

SILETZ COMMUNITY HEALTH CLINIC POLICY



MEDICAL STAFF

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PART 6A
Siletz Clinic Medical Staff Bylaws

I. PREAMBLE

Recognizing that the Medical Staff is responsible for the quality of care in the health clinic, and must accept and assume this responsibility subject to the authority of the Confederated Tribes of Siletz Indians through their elected Tribal Council, and that the best interest of patient care is protected by concerted effort; the health professionals practicing at Siletz Community Health Clinic hereby organize themselves in conformity with the approved Bylaws and Rules and Regulations.

II. NAME

The name of the organization shall be "the Medical Staff" of the Siletz Community Health Clinic.

III. DEFINITIONS

- A. For the purpose of these Bylaws, the term "Medical Staff" shall be interpreted to include the health professionals who provide patient care at the Siletz Community Health Clinic. See Article VI for definitions of Medical Staff categories.
- B. The Siletz Community Health Clinic will be referred to hereafter as "Clinic" for the purpose of these Bylaws.
- C. The "Governing Body" is the Siletz Tribal Council ("Tribal Council") and is composed of nine members elected by the duly enrolled members of the Confederated Tribes of Siletz Indians of Oregon (CTSI). The Tribal Council conducts regular monthly meetings. Decisions are embodied in a resolution or ordinance depending on the intended purpose of the decision. The Tribal Council approves all major contracts, policies that affect the delivery of health care, and the appointment, reappointment and assignment or curtailment of clinical privileges for all Active and Visiting medical staff members.
- D. The "Executive Committee" will consist of a representative of the Tribal Council, General Manager or designee, the Health Director, the Medical Director, Clinical Services Director, and Administrative/Quality Improvement Coordinator. If the Medical Director has a conflict of interest, the Health Director will appoint another Active Member of the Medical Staff to serve in his/her place. The Executive Committee is empowered by the Tribal Council to grant temporary privileges on a 90-day basis to Active/Visiting or Temporary Medical Staff and to recommend to the Tribal Council the appointment, reappointment and assignment or curtailment of clinical privileges for all Active/Visiting medical staff members. The Executive Committee also acts in urgent situations to temporarily suspend any or all privileges of any Active/Visiting or Temporary medical staff member when there is concern for safety to patients. Decisions require a consensus of all members.

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The Executive Committee gathers information, conducts investigations and is empowered to make recommendations on the assignment or curtailment of clinical privileges for all Active/Visiting or Temporary medical staff members. The Executive Committee is responsible to define, determine, and maintain quality professional services.

IV. PURPOSE

The purpose of the Medical Staff shall be to:

- A. Assure that all patients treated in the Clinic receive the best possible care within the capabilities of the staff and facility through the review of the quality of patient care and effective use of the Clinic;
- B. Assure a high level of professional performance of all practitioners authorized to practice in the Clinic through the appropriate delineation of clinical privileges and evaluation of performance through continuous performance improvement programs;
- C. Provide a means whereby continuity of care can be discussed and coordinated;
- D. Initiate and maintain rules and regulations for the governance of the Medical Staff as delegated by the Tribal Council;
- E. Provide for training to maintain education standards and continuing medical education which reflects efforts to correct identified clinical deficiencies and is relevant to the everyday practice of medicine;
- F. Provide representation for all clinical disciplines at the Clinic and provide a means whereby problems of a clinical administrative nature may be discussed by the clinical staff and brought to the attention of the Tribal Council. The clinic has internal processes to achieve this. All complaints and concerns are investigated, tracked, and reviewed. Tribal Council is notified of such incidents in the quarterly report.
- G. Consistently maintain compliance with ambulatory health care standards for quality patient care set forth by accrediting agencies.

V. ETHICS AND ETHICAL RELATIONSHIPS

- A. Principles of Medical Ethics adopted by the American Medical Association, American Dental Association and other applicable professional associations, shall govern the professional conduct of members of the Medical Staff. See below. Behavior reflecting discredit to the Clinic or evidence of unethical behavior shall be cause for disciplinary action in accordance with CTSI Personnel Policies and/or these Bylaws.

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B. AMA Code of Medical Ethics and AMA Principles of Medical Ethics At the SCHC

“Physician” denotes medical provider (NP, PA, MD, DO)

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician.

Principles of medical ethics:

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

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- C. Medical staff members shall work cooperatively, collaboratively and constructively with each other and with other Clinic and Tribal employees to maximize the quality of patient care and to avoid disruption of the patient care and operations of the Clinic. This includes but is not limited to the following:
1. Treat all patients, families, medical staff members and Tribal employees with respect and dignity;
 2. Provide complete information to patients about their care to ensure informed decision making;
 3. Participate actively and constructively in resolving system problems that have the potential to harm patients;
 4. Maintain confidentiality in all health care matters;
 5. Assure that conflict is resolved in a professional, constructive manner.

VI. CATEGORIES OF THE MEDICAL STAFF

A. Active

Those members who are either CTSI employees or contracted providers and who provide direct patient care within the scope of their respective licensure. Active staff include: physicians, nurse practitioners, physician assistants, dietitians, optometrists, pharmacists, social workers, dentists and dental hygienists. Active staff spends a large proportion of their professional time at the Clinic or within the service area and may vote at Medical Staff meetings.

B. Allied

Those members who are regular CTSI employees and generally work with patients under the orders or supervision of an Active member of the Medical Staff. Allied Medical Staff include: nurses, medical technologists, medical and dental assistants, health educators, pharmacy technicians, health navigators, and referral specialist. Allied Staff may vote at Medical Staff meetings.

C. Temporary

Those members who provide services on a short-term basis. They are not eligible to vote at Medical Staff meetings. This may include providers with degrees doing an educational rotation at the Clinic.

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D. Visiting

Those members who provide contractual services but are generally available for Clinic responsibilities less than 16 hours a week and therefore do not regularly participate in Medical Staff activities and are not eligible to vote.

E. Students

While not considered members of the Medical Staff, may be assigned to an Active medical staff member who will evaluate and monitor the student's work, assigning responsibilities appropriate to the student's ability. All chart entries made by the student shall be co-signed by a member of the Active Medical Staff. Such entries shall include work-ups, progress notes, orders, and consultations. Students will wear nametags to identify that they are students. See Rights and Responsibilities in Part 1 Administration Policy, Section V.A.

VII. MEMBERSHIP

A. Selection and Qualifications

1. The selection of persons to be recommended for appointment to the Active, Visiting and Temporary Medical Staff shall depend on a thorough study of the qualifications of each applicant. No applicant shall be denied membership on the basis of sex, race, and creed of national origin, religion, or disability.
2. Allied Staff membership is a condition of full-time employment to a position as described in Section VI.B and is not subject to those sections of the Bylaws referring to Appointment, Reappointment, Assignment or Curtailment of Privileges.
3. Applicants for Active, Visiting and Temporary medical staff membership shall complete an application for medical staff membership (see Part 19 Credentialing Policy) and indicate in writing that he/she has received and read the Bylaws and Rules of the Medical Staff and that he/she agrees to be bound by the terms thereof. Applicants who are Tribal employees must also meet the qualifications and standards for employment developed by CTSI and contained in the CTSI Personnel and Operations Manuals

VIII. CLINICAL PRIVILEGES, INITIAL APPOINTMENT, REAPPOINTMENT

A. Clinical Privileges

1. Regular Privileges
 - a. The granting of clinical privileges is distinct from the granting of medical staff membership, though both result from the careful review and consideration of an applicant's credentials. This review must take place by

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the Executive Committee at the time of application or reapplication to the medical staff but may also be done at any time that modification of privileges is indicated or requested. A detailed listing of clinical privileges may be found in Part 19 Credentialing Procedures.

- b. Medical staff membership is required for any clinical privileges to be granted, but no member can hold unlimited privileges. The granting of privileges must reflect the training, experience, and qualifications of the applicant as they relate to the staffing, facilities, and capabilities of the Clinic. Granting of clinical privileges shall be made by resolution of the Tribal Council after recommendation by the Executive Committee.

2. Temporary Privileges (Active Staff, Temporary Staff and Volunteers)

Active staff, temporary staff and volunteers may be extended temporary clinical privileges up to 90 calendar days. The Executive Committee makes the granting of these privileges. Grantees (except volunteers) are expected to participate, when feasible, in medical staff committees and in-services.

3. Temporary Privileges (Visiting Staff)

Visiting physicians, dentists and consultants on official business may be extended temporary clinical privileges up to 90 calendar days. The Executive Committee makes the granting of these privileges. Grantees are expected to participate, when feasible, in medical staff committees and in-services.

4. Emergency Privileges

In case of life threatening emergency, any physician, dentist, or other member of the medical staff, to the degree permitted by his/her license and regardless of service or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Clinic as necessary, including the calling for any consultation necessary or desirable. An emergency is defined as a situation in which serious permanent harm may result to a patient or in which the life or limb of the patient is in immediate danger and any delay in administering treatment would add to that danger. Emergency privileges may be granted by the Executive Committee for physician, dentist, nurse practitioners, physician assistants and other allied health workers during declarations of emergency, such as natural disaster or public health emergency.

B. Initial Appointment

- 1. Initial Appointment to the Active, Temporary and Visiting Medical Staff shall be made by resolution by the Tribal Council upon recommendation of the Executive Committee. The term of initial appointment is one year.

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2. Membership confers only such privileges as may be provided under the Bylaws and Rules of the Medical Staff. Each appointee shall signify acceptance of privileges granted by signing a statement indicating compliance to the Bylaws and Rules. If privileges granted are not to the satisfaction of the member, appeal procedures are outlined in Part 6, Section 6A.X.

C. Reappointment

1. Application for initial renewal will occur one year after appointment. Subsequently, applicants shall apply for reappointment at least every three years. Renewal is not automatic or guaranteed but based on the recommendation of the Executive Committee in accordance with the Medical Staff Bylaws. Reappraisal of clinical privileges will include a reassessment of credentials. In addition to the criteria for initial appointment, reappraisal will include: performance of the Medical Staff; additional CME; report from National Practitioners Data Bank; results of continuous quality improvement activities (including peer review); health status, including mental health/ emotional health and freedom from chemical dependency/drug abuse; department and relationships with colleagues, staff of CTSI, patients and the community.
2. Reappointment is recommended if performance is satisfactory as documented by the Executive Committee and the results of recommendations for improvement, if any, presented to the individual involved. If improvement is required but does not occur, corrective action may be recommended to the Executive Committee including denial of reappointment.

IX. CORRECTIVE ACTIONS

The corrective actions listed are to permit the Medical Staff to regulate itself in respect to membership and clinical privileges in order to ensure responsible, safe, orderly and efficient service to patients.

A. Initial Procedures

1. Grounds for Corrective Action: Corrective action may be taken against any member of the Active/Visiting or Temporary Medical Staff if the activities of such member are detrimental or are reasonably likely to be detrimental to patient safety or the delivery of quality patient care, are disruptive to the operations of the Clinic, result in a formal complaint, and/or are in violation of these Bylaws or Medical Staff Rules. This includes incapacitation or impairment in the ability of a member to carry out job duties for any reason, including disease or affliction – chronic or temporary.
2. Grounds for Automatic Termination: Medical Staff appointment shall automatically terminate and all clinical privileges shall automatically be revoked, upon the occurrence of any of the following:

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- a. Medical staff member involuntarily surrenders the license or certificate authorizing the member to practice his/her profession
 - b. Medical staff member resigns, or is terminated from employment or contract with CTSI.
3. Grounds for Immediate Temporary Suspension: Should a member of the Medical Staff present for duty in an apparently impaired state from the use of alcohol, drugs, medications (legal or otherwise), or other psychological/emotional instability; the Medical Director and/or Health Director (or designee) shall be immediately summoned. If he/she confirms the presence of impairment, the Medical staff member will be temporarily suspended and relieved of duty immediately. The Health Director or designee will arrange for coverage for the staff member's professional duties and the issue will be referred to the Executive Committee for further review and action (see IX.B.3).
- a. Impaired provider is one whose ability to function in usual roles has been reduced or compromised by various forces. Examples include mental illness, physical illness, or major life event that interferes with their ability to provide safe care.
 - b. Incapacitated provider is one who is physically or mentally impaired in the ability to provide patient care.
 - c. Incompetent provider is a subset of behavior in which the provider fails to properly adhere to standards of care, lifelong learning, does not stay up to date on current medical standards or practices, and/or fails to follow professional guidelines, State board regulations, and other laws governing the medical facility.

4. Initiation of Corrective Actions:

Any person who has reason to believe that corrective action against a member of the Medical Staff may be warranted may request that corrective action be initiated against that staff member. If the Member is also a Tribal employee, corrective actions related to employment matters need to follow the procedures developed by CTSI and contained in the CTSI Personnel and Operations Manuals. For non-employment issues concerning Acting/Visiting or Temporary Medical Staff, the request for corrective action needs to be made in writing to the Medical Director or Health Director. All requests will be screened to determine whether formal review for corrective action is warranted. As part of the screening process, additional information (including peer review consultations) may be requested. During this initial screening process, Active/Visiting/Temporary Medical staff members are not considered to be "under an investigation" for the purposes of certain reporting requirements under the Health Care Quality Improvement Act, found in 42 U.S.C. 11133.

