STDs and follow-up.
    f. Review danger signs:

Hormonal Contraception Warning Signs (Acronym **ACHES**)

- **A**bdominal Pain
- **C**hest Pain
- **H**eadaches
- **E**ye Problems
- **S**evere Leg Pain
- Heavy bleeding
- Depression
- Prolonged pain, redness, pus, bleeding, or itching at injection or insertion site

IUD Warning Signs (Acronym **PAINS**)

- **P**eriod late (pregnancy); abnormal spotting or bleeding
- **A**bnormal pain, pain with intercourse
- **I**nfection exposure (STI); abnormal vaginal discharge
- **N**ot feeling well, fevers, chill
- **S**tring missing, shorter or longer

g. Provide information about managing missed pills, late patch and ring placement, patch falling off, ring falling out, use of back-up method.
h. Instruct patient about health promotion and disease prevention
i. All women planning or capable of pregnancy should be counseled about the need to take a daily supplement containing 0.4 to 0.8 mg of folic acid.
j. Advise patients that contraceptives do NOT provide STD/HIV protection.
k. Correct and consistent use of condoms is recommended for STD/HIV protection.
l. Instruct patient about Emergency Contraception use and availability.

3. Documentation of counseling **must** be included in the patient record (i.e., checkbox or written statement).
4. Patient information sheets *should* be used for education.
5. When counseling male patients, discussion *should* include information about female-controlled methods where appropriate (including emergency contraception), encourage discussion of contraception with partners, and provide information about how partners can access contraceptive services. Male patients *should* also be reminded that condoms *should* be used correctly and consistently to reduce risk of STDs, including HIV.
6. When counseling any patient, encourage partner communication about contraception, as well as understanding partner barriers (e.g. misperceptions about side effects) and facilitators (e.g., general support) of contraceptive use.
7. A procedure consent form **must** be signed by the patient prior to inserting an IUD or implant.
8. Clinical evaluation of a patient electing permanent sterilization *should* be guided by the provider who performs the procedure.
9. Provide Zika education and prevention strategies.

F. **Counseling Returning Patients**

When providing contraceptives for returning patients, an assessment *should* include the following:

- Method concerns
- Method use (consistent, correct) at beginning of visit
- Method use (consistent, correct) at end of visit
- Any changes in patient's history (i.e., risk factors, medications)

If appropriate, provide additional contraceptives and discuss a follow-up plan.

G. **When Patients Should Initiate/Taking Contraceptives**

Providers **will** refer to the CDC's *U.S. Selected Practice Recommendations (US SPR) for Contraceptive Use, 2016*, for information, including how to initiate the chosen contraceptive method and how to address problems and side effects the patient may experience with their method and instructions for incorrect method use. http://www.cdc.gov/reproductivehealth/UnintendedPregnancy/usspr.htm

To facilitate a patient's use of contraception, providers will begin contraception at the time of visit rather than waiting until next menses (also known as "quick start"). Quick start will be implemented if the provider can be reasonably certain that the patient is not pregnant.

If a patient chooses a method that is not available on-site or the same day, patient will be provided another method to use until she or he can start the chosen method.

Katy Trail Community Health medical clinics in Sedalia, Warsaw, Versailles & Marshall will provide the below methods/ services in office:

- Emergency Contraception
- IUD/IUS (Mirena, Kyleena, Skyla)
- Hormonal Implant
- 3- Month hormonal injection
- Oral contraceptives
- Combined & Progestin only oral contraceptives
- Abstinence Education
- Fertility Awareness
- Male Condoms
- Vaginal Ring

Katy Trail Community Health medical clinics in Sedalia, Warsaw, Versailles & Marshall will not provide the below methods/ services in office but will instead offer a referral to the patient(s) choosing this method. Referred services are not Title X funded:

- ParaGard IUD/IUS
- Hormonal Contraceptive Patch
- Contraceptive Sponge
- Spermicidal Method or Products
- Female Condoms
- Sterilization

- Cervical Cap/Diaphram

Katy Trail Community Health will utilize evidence-based practices when completing any procedures or issues identified during birth control counseling, prescribing or procedure:

Protocols:
Female & Male Condom Procedure:
Female and Male Condom
INFORMED CONSENT:
Will be obtained prior to receiving services
Patients will sign general consent for services

1. **Non-contraceptive benefits**
    a. Protection against sexually transmitted infections, including HIV.
    b. Available without a prescription at low cost.
    c. Male participation in contraception.
    d. Prevention of premature ejaculation.
    e. Prevention of sperm allergy in women.

2. **Subjective Data- History (see above, section B)**
Provider will caution regarding male condom disadvantages that may lead to inconsistent or lack of use. Provider will encourage couples to try different brands and lubricants until they find one that is acceptable.
    a. Allergy to latex or spermicide in condoms. Plastic condoms are an excellent alternative.
    b. An inability, in some men, to maintain an erection if condom is used.
    c. Male partner will not accept responsibility for birth control.
    d. Natural membrane condoms are contraindicated where there is a risk of infection since they allow passage of very small viruses such as the human immunodeficiency virus (HIV).
    e. Condoms with spermicidal lubricant should not be used for anal intercourse; for multiple acts of vaginal intercourse each day (>2 times); or for those at high risk for HIV.
3. **Objective Data**
    a. Physical Assessment is not necessary
4. **Assessment and plan**- patient education
    a. Give patient a condom fact sheet. Advise that female condoms may be squeaky during use.
    b. Inform patient of effectiveness: male condom - pregnancy rate 18% with typical use and 2% with perfect use. Female condom - pregnancy rate 21% with typical use and 5% with perfect use.
    c. Counsel regarding emergency contraception in the event of condom breakage.
5. **Side effects and complications**
    a. Breakage.
    b. Allergy or skin irritations.
6. **Follow Up Visits**

a. Recommend return for age appropriate periodic assessment

7. **Referral (Referred services are not Title X funded)**
   a. As indicated by history, physical examination or lab findings

Natural Family Planning
INFORMED CONSENT:
Will be obtained prior to receiving services
Patients sign general consent for services

Natural Family Planning (NFP) is also known as Fertility Awareness-Based Methods, which encompasses Standard Days, Calendar Rhythm, TwoDay, Billings Ovulation, and Symptothermal Method as possible methods to identify when ovulation might occur. These methods of "natural family planning" increase the users' knowledge of their reproductive potential and enhance self-reliance. They can be used to avoid pregnancy, to achieve pregnancy, to detect pregnancy, or to detect impaired fertility. NFP relies on identifying the "fertile window" in the menstrual cycle when intercourse is most likely to result in a pregnancy. To avoid pregnancy, couples either use another method or do not have sex during the fertile time. These methods involve keeping track of menstrual cycle days, observing, recording and interpreting the body's fertility signs.