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B. Preliminary Corrective Action

1. Medical Director and/or Health Director upon receiving and screening a request for corrective action may initiate any or all of the following: Review of adherence to guidelines for policy, practice, or procedure.
 - a. Reports of findings
 - b. Memoranda for Notification of Deficiencies
 - c. Request and response for explanation, clarification, or justification in regard to professional practices.
 - d. Recommendation for in-service education, remedial training or experience.
 - e. Counseling
 - f. Reprimand
 - g. Recommendation to the Executive Committee to review privileges to consider curtailment of privileges
 - h. Recommendation to Executive Committee to conduct disciplinary investigations to consider formal discipline.

2. Executive Committee
 - a. Upon request of the Medical Director and/or Health Director, the Executive Committee will gather such information and conduct such investigations and interviews as it deems necessary to exercise its responsibilities to ensure compliance with these ByLaws; define, determine, and maintain a professional standard of care; establish and maintain quality of services; and make corrective action recommendations in following the personnel manual.
 - b. Investigations may consider relevant information, including, but not limited to:
 - i. Results of monitoring and consultative activities
 - ii. Other performance improvement activities
 - iii. Statements of witnesses
 - iv. Letters of complaint from patients, staff members or others

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- v. Incident reports
 - vi. Medical records review and specialty review as indicated
 - vii. Reports, recommendations or evaluations by a supervisor or peer review consultant
 - viii. Prior corrective or disciplinary actions
 - ix. Documentation related to the affected staff member's qualifications or requirements for medical staff membership or clinic privileges.
 - x. Statements made by the affected staff member
- c. Investigations conducted under the authority of this section shall be considered an administrative matter and not an adversarial proceeding. Prior to completion of the investigation, the Executive Committee may afford the affected staff member an opportunity to meet on an informal basis. Such a meeting does not constitute a hearing and the affected staff member is not entitled to have legal counsel present during any such meeting.
- d. Within 15 working days from the date the investigation commenced, the Executive Committee shall submit a written report to the Human Resources detailing the findings and conclusions.
3. Executive Committee Recommendations
- a. May request additional investigation and/or informal meeting with affected medical staff member including outside chart audits.
 - b. May impose monitoring and/or proctoring requirements on the affected staff member's clinical practice for a specified period of time.
 - c. May impose summary suspension or administrative suspension of clinical privileges up to 30 days pending investigation. If the suspension was due to an impairment (see IX.A.3). The affected medical staff member will be examined by another medical staff member or provider for determination of fitness to resume duty. The recommendation to reinstate or deny clinical privileges will be reviewed by Tribal Council at the soonest opportunity.
 - d. May recommend to Tribal Council the denial of Active/Visiting medical staff appointment and reappointments with full knowledge that this will likely result in termination of the medical staff member's contract or employment.

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- e. Shall provide a written notice to the affected medical staff member for each corrective action, stating the reasons for the disciplinary action, the date it shall take effect, and the medical staff member's appeal rights. The notice shall be given at the time such action is taken and a copy of all such notices, signed by the medical staff member, shall be placed in the member's credentials file and shall serve as evidence of delivery.

4. Appeal of Executive Committee Corrective Actions

- a. The affected medical staff member may appeal corrective action taken against him/her by submitting a written appeal to the attention of the Health Director within ten (10) working days after receipt of the written notice of action from the Executive Committee.
- b. The appeal shall explain the reasons why the affected medical staff member is appealing the action and the remedy the staff member is requesting. The Executive Committee will review the appeal and make a decision within ten (10) working days after receiving the appeal.
- c. Decisions to recommend to the Tribal Council to approve and deny Active/Visiting medical staff appointment, reappointments and/or clinical privileges will include the affected medical staff member's appeal.

C. Summary Suspension of Privileges

Involuntary relinquishment of privileges may be instituted by the Executive Committee in the following instances, effective until such time as basis is proven groundless or removed by formal review by the Tribal Council:

- 1. Staff member's license to practice is suspended, or has restrictions or any stipulations placed on it that may have a potentially significant adverse impact on the patients, the medical staff, or the efficiency of the facility.
- 2. Staff member is under formal investigation by Department of Justice for violation of prescribing of restricted drugs.
- 3. Staff member is under legal proceedings for criminal act.
- 4. Temporary administrative suspension is in effect in excess of 30 days aggregation during the calendar year.

D. Administrative Suspension

Temporary administrative suspension of all or part of an Active/Visiting or Temporary staff member's clinical privileges may be instituted by the Executive Committee until such time

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as the problem is corrected, or for time stated, (with provision for alternative patient care) in the following instances:

1. Violation of rules and regulations for medical records completion (Section 6B.X Medical Records)
2. Violations of By-laws and Rules of the Medical Staff (Section 6A and 6B)
3. The availability of temporary administrative suspension and possible action does not preclude as options other appropriate administrative actions by the Health Director or Medical Director, such as denial or delay of leave
4. Temporary administrative suspensions that exceed an aggregate of 30 days in a calendar year are cause for automatic suspension and recommendation for formal discipline

E. Reinstatement of Privileges for Impaired Medical Staff Member

Prior to reinstatement, the medical staff member shall be examined by another medical staff member or provider for fitness-for-duty. A copy of the examination and determination of fitness to resume duty will be reviewed by the Executive Committee

F. Reporting to State Licensing Board(s) and National Data Bank

When there is a professional review action adversely affecting the staff member's medical staff appointment and/or clinical privileges for more than 30 days, the Medical Director will report to the appropriate state licensing board(s) and the National Practitioner Data Bank within 15 days from the date the adverse action was taken. The Medical Director will also report the acceptance of a surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct, or in return for not conducting an investigation or professional review action. Revisions to such actions must also be reported (see Title IV of the Health Care Quality Improvement Act of 1986 (PL99-660))

G. Privacy

All such information, including original data, minutes of committee meetings, reports, interviews, recommendations and memoranda developed or gathered in correlation with disciplinary investigations are to be held confidential and not available for public, legal, patient, staff, or personnel review except:

1. When specifically ordered by a court of competent jurisdiction;
2. For official purposes necessary for quality assurance function, corrective action or disciplinary action;

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3. For legitimate purpose of research, training or education when in a form precluding individual patient or staff identification;
4. For data system collection and manipulation when specific patient or staff identification is by code;
5. For any reporting to the state licensing board(s) and the National Practitioners Data Bank as outlined in Article X.F.

H. Liability

1. The medical/professional staff, and administrative personnel will be held free of liability for all acts taken to fulfill their disciplinary responsibilities provided that such action is in conformity with these Bylaws.
2. Title IV of the Health Care Quality Improvement Act of 1986 (PL99-660) provides limited protection on damages for professional review actions insofar as general review requirements of the Act are met. A professional review action must be taken:
 - a. In the reasonable belief that the action was in the furtherance of quality health care;
 - b. After reasonable effort to obtain the facts of the matter;
 - c. After adequate notice and appeal procedures are afforded to the affected medical staff member or after such other procedures that are fair to the affected medical staff member under the circumstances.

X. APPEAL RIGHTS

This section applies to granting or restricting of Medical Staff privileges and/or membership.

A. Corrective Actions Giving Rise to the Right of Appeal

An affected member of the Active/Visiting Medical Staff shall have the right to appeal whenever the Tribal Council recommends, takes, or proposes to take one or more of the corrective actions that affects that member's clinical privileges or membership status.

B. Notice to Affected Staff Member

As soon as possible after the Tribal Council proposes to take a corrective action, the Health Director shall provide the affected staff member with a written notice stating:

1. that a corrective action has been recommended, proposed or taken against the staff member;

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2. the type of corrective action that has been recommended, proposed, or taken;
3. the reasons for the action or recommended proposed action;
4. that the staff member has the right to appeal the action or recommended/proposed action;
5. that the staff member has ten (10) working days from the date of the notice to submit an appeal, which must be in writing and addressed to the Health Director;
6. that a professional review action adversely affecting the staff member's medical staff appointment and/or clinical privileges for more than 30 days or the surrender or restriction of clinical privileges while under investigation for possible professional incompetence or improper professional conduct, will be reported to the appropriate state licensing board(s) and the National Practitioner Data Bank.

C. Appeal Requests

The affected staff member shall have ten (10) working days from the date of the notice to request a hearing, which request shall be in writing and submitted to the Health Director for Tribal Council. The appeal request shall explain the reasons why the medical staff member is appealing the corrective action and the remedy the medical staff member is requesting. The failure of the affected staff member to appeal within the time and the manner provided in these Bylaws shall be deemed to be a waiver of the right to such review and the Tribal Council action will be deemed final.

D. Fair Hearing

1. If the affected staff member requests a Fair Hearing within the prescribed ten (10) days working period, the Tribal Council Chairman will empanel a Fair Hearing of 3-5 individuals who have not previously been associated with the case.
2. If a Fair Hearing is requested on a timely basis, the affected staff member must be given notice stating: the place, time and date of the hearing, which date shall not be less than 30 calendar days after the date of the notice, and names of panel members, the affected staff member has no right to participate in the Fair Hearing selection process or to reject any selected member. If the affected staff member has objection to any of the Fair Hearing panel members, he/she may submit the objection in writing to the Tribal Council Chairman within five (5) working days following receipt of the review notice. The Tribal Council will review the objection(s) and determine if removal of a member is warranted.
3. Fair Hearing Panel Composition and Procedures
 - a. A Fair Hearing panel will be appointed by the Tribal Council Chairman from a list of candidates offered by the Executive Committee, and shall consist

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of not fewer than three (3) nor more than five (5) members who are members of the Medical Staff. At least one panel member shall be in the same professional discipline as the affected staff member. No member of the Panel may have been an accuser, investigator, fact finder, initial decision-maker, or have participated in the matter. Knowledge of the matter will not preclude any person from serving on the Fair Hearing panel.

- b. One member shall be appointed to preside as the Chairman of the Fair Hearing of the Panel.
 - c. The Executive Committee of the medical/professional staff will be represented by at least one of its members. The person or persons who initiated the complaint may be present, at the discretion of the Executive Committee.
 - d. The affected staff member shall be present.
 - e. Either side of the issue may submit written statements of witnesses or consultants.
 - f. Legal counsel for either side, if present, may not cross-examine witnesses or others present. The role of legal counsels is restricted to consultative functions.
 - g. A record of the hearing will be made by either tape recording or court reported, from which a transcript can be prepared. The affected staff member at no charge may obtain one copy of the proceedings.
 - h. The affected staff member has the right to present evidence determined to be relevant by the Chairman of the Fair Hearing, regardless of its admissibility in a court of law.
 - i. All decisions as to the order, format, and conduct of the hearing will be at the discretion of the Chairman of the Fair Hearing.
 - j. The Fair Hearing panel will decide the issue and notify, in writing, the affected staff member, the Tribal Council and the Executive Committee within three (3) days of the hearing, to include: decision, reason for decision, action recommended.
4. If the Fair Hearing panel upholds the Tribal Council's actions or proposed actions, the decision will be final for the Tribe. If the decision of the Fair Hearing panel is to overturn the Tribal Council's actions or proposed actions, the affected Medical Staff member will be reinstated and reimbursed for any lost income/ benefits that may have occurred. A copy of the Fair Hearing panel decision will be placed in the credentials file for the affected member.

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5. If the affected staff member feels that the decision and recommendation made by the Fair Hearing Panel was unreasonable, arbitrary, capricious, or discriminatory, the affected staff member may request that the CTSI Tribal Court review the case.

XI. ORGANIZATION OF THE MEDICAL STAFF

A. Medical Director

A licensed member of the medical staff, employed by CTSI, shall serve as Medical Director. During any absence by the Medical Director, the Clinical Services Director shall act as Medical Director.

Responsibilities include:

1. Supervises Medical Staff and is responsible for the maintenance of professional standards of all areas of patient care.
2. Organizes Medical Staff committees and call schedules.
3. Evaluates performance of medical staff including professional competence, ethics, conduct and performance and makes recommendations to the Executive Committee.
4. Other specific duties:
 - a. Act in coordination and cooperation with the Health Director and Clinical Services Director in all matters of mutual concern within the clinic.
 - b. Call, preside at and be responsible for the agenda of all general meetings of the Medical Staff.
 - c. Be responsible for the enforcement of Medical staff Bylaws and Rules and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action is indicated.
 - d. Appoint committee members to all standing, special, and multidisciplinary Medical Staff committees.
 - e. Represent the views, policies, needs and grievances of the Medical Staff to the Health Director, Clinical Services Director, Planning/QI Committee, Executive Committee and Health Committee
 - f. Receive and interpret the policies of the Clinic to the Medical Staff and report to the Planning/QI Committee of the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

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- g. Recommend to the Health Director the educational and continuous performance improvement activities of the medical staff.
- h. Be the spokesperson for the Medical Staff in its external professional and public relations.
- i. Participate in every phase of administration affecting patient care through cooperation with the nursing service and the clinic administration including personnel, supplies, special regulations, and program policy and budget determination.
- j. Participate in the certification/accreditation activities and performance improvement program of the clinic.
- k. Provide patient care.