1. **Non-contraceptive benefits**
Available without a prescription

2. **Subjective data**-History (see above, Section B, *Subjective Data*)
The following conditions may preclude satisfactory use or make use of the natural family planning inadvisable:

a. Women or their partners unwilling to comply with abstaining from unprotected vaginal intercourse during fertile periods
b. Women who are unable to observe and chart the signs of fertility
c. Women that have conditions affecting their body temperature regulation (fever, insomnia, irregular sleeping habits and shift workers)
d. Women who have unpredictable or irregular menstrual cycles (polycystic ovarian syndrome, postpartum, and perimenopause)
e. Women who have difficulty assessing cervical mucus because of a vaginal infection or use of vaginal agents (lubricants and spermicides)
f. Women who are at high risk of acquiring an STI or HIV
g. Women who have medical conditions for which pregnancy poses an unacceptable health risk or for personal reasons must avoid pregnancy, and thus a more effective method would be advisable

3**. Objective Data**
a. Physical examination is not necessary

4. **Patient Education**
a. Eligible candidate for natural family planning
b. Provide back-up method of contraception as indicated

c. Authorize EC
d. Return for age appropriate periodic assessment
e. All education topics and the patient's understanding of this education **must** be thoroughly documented in their medical record.
f. Family Planning patients *should* receive:

• Information about all types of contraceptive options if they are new or undecided.
• Information that to prevent pregnancy, use a barrier method or avoid sexual intercourse when ovulation or fertile times are identified.
• Information about natural family planning methods including mechanism of action, efficacy, benefits/risks, advantages/disadvantages, etc. patient **must** know only the day of her menstrual cycle to consider herself potentially fertile on days 8-19. During these fertile days the couple either abstains or uses a barrier method.
• Information about these methods:
Calendar Rhythm Method: the patient **must** have recorded the length of her previous 6-12 menstrual cycles in order to identify the longest and shortest of these cycles. Calculations are then made to identify the probable days of fertility during the current cycle. Subtract 18 from the number of days in the shortest cycle, and 11 from the number of days in the longest cycle. During these fertile days the couple either abstains or uses a barrier method.
TwoDay Method: If a patient notices cervical secretions of any type YESTERDAY or TODAY, the patient *should* consider themselves fertile TODAY.
Billings Ovulation Method: Changes in the characteristics of the cervical mucus is a signal of the beginning and end of the fertile time. When cervical mucus changes from thick cloudy or white and sticky to more abundant, clear, stretchy, wet and slippery indicates ovulation. Ovulation most likely occurs within one day before, during, or after the last day of abundant, clear, stretchy, slippery secretions.
Symptothermal Method: The temperature of the body at rest, called the basal body temperature, is lower in the first part of the cycle, rises to a higher level beginning around the time of ovulation and remains at that level for the rest of the cycle. The patient *should* take her temperature when the patient wakes up in the morning and record her temperature on a chart each day of her menstrual cycle to calculate her fertile time.
Natural Family Planning or Fertility Awareness may incorporate one or more of these methods to help predict when ovulation might occur.
Information about the advantages and disadvantages of this method:

o **Advantages**: Safe; is affordable and available to all; may encourage the male partner's participation; increases the users' knowledge of their reproductive potential; and enhances self-reliance.
o **Disadvantages**: NFP offers no protection against STDs, **must** rely on the cooperation of the male partner, and is not suitable for all women to use. Conditions that make NFP difficult to use include recent childbirth, current breastfeeding, recent menarche, anovulatory cycling (PCOS) or obesity-related infrequent cycles, recent discontinuation of hormonal contraceptive methods and approaching menopause. NFP is not recommended for women who have irregular menstrual cycles; are unable to interpret their fertility signs or the presence of secretions; have persistent reproductive tract infections or inter-menstrual bleeding

that can hinder identification of secretions; are unable to abstain or use other methods during the fertile days; or are unmotivated to observe and record changes in their bodies.

□□Instruction on use of computer and phone apps for fertility awareness, (e.g., FDA approved, Natural Cycles)
□□Instruction about health promotion and disease prevention.
□□Counseling about the need to take a daily supplement containing 0.4 to 0.8 mg of folic acid.
□□Inform patient that natural family planning methods do NOT provide STD/HIV protection - correct and consistent use of condoms is recommended for STD/HIV protection.
□□Instruction about EC use and availability.

5. **Side effects and complications**
   a. No side effects
6. **Follow up visits**
   a. Recommend return for age appropriate periodic assessment
7. **Referral**

(Referred services are not Title X funded)
As indicated by history, physical examination or lab findings

IUD Placement and removal

INFORMED CONSENT:
Must be obtained prior to receiving services

a. Clients **must** sign general consent for services

1.Non-contraceptive benefits

2.Subjective Data – Cautions-The following conditions my preclude satisfactory use or make use of the IUD inadvisable:

a. LMP
b. No contraindication for IUD use per the current U.S. Medical Eligibility Criteria for Contraceptive Use
c. Comprehensive medical, family, social, sexual, reproductive life plan and contraceptive history (initial or updated as indicated).
d. Document any unprotected intercourse in last 5 days.

3.Objective Data

a. Age appropriate physical assessment, as indicated BP
b. Weight and BMI as indicated
c. Normal pelvic exam (no signs of current vaginal or cervical infection, and no sign of pregnancy)
d. Pregnancy test if indicated.
e. Chlamydia and Gonorrhea screening, if indicated.
f. Wet mount to rule out bacterial vaginosis and trichomonas vaginitis, if symptomatic

4. Assessment Plan
    a. Candidate for IUD use
    b. Provide information on effectiveness, benefits, side effects, and risks specific to intrauterine device. Client must demonstrate clear understanding of all information and counseling provided, as documented in the medical record. This must include a signed consent from either the manufacturer or clinic specific.
    c. Initiation of LNG-IUD including Mirena, Skyla, Liletta, or Kyleena
        - LNG-IUD inserted within first 7 days since menses, no additional back-up method is needed.
        - If LNG-IUD inserted > 7 days since menses, the client will need to abstain from intercourse or use additional back-up method for 7 days.
        - **Post abortion (Spontaneous or Induced)**: the client will need to use back-up method or sustain from intercourse for next 7 days, unless inserted immediately post abortion.
        - **If switching from the Cu-IUD to the LNG-IUD**: If client has had sexual intercourse since the start of her current menstrual cycle and it has been > 5 days since bleeding started, consider ECP at time of LNG-IUD insertion
        - **Special Considerations for LNG-IUD**: If woman is > 21 days postpartum and not fully breastfeeding and no return of menses she needs to abstain from intercourse or use a backup method for 7 days
    d. Use of NSAIDs: advise IUD users to use NSAIDs prophylactically for first 3 months following IUD insertion. Typical recommendation: Ibuprofen 600 mg PO every 6 hours when awake for first 3-5 days of every cycle for 3 cycles. Other OTC NSAIDs at equivalent doses may be used.
    e. Advise the client to return for routine health care or at any time to discuss side effects or other problems she may experience.
    f. If IUD expulsion occurs within 3 months after insertion, consult with pharmaceutical representative for possible free replacement of device.

5.Insertion Procedure
    a. Premedication has not been found to decrease discomfort of IUC placement but may be indicated in the following situations: a. Misoprostol 400 mg buccal 90 minutes prior to insertion. If client has stenotic cervical canal, particularly if she has failed prior placement attempt using cervical dilators.
    b. If client found to have BV, treat with systemic not topical metronidazole. No need to delay IUC placement but reinforce the importance client takes her medication. Women with current purulent cervicitis, chlamydial or gonococcal infection should not undergo IUC insertion until treatment is complete.
    c. Important elements for placement include:
        1. After assessment of the uterus, prep cervix with antiseptic solution.
        2. Place tenaculum to cervical lip to straighten axis of uterus & to stabilize uterus. Apply gentle traction on tenaculum to reduce risk of perforation.
        3. Careful uterine sounding for size to confirm that client is candidate.
        4. Open IUD package, load IUC and place IUC according to manufacturer's instruction for specific device selected for insertion.
        5. Trim strings to 1½ -2 inches.

6. Remove tenaculum, observe for bleeding. If bleeding, apply silver nitrate or Monsel as indicated.
7. Observe client for any signs of vasovagal response. To reduce the risk of vasovagal, have client strongly tense leg muscles, grip her arm, or move fingers and toes. Document client's response to procedure.

6.Removal Procedure and Education

a. Review procedure for removal of intrauterine device.
b. Discuss options for birth control if client is seeking different method.
c. If seeking pregnancy counsel on preconception health.
d. The intrauterine device is removed by securely grasping the strings at the external os with ring forceps and applying steady gently outward traction, the device should easily be removed.
e. Evaluate the intrauterine device to make sure it is intact.
f. If IUD strings are not visualized and client desires removal, a cytobrush may be inserted into the endocervical canal, twisted and then withdrawn in an attempt to pull retracted strings into view in the vagina.
g. If the strings are not found with the cytobrush, an IUD hook may be used to locate the strings in the cervical canal or uterus.
h. A tenaculum is placed on the cervix, the IUC hook is inserted into the cervical canal, and an effort is made to hook the strings and pull them into the vagina, where they can be grasped with ring forceps.
i. Assess client immediately after procedure for any vasovagal response or pain.
j. If unable to remove without difficulty, patient to be referred.

7.Side Effects and complications

a. Reinforce IUD education, including signs and symptoms of possible IUC complications (e.g., infection, expulsion, perforation, pregnancy).
b. Instruct client to seek urgent care if any symptoms of PID, heavy vaginal bleeding, severe cramping, or symptoms of pregnancy.
c. Discuss sexually transmitted infections and their associated risk(s) with an IUC.
d. Counsel on safer sex practices, consistent condom use.
e. Instruct client on the appropriate removal time for the IUD. Manufacturers suggested removal time include: *Paragard – 10 years, *Mirena – 5 years, *Skyla – 3 years, *Liletta – 6 years, *Kyleena – 5 years.
f. Discuss risks of IUD if pregnancy occurs and need for IUD removal.
g. Advise client that infection risk is greatest within the first month of insertion.
h. Advise client of menstrual changes that can occur with IUC use.

8. Follow-up Visits

a. Encourage annual well woman care and to RTC PRN for problems.

9. Referrals

(Referral services are not Title X funded)

As indicated by history, physical examination, or lab findings. Any client who has difficult insertion or removal.

10.Contraceptive Issues

Katy Trail Community Health is aware that there are possible issues that may arise in relation to birth control. Katy Trail maintains explicit instructions for these issues and routinely reviews information as well as educates providers on best practices.

IUD Missing Strings

1.Definition: If the IUD tail strings are missing, it may indicate the tail strings were cut too short, the IUD has been expelled, that the tail strings have been lifted into the endocervical or endometrial cavity, or that the IUD has perforated the uterus. Management differs depending upon the position/location of the IUD, if pregnant, or abnormal vaginal bleeding.

2.Subjective

a. LMP
b. Comprehensive medical, family, social, sexual, reproductive life plan and contraceptive history (initial, or updated as indicated).
c. Denies IUC expulsion.
d. IUC string(s) not felt.

3.Objective

a. Endocervical inspection may or may not reveal string(s).
b. Pelvic exam not consistent with intrauterine pregnancy.
c. Urine pregnancy test as indicated.

4. Assessment and Plan

a. IUD string(s) not visible.
b. Counsel on the options for alternate birth control methods until evaluation is complete. Offer another choice of birth control as needed.
c. Order pelvic u/s to determine location of intrauterine device.
d. If removal of IUD is necessary, offer another choice for birth control. Client may have another IUD inserted at this time if still desires IUD.
e. If any part of the IUC itself is found to be in the endocervical canal, remove IUC. Offer (EC) if client has had any intercourse within last 5 days.
f. All adolescent counseling must include:
    1. Abstinence.
    2. Ways to resist sexual coercion.
    3. Encourage family involvement.
g. Document client verbalizes clear understanding of information and counseling provided.
h. RTC as warranted based on history and findings.
i. If client is pregnant, initiate pregnancy counseling.

5.Education

a. Reinforce IUC education if client chooses to continue method or plans insertion of another IUC.
b. Recommend that client RTC annually and PRN for problems

6. Referrals

(Referral services are not Title X funded)

a. As indicated by history, physical examination, or lab findings. Any client who has difficult insertion or removal.
b. Any question of possible partial expulsion of IUC and further evaluation is needed.
c. Any unsuccessful attempt to remove IUC.