B. Meetings

1. Committee functions, which are primarily the responsibility of the Medical Staff, will be accomplished by the Medical Staff meeting as a committee of the whole, with other Clinic staff attending as appropriate.
2. The Medical Director may appoint special subcommittees.
3. The Medical Staff shall meet at least semiannually. Attendance by the Active and Allied Medical Staff is mandatory with the exception of those instances of emergency or previously arranged authorized leave. A quorum (one half of the Active and Allied Medical Staff plus one member) must be present, and a simple majority vote is needed to conduct business. Written minutes, including attendance, shall be maintained at each of these meetings and made available to all medical staff members.
4. Special meetings of the Medical Staff may be called at any time by the Health Director or the Medical Director or at the request of the Tribal Council or by a majority of the Active and Allied Medical Staff. Sufficient notice of Medical Staff meetings shall be posted via e-mail to the members at least 24 hours before the time set for the meeting.

C. Reporting and Approval Mechanisms

1. Recommendations from the Medical Staff will be forwarded to the Health Director and Medical Director. The Planning/QI Committee will review policy recommendations.
2. The Planning/QI Committee will meet at least every other month to:

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- a. Receive and act upon recommendations of the Medical Staff and Clinic support areas including recommendations to the Health Committee for approval of Clinic policies;
 - b. Review quality improvement reports and activities and assure that:
 - c. Important problems or concerns in the care of patients are identified;
 - d. The frequency, severity, and source of suspected problems or concerns are evaluated;
 - e. Measures to resolve important problems or concerns have been implemented;
 - f. Problems or concerns are reevaluated to determine whether the corrective measures have been achieved
3. Receive, review and coordinate proposed activities (both short and long range planning) involving CTSI, the local community, the Clinic and Community Health.

XII. FUNCTIONS OF THE MEDICAL STAFF

A. Planning and Management

The planning and management functions of the Medical Staff includes the following:

1. coordinate the activities and general policies of the various clinical services;
2. receive and act upon committee reports;
3. implement policies of the Medical Staff;
4. provide liaison between Medical Staff, the Health Director, the Health Committee, and the Tribal Council.
5. make recommendations on Clinic management matters affecting patient care;
6. ensure that the Medical Staff is kept abreast of the accreditation process and informed of the accreditation status of the Clinic; and
7. take all reasonable steps to ensure professional, ethical conduct and competent clinical performance.

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B. Quality Improvement

1. The Medical Staff conduct quality improvement activities in accordance with the Clinic's Quality Improvement Plan, which is found in Part 2 Quality Improvement Policy.
2. The Executive Committee, in conjunction with other appropriate Clinic staff, maintains an active peer-based system to monitor the quality of care and assures that high quality care is being delivered. In addition, the Executive Committee reviews requests for assignment or curtailment of privileges and makes recommendations based upon peer review based investigations.
3. Medical Staff Meeting is a special subcommittee of the Medical Staff and meets at least monthly. The Committee holds patient staffing and provides a communication link between Medical Staff and other disciplines.

C. Pharmacy and Therapeutics

The Pharmacy and Therapeutics Committee is a subcommittee of the Medical Staff and meets at least quarterly. It shall be composed of a least one medical staff member (chairperson), one pharmacist, a representative from administration, and other members as appointed by the Medical Director. The Committee functions are to maintain the Clinic formulary, review and recommend policies related to dispensing of medications.

D. Medical Records

The Medical Staff in conjunction with the Medical Support staff shall:

1. Assure all medical records conform to the problem focused format;
2. Review the essential components for complete and accurate medical records;
3. Recommend policies and procedures related to medical records including periodic review and update of forms;
4. Assure confidentiality of medical information.

E. Infection Control

The Medical Staff will participate in infection control through cooperation and participation in the Clinic's Infection Control Plan and will review this Plan annually.

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XIII. RULES AND REGULATIONS

The Medical Staff shall, in accordance with applicable tribal law and these Bylaws, adopt such rules and regulations to more specifically implement the general principles found within these Bylaws. The rules and regulations shall relate to the proper conduct of staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Clinic. Such rules and regulations may be amended or repealed at any regular meeting by a majority vote of the Active and Allied Medical Staff. Such changes shall become effective when approved by the Medical Director, Health Director and Tribal Council.

XIV. ADOPTION AND AMENDMENTS

These Bylaws shall be adopted by a majority vote of the Active and Allied Medical Staff and shall replace any previous Bylaws and shall become effective when approved by the Tribal Council. These Bylaws may be amended at any regular or special meeting of the Medical Staff by a majority vote of the Active and Allied Medical Staff, and shall be effective when approved by the Tribal Council.

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**PART 6B
Rules and Regulations**

I. POLICY

It is the policy of the Siletz Community Health Clinic (SCHC) to offer optimal medical care to all patients registered at the facility.

II. ORIENTATION

- A. New medical staff fulfills requirements of the Siletz Clinic Medical Staff Bylaws for membership (Section 6A.VII.) prior to assuming patient care duties.
- B. New medical staff meets with administrative staff and is subject to general orientation to SCHC and the tribal government (CTSI) prior to assuming patient care duties. Medical staff also completes an orientation specific to their position; this orientation is required for credentialing.
- C. New medical staff is oriented to policies and procedures regarding confidentiality. New staff is required to sign a statement acknowledging the orientation.
- D. New medical staff is oriented to the Rights and Responsibilities of Patients.

III. RECREDENTIALING REQUIREMENTS

A. Continuing Education

Medical staff maintains continuing education requirements for their licensure and/or credentials and current ACLS or BLS certification as determined by the Executive Committee.

B. Peer Review

Professional health care staff participates in peer review activities as deemed appropriate by the Executive Committee.

IV. CONSULTATIONS

A. Required Consultations

Except in emergencies, consultations with other qualified providers are required for cases in which, according to the judgement of the attending practitioner:

- 1. The diagnosis is obscure, or
- 2. There is doubt as to the best therapeutic measures to be utilized.

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B. Consultants

A consultant must be well-qualified to give an opinion in the field in which the opinion is sought. The status of consultant is determined by the medical staff based on the individual's training, experience, competence and credentials. A recommendation for consultation is made without regard to the patient's ability to pay. If the patient refuses for any reason that should be documented in the patient's chart.

C. Essentials of Consultation

A satisfactory consultation includes examination of the patient and the record. An opinion signed by the consultant is included in the medical record. When a telephone consult is obtained, the medical staff member (physician, nurse, dentist or pharmacist) obtaining the consultation enters the consultant's recommendation in the patient's chart.

V. TREATMENT OF MINORS

A. Policy

Siletz Community Health Clinic provides holistic care to minor children. In an effort to provide safe and age-appropriate care, the SCHC has implemented the policies in this document regarding treatment of minors.

B. Definition of an Adult (Legal Age)

1. The general age of majority in Oregon is 18 years (*OR.S. 109.510*) except for married persons, who attain majority when they are married according to law.
2. Parents or legal guardians are responsible for accompanying children under age 15 for all appointments.

C. Services Provided to Minors

1. Minors under the age of 18 must be accompanied by a parent or legal guardian when seeking service for sports physicals, well child exams, and pre-op physicals and clearance for surgery.
2. A designated representative may bring a minor in for services if accompanied by written permission from the parent(s) or legal guardian. This is excluded with services listed in step 1 above.
3. SCHC will stock and maintain appropriate pediatric equipment, supplies, and medications for services provided at our facility.
4. SCHC will ensure a provider certified in PALS will be in the building when services to minors are provided.

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5. Immunizations and medications to be ordered and administered within SCHC will be done by RNs or certified Medical Assistants.
6. All medical and surgical procedures will be performed in accordance with Section 6K of this policy.

D. Minor Consent Exception to Policy Per Oregon Revised Statutes

1. Notwithstanding any other provision of law, a minor who may have come in contact with any venereal disease, including HIV, may give consent to the furnishing of hospital, medical or surgical care related to the diagnosis or treatment of such disease, if the disease or condition is one which is required by law or regulation adopted pursuant to law to be reported to a state or local health agency or officer. Such consent shall not be subject to disaffirmance because of minority. (ORS 109.610)
2. The consent of the parent, parents, or legal guardian of such minor shall not be necessary to authorize such hospital, medical or surgical care and without having given consent the parent, parents, or legal guardian shall not be liable for payment for such care rendered.
3. Providers may provide birth control information and services to persons of any age without parental consent. (ORS 109.640).
4. A minor 15 years of age or older may give consent, without the consent of a parent or guardian of the minor to hospital care, medical or surgical diagnosis or treatment by a physician, physician assistant, nurse practitioner, or dentist who are licensed by their respective boards (ORS 109.640).

REFERENCE: Oregon Revised Statute

VI. AFTER HOURS ACCESS/ON-CALL SERVICES/EMERGENCIES

A. After Hours Access and On-Call Policy

All patients can access a provider to address urgent and emergent needs after normal business hours through the clinic’s telephone service. The ability of patients to have access to clinical advice when the clinic is closed reduces patient use of the emergency room, promotes continuity of care, and fosters patient centered care.

B. Procedure

1. On-call responsibilities will be shared among employed health-care professionals who possess privileges to provide client care at SCHC. A schedule of on-call providers will be established at least two weeks prior to the month during which the schedule will be in effect. The schedule will be disseminated among all

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providers involved in the service, and the paging service will be supplied with a copy. Currently, the on-call responsibility is rotated among eligible providers on a one-to-two-week basis.

2. When a client calls the clinic after regular business hours, he or she will hear a recording that:
 - a. Identifies the Siletz Community Health Clinic as the recipient of the call.
 - b. Directs all patients to go to the nearest emergency room if this is a medical emergency.
 - c. Specifies the clinic's usual business hours.
 - d. Directs patients to call the answering service if they have questions that cannot wait (the appropriate telephone numbers are included in the recorded message) and they are a registered patient with the Siletz Clinic.
 - e. Directs patients to call during regular business hours to arrange an appointment if their problem is not emergent.

3. The answering service collects the standard information needed to relay the message to the on-call provider: Patient name, phone number, and a brief statement of the patient's needs. The answering service then contacts the on-call provider, using the on-call provider's preferred contact number.
 - a. If the provider answers the phone, the call from the patient is patched through to provider via the answering service.
 - b. If the provider does not answer, the answering service will leave a message for the provider. The provider will call the answering service, get pertinent information and call the patient.
 - c. If the on-call provider does not respond in thirty minutes, the answering service will contact the next provider on the list or the Medical Director.
 - d. Providers are expected to contact patients within thirty (30) minutes of receiving the call and provide clinical advice as needed.

4. The on-call providers serve to triage patient needs but cannot admit a patient as they do not currently hold hospital privileges.
 - a. Patients with problems that seem urgent are advised to go immediately to the emergency facility nearest to the patient.

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- b. Purchased/Referred Care (PRC) eligible patients are advised to report emergency visits to PRC within 72 hours at 444-1236. On-call providers do not authorize payment for emergency services.
 - c. Concerns are addressed within the limitations of a telephone conversation, and the patients are instructed to seek emergency medical care if, in their estimation, the problem is more urgent than can be conveyed to the on-call provider.
5. Patients are invited to contact the clinic during regular business hours to arrange appointments whenever their medical problems are not urgent or emergent. Any clinical advice provided over the phone must be documented in the patient's clinical record. On-call providers do not authorize payment for emergency services.
 6. Within the purview of standard medical practice, providers may prescribe medications as deemed necessary and appropriate following a conversation with a patient or family member, but prescriptions for narcotics are not filled by on-call providers.
 7. Internal medicine providers who are on call may direct parent/guardians calling with urgent questions about a child to the ER or Urgent Care. Other medical advice can only be given if provider requests as part of the credentialing process.

C. Emergencies

1. During regular hours, emergency cases are examined immediately by Medical Staff. If the patient cannot be adequately managed at SCHC, he or she is stabilized and transferred to the nearest emergency room. Medical Staff must call the receiving ER. Also, Medical Staff must decide the most prudent mode of transport.
2. In an emergency, a patient eligible for PRC may be admitted directly to a facility without prior visitation at SCHC. The patient, referral provider or accepting facility must seek authorization within 72 hours.

VII. TRANSFER AND REFERRAL

A. Code Blue and Transfers

1. Definition

Code Blue is described in the Risk Management Policy and is used when emergent medical care is needed in the clinic for conditions such as: cardiac arrest, loss of consciousness, trauma.

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2. Purpose

To provide guidelines for initiating Advanced Cardiac Life Support (ACLS) according to the measures provided by the American Heart Association (AHA) to patient with no palpable pulse and/or no discernible respirations.

3. Policy

It is the policy of SCHC to provide accurate and up to date guidelines on BLS and ACLS protocol for staff.

4. Procedures

- a. When a patient is found down with no palpable pulse and/or no discernible respirations, the individual noting the patient's condition will start Basic Life Support (BLS).
 - i. Anyone trained in CPR or BLS is to respond to the scene as a first responder to a medical emergency. As more medically trained personnel arrive, the first responders may be asked to transfer care. First responders should not leave the patient or the scene when advanced medical personnel arrive. Their help and input continues to be valuable and needed.
- b. The person who first observes a patient in need of emergent medical care will either call over the PA system Code Blue followed by the location of the patient or delegate another person to make this call.
 - i. Call 5501
 - ii. Wait for two faint beeps and hit 00: "CODE BLUE (area where needed)"
- c. When Code Blue is heard over the PA system, a member of the nursing staff should bring the code cart and Automatic Electronic Defibrillator (AED) to the scene immediately.
- d. Basic airway management shall be maintained by a BLS certified staff member.
 - i. Immediate assessment of patient is done: A (airway) B (breathing) C (Circulation).
 - ii. STABLE-transfer of care to in-house provider for care
 - iii. UNSTABLE-911 is called for transfer to local hospital ER

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- e. ACLS/PALS protocols will be followed per American Heart Association Guidelines. An ACLS provider will be in the clinic at all times during office hours. A PALS (Pediatric Advanced Life Support) provider will be in the clinic at all times when a pediatric patient is present.

5. Transfer of Care

- a. No patient shall be transferred to another facility without positive acceptance by the receiving facility or provider prior to transfer. Local ambulance services agreements require patients to be transported to the closest hospital, which is Samaritan Pacific Communities Hospital.
 - i. If sending a patient to the hospitalist for direct admission, provider must call the hospitalist on call to be certain (s)he is willing to receive the patient. Provider should always fax pertinent chart notes, labs, and diagnostics. Acceptance should be by an attending provider at the receiving facility except in an emergency.
 - ii. If transferring a patient to a hospital emergency department, the provider should always call the emergency room to relay a brief summary, patient history and demographic information including problem list and allergies. (S)he should be assured that all pertinent lab, EKG, etc. will accompany the patient. The ER provider should be given provider's name and phone number in case (s)he needs more information. If the ER doctor is too busy to come to the phone, the information should be given to a nurse.
 - iii. When sending a patient out via ambulance we do not have a choice in what facility they are sent to. Local policies dictate they are transported to nearest facility and then transferred if deemed necessary by receiving facility.
- b. Provider should carefully consider transportation options. A general rule is that if the patient is sick enough to go the Emergency Room, he/she should be transported by ambulance. Occasionally, families/patients refuse ambulance transport. The provider shall review the risks with the patient/family and have them sign an "Against Medical Advice" (AMA) form.
- c. No patient shall be transferred in an unstable condition unless it is beyond the means of SCHC staff to achieve stabilization, or if, by remaining, the patient's condition would probably result in death or permanent impairment.
- d. A licensed member of the Code Team remains with the patient until care is transferred to the paramedics. Report is given to the paramedics and assistance in transferring patient from our gurney to theirs.

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e. Records from the receiving facility will become a part of the patient's permanent record.

6. After the Code

Staff will debrief and an incident report written with copies to Administration and the Safety Committee. Recommendations for improvement to the process will be made.

B. Referrals

1. Providers refer to appropriate specialty when services needed are not available in the clinic. A referral is sent to the referral specialist who coordinates the visit with specialist and patient. See Part 7 Nursing Procedures, Referrals to Other Health Care Providers, for detailed information.
2. Once the referral is complete the notes and documents from the visit will be scanned and sent to provider in box for electronic signature.

VIII. REPORTING REQUIREMENTS

There is mandatory reporting for specific health related conditions in the State of Oregon including child and elder abuse. Medical Staff are to report their concern to the appropriate authorities and document in the patient's chart the reason for reporting and the action taken. The following are reportable conditions:

A. Disease

Medical Staff caring for a patient who is diagnosed with a reportable disease is responsible for reporting the case to the Lincoln County Health Department. The reference laboratory auto reports reportable disease to the local County Health Department.

Reportable infectious diseases are listed at Oregon's Health Authority website. They are also included in SCHC Infection Control Policy.

See O.R.S. 433.004 and the SCHC Infection Control Policy.

B. Injury

Medical Staff is required to makes an immediate verbal report followed by a written report to the appropriate authority if Medical Staff, intern or resident has reasonable cause to suspect a person is seeking care or treatment for a physical injury caused by a knife, fire arms, other deadly weapon or dog bite. The animal bite form can be found on the on J/Drive. This must be completed and submitted to Lincoln County Animal Services within 24 hours of incident.

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See O.R.S. 146.750.

C. Child Abuse

An immediate verbal report is made to the local office of Children's Services Division (Tribal ICW for CTSI Tribal children) and/or to a law enforcement agency within the county where the person making the report is located at the time of contact followed by a written report as soon as possible.

"Child" means an unmarried person who is under 18 year of age.

See O.R.S. 419B.005 to 419B.010 for specifics on the definition of abuse and reporting requirements.

For the rights of emancipated minors see ORS 419B.550 to 419B.558.

D. Elder Abuse

A verbal report is made immediately by telephone to the local office of the Senior and Disabled Services Division or to a law enforcement agency within the county where the person making the report is located at the time of contact.

"Elderly person" means any person 65 years of age or older who is not subject to the provisions of ORS 441.640 to 441.665, which pertains to residents in nursing homes.

See O.R.S. 124.050 to 124.095 for specifics on the definition of abuse and reporting requirements.

E. Vulnerable Adult Abuse

1. Adult with Physical Disabilities

A verbal report is made immediately by telephone to the local office of the Department of Human Services or non-emergent phone line of local law enforcement agency.

2. Adult with Developmental Disabilities

A verbal report is made immediately by telephone to the county developmental disability program or non-emergent phone line of local law enforcement agency.

3. Adult with Mental Illness

A verbal report is made immediately by telephone to the county mental health program or non-emergent phone line of local law enforcement agency.

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F. Driving Impairments

Medical providers are mandatory reporters. The providers will report to DMV (form on website) when functional impairments such as impaired vision and/or cognitive impairments such as lapses in consciousness that may affect the patient’s ability to safely operate a motor vehicle.

See OAR Chapter 735, division 74.

IX. PATIENT TERMINATION OR RESTRICTION POLICY

A. When circumstances arise that require termination of a particular patient’s association with SCHC, the following guidelines are considered:

1. Remedial actions are reviewed to attempt to maintain a cooperative relationship between the patient and SCHC.

Some transgressions may require more urgent action on the part of administrators to protect all patients, staff and visitors.

2. The availability of alternative medical care for the patient in question is considered.

B. If termination is deemed beneficial to both SCHC and the patient, the eligibility status of the patient is determined:

1. Eligible for Purchase/Referred Care (PRC) primarily Siletz tribal members living in the eleven county service area
2. Other Native Americans (Direct)
3. Non-Native American either Siletz community member or employee of CTSI (Ineligible).

C. Depending upon the eligibility status of the patient, the following actions are part of the termination process:

1. PRC members are contacted by the Health Director or designee, by certified mail and informed of the decision to terminate their privilege to utilize SCHC. By virtue of their coverage through PRC services, Tribal members may be referred immediately to other providers who can continue the care.
2. Other established patients, direct and ineligibles, are contacted by the Health Director or designee, by certified mail and informed of the decision to terminate their privilege to utilize SCHC. If the patient is terminated due to failure to fulfill the financial obligations to SCHC, patient has 30 calendar days to establish a relationship with another provider; SCHC provides emergency care during the 30-day period.

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3. A patient's privilege to utilize SCHC is terminated immediately and without advance notice if there is imminent danger or a perceived threat toward any employee or patron. In this situation, an incident report is filed with a copy to the CTSI General Manager.

D. Any appeals or requests for reinstatement are reviewed by the Executive Committee. Involved parties are notified of the appeal and Medical Staff must be willing to see and assume care for the patient.

X. MEDICAL RECORDS

A. All entries in the patient's medical record for each visit include, but are not limited to:

1. Date, Medical Staff name and profession
2. Chief complaint or purpose of visit
3. Clinical findings
4. Diagnosis or impression
5. Studies ordered, such as laboratory or x-ray studies
6. Care rendered and therapies administered
7. Disposition, recommendations and instructions given to the patient

B. Every formal patient encounter between a patient and medical staff requires an entry in the medical record. This includes documentation when medical advice is given to a patient by telephone.

C. In event of EHR or power down time, handwritten records will be utilized. These must be legible. These documents will be scanned into the permanent EHR when services available.

D. Visit entries in the EHR are electronically signed. Each provider's signature and initials are on file in the Medical Support Department.

E. In every medical record there is a current problem list or health summary indicating significant diagnoses and surgical procedures.

F. Each patient's medical record prominently displays all known drug sensitivities.

G. Special data collecting concerning health measures and patient education conform to the format approved by the medical staff.

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H. Informed Consent

Discussions with the patient concerning the necessity, appropriateness and risks of any proposed procedures, and discussions of treatment alternatives (informed consent) are documented in the medical record.

I. Written medical information obtained at SCHC or from referral facilities shall become a part of the patient's records in a timely manner.

J. Outside health records are requested when deemed necessary for ensuring the continuity of care.

K. No information shall be released from the medical record unless a current authorization is present in the chart (when a patient accepts referral to an outside provider, it is implied that patient has authorized the referring medical staff member to release pertinent records to facilitate the referral.)

L. Clinical information relevant to a patient is readily available to authorized medical staff anytime SCHC is open to patients.

M. Only the active, visiting and allied medical staff shall independently and electronically enter or dictate pertinent information regarding the patient's health or care. Student documentation is reviewed, corrected if necessary, and co-signed by a member of the active medical staff.

N. Any delinquent or inadequate medical record which has not been completed within seven days from the patient encounter is referred to the Medical Director and, if necessary, to the Health Director for appropriate action.

XI. APPOINTMENT SYSTEM

A. Hours of Operation

See Part 1 Administration Policy, Section II.

B. No-Shows, Late Arrivals, and Cancellations

The Medical Clinic follows the SCHC policy on no-shows, late arrivals, and cancellations. The No-Show policy is located in Part 1 Administration Policy, Section VI.

XII. MEDICAL STAFF OUTSIDE ORDERS

A. Some registered patients do not see Medical Staff at SCHC on a regular basis. SCHC must ensure those patients are receiving prescriptions and/or treatments under direct medical supervision.

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- B. The following guidelines are in effect for pharmacy, laboratory and other services:
1. Pharmacy: Outside prescriptions are filled for Purchased/Referred Care eligible patients who are registered at SCHC. If the prescribed medication is not included in the prescription formulary, the pharmacy follows outside formulary guidelines. Patients are informed of the benefits, side effects, actions, drug interactions and dosing schedule of their medication by the Pharmacist.
 2. Laboratory: Outside lab orders must be received in writing and the order attached permanently to the lab requisition. Labs are not drawn until the Lab Technician has the information necessary to complete the lab requisition. The order and disposition are documented on the lab requisition and the original order is attached.
 3. All Services:
 - a. Patient is registered and determined eligible for services provided at SCHC.
 - b. The order is verified as being made by a licensed provider.
 - c. Any questions or concerns are communicated directly to the ordering provider.
 - d. Follow-up test results are sent directly to the ordering provider with a copy kept in the patient's medical record along with documentation that the results were sent.
 - e. In an emergency, the patient is asked to see an SCHC provider.

XIII. OTHER POLICIES AND GUIDELINES

The medical staff reviews and approves policies, guidelines and procedures at regular meetings with a majority vote. Minutes of these meetings are made available to medical staff and they are responsible to know and adhere to approved policies, guidelines and procedures.

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Program	Medical Staff
Policy	Anaphylactic Reactions
Date Approved	08/13/99
Date Revised	05/06/06; 05/02/09; 02/04/12; 11/20/15; 12/21/18; 12/17/21

PART 6C
Anaphylactic Reactions

I. POLICY

Medical staff at the Siletz Community Health Clinic is trained to anticipate possible untoward reactions to injected or ingested substances, including medications administered at the clinic, and will act in such situations to alleviate patient discomfort and/or prevent deterioration of medical status.

II. ANAPHYLAXIS

Anaphylaxis is defined as a serious allergic reaction that is rapid in onset and may cause death. To recognize anaphylactic reactions think fast.

FACE: itching, redness, swelling, pale or blue color	STOMACH: pain, vomiting, diarrhea, nausea
AIRWAY: trouble breathing, coughing, wheezing, trouble swallowing or speaking	TOTAL BODY: hives, rash, weakness, dizziness, sense of doom, loss of consciousness

SIGNS AND SYMPTOMS USUALLY OCCUR WITHIN 15 MINUTES OF EXPOSURE BUT MAY OCCUR WITHIN SECONDS.

Most anaphylactic reactions that occur within the clinic are most frequently reported following administration of antibiotics, immunogenic substances (such as injections for allergy desensitization) or immunizations. Clinical presentation of an adverse reaction depends on the portal of entry of the foreign substance (antigen), the amount absorbed, the rate of absorption and the degree of the patient’s sensitivity. These reactions represent true medical emergencies, and prompt recognition and action are essential. Anaphylaxis may also occur as a result of a patient’s exposure to an antigen outside the clinical setting. When patients arrive at the clinic complaining of possible reactions to foreign substances, or when potential antigens are administered at the clinic, medical personnel must take prompt action to recognize and initiate treatment for anaphylaxis.

III. PROCEDURE

- A. Whenever injections (immunizations, antibiotics, allergy shots, or other therapeutics) are being administered in the clinic, a provider trained in emergency treatment of anaphylaxis will be present. Patients receiving injections will remain in the clinic for at least ten minutes for observation.
- B. Emergency equipment and supplies are kept in a location that is clearly marked and that is convenient to the medical staff. Monthly reviews of this material are conducted and documented to ensure that the supplies are adequate and updated. All medications due to expire within one month of the review will be discarded and replaced.