IUD Perforation

1.Definition: Uterine perforation is rare but can occur during placement of an IUD with either the uterine sound or the IUD itself. Acute uterine perforation during placement rarely results in a medical emergency, but measures should be taken to determine that the client is stable

2.Subjective: May include:

a. Day of procedure:
    1. Sudden onset of intense pelvic pain.
    2. Cramping.
    3. Dizziness.

3.Objective: May Include:

a. Excessive uterine depth greater than expected from bimanual exam, on sounding or with introduction of IUC.
b. Abrupt loss of uterine resistance during sounding or during IUC placement.
c. Client tachycardia, diaphoresis, hypotension, bleeding or syncope.

4.Assesment and Plan:

a. If suspect perforation with sound, **STOP**, remove sound and do not proceed with insertion.
    1. Provide supportive care.
    2. Call physician, as needed.
b. If perforation suspected with IUD insertion, do not deploy IUD and remove inserter
    1. Provide supportive care.
    2. Call physician, as needed.
c. If IUD already deployed, attempt to gently remove IUD. If excessive resistance when attempting to remove IUD, **STOP**. Refer for definitive treatment.
    1. Provide supportive care PRN (e.g. O2).
    2. Consult physician and/or refer to ER immediately.
    3. Arrange transportation appropriate to client's condition.
d. If removal is successful, provide supportive care, observe closely and call physician, as needed.
    1. If client is stable, she may go home after serial measurements of vital signs:
        i. Provide alternative method of birth control.
        ii. Advise strict pelvic rest until follow-up visit.
        iii. Have client RTC in 1-2 weeks. May consider another IUC insertion attempt at that time.

5.Education

a. Reinforce importance of ER referral and/or follow-up care.

6. Referrals

(Referral services are not Title X funded)

a. As indicated by history, physical examination, or lab findings.
b. Any client with unresolved or complicated acute uterine perforation.

Implant Placement and Removal

1.Definition: The etonogestrel implant (Nexplanon) is a single rod with 68 mg etonogestrel. This is a long-acting reversible contraceptive method (LARC).The method is a progestin-only method. A small amount of hormone is released daily for suppression of ovulation. The implant is over 99% effective and is labeled to provide contraception for 3 years. The implant can be removed and a new device inserted at the same time if the client desires to continue with an implant as a contraceptive method. Unscheduled spotting or light bleeding is common with implant use and some women experience amenorrhea. Insertion of contraceptive implant **must be done** by trained medical provider.

2.Subjective

a. LMP
b. Comprehensive medical, family, social, sexual, reproductive life plan and contraceptive history (initial, or updated as indicated).
c. Evaluation for allergies to antiseptic, local anesthesia to be used and components of the implant.
d. Client's desire for long-term contraception.
e. Reasonable certainty the client is not pregnant.

3.Objective

a. For initial assessment: weight including BMI and BP.
b. Periodic physical assessment as indicated.
c. Negative sensitive urine pregnancy test (UCG) only if client has unexplained irregular or delayed menses or symptoms of pregnancy. Routine pregnancy testing is not necessary.
d. STI screening as indicated.
e. Pap test (per current guidelines).
f. Other lab work as indicated

4.Assessment and Plan

a. Client is candidate for contraceptive implant.
b. Initiation of Contraceptive Implant
    1. Implant can be placed at any time in cycle; back-up method is needed 7 days.
    2. If the implant is inserted within the first 5 days of LMP, no additional contraceptive protection is needed. If the implant is inserted > 5 days of LMP, the client will need to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days.
    3. The implant can be inserted anytime it is reasonably certain the woman is not pregnant.
c. If Postpartum and *Breastfeeding*:
    1. Immediately post-delivery the implant can be placed.

2. If breastfeeding nearly exclusively < 6 months postpartum & amenorrheic no additional contraceptive protection is needed. *Otherwise,* a client who is > 21 days postpartum and has not experienced return of her menses she will need to abstain from intercourse or use additional contraceptive protection for the next 7 days.
3. If menses has returned and it has been > 5 days since menstrual bleeding started, she will need to abstain from intercourse or use additional contraceptive protection for the next 7 days.

d. <u>If Postpartum and *not Breastfeeding*</u>*:*
   1. The postpartum client is < 21 days postpartum no additional contraceptive is needed.
   2. If > 21 days postpartum and has not experienced return of her menstrual cycle she will need to abstain from intercourse or use additional contraceptive protection for the next 7 days.
   3. If menses has returned and it has been > 5 days since menstrual bleeding started, she needs to abstain from intercourse or use additional contraceptive protection for the next 7 days.

e. <u>Post abortion (Spontaneous or Induced)</u>
   1. The implant can be inserted within the first 7 days, including immediately post abortion.
   2. The woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days unless the implant is placed at the time of a surgical abortion.

f. Switching from another contraceptive method:
   1. The implant can be started immediately if it is reasonably certain that the woman is not pregnant. Waiting for her next menstrual cycle is not necessary.
   2. If it has been >5 days since menstrual bleeding started, the woman needs to abstain from sexual intercourse or use additional contraceptive protection for the next 7 days

g. Switching from an IUD**:** If the woman has had sexual intercourse since the start of her current menstrual cycle and it has been > 5 days since menstrual bleeding started, theoretically, residual sperm might be in the genital tract, which could lead to fertilization if ovulation occurs. A health care provider may consider any of the following options:
   1. Advise the women to retain the IUD for at least 7 days after the implant is inserted and return for IUC removal.
   2. Advise the woman to abstain from sexual intercourse or use barrier contraception for 7 days before removing the IUC and switching to the new method.
   3. If the woman cannot return for IUD removal and has not abstained from sexual intercourse or used barrier contraception for 7 days, advise the woman to use ECPs (with the exception of ulipristol acetate) at the time of IUC removal.

h. Client must demonstrate clear understanding of all information and counseling provided, as documented in her medical record.

i. Advise the client to return at any time to discuss side effects or other problems.
   1. If she wants to change the method being used and/or when it is time to remove or replace the contraceptive method. No routine follow-up visit is required.

j. Treatment of bleeding irregularities with the implant:
   1. Oral celecoxib 200mg daily x 5 days.
   2. Oral mefenamic acid 500mg 3 times daily x 5 days.
   3. Ibuprofen 800mg 3 times daily x 5 days with food.
   4. CHCs daily if not contraindicated
   5. Conjugated estrogen 1.25 mg daily x 21 days

5.Education

a. Provide pre-insertion counseling including effectiveness, risks, benefits, side effects, and how to discontinue use of method.
b. Discuss with client there will be a change in her menstrual cycle. Bleeding may be irregular and unpredictable throughout the period of implant use.
c. Advise contraceptive implant does not provide any protection against HIV or other STIs.
d. Counsel client once implant is removed her fertility can return very quickly and if she does not desire a pregnancy, she needs to use another form of contraception.
e. Discuss with client mechanism of how implant works.
f. Discuss after insertion care of site with the client.
g. Advise client to contact clinic if she develops symptoms of infection at insertion site (tenderness, redness, swelling, discharge).
h. Discuss with client certain medications (prescriptive & OTC) and/or herbs (e.g. St. John's Wort) may have an impact on the effectiveness of the implant.
i. All adolescent counseling must include:
    1. Abstinence
    2. Ways to resist sexual coercion.
    3. Encourage family involvement.
j. Client must demonstrate clear understanding of all information and counseling provided, as documented in her medical record.
k. Provide user card to client that has documented date for implant removal

6.Removal Procedure

a. Review procedure for removal of implant.
b. Discuss options for birth control if client is seeking different method.
c. If seeking pregnancy, counsel on preconception health.
d. The implant is removed by placing the patient in the supine position. Aseptic conditions are maintained. The rod is located by palpation. The area is cleaned with antiseptic. 1% lidocaine with epinephrine is injected just underneath the end of the implant closest to the elbow. After firmly pressing down on the end of the implant closer to the axilla a 23 mm incision is made with a scalpel. The rod is pushed to the incision site and grasped with a mosquito forceps and gently removed.
e. Evaluate the device to make sure it is intact.
f. If unable to remove without difficulty, patient to be referred.

6. Referrals

(Referral services are not Title X funded)

a. As indicated by history, physical examination, or lab findings.

<u>Pregnancy with IUD</u>

1.Definition:

Pregnancy of any kind is rare with an IUD in place. Pregnancies among women with IUDs are at higher risk for complications such as spontaneous abortion, septic abortion, preterm delivery, and

chorioamnionitis. Pregnancy with an IUD in place requires removal of device. Early removal reduces the risk of spontaneous miscarriage, preterm delivery, or septic spontaneous abortion

2.Subjective

a. May or may not have expelled IUD.
b. IUD string(s) may or may not be felt or visible.
c. LMP including menstrual history, gravida, and parity.
d. Symptoms of pregnancy which may include nausea/vomiting, breast tenderness, fatigue, urinary frequency, bloating, and/or mood changes.
e. Negative for signs and symptoms of infection or bleeding.

3.Objective

a. Visualization of the cervix to note:
    1. Presence or absence of bleeding/discharge.
    2. Presence or absence of threads.
    3. Color, number, and length of threads, if present.
b. Pelvic examination to note:
    1. Palpation of os for IUC presence.
    2. Uterine sizing (if pregnancy suspected).
c. Adnexal tenderness or masses (suspect ectopic pregnancy).
d. Positive sensitive urine pregnancy test.

4.Assessment and Plan

a. Intrauterine Contraceptive Complication of Pregnancy
b. Confirm that the pregnancy is intrauterine and not ectopic.
c. Consult with/refer to MD immediately for removal. Early removal reduces the risk of spontaneous miscarriage, preterm delivery, or septic spontaneous abortion.
d. Discuss pregnancy options and refer for appropriate care.
e. If the woman plans to have an induced abortion, remove the device promptly rather than wait for removal at the time of abortion to reduce removal complications.
f. If client refuses IUD removal, the following should be documented in her chart: Client informed of increased risk of spontaneous abortion, premature labor, and septic infection because of an IUD. Client chooses to not have IUD removed and accepts the increased risks that have been explained to her and where to seek emergency care. Refer to MD.

5.Eduction

a. Reinforce IUD education if client chooses to continue method or plans insertion of another IUD.
b. Review safer sex education, if appropriate.
c. Advise client she has an increased risk for spontaneous abortion (including septic abortion that may be life threatening) and for preterm delivery if the IUD is left in place.
d. Counsel client on choosing another method of birth control if IUC is removed and she does not desire pregnancy (Refer to specific method protocol).
e. Recommend that client RTC annually and PRN for problems.
f. IUD Warning Signs:
    a. P – Period late (pregnancy), abnormal spotting or bleeding

b. A - Abdominal pain, pain with intercourse or urination
c. I - Infection exposure (any STD), abnormal discharge.
d. **N** – Not feeling well, fever, chills, nausea/vomiting
e. **S** – String missing, shorter or longer

6. Referrals
(Referral services are not Title X funded)
a. As indicated by history, physical examination, or lab findings.
b. Any client with signs and symptoms of perforation.
c. Suspected ectopic pregnancy (STAT referral).
d. Pregnant clients with IUC in place.

Deep Implant

1.Definition: An uncommon complication of contraceptive implants is deep insertion. This means the implant is nonpalpable or otherwise difficult to remove.
2.Subjective: May include:
a. Day of procedure:
1. Non-palpable implant
2. Pain
3. Paresthesia
3.Objective: May Include:
a. Non-palpable implant

4.Assesment and Plan:
a. A non-palpable implant should always be located prior to attempting removal. Given the radiopaque nature of the implant, suitable methods for localization include:
1. Two -dimensional X-ray and X-ray computer tomography.
2. Ultrasound scanning
b. If the implant cannot be found in the arm after comprehensive localization attempts, consider applying imaging techniques to the chest as events of migration to the pulmonary vasculature have been reported.
c. If the implant is located in the chest, surgical or endovascular procedures may be needed for removal; healthcare professionals familiar with the anatomy of the chest should be consulted.
5.Education
a. Reinforce importance of ER referral and/or follow-up care.

6. Referrals
(Referral services are not Title X funded)
a. As indicated by history, physical examination, or lab findings.
b. Any client with a deep implant or implant in the pulmonary vasculature should be referred to a healthcare specialist who has experience in removals of deeply inserted implants.

Pregnancy with Implant

KATY TRAIL COMMUNITY HEALTH
Title X Policies

1.Definition:
Pregnancy of any kind is rare with an implant in place. Pregnancies among women with implants are at a slightly higher risk of ectopic pregnancy. Pregnancy with an implant in place requires removal of device. Early removal reduces the risk of spontaneous miscarriage, preterm delivery, or septic spontaneous abortion

2.Subjective
a. Palpable or Non-palpable implant
b. LMP including menstrual history, gravida, and parity.
c. Symptoms of pregnancy which may include nausea/vomiting, breast tenderness, fatigue, urinary frequency, bloating, and/or mood changes.
d. Negative for signs and symptoms of infection or bleeding.
e. Unusual vaginal bleeding or lower abdominal pain

3.Objective
a. Palpation of implant
    1. If palpable refer to OB/GYN.
    2. If not palpable confirm presence via x-ray, CT, US or MRI
b. Pelvic examination to note:
    1. Uterine sizing (if pregnancy suspected).
c. Adnexal tenderness or masses (suspect ectopic pregnancy).
d. Positive sensitive urine pregnancy test.