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IV. MANAGEMENT OF ANAPHYLACTIC REACTION

- A. All patients exhibiting signs or symptoms of allergic (anaphylactic) reaction will have vital signs checked immediately, every 15 minutes thereafter, and as frequently as clinical status dictates.
- B. Mild to Moderate Anaphylactic Reaction (Mild is urticaria alone. Moderate is urticaria, SOB, wheezing. Patient conscious and blood pressure is maintained)
1. Epinephrine, 1:1000, 0.3 to 0.5 ml, IM; pediatric dose – 0.01 ml/kg IM (Max 0.3 ml/kg). Repeat every 5 to 15 minutes as needed.
 2. Diphenhydramine, 25 to 50 mg, IM; pediatric dose – 1-2 mg/kg (Max 50 mg) IM.
 3. If the response is adequate (decreased signs and symptoms), prescribe or administer an antihistamine such as, diphenhydramine, to be taken three to four times daily as needed
 4. If the patient responds poorly or if additional signs or symptoms develop, continue supportive and therapeutic measures and activate the EMS to arrange transport to an emergency facility
- C. Severe Anaphylactic Reaction-Call 911
- Promptly and simultaneously, administer.
1. Epinephrine 1:1000, 0.3 to 0.5ml IM; pediatric dose-0.01mg/kg (Max 0.3ml/kg) IM. Repeat dose at 5 to 10 minute intervals up to 3 doses..
 2. Lay the patient down; elevate the legs
 3. Maintain an adequate airway and ventilate the patient. Oral airway and/or advanced airway may be necessary
 4. Administer oxygen: 6-8 liters per face mask or up to 100% oxygen as needed.
 5. Obtain intravenous access and administer rapid IV bolus of Normal Saline.
 6. Monitor patient closely. Have crash cart close by, open and ready to go. Be prepared to perform CPR if necessary.
 7. Monitor vital signs every 5 minutes
 8. Administer other medications as ordered by provider.

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D. Cautions in Use of Epinephrine

It must only be given in the IM route in the emergent treatment of anaphylactic reactions. The use of Epinephrine by the IV route is potentially very hazardous and should only be done by trained medical staff. Epinephrine is available in 2 strengths. For anaphylaxis the dose is Epinephrine 0.5mg/0.5ml in a 1:1000 solution to be given IM. Epinephrine 1mg/10ml in a 1:10,000 solution for IV use is primarily used in the event of cardiac arrest. Both strength of epinephrine are stored in the crash cart.

V. INJECTIONS

Whenever injections (immunizations, antibiotics, allergy shots, or other therapeutics) are being administered, Medical Staff trained in emergency treatment of anaphylaxis is present. This individual remains immediately available for 30 minutes after administration of injections. Patients receiving injections remain in SCHC for at least 10 minutes following administration. See nursing procedures for detailed instructions on injections.

VI. EMERGENCY EQUIPMENT AND SUPPLIES

Emergency equipment and supplies are kept in a location that is clearly marked and that is convenient to the medical staff. Monthly reviews of this materiel are conducted and documented to ensure that the supplies are adequate and updated. All medications due to expire within one month of the review are discarded and replaced.

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PART 6D
Policy and Procedure for Safe Prescribing of Chronic Opioid Therapy for Patients with Chronic Non-Cancer Pain

I. POLICY

It is the policy of the Siletz Community Health Clinic (SCHC) to ensure medical professionals provide appropriate, effective, safe and adequate pain control for patients with non-malignant chronic pain, with the goal of further improving patients’ quality of life and functional status in the community.

II. GOAL

To reduce the morbidity and mortality that is associated with inappropriate use of opiate drugs, while treating chronic non-cancer pain (CNCP). By shifting the focus for patients and providers from high doses of opiates to lifestyle changes and functional improvement, both the prescribers and their patients will experience an improvement in overall well-being.

III. MISSION

Patients with CNCP have a right to medically appropriate, evidence based treatment. Treatment must be individualized based on a comprehensive medical and psycho-social assessment of the patient. Clinicians (physicians, NP’s and PA’s) have the responsibility to diagnose and manage chronic pain with the goals of:

- A. Optimizing the patient’s functioning, sense of well-being and safety.
- B. Minimizing potential adverse effects of treatment. These include adverse effects on the individual patient as well as adverse effects on others (e.g. through diversion of prescribed medications to others).

Multiple medications, both non-opioid and opioid, are effective for the treatment of CNCP. It is recommended that non-opioid medications be considered first. The expected improvement of pain with opioids is only 20-30%, some patients do not respond to opioids.

IV. TARGET POPULATION

- A. The recommendations in this guideline apply to patients with CNCP who are on chronic opioid therapy.
- B. Chronic non-cancer pain is pain in which causes cannot be removed or otherwise treated and no relief or cure has been found after reasonable efforts.

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- C. Chronic opioid therapy is daily or near-daily doses of opioid medication (American Pain Society-Academy of Pain Medicine).
- D. To support the implementation of this guideline, patients will be identified as being on chronic opioid therapy if they have:
 1. Filled at least 5 prescriptions for opioids in the past 90 days; or
 2. Been taking opioids for at least 90 days in a pattern or quantity that indicates daily or near daily use.

V. CONSIDERATIONS

Before a pain agreement is instituted these considerations must be taken:

- A. Because of the potentially serious adverse long term effects of opioids, it is critical that the prescriber comprehensively assess the risks and benefits of opioid treatment prior to deciding whether to prescribe opioids. Consider opioid therapy when:
 1. Other physical, behavioral and non-opioid measures have failed (e.g. physical therapy, cognitive behavioral therapy, NSAID's, antidepressants, antiepileptic).
 2. The patient has demonstrated sustained improvement in functions and pain levels in previous opioid trial.
 3. The patient has no relative contraindication to the use of opioids (e.g. current or past alcohol or other substance abuse).
 4. There is an explicit decision and agreement between prescriber and patient to initiate chronic opioid therapy. The patient needs to be informed of the benefits and risk of opioid therapy of indefinite duration.

VI. PROCEDURE

A. Initial Assessment for New CNCP Medication

PRIOR TO OPIOID PRESCRIPTION:

1. Review all relevant prior records prior to prescribing. What prior attempts were made to treat this pain with non-opioid modalities?

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2. Diagnostics reviewed or ordered as indicated. Perform a thorough chart review to ensure all non-opiate modalities have been trialed. Document those modalities in the chart.
3. Physical Exam
4. Render a diagnosis: Is the diagnosis appropriate for opioid treatment? Research has found that many painful ailments respond poorly to opioids and in some cases significant morbidity can be associated with chronic opioid prescribing. For example, chronic disability is associated with long term opioid use for low back pain without evidence of benefit. Fibromyalgia, chronic headaches, and other conditions are relative contraindications to the use of chronic opioid prescribing. (Jackson County Opioid Prescribing Guidelines).
5. Assessment and Management of Opioid Risks (includes substance abuse, mental health disorder, falls, overdoses, diversion, etc)
 - a. PDMP query
 - b. UDS
 - c. Opioid Risk Tool (ORT)-patients with a ≥ 7 are not good candidates for chronic opiates
 - d. Clarification for appropriate opiate prescribing.
 - i. Chronic opiates will not be prescribed for patients with active substance abuse except in the context of a clearly documented treatment plan developed jointly and agreed to by the patient, prescribing provider and the substance abuse provider.
 - ii. Co-prescription with other psychoactive drugs with potential for abuse and sequela such as: benzodiazepines and sedative-hypnotics will not occur, except for rare circumstances and will not be prescribed on a chronic basis. This is becoming a community standard in Oregon.
 - iii. Opioids should never be prescribed to an individual on Suboxone or Methadone Maintenance therapy without first conferring with the addiction provider.

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6. Perform an Obstructive Sleep Apnea screening: STOP BANG

B. Create a Treatment Plan

1. Medical interventions: pharmacological, procedural, surgical
2. Behavioral therapies: education, case management, psychotherapies/ pharmacological
3. Physiotherapy modalities: physical therapy, passive modalities (home exercise programs)
4. Patient lifestyle improvement: exercise, weight loss, sleep
5. Substance abuse referrals if indicated

C. Chronic Pain Treatment Recommended Checklist Prior to Pain Agreement:

1. Hx and Px with assessment of baseline function and pain
2. Review all relevant prior records
3. Has there been a prior unsuccessful attempt to treat with non-opioid modalities?
4. Opioid Risk Tool Assessment completed
5. PHQ-9 completed
6. UDS
7. PDMP
8. Is the diagnosis appropriate for opioid treatment? Are there co-prescribed drug risks?
9. Benzodiazepines are contraindicated
10. Sleep risk assessment (STOP BANG or equivalent)
11. Create a treatment plan that does not utilize opioids
12. Appropriate referrals

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13. Have you explored all reasonable non-opioid treatment options: medical, behavioral, physiotherapy, and life style changes?
14. Have you considered partnering with a substance abuse treatment program?
15. Check women of child bearing age for pregnancy

D. Pain Committee

1. Rules to be met when a pain agreement is appropriate
 - a. Review and sign materials risk on a yearly basis.
 - b. Establish treatment goals and review these goals annually.
 - c. Review, discuss and sign an opioid agreement with patient.
 - d. Monitor compliance:
 - i. UDS-based on risk based or ORT results: see worksheet for reassessment intervals.
 - ii. PDMP (Prescribers Drug Monitoring Program) for every refill of scheduled medications.
 - iii. Pill counts-per ORT results.
 - e. Monitor improvement in pain and functioning at least every three months.
 - i. PHQ evaluation per recommendations.
 - f. Provide consultation as needed: specialist referral (orthopedics, neurology etc), mental health, substance abuse, pain management.
 - g. Clarify with patient that only one provider will be prescribing the opiate medications.
 - h. Opioid dosage shall not exceed 80 MED in noncancer diagnosis.
2. Requests that will not be authorized without extenuating circumstances (acute injury/surgical intervention).

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- a. Early refills. This would be considered a dose escalation without provider prescription.
 - b. Request to refill a second lost or stolen prescription excuse. Only one excuse is allowed per agreement if a police report is produced.
 - c. Document reason for early refill in patient chart.
3. The medical standard against co-prescription with other psychoactive drugs with potential for abuse. These include benzodiazepines, Ritalin type medications and sedative-hypnotics. As benzodiazepines have been reported in a high proportion of overdose deaths, opioid therapy will not be prescribed if patient is on a regularly scheduled dose of benzodiazepines as well as vice versa. (OHSU Guidelines for safe Chronic Opioid therapy prescribing.)

E. Maintenance

1. Is patient following the treatment plan?
2. Check for aberrant behaviors.
3. Assess for adverse side effects.
4. Physical exam, labs reassessment at regular intervals.
5. Refer to, or collaborate with non-opioid treatment partners.

F. Records for the Chart

1. Pain assessment and documentation: progress note
2. PDMP query: with every scheduled medication prescription or refill.
3. UDS (quantitative versus qualitative): frequency as per ORT recommendations.

G. Non Opioid Treatments That Can and Should Be Utilized If Appropriate to Decrease the Dosage of Addictive (Opiate) Medications

1. Medical Interventions
 - a. Non opioid medications that may aid in chronic pain management.

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- i. NSAIDS, Acetaminophen
 - ii. Tricyclic antidepressants (neuropathic pain)
 - iii. Anti-epileptics (neuropathic pain)
 - iv. Anti-depressants (treating underlying depression)
 - v. Topical medications
 - b. Minimally invasive surgical procedures.
 - i. Nerve blocks, steroid injections
 - ii. Interventional treatments: ablations, restorative injections, stimulators, implantable devices
 - iii. Surgical treatment
 - c. Complementary and alternative treatments
 - i. Massage therapy
 - ii. Acupuncture
- 2. Behavioral Interventions
 - a. Educational groups
 - i. Preventative
 - ii. Support
 - b. Psychotherapy
 - i. Individual counseling
 - ii. Group therapy
 - iii. CBT (Cognitive Behavioral Therapy)
 - iv. EMDR (Eye Movement Desensitization and Reprocessing Therapy)

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- c. Substance abuse treatment
 - i. Residential
 - ii. Outpatient
 - iii. Medication assisted treatment referral
- d. Trauma informed care
 - i. PTSD screening
 - ii. DV screening
 - iii. Child abuse screening

3. Physiotherapy Interventions

- a. Functional Therapies
 - i. Occupational Therapy (OT) and Physical Therapy (PT)
 - ii. Passive Modalities: These include heat, cold, electrical stimulation (TEN's units), Alpha Stim, ultrasound and massage.

4. Patient Lifestyle

- a. Healthy Sleep management
- b. Weight management
- c. Diet and nutrition
- d. Stress reduction
- e. Exercise

H. Opioid Risk Tool: Recommendations for Office Visits and UDS

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		Mark Each That Applies	Items Score Female	Items Score Male
Family History of Substance Abuse	Alcohol		1	3
	Illegal Drugs		2	3
	Prescription Drugs		4	4
Personal History of Substance Abuse	Alcohol		3	3
	Illegal Drugs		4	4
	Prescription Drugs		5	5
Age	Mark the box if 16-45		1	1
History of Preadolescent Sexual Abuse			1	0
Psychological Issues	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia		2	2
	Depression		1	1
	TOTAL			

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1. Total Score Risk Category

Low Risk 0-2

Moderate Risk 4-7

High Risk ≥ 8

2. Recommended Frequency of Chronic Pain Visits and Urine Drug Tests

From ORT Data:

a. Low Risk by ORT (Score 0-3): Low dose less than 40 Morphine Equivalent Dose (MED)/day. Compliant with medication plan. No personal or family history of alcohol and/or drug abuse. No mental health issues.

i. Visit every three to four months

ii. UDS every six months

iii. PDMP every visit

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- b. Moderate Risk by ORT (Score 4-7): Taking between 40 and 120 Morphine Equivalent Dose (MED)/day. Personal or family history of alcohol and/or drug abuse. Personal history of mental health issues.
 - i. Visit every one to two months
 - ii. UDS every three months
 - iii. Pill count per provider recommendation
 - iv. PDMP every visit
- c. High Risk by ORT (Score ≥ 8 or >120 MED): Taking more than 120 Morphine Equivalent Dose (MED)/day. Current alcohol and/or drug abuse or 25 years old and under or significant poorly controlled psychiatric co-morbidity.
 - i. Visit every month
 - ii. UDS every month
 - iii. PDMP every visit
 - iv. Review appropriateness of chronic opiate therapy if aberrant behaviors: Discontinue opioids and refer for addiction management.

3. Monitor opioid dose: Do not exceed 80mg of MED

I. Aberrant Behaviors That Would Require Further Review and Consideration of Discontinuing Opiate Therapy. Consider Referral to Addiction Treatment Program

- 1. Selling prescription drugs
- 2. Forging prescriptions
- 3. Stealing or borrowing drugs
- 4. Frequently losing prescriptions-one lost RX in the lifetime of the pain agreement is allowed if there is a police report.

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5. Aggressive demand for opioids
6. Injection oral/topical drugs
7. Unsanctioned use of opioids
8. Unsanctioned escalation of dosage
9. Failing a drug screen
10. Getting opioids from multiple providers
11. Recurring ER visits for chronic pain

J. Urine Drug Screening

1. Point of Care (POC) urine drug screens-performed in house.
2. Gas-chromotography-performed if positive urine drug screen.
3. Quantitative urine drug screens-used for compliance to prescribed dosages and medications
4. All Chronic Opioid Therapy (COT) patients have at least one quantitative urine drug screen per year. More frequent quantitative screens will be per risk stratification and the provider's discretion. This test will not be covered by the clinic. This test will be an out of pocket expense. The clinic will continue to cover the POC UDS that are completed in house.

K. Confirmatory UDS

1. If a confirmatory UDS demonstrates:
 - a. UDS negative for opioids you prescribe: send urine for confirmatory. Give a two week script and let the patient know we may have to discontinue pain services the patient is no longer eligible for chronic pain services.
 - b. UDS positive for amphetamine or methamphetamine-send for confirmatory results.
 - c. UDS positive for drug (benzodiazepines, opioids, etc) you did not prescribe or have knowledge of, send confirmation.

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2. Discuss results with patient. What barriers are there in staying on the prescribed medication or dosage. If reasonable, the prescriber may consider keeping the patient on the medication with increasing frequency of interactions.
3. If patient will continue to receive medication have a discussion reviewing with the patient the opioid management treatment plan, while discussing 'red flags' such as frequent early refills, escalating dose without consultation with provider or getting opioids from multiple providers.
4. If aberrant behaviors continue following discussion with patient and review of expectation the provider will move forward with discontinuing chronic opioid treatment.
 - a. Prescriber will start a controlled taper and a referral to an addiction specialist or drug treatment specialist.
 - b. The patient will no longer be eligible for chronic pain services at the SCHC or its providers.

L. Managing Patients New to your Practice Already on Opioids:

1. The clinic does not prescribe opiate medications on a patient's first visit. The as-yet-to-be patient's perceived crisis ("I'm running out of my pain meds today") does not become your crisis until you write the first prescription.
2. Follow the same procedure, as reviewed above, for new patients when considering whether to take over management of a new patient's chronic pain medication.
3. Opioid medications will not be prescribed until previous medical records have been received at SCHC and reviewed by provider.

M. Policy for Existing Patients on Chronic Opioid Therapy (COT)

If morphine equivalents per day (MED) exceed the dose limit, the provider will inform the patient about the recommended dose limit and take the following action within 3-6 months of the institution of this policy:

1. The risks of the medication outweigh the benefit, so an opioid taper will be recommended.
2. In general, it is recommended that providers reduce the MED dose by 10%-20% per month until the ceiling limit is reached.

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3. Referral to low cost alternative therapies will be encouraged (yoga, pool therapy, acupuncture, etc).
4. If a patient does not agree to a taper, he or she is welcome to seek care at a different clinic or at a specialized pain clinic (at patient's expense). For both of these options, prescription for opioids will be written by the new provider.

N. Siletz Community Health Clinic Practice Wide Opioid Dose Limit Policy PRIMER

1. DOSE LIMIT: 80mg or morphine equivalents per day

References: Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, Weisner CM, Silverberg MJ, Campbell CI, Psaty BM, Von Korff M. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med* 2010;152(2):85-92.

2. Do Not Exceed 80mg MED-Morphine Equivalence Dose

TABLE 2 Name of Opioid	Morphine equivalent conversion factor (mg)*	Dose equivalence to 80mg of morphine
Buprenorphine (Butrans)	1.8	n/a
Codeine	0.17	500mg
Fentanyl	3.6	30mcg
Hydrocodone	1.0	80mg
Hydromorphone	4.0	20mg
Methadone	---	--- (a-see note below)
Morphine	1.0	80mg
Oxycodone	1.5	60mg
Oxymorphone	3.0	25mg
Tramadol	0.25	400mg (b-see note below)

Do NOT use this guide to convert patients from one opioid to another!!

3. Tramadol dose above 400mg is not recommended.
4. A recent cohort study supports the 120 MED dosing threshold. It "provides the first estimates that directly link receipt of medically prescribed opioids to overdose risk and suggests that overdose risk is elevated in chronic non-cancer pain patients receiving medically prescribed opioids, particularly in patients receiving higher doses". Therefore our clinic will consider 80 MED the maximum for opiate prescribing.

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O. Provider Talking Points for Patients About High Dose Opioid Risks

Limiting the dose of opioid medications is the safest option for the patients. The reasons this is the safest way to treat chronic non-cancer pain with chronic opioid therapy are below. These issues are reviewed annually with the signed Materials Risk Form.

1. This policy affects all patients with chronic non-cancer pain who are treated with chronic opioid therapy.
2. There is little data to suggest that long term use of opioids improves pain or functional outcomes past 3 months.
3. Opioids do not eliminate pain; increased opioid dose does not typically improve pain control, especially past certain doses.
4. The expected improvement of pain with opioids is only 20-30% and some patients do not respond to opioids at all.
5. There is data to suggest that long term use of opioids is associated with several risks including:
 - a. Unintentional overdose, potentially fatal
 - b. Endocrine side effects
 - i. Low testosterone in men
 - ii. Early menopause in women
 - iii. Potential for low bone mass
 - c. Increased risk of falls in elderly
 - d. Decreased cognition
 - e. Somnolence
 - f. Driving hazards
 - g. Worsening of sleep apnea, both central and obstructive
 - h. Hyperalgesia (worsening of pain over time)

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- i. Opioid tolerance
 - j. Opioid physiologic dependence
 - k. Opioid addiction
 - l. Chronic nausea
 - m. Constipation and small bowel obstruction
 - n. Gastroparesis
6. Increased dose of an opioid past 100-150mg of MED is usually associated with worse side effects and no improvement in analgesia.
 7. Two large cohort studies have shown that doses of opioids higher than 100mg of morphine equivalents are associated with a substantially increased risk of unintentional overdose risk (OR 2.8 and OR 8.9) Dunn, Annals of Internal Medicine, 2010; 152:85-92; Gomes, Archives of IM, 2011;171(7): 686-691.
 8. Concurrent use of chronic benzodiazepines and opioids is not advised and can increase risk for unintentional overdose. Benzodiazepines will not be prescribed in patient's that are prescribed chronic opioid therapy.

P. Suggestions for Opioid Tapers

1. Patients are typically able to easily tolerate a 10-20% reduction of their total daily MED over 1-2 weeks.

Q. Functional Pain Scale

1. Are you in Pain?
 - Yes = continue
 - No pain = 0
2. Is pain tolerable?
 - Yes = continue to question 3
 - No = continue to question 4

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3. Does it prevent you from doing activities?

Yes = 2 (pain tolerable)

No = 1 (pain tolerable)

4. Can you use the telephone, watch television or read?

Yes = 3 (pain intolerable)

No = 4

5. Pain is intolerable and can't use telephone, watch television or read.

Yes = 4

Note: Unable to verbally communicate because of pain = 5

Ideally, all patients should reach a 0 to 2 level, preferably 0 to 1. It should be made clear to the respondent that limitations in function only apply if limitations are due to the pain being evaluated.

First determine whether or not pain is present. If subject replies that pain exists, the other two categories in the assessment are evaluated – subjective and functional.

Second is to have the patient rate the pain subjectively as tolerable or intolerable.

Third, if pain is tolerable the next step is to determine whether pain interferes with any activity. If pain is intolerable, the next step is to ascertain whether pain is so intense as to prevent passive activities e.g. using telephone, watching television or reading.

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SILETZ COMMUNITY HEALTH CLINIC	
Program	Medical Staff
Policy	Over-the-Counter Access for Plan B for Women 18 and Older
Date Approved	08/17/07
Date Revised	02/04/12; 11/20/15; 12/21/18; 12/17/21

PART 6E

Over-the-Counter Access for Plan B for Women 18 and Older

I. PURPOSE

Define SCHC policy on emergency contraception.

II. PLAN B IN GENERAL

Plan B, often referred to as "emergency contraception" or the "morning after pill", is a method of preventing pregnancy after a contraceptive fails or after unprotected sex. It is not for routine use.

III. PLAN B AT SCHC

- A. The pharmacy will not dispense emergency contraception as an over-the-counter medication.
- B. SCHC provides emergency contraception by prescription after being triaged by nursing or medical staff.
- C. After reviewing patient chart and circumstances, provider will prescribe if indicated and safe.
- D. Emergency contraception must be started within 72 hours after unprotected intercourse.

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Date Approved	08/13/99
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**PART 6F
Immunizations and Standing Orders**

I. IMMUNIZATIONS

A. Policy

It is the policy of the Siletz Community Health Clinic (SCHC) for licensed nursing staff to give immunizations based on standing orders obtained for Oregon Health Authority in conjunction with Centers for Disease Control (CDC).

B. Parent Requests Immunization

1. If the requestor is a parent desiring vaccination of a child, Oregon Immunization Alert is accessed to assure necessity of immunizations. If immunizations were not administered in Oregon, the parent must obtain immunization records from the previous provider.
2. Immunization records may be in the form of documentation from the school if the child is not an SCHC patient. If the child is currently a patient clinic records serve as sufficient proof of need for vaccination.
3. Only the child’s parent or legal guardian is authorized to request vaccinations for the child if they are under the age of 15.

C. Non-Registered Patient Requests Immunization

If the person requiring immunizations is not currently a patient of SCHC, immunizations may be given, upon completion of the Vaccine Administration Record, and proof of payment (if applicable). This will serve as consent for treatment as a record is not generated.

D. SAFEGUARDS

1. A screening questionnaire must be completed by anyone seeking vaccination that has not been examined by a provider.
2. A provider trained in BLS protocols must be in the clinic whenever immunizations are given to address potential emergencies. Standing orders for all immunizations are kept in a binder in the nursing supervisor’s office labeled “Immunization Action Plan and Standing Orders.” These are updated annually.

See Part 7 Nursing Procedure, Immunization Administrative

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II. STANDING ORDERS

A. Policy

Medical providers at SCHC utilize standing orders to improve accessibility and treatment for patients. Standing orders are reviewed by medical staff annually and approved by Medical Directory each year.

B. Depo Provera Injections

1. Policy

Nursing staff will provide continuation of family planning treatment for female patients who have been started on Depo-Provera by their Primary Care Provider. With standing orders in place, nursing staff (RN or CMA) can provide contraceptive treatment for women who seek an effective way to preventing unexpected pregnancy. The nursing schedule provides additional scheduling options and prevents delaying access to healthcare services for patients.