4.Assessment and Plan
a. Implant contraceptive complication of pregnancy
b. Confirm that the pregnancy is intrauterine and not ectopic.
c. Consult with/refer to MD immediately for removal. Early removal reduces the risk of spontaneous miscarriage, preterm delivery, or septic spontaneous abortion.
d. Discuss pregnancy options and refer for appropriate care.
e. If the woman plans to have an induced abortion, remove the device promptly rather than wait for removal at the time of abortion to reduce removal complications.

5.Eduction
a. Reinforce implant education if client chooses to continue method or plans insertion of another implant.
b. Review safer sex education, if appropriate.
c. Advise client she has an increased risk for spontaneous abortion (including septic abortion that may be life threatening) and for preterm delivery if the implant is left in place.
d. Counsel client on choosing another method of birth control if implant is removed and she does not desire pregnancy (Refer to specific method protocol).
e. Recommend that client RTC annually and PRN for problems.

6. Referrals
(Referral services are not Title X funded)

a. As indicated by history, physical examination, or lab findings.
b. Any client with signs and symptoms of perforation.
c. Suspected ectopic pregnancy (STAT referral).
d. Pregnant clients with deeply inserted implant in place.

Pregnancy with Injection

1.Definition:
Pregnancy of any kind is rare with contraceptive injection. Pregnancies among women with injections are at a slightly higher risk of ectopic pregnancy.

2.Subjective
a. LMP including menstrual history, gravida, and parity.
b. Symptoms of pregnancy which may include nausea/vomiting, breast tenderness, fatigue, urinary frequency, bloating, and/or mood changes.
c. Negative for signs and symptoms of infection or bleeding.
d. Unusual vaginal bleeding or lower abdominal pain

3.Objective
a. Pelvic examination to note:
    1. Uterine sizing (if pregnancy suspected).
b. Adnexal tenderness or masses (suspect ectopic pregnancy).
c. Positive sensitive urine pregnancy test.

4.Assessment and Plan
a. Injection contraceptive complication of pregnancy
b. Confirm that the pregnancy is intrauterine and not ectopic.
c. Consult with/refer to MD immediately
d. Discuss pregnancy options and refer for appropriate care.

5.Eduction
f. Review safer sex education, if appropriate.
a. Advise client she has an increased risk for spontaneous abortion (including septic abortion that may be life threatening) and for preterm delivery.
b. Counsel client on choosing another method of birth control if she does not desire pregnancy (Refer to specific method protocol).
c. Recommend that client RTC annually and PRN for problems.

6. Referrals
(Referral services are not Title X funded)
a. As indicated by history, physical examination, or lab findings.
b. Suspected ectopic pregnancy (STAT referral).

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Pregnancy Confirmation, Diagnosis & Non Directive Counseling
Policy Number: 8.86
BOD Approval: 11/14
Effective Date: 1/16
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide pregnancy diagnoses and counseling to all patients in need of this service.

II. GUIDELINES:

Pregnancy testing is one of the most common reasons for a first visit to the family planning facility. It is therefore important to use this occasion as an entry point for providing education and counseling about family planning.

Pregnancy cannot be accurately diagnosed and staged through laboratory testing alone. Pregnancy diagnosis consists of a history, pregnancy test, and physical assessment, including pelvic examination. KTCH will have available a pregnancy test of high sensitivity. For pregnant patients, if the medical exam cannot be completed in conjunction with the laboratory testing, the patient will be counseled regarding the importance of receiving a physical assessment as soon as possible. This can be done onsite, by a provider selected by the client, or by a provider to which the client has been referred by KTCH.

For those patients with positive pregnancy test results will receive an MFHC approved resource packet that includes a list of licensed, qualified comprehensive primary care health providers (including providers of prenatal care). The resource packet suffices as a prenatal referral; however KTCH will provide a direct referral as needed. These patients will also be given information about good health practices during early pregnancy, especially those which serve to protect the fetus during the first three months (e.g., good nutrition, avoidance of smoking, drugs, and exposure to x-rays). For clients with a negative pregnancy diagnosis, the cause of delayed menses will be investigated. If ectopic pregnancy is suspected, the client will be referred for immediate diagnosis and therapy.

RNs/LPNs/MAs and other clinical staff responsible for pregnancy test appointments may perform the test, confirm the pregnancy, and provide basic factual acknowledgement of the options available to the client (education) under approved standing orders and protocols and provide the MFHC *Your Pregnancy Options* Card.
Subrecipients may provide nondirective pregnancy counseling and information to pregnant clients. For pregnant clients who wish to discuss their pregnancy options in detail (nondirective pregnancy counseling), this must be done by an APP or physician. Advanced Practice Providers (APPs) includes

physician assistants, certified nurse practitioner (CNP), clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), and certified nurse-midwife), and physicians must Nondirective pregnancy counseling may include detailed information on prenatal care, delivery, infant care, foster care, adoption and termination.

In the event a client wishes to receive nondirective pregnancy counseling and an APP or physcican within the Title X project is not available, or in the event an APP or physician claims conscientious objection, referrals to other programs offered by Katy Trail Community Health for nondirective pregnancy counseling can be made as long as financial separation requirements have been met. To meet financial separation requirements, "other programs" are defined as those who are funded with other grants or unrestricted assests and are recognized as such through a separate encounter and cost center within Katy Trail Community Health's accounting system.

KTCH will offer pregnant women the opportunity to be provided information and counseling regarding each of the following options:

- Prenatal care and delivery;
- Infant care, foster care, or adoption; and
- Pregnancy termination.

If requested to provide such information and counseling, KTCH will provide neutral, factual information, and nondirective counseling on each of the options, and referral upon request, except with respect to any option(s) about which the pregnant woman indicates she does not wish to receive such information and counseling [59.5(a)(5)].

MFHC's Pregnancy Options brochure (available at www.mfhc.org/agency) will be available to all family planning clients who present with a positive pregnancy test, unless upon request, the pregnant client indicates she does not wish to receive such information. If MFHC's Pregnancy Options brochure is declined by the pregnant client, this information will be documented in the client's chart.