2. Procedure

- a. Nursing assessment of patient history, last menses and last visit with a provider should be evaluated. Patient will be an established care patient at Siletz Community Health Clinic. Patient must have current prescription for Depo Provera from SCHC provider. Orders are good for 1 year. After 1 year the patient will need a follow up visit with provider to discuss renewal of order.
- b. Weight must be obtained at every visit and documented in the medical record. Review weight and bring to provider attention any weight gain greater than 15 pounds since starting Depo Provera.
- c. Updates of any changes to patient health history and information should be included.
- d. History of any of the following issues is a contraindication for administration of Depo Provera and/or other contraception:
 - i. Confirmed pregnancy
 - ii. Undiagnosed vaginal bleeding
 - iii. History of breast cancer

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- iv. History of stroke
- v. History of blood clots in legs
- vi. History of liver disease
- vii. Allergy to Depo-Provera
- e. If a contraindication has been detected, you must consult with ordering provider prior to administration of Depo Provera. An appointment might be necessary to discuss an alternative means of birth control.
- f. Determine that patient is returning for routine Depo that has been initiated by PCP and has Depo-Provera currently ordered in medication tab of EHR with available refills.
- g. If patients is returning for routine Depo and is not past due, administration of Depo-Provera is recommended. Routine administration of Depo Provera is every 11-13 weeks.
- h. If patient is overdue for Depo injection, patient will complete a pregnancy screening test with negative result prior to receiving injection. A patient is considered overdue if it has been 15 weeks or more since last injection.
- i. If patient's prescription for Depo Provera is out of refills, and patient is in office for injection, discuss situation with provider to obtain a 1 time refill and verbal order to proceed with injection. Make a follow up appointment with provider before patient leaves, to be seen within the next 12 weeks to discuss refill.
- j. Recommend annual screening of chlamydia and gonorrhea for all sexually active women younger than 25 years, as well as older women with risk factors such as new or multiple sex partners, or a sex partner who has a sexually transmitted infection.

www.cdc.gov/std/prevention/screeningreccs.htm
- k. Document the visit using a SOAP note and Standing Orders Module.
- l. Provide patient education
 - i. Possible side effects

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Sudden onset severe headaches, dizziness, fainting, eyesight changes or speech, numbness in an arm or leg, severe pain or swelling in calf, heavy vaginal bleeding, abdominal pain or tenderness requires patient to be seen by provider

ii. Other possible side effects include:

- A) Weight gain with Depo - approximately 10 lbs. per year.
- B) Missed periods
- C) Depression
- D) Acne
- E) Bloating, nausea, breast swelling and breast tenderness.

m. Give patient a reminder card to follow up in 12 weeks for next injection. If the patient is out of refills on Depo Provera set up a provider appointment to discuss and obtain refills

3. Standing Order

The Medical Director approves the administration of Depo Provera by Registered Nurses at Siletz Community Health Clinic during RN only visits, providing they adhere to all guidelines listed above in Depo Provera Policy, Procedure, and Standing Order.

C. Pharyngitis

1. Policy

A Registered Nurse (RN) will follow standing orders in order to provide quality care to patients with frequently encountered medical issues that can be treated and diagnosed with very clear evidence based guidelines.

2. Purpose

This standing order provides guidelines for RNs to follow when providing care to patients who are experiencing pharyngitis (sore throat), a condition that can be diagnosed by collecting patient history and laboratory testing.

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3. Procedure

- a. Any patient that is scheduled for an appointment with an RN for evaluation of a sore throat must be an established patient at the Siletz Community Health Clinic.
- b. If the symptoms indicate the patient may have strep throat, the nursing staff will complete a throat swab and order and obtain a rapid strep screen. If the patient is younger than 18, a Group A Strep culture will be ordered and collected as well. The RNs place the order in the lab module in EHR making sure to utilize the name of the provider they are working with.
- c. Symptoms that are associated with strep throat include but are not limited to (reference: 1):
 - i. Tonsillar erythema
 - ii. Tonsillar enlargement with or without exudate
 - iii. Tender anterior cervical lymph nodes
 - iv. Fever
 - v. Headache
 - vi. Abdominal pain
 - vii. Nausea/vomiting
 - viii. Scarletina rash
- d. If the patient has a positive rapid strep, antibiotics are ordered, if female, obtain LMP, birth control method and possibility of pregnancy. Obtain urine HCG if indicated.
 - i. Treatment for Strep Throat (reference: 1&2):
 - ii. Pediatric
 - A) Children less than 3 years must be seen by provider for evaluation of symptoms.
 - B) Children ≥ 3 years and Adolescents:

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Penicillin Oral: 50 mg/kg once daily or 25 mg/kg twice daily for 10 days; maximum daily dose: 1,000 mg/day (Gerber 2009; Shulman 2012) (reference: 2)

OR-Amoxicillin, oral: 25mg/kg (max=500mg/dose) BID x 10 days.

- iii. Adolescent-Adult: Penicillin V 500mg PO BID x10days or Amoxicillin-Clavulanate 875mg/125mg po BID for 10 days (Sanford Guide).
 - A) If the patient has an allergy to penicillin: Cephalexin 20mg/kg/dose BID (max=500mg/dose) x10 days
 - B) If anaphylactic reaction to PCN: Clindamycin, oral 7mg/kg/dose TID (max=300mg/dose) x10 days
- iv. If the patient has an allergy to Penicillin, Cephalosporin and Clindamycin the RN should consult with provider for proper treatment.
- e. If the patient has a positive rapid strep the RN should provide education to the patient:
 - i. Home remedies: gargle 3-4 times per day, warm salt water
 - ii. OTC medications for discomfort
 - iii. Increase fluids and if needed take medications with food
 - iv. Rest
 - v. Do not share cups and other food items with others and wash hands and cover mouth to prevent others in getting strep.
 - vi. Follow-up in 48-72 hours if signs/symptoms don't resolve.
 - vii. Encourage the patient to discard toothbrush 24 hours after start of antibiotic.
 - viii. Encourage the patient to take all antibiotics as prescribed

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- ix. If on oral contraceptives, discuss possibility of decreased effectiveness of birth control while on antibiotics. Use back up birth control during this period.
- f. If the patient has a negative rapid strep the RN should provide the following education:
 - i. Home remedies: gargle 3-4 times per day, warm salt water
 - ii. OTC medications for discomfort
 - iii. Increase fluids
 - iv. Follow-up in 72 hours if signs/symptoms do not improve or resolve
 - v. If patient is under 18, place order for throat culture and send sample to lab for processing. Notify parent or guardian they will be notified of results in approximately 72 hours. Encourage them to follow up or call if symptoms persist or worsen.
- g. Document visit using SOAP note, lab module, and medication module in Next Gen as indicated. Send encounter to supervising provider to sign off on orders.

4. Standing Order

The Medical Director approves the above orders to be carried out by Registered Nurses at Siletz Community Health Clinic during RN only visits, providing they adhere to all guidelines listed above in Pharyngitis Policy, Procedure, and Standing Order.

D. Pregnancy Test

1. Policy

The RNs will follow standing orders in order to provide quality care to patients with frequently encountered medical issues that can be treated and diagnosed with very clear evidence based guidelines.

2. Purpose

This standing order provides guidelines for RNs to follow when providing care to patients who would like a screening for pregnancy. Pregnancy can be diagnosed

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through laboratory testing. Identifying and initiating care for pregnancy early in gestation will ensure the wellbeing and safety of the mother and her fetus.

3. Procedure

- a. The patient is scheduled for an appointment with an RN to complete a pregnancy test. Patients who are scheduled with RNs must be established patients at Siletz Community Health Clinic.
- b. Patient requests HCG Screen to determine pregnancy status. Nursing will gather information that will include:
 - i. Last menstrual cycle
 - ii. Type of birth control if any
 - iii. Nausea or vomiting
 - iv. Any other relevant symptoms
 - v. Urine sample and CLIA waived urine pregnancy test
- c. If pregnancy test is positive the following should be completed:
 - i. Generate pregnancy confirmation letter in Next Gen. Make sure to include patient's estimated date of delivery.
 - ii. If patient does not have OHP or any other form of insurance the patient will be referred to the Benefits Coordinator.
 - iii. Create a referral to outside OB GYN for Obstetrical care.
 - iv. Place order for prenatal vitamins.
- d. Discuss patient education and answer patient questions:
 - i. Cessation of alcohol
 - ii. Drug use (street) adverse effects to fetus
 - iii. Cessation of tobacco and the harmful effects to fetus
- e. Encourage the patient to follow up with question and concerns.

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4. Standing Order

The Medical Director approves the above orders to be carried out by Registered Nurses at Siletz Community Health Clinic during RN only visits, providing they adhere to all guidelines listed above in Pregnancy test Policy, Procedure, and Standing Order.

E. Dysuria

1. Policy

The RNs will follow standing orders in order to provide quality care to patients with frequently encountered medical issues that can be treated and diagnosed with very clear evidence based guidelines.

2. Purpose

This standing order will provide guidelines for nursing staff to follow when providing care to patients who are experiencing abnormal urinary symptoms that can be diagnosed by collecting the patient's history and through laboratory testing.

3. Procedure

- a. Patients who present with a complaint of abnormal urinary symptoms can be scheduled for an appointment on the nursing schedule if there are no available provider visits and the walk in clinic is unable to serve the patient.
- b. Patients who are scheduled with RNs must be established patients at Siletz Community Health Clinic.
- c. Ask the patient when the symptoms started, if there is a history of similar symptoms, and if there are any concern for STIs. If the patient is female update the women's health tab and obtain LMP.
- d. The nurse will assess the patient for:
 - i. Dysuria
 - ii. Urinary frequency
 - iii. Urinary urgency
 - iv. Post-void residual sensation

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- v. Malodorous urine
 - vi. Vaginal discharge (does it have a color or odor)
 - vii. Fever or chills
 - viii. Hematuria
 - ix. Nausea or vomiting
 - x. Abdominal pain
 - xi. Flank pain
- e. Complicating factors to watch for and identify:
- i. History of pyelonephritis
 - ii. Flank pain
 - iii. Temperature > 101 and/or Rigor
 - iv. Diabetes
 - v. Pregnancy
 - vi. Immunosuppression
 - vii. Underlying UTI disease or renal calculi
 - viii. Recent medical intervention (hospitalization or catheterization)
 - ix. Recurrent UTI's or failure of previous therapy.
- (Referral to provider if the patient presents with this history).
- f. Factors for which a short course therapy may be appropriate at the provider's discretion:
- i. Potential for Sexually Transmitted Infection (STI); partner infected, other genitourinary symptoms. The patient should be seen and STI's ruled out.

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- ii. Recent pyelonephritis or failure of antibiotic treatment. Patients at risk for possible complicated infection.
- g. If determination is made that patient is not complicated, nursing will order labs according to patient's complaints. Consultation with a provider may be utilized by the nurse for additional concerns to ensure proper labs are ordered.
 - i. Lab work to be ordered:
 - A) Urinalysis
 - B) STI Panel (if indicated or requested)
 - ii. Verify any drug allergies with patients and the pharmacy they use.
 - iii. Once in-house urinalysis is complete, consult with PCP if available. If not, consult with the walk-in provider.
 - iv. Carry out any verbal orders received. Send any non-controlled medications electronically to patient's pharmacy of choice.
 - v. Document visit using SOAP template and orders module in Next Gen. Send encounter to PCP for sign off of visit.
- h. Patient Education
 - i. Increase fluid intake
 - ii. Over the counter pills from the patient's local pharmacy can help reduce symptoms (pyridium) or the generic brand name (phenazotyriane-AZO)
 - iii. Urination after sex is not reported to prevent issues, but it is encouraged to help prevent urinary issues
 - iv. The use of whole cranberry products is encouraged, but again not proven to prevent adverse symptoms with UTIs
 - v. If antibiotics are ordered encourage the patient to take all antibiotics as prescribed and follow-up if signs and/or symptoms do not resolve.

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4. Standing Order

The Medical Director approves the above orders to be carried out by Registered Nurses at Siletz Community Health Clinic during RN only visits, providing they adhere to all guidelines listed above in Dysuria Policy, Procedure, and Standing Order.

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**PART 6G
Informed Consent**

I. PURPOSE

Patients have the right to "give, withhold or withdraw consent to have special procedures or treatments done to the extent permitted by law."

II. POLICY

It is the policy of the Siletz Community Health Clinic (SCHC) to obtain written, informed prior consent and to consider the consent as a part of the patient's medical record for non-routine treatment.

III. ELEMENTS OF INFORMED CONSENT

- A. For a written consent to be legally valid, the following conditions must be met:
 - 1. Patient is competent (consent should be obtained from legal guardian/ representative for mentally incapacitated or minors as determined by state law).
 - 2. Consent is obtained voluntarily.
 - 3. Consent is informed, which includes:
 - a. Explanation of plan or treatment
 - b. Explanation of treatment in language understood by the patient
 - c. Need for treatment
 - d. Alternatives
 - e. Risks
 - f. Probability of success
 - g. Prognosis if treatment is not provided

IV. CRITERIA AND MEDICAL PROCEDURES REQUIRING INFORMED CONSENT

- A. The following criteria are used to determine when written informed consent is applicable:
 - 1. Major or minor surgery involving an entry into the body, either through an incision or through a natural body opening.