Clients who are found not to be pregnant will be given information about the availability of contraceptive and infertility services, as appropriate.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Title X Referral and Follow-up
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.87
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will assure that all family planning required services are offered either onsite or by referral. When required services are to be provided by referral, KTCH will provide care coordination or use of referral arrangement for the provision of services

II. GUIDELINES:

Efforts *may* be made to aid the client in identifying potential resources for reimbursement of the referral provider, but KTCH is not responsible for the cost of this care. KTHC will maintain a current list of referrals including:

- Health care providers;
- Local health and human services departments;
- Hospitals;
- Voluntary agencies; and
- Health services projects supported by other federal programs.

Whenever possible, patients will be given a choice of referral agency from which to select.

KTCH will make arrangements for the transfer of pertinent client information, including charts, to a referral agency. Patient information will only be transferred after the client has given written, signed consent or for continuation of care reasons. KTCH is expected to be in compliance with the confidentiality requirements under the Health Insurance Portability and Accountability Act (HIPAA).

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Required Components
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.88
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) is committed to providing comprehensive family planning services.

II. GUIDELINES:

The services provided to family planning clients, and the sequence, in which they are provided, will depend upon the type of visit and the nature of the service requested. However, the following components will be offered to and documented on all clients:

Education-

- Presentation of relevant information and educational materials, based upon client needs and knowledge;

Counseling-

- Interactive process in which a client is assisted in making an informed choice;

Informed Consent-

- Explanation of all procedures and obtaining a general consent covering examination and treatment;

History-

- Obtaining of a personal and family medical and social history;

Physical Assessment-

- Performance of a physical examination and any necessary clinical procedures, as indicated;

Laboratory Testing-

- Performance of routine and other indicated laboratory tests;

Follow-up and Referrals-

- Planned mechanism for client follow-up;
- Performance of any necessary clinical procedures;
- Provision of medications and/or supplies as needed; and
- Provision of referrals as needed.

Return visits, with the exception of routine supply visits, will include an assessment of the client's health status, current complaints, and evaluation of birth control method, as well as an opportunity to change methods.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Title X Required Services
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.89
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide specific services as required by all projects funded under Title X. When required services are to be provided by referral, KTCH will establish formal arrangements with a referral agency for the provision of services and reimbursement of costs, as appropriate. All required services will slide to zero on a sliding fee scale.

II. GUIDELINES:

Required services include:

- FDA-approved contraceptives
- Emergency Contraception
- Achieving pregnancy counseling
- Basic infertility services
- Breast exam according to current guidelines
- Pelvic exam according to current guidelines
- Pap smear according to current guidelines
- STD and HIV screening (as indicated)
- Pregnancy testing and counseling
- Preconception health

The following laboratory tests are required by Title X if they are required for the provision of a specific method of contraception or according to screening recommendations as stipulated in Quality Family Planning (QFP).

- Gonorrhea and Chlamydia
- Diabetes testing
- Hepatitis B testing
- Syphilis serology (VDRL, RPR)
- HIV Testing

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Sexually Transmitted Illnesses
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.90
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

The increasing incidence and prevalence of STIs, particularly among adolescents, requires that Katy Trail Community Health (KTCH) increase their efforts to provide education and information about the more common STIs and HIV/AIDS.

II. GUIDELINES:

KTCH will offer STI services in accordance with Centers for Disease Control and Prevention's (CDC's) STI treatment and HIV testing guidelines. Gonorrhea and Chlamydia tests are made available for clients requesting IUD insertions and/or all sexually active females ≤25 years of age. KTCH will make available detection and treatment of the more common STIs. At-risk clients will be urged to undergo examination and treatment as indicated, either directly or by referral. When treatment is provided onsite, appropriate follow-up measures will be undertaken.

Tests for gonorrhea, syphilis, Chlamydia, and HIV will be provided as indicated by client request or evidence of increased risk for infection.

KTCH will comply with state and local STI reporting requirements. Missouri regulations can be found at: **www.sos.mo.gov/adrules/csr/current/19csr/19c20-20.pdf.**

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Title X Data Reporting
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.91
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide reports as required by Missouri Family Health Coalition (MFHC).

II. GUIDELINES:

Data/CVR System-

KTCH is contractually required to submit encounter data for all family planning clients served, even for full-pay clients, regardless of the funding source to which the claim is billed. Mandatory data elements are contained in the MFHC Clinic Visit Record (CVR).

A CVR is generated from a family planning client on a family planning visit at KTCH.

The website where CVRs will be uploaded is **http://mfhc-cvr.org/**.

Data will be submitted by the 10th of every month. KTCH will contact MFHC if a temporary extension is required.

After data has been entered or uploaded, KTCH cannot alter it without contacting MFHC. KTCH will contact MFHC by calling (573) 636-4060, for any changes.

Encounter data will accurately reflect information documented in clinical charts. KTCH will perform audits of their data systems to ensure that data is reliable and valid

Family Planning Annual Report (FPAR)-

Aggregate client data is submitted annually by MFHC to the Department of Health and Human Services (DHHS), Office of Population Affairs (OPA), on the Family Planning Annual Report (FPAR). Individual contractor data for the prior calendar year is compiled into one, statewide report and submitted every February.

KTCH is responsible for verifying the number of unduplicated medical clients reported through the MFHC CVR system. KTCH is also responsible for submitting data not collected through the MFHC CVR system including:

- Pap smears by abnormal result;
- Positive HIV tests
- FTE providers
- Revenue report
- User data by county

Data for the calendar year will be submitted before January 15 of the following year.

Additional FPAR data requested from MFHC is due no later than February 15.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Title X Training
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.92
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) is committed to including Title X training in new staff orientation and annual training

II. GUIDELINES:

Orientation and in-service training regarding Title X will be provided to all applicable staff. All applicable staff will be trained in, or have sufficient knowledge of the basics of reproductive health, and the purpose and eligibility requirements of the Title X program. All applicable staff will participate in continuing education related to their activities. KTCH will maintain documentation of continuing education to evaluate the scope and effectiveness of the staff-training program.

KTCH will provide annual training on child abuse/adolescent services and human trafficking. MFHC will request documentation of these trainings during monitoring visits.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Confidentiality
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.93
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) assures patient confidentiality and provides safeguards for individuals against the invasion for personal privacy. No information obtained by about individuals receiving services may be disclosed without the patient's consent, except as is necessary to provide services to the patient or as required by law. Concern with respect to the confidentiality of information, however, may not be used as a rationale for noncompliance with laws requiring notification or reporting of child abuse, child molestation, sexual abuse, rape, incest, intimate partner violence, human trafficking, or similar reporting laws. Patients will be informed about any exceptions to confidentiality. Information may otherwise be disclosed for operational purposes in summary, statistical, or other form that does not identify the individual.

II. GUIDELINES:

Privacy Acknowledgement:

Patient-

KTCH's privacy notice will be posted publically at all locations and on the KTCH website for patient access. Additionally, printed copies are available at all locations for if patients request a copy. A confidentiality assurance statement and acknowledgement of the notice of privacy practices will be obtained and will appear in the patient's health record.

Staff & Additional Personnel-

KTCH requires that confidentiality statements are signed by employees, contracted providers, and business associates. Additionally, KTCH maintains and routinely educates staff, students, and volunteers on written privacy and security policies and procedures.

Release of PHI:

A written consent is required for the release of personally identifiable information, except as may be necessary to provide emergency services to the patient or as required by law, with appropriate safeguards for confidentiality.

Title X Data Reporting:

All identifying data collected through the Title X program is considered confidential. Non-identifying data is utilized in numerous ways to assists in clinic management, program planning, and evaluation at the subrecipient/agencies, council, regional, and national levels.

Patient Privacy:

Patients will be provided privacy during all stages of an appointment, including but not limited to: registration, eligibility determination, history taking, examination, counseling and fee collection.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Prohibition of Abortion/Referrals
BOD Approval: 11/2019
Responsibility: Clinical Staff

Policy Number: 8.94
Effective Date: 11/2019
Distribution: All Departments

I. POLICY:

KTCH will not provide, promote, refer for or support abortion as a method of family planning, except in the case of medical emergency. Additionally, KTCH will not use family planning funding in programs where abortion is a method of family planning.

II. GUIDELINES:

Patients will not be subjected to coercion in the use of any particular method of family planning. Patient's acceptance of family planning services will not be a prerequisite to eligibility or receipt of a non-Title X service. Staff will be informed they may be subject to prosecution if they coerce or attempt to coerce any person to undergo an abortion or sterilization procedure

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Intimate Partner Violence (IPV) & Human Trafficking
Policy Number: 8.95
BOD Approval:
Effective Date: 10/19
Responsibility: Clinical Staff
Distribution: All Departments

I. POLICY:

Patients will be offered education and information on domestic violence and sexual abuse. Clients will be offered appropriate counseling and referrals as indicated regarding future planned pregnancies, management of a current pregnancy, and other concerns that can be affected by domestic violence.

II. GUIDELINES:

IPV is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent and are aimed at establishing control by one partner over the other. Providers will screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services.

Patients will be offered appropriate counseling and referral as indicated regarding future planned pregnancies, management of a current pregnancy, and other individual concerns in terms of how domestic violence can affect health outcomes. Preconception counseling should be provided if the client's history indicates a desired pregnancy in the future.

Human Trafficking by Federal definition is a crime that involves exploiting a person for labor, services, or commercial sex.

The Trafficking Victims Protection Act of 2000 and its subsequent reauthorizations define human trafficking as:

a) Sex trafficking in which a commercial sex act is induced by force, fraud or coercion, or in which the person induced to perform such act has not attained 18 years of age; or
b) b) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery. (22 U.S.C. § 7102 (9)).

KTCH will routinely train and familiarize all staff members with Missouri law regarding human trafficking on an annual basis for all employees providing care to family planning clients.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Preconception Health Services
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.96
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will have a preconception care and reproductive life plan policy

II. GUIDELINES:

A reproductive life plan will be discussed with each client. Preconception and interconception counseling will be provided if the client indicates a desired pregnancy in the future.

KTCH will ensure that all women who are sexually active, desire conception or are unsure about conception, have had an adverse birth outcome, and/or are at risk for an adverse birth outcome, are provided with counseling services about preconception care and reproductive life planning.

Preconception Care and Reproductive Life Planning counseling services will consist of the following key components:

1. Risk Assessment/Screening: The screening and assessment entails a discussion of client's history including:
   - Age
   - Previous menstrual history
   - Pregnancy history (preterm birth/delivery, complications, pregnancy loss, second trimester loss, 3 or more SABs and ectopic pregnancy)
   - Family history
   - Social history
   - Surgical history (cervical surgery)
   - Health history
   - Medication history
   - Immunization history
   - Occupational hazards and environmental exposure
   - Birth defect

   This information will be documented in client's medical record.

2. Counseling/Education: Client counseling and education will emphasize the following:
   - Risks of tobacco, alcohol, and recreational drug use
   - Management of chronic conditions
   - Planning and spacing pregnancies

- Good oral health practices
- Physical activity
- Prenatal care
- Folic acid
- Immunizations
- Nutrition
- Mental health (stress reduction)
- Information about risks of exposure to teratogens, handling cat litter, and eating raw fish or meat
- Provision of relevant educational materials
- Educational/career planning
- Role of other factors like education and financial readiness in healthy pregnancy/children
- Birth control methods

This information will be documented in client's medical record.

3. Examination:
   - Physical examination - to assess any contraindications for pregnancy
   - Pelvic examination – inspect and palpate for abnormalities
   - Laboratory testing – routine and other indicated laboratory tests including testing for Chlamydia if 25 years of age or younger and opt-out HIV testing

4. Referral and Follow-up: clients will be referred as needed for:
   - Primary care services for treatment and management of chronic conditions
   - Behavioral health services (depression, family violence, and substance abuse treatment/assessment)
   - Screening and treatment for Sexually Transmitted Infections
   - Genetic counseling
   - Oral health services
   - Prenatal care
   - Nutrition/diet counseling
   - Smoking cessation

Family planning services will be offered if client decides against pregnancy at the present time.

KATY TRAIL COMMUNITY HEALTH
Title X Policies

Policy Title: Voluntary Participation
BOD Approval: 11/14
Responsibility: Clinical Staff

Policy Number: 8.97
Effective Date: 1/16
Distribution: All Departments

I. POLICY:

Katy Trail Community Health (KTCH) will provide Title X services and supplies on a voluntary basis.

II. GUIDELINES:

Patients will not be subjected to coercion in the use of any particular method of family planning. Patient's acceptance of family planning services will not be a prerequisite to eligibility or receipt of a non-Title X service. Staff will be informed they may be subject to prosecution if they coerce or attempt to coerce any person to undergo an abortion or sterilization procedure