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2. All procedures involving use of anesthesia, regardless of whether an entry into the body is involved.
 3. Non-surgical procedures, including the administration of medicines that involve more than a slight risk of harm to the patient, or that may cause a change in the body structure of the patient.
 4. Any experimental procedures.
 5. Any taking of photographs, videotaping, digital imaging and other visual records that identify the patient.
 6. All other procedures that the medical staff determines will require a specific explanation to the patient.
- B. The medical staff agrees that the following procedures require written, informed consent:
1. Anesthesia
 2. Aspiration of joints
 3. Biopsies
 4. Circumcision
 5. Injection of joints, bursa or trigger point
 6. Lumbar puncture
 7. Nail care: debridement, avulsion or removal
 8. Implantable birth control devices or IUD insertion or removal
 9. Oral Surgery (see special form)
 10. Paracentesis or Thoracocentesis
 11. Photographs (consent only needed if intended to be used for other purpose)
 12. Oral Surgery (see special form)
 13. Vasectomy

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V. OBTAINING CONSENT

- A. Medical Staff is responsible for ensuring the patient is informed as to the plan of treatment, the need for treatment, alternatives, risks, probability of success and prognosis if treatment is not provided.
- B. The patient is asked to sign a written statement acknowledging his or her consent and it is witnessed by a staff member who can attest to the patient's competence.
- C. Medical Staff affirms that informed consent has been obtained by signing the written consent.
- D. Any doubts over the necessity of obtaining a special consent from the patient for a procedure should be resolved in favor of procuring the consent.
- E. Should a procedure be performed without a written informed consent, the responsible medical staff member should document in the medical chart why a written informed consent was not obtained.

VI. PEER REVIEW

Adherence to this policy is monitored and audited at least annually and through the peer review process.

SILETZ COMMUNITY HEALTH CLINIC	
Program	Medical Staff
Policy	Provision of Employee Uniforms
Date Approved	06/17/99
Date Revised	04/29/02; 05/06/06; 05/02/09; 02/04/12; 11/20/15; 12/21/18; 12/17/21

**PART 6I
Provision of Employee Uniforms**

I. PURPOSE

Employee uniforms convey a sense of unity to clients utilizing a medical facility. More importantly, uniforms represent a means of controlling the spread of infectious material; uniforms can be changed rapidly in the event of unexpected exposure and are easily sanitized.

II. POLICY

It is the policy of the Siletz Community Health Clinic (SCHC) that all personnel with responsibility for direct patient contact wear uniforms rather than street clothing.

III. DISTRIBUTION AND MAINTENANCE OF UNIFORMS

- A. Employees who are responsible for direct patient contact receive two sets of scrubs (each set is comprised of pants, smock and a lab overcoat) once they complete the first 90 days of probationary period. The maximum SCHC will pay for the initial two sets is \$250.
- B. After the initial two sets are purchased by SCHC, the employee can be reimbursed up to \$150 per year for scrub purchases. Follow CTSI standard reimbursement procedure.
- C. Employees will review appropriate catalogs to select proper sizes and styles (uniforms usually take the form of "scrubs" and/or a lab overcoat; variations will be considered on a case-by-case basis).
- D. Employees are responsible for laundering their uniforms and may use the SCHC laundry service or their own facilities. Uniforms contaminated with blood or body fluid are laundered according to infection control policies.

SILETZ COMMUNITY HEALTH CLINIC	
Program	Medical Staff
Policy	Peer Review
Date Approved	05/12/99
Date Revised	07/16/01; 05/06/06; 05/02/09; 02/02/12; 11/20/15; 12/21/18; 12/17/21

**PART 6J
Peer Review**

I. PURPOSE

Creditable organizations maintain active, integrated and organized processes of peer review as part of its quality management and improvement programs. The Siletz Community Health Clinic is committed to standards of care which emulate those of accrediting bodies to include ongoing peer review. Peer review, quality improvement activities and risk management are linked in a systematic way.

II. POLICY

It is the policy of the Siletz Community Health Clinic (SCHC) to provide ongoing, peer-based review and regular monitoring of specified aspects of the care provided to patients at this facility.

III. APPROACH

- A. Peer review is an important role in evaluating the quality of care because unstructured judgements by single reviewers are less reliable than peer-based review in identifying problematic trends in provider care. The following approach to peer review is utilized at SCHC:
 1. Professional health care staff participates in peer review activities. Other staff, both ancillary and administrative, are involved as deemed appropriate by the Medical Director, Administrative Officer/QI Coordinator or Health Director.
 2. At least two health care professionals, one of whom may be a physician or dentist, provide peer based review within their scope of practice for professionals such as nurse practitioners, physician assistants, dental hygienists, podiatrists and optometrists. Peer review is included in employee’s or contracted health provider’s performance evaluation. If a medical staff member in a specific discipline is involved in patient care at the facility, arrangements are made for outside review by a similarly credentialed individual.
 3. Peer review criteria includes aspects of care determined to be important to practitioners and is coordinated by the Executive Committee.
 - a. Each discipline establishes criteria and a monitoring schedule. The Administrative Officer/QI Coordinator provides assistance upon request by providing random lists, assisting Medical Staff to complete review, collecting the review sheets and summarizing results.
 - b. The specific results of peer review activities are reviewed with the medical staff member involved and the supervisor and will be maintained in a confidential file by the Administrative Officer/QI Coordinator. The specific

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Program	Medical Staff
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results are considered in the criteria used for granting continuation of clinical privileges.

- c. An evaluation summary of peer review activities is prepared and signed by the primary reviewer and the medical staff member. If the medical staff member is the Medical Director or Dental Director then the Health Director or designee is included in any discussion and will also sign the evaluation summary.
- d. All evaluation summaries are reviewed by the Executive Committee and evaluated to identify unacceptable or unexpected trends or occurrences that influence patient outcomes. Quality improvement action is reported in the Executive Committee minutes and the quarterly report which is distributed to the Siletz Tribal Council.

SILETZ COMMUNITY HEALTH CLINIC	
Program	Medical Staff
Policy	Medical Procedures
Date Approved	12/21/18
Date Revised	12/17/21

PART 6K Medical Procedures

I. POLICY

- A. To assure patient safety and procedural appropriateness of medical and surgical procedures that are offered to the patient population, medical providers at the Siletz Community Health Clinic (SCHC) have adopted the procedural standards of care as demonstrated in Pfenninger, John, and Grant Fowler. Procedures for Primary Care. Second. St. Louis: Mosby, 2011. In addition, other nationally recognized guidelines may be used. Including, but not limited to:

All medical providers have access to evidenced based guidelines via: <https://www.uptodate.com/home>

- B. Medical and surgical procedures are only performed by licensed professionals who have been granted designated procedural privileges through SCHC credentialing and privileging process.
- C. Access to the surgical/procedure room is restricted to those clinic personnel involved in the patient's treatment. Students in training may be allowed when a patient or parental consent is given and documented in the EHR.

II. PROCEDURE

- A. The following should be considered in determining whether the patient is suitable for the clinic procedure:
1. Obstructive Sleep Apnea (OSA) severity
 2. Coexisting diseases
 3. Review of current medications especially blood thinners
 4. Invasiveness of procedure
 5. Type of anesthesia
 6. Anticipated post-procedural opioid requirements
 7. Adequacy of post discharge care
- B. Appropriate informed consent is signed and documented in the EHR. See Informed Consent section of this policy.

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- C. The provider performing the procedure is responsible for the time-out process prior to beginning the medical/surgical procedure. Staff assisting in the medical/surgical procedure are present during the timeout. The patient's name, DOB, type of procedure, correct surgical/procedural site are discussed and verified. Discussion and verification obtained during the time out process is documented in the EHR.
- D. Staff that are assisting with the procedure have been trained about room set up and specifics for the procedure being performed.
- E. All equipment necessary for performing the procedure is immediately available and functional. Any implantable devices (i.e., IUD or Nexplanon) are prepared prior to the procedures and are available.
- F. When necessary, removal or covering of patient clothing prior to entering the procedure room, to minimize the potential cross-contamination of the surgical environment and SCHC staff.
- G. Surgical drapes and pre-procedure site antisepsis (i.e., betadine) will occur, as appropriate to services provided, patient requirements and needs.
- H. Any surgical procedure that results in the removal of tissue from a patient shall be sent for pathology except for the following:
 - 1. Skin tags
 - 2. Sebaceous cysts
 - 3. Debrided, devitalized tissue
 - 4. Warts
- I. Infection control practices are followed according to the Infection Control policy.
- J. Appropriate PPE will be worn by all providers and staff during any medical procedure. PPE is selected based on type of procedure being performed. In accordance with the Infection Control Policy, clinic staff are to wash their hands consistently prior to donning and after doffing PPE.
- K. Written discharge instructions and education are given to patient, parent or guardian.
- L. Document the following in EHR: Informed consent, procedure note, discharge education and instructions, purpose of visit (POV) and CPT code.

SILETZ COMMUNITY HEALTH CLINIC	
Program	Medical Staff
Policy	Emotional Support Animals
Date Approved	12/21/18
Date Revised	12/17/21

**PART 6L
Emotional Support and Service Animals**

I. DEFINITIONS

A. Emotional Support Animals

Therapy pets, comfort pets or companion animals are not considered service animals under the Americans with Disabilities Act (ADA).

B. Service Animals

An animal that has been professionally trained to do work or perform tasks for an individual with a disability. The task performed by the animal must be directly related to the person’s disability.

II. POLICY REGARDING LETTERS FOR EMOTIONAL SUPPORT ANIMALS

A. In following with the laws and regulations as laid out by the Air Carrier Access Act, the medical providers at the Siletz Community Health Clinic will not be able to write an emotional support animal letter to allow pets to cohabitate with a patient.

B. The following requirements for documentation must be met by a licensed mental health professional and the patient is under his/her professional care. This documentation must state:

1. Patient has a mental or emotional disability that is recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM V). The mental or emotional diagnosis must comply with the current edition of the DSM-V.
2. Patient needs the emotional support or psychiatric support animal as an accommodation for activity.
3. The document must, in detail list how this emotional support animal will be involved in the patient’s treatment plan for the above diagnosis.
4. The individual providing the assessment and the patient under his/her professional care; the license of the healthcare professional; date and type of professional license; and jurisdiction or state in which the license was issued.

SILETZ COMMUNITY HEALTH CLINIC	
Program	Medical Staff
Policy	Emotional Support Animals
Date Approved	12/21/18
Date Revised	12/17/21

III. POLICY FOR PETS IN SCHC

A. Policy

Only working service dogs are permitted at the Siletz Community Health Clinic (SCHC).

B. No-Pet Policy Application

1. This No-Pets policy applies to:
 - a. Pets
 - b. Emotional support animals
 - c. Comfort animals
 - d. Therapy animals

C. Purpose

1. SCHC complies with the Americans with Disabilities Act (ADA) allowing access for all individuals to public places; therefore, working service dogs are allowed to accompany the patients. Service animals are individually trained to perform work or tasks for people with disabilities. Service animals are required to be leashed or harnessed except when performing work or tasks where such tethering would interfere with the dog's ability to perform the work or tasks.
2. Emotional Support Animals (ESA) are dogs whose sole function is to provide comfort or emotional support and do not qualify as service animals under the ADA. Under ADA regulations that became effective on March 15, 2011 there are no protections for emotional support animals in terms of access to public accommodations in public entities. The Department of Justice has stated that emotional support animals are not protected as service animals under these regulations.
3. Patients will be asked to remove pets that are not service animals from the clinic.

IV. POLICY FOR SERVICE ANIMALS

A. Examples

People who are blind or have low vision use dogs to guide and assist them. People who are deaf use dogs to alert them to sounds. People with mobility disabilities use dogs to pull a wheelchair or retrieve items. People with epilepsy use a dog to warn them of an imminent seizure.

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- B. SCHC may ask if the dog is required because of a disability and the work or tasks the dog has been trained to perform.
- C. SCHC cannot require special identification cards for dogs or ask about the patient's disability.
- D. Patients with disabilities who use service dogs cannot be charged extra fees, be isolated from other patrons, or be treated less favorably than other patients; however, the owner of the service dog is responsible for damages caused by his or her service dog.
- E. SCHC will not ask a person with a disability to remove his or her service dog from the premises unless:
 1. The dog is out of control and the dog's owner does not take effective action to control it.
 2. The dog poses a direct threat to the health or safety of others.
 3. The dog poses a sanitation hazard or creates unsanitary conditions for patients or employees.

In these cases, SCHC will give the person with the disability the option to obtain services without having the dog on the premises.

- F. SCHC will not be responsible for the service dog while the patient with a disability is on SCHC's premises. The care or supervision of a service dog is solely the responsibility of his or her owner.
- G. SCHC is not and will not be required to provide care or food for a service dog or provide a special location for it to relieve itself.
- H. SCHC will not use allergies and/or fear of dogs as a valid reason for denying access or refusing service to patients with service animals.
- I. Call the U.S Department of Justice's toll-free ADA Information Line at 800-514-0301 (voice) or 800-514-0383 (TTY) for further information concerning service animals.

SILETZ COMMUNITY HEALTH CLINIC	
Program	Medical Staff
Policy	Patient Notification of Lab and Diagnostic Results
Date Approved	12/21/18
Date Revised	12/17/21

PART 6M
Patient Notification of Lab and Diagnostic Results

I. POLICY

SCHC patients will receive accurate and timely notification of their lab and diagnostic results.

II. PROCEDURE

- A. All laboratory and diagnostic results (in-house and reference) are routed to the ordering and/or follow-up provider via the Electronic Health Record (EHR) or by paper copy.
- B. Patients will be notified within 7-10 business days regarding their laboratory and diagnostic results by any of the listed methods:
 - 1. Phone
 - 2. Letter
 - 3. Follow up appointment to discuss results
- C. Patients are asked to call their medical team or provider if results are not made known to them within the 7-10 day timeframe.

III. DOCUMENTATION

The following is documented in the EHR: Date notified, how patient was notified, what the patient was told and if follow up is indicated